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# CCLHO

## California Conference of Local Health Officers

Department of Health Services  
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Sacramento, CA 95899-7413  
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Eileen Eastman, Executive Administrator

March xx, 1997

Dear Health Officer:

The Medical Board of California (MBC) instituted a new program in 1994 called "Citation and Fine," whereby they are able to cite and fine physicians who, basically, commit minor infractions of the Medical Practice Act. This program has been recently expanded to include the failure to report communicable diseases and other reportable conditions by physicians in practice. The new regulations, which include failure to report pursuant to the California Code of Regulations, Title 17, Section 2500, became effective on December 24, 1996.

As you are aware from your experience in this area, not all required diseases are reported by all physicians. Some do not seem to be aware that it is their responsibility while others simply feel they do not have the time. We all know of instances where failure to report has resulted in outbreaks of disease or other problems for the community.

For the purposes of developing a uniform approach to the Citation and Fine Program, Guidelines have been developed by CCLHO to assist local Health Officers in understanding and implementing the Program. We have worked with the MBC and with the California Medical Association in their preparation. These Guidelines include definitions, a "decision tree," a proposed report form and a series of letters which may be adapted for use by local health departments. They also include relevant copies of laws and regulations pertinent to the Citation and Fine Program and to reporting diseases and a listing of the reportable diseases and conditions that may be sent with the letter to physicians.

This new program provides a real opportunity for local Health Officers to educate the physicians in their communities about the importance and value of reporting, particularly when faced with such serious and eminently communicable diseases such as *E. coli* 0157:H7 and multiple-drug-resistant (MDR) tuberculosis. These new regulations should be used judiciously to improve the level of communicable disease reporting by physicians. The first steps should focus on educating physicians and developing cooperative relationships between them and local health departments. "Citation and Fine" should not be used as the first course of action against a noncompliant physician but should be used only after reasonable efforts at obtaining compliance have been made.

We hope this information is helpful. If you have any questions about these suggested guidelines, please contact Eileen M. Eastman, Executive Secretary, CCLHO at (916) 654-0023.

Sincerely,

Thomas J. Prendergast, Jr., M.D., M.P.H.  
President

Enclosure

California Conference of Local Health Officers

Guidelines for  
Implementation

of the

*Citation and Fine Program*

of the

Medical Board  
of California

## **INTRODUCTION:**

The Citation and Fine Program of the Medical Board of California (MBC) has been expanded to include the failure to report communicable diseases and other reportable conditions by physicians in practice. This became effective December 24, 1996 when Title 16 of the California Code of Regulations was amended. The MBC did not add the requirement to report communicable diseases and other related statutes directly to the list of "Citable Offenses" but, instead, chose to list these under the offense of "unprofessional conduct." A two-page excerpt from the original regulations package which explains the revisions to Section 1364.11 is included in the Appendix. The new regulations and relevant statutes and other regulations are also included in the Appendix.

It is the clear intent of the Citation and Fine Program to improve the level of communicable disease reporting by physicians. The first steps, however, should focus on the educational outreach efforts and the maintenance of cooperative relationships between local health departments and physicians. "Citation and Fine" is not normally intended as the first course of action against a noncompliant physician but, rather, should be used only after reasonable efforts at obtaining compliance have been attempted.

It is likely that local Health Officers will be the only source of "complaints" to the MBC as no one else in the community will be aware of the failure to report communicable diseases. For this reason, CCLHO has worked with the MBC and the California Medical Association to develop these guidelines to provide a uniform approach to this Program.

By definition, a physician's "failure to report" includes:

1. No report received.
2. Incomplete reporting where all requested information is not provided in the required time frame.
3. Delayed reports not adhering to the required time frame.

## **DECISION TREE:**

Included in these Guidelines is a "decision tree" which may be helpful in suggesting an appropriate progressive course of action to take against physicians who do not report.

The "decision tree" provided separates the emergency diseases (those reportable immediately by telephone) including tuberculosis from others and recommends a course of action. These guidelines have been developed as a framework only and Health Officers should consider each individual situation including the level of cooperation from the physician as well as the consequences to the public health of the community. Title 17, California Code of Regulations, Section 2500 lists the reportable diseases and the urgency of reporting, i.e., whether reportable immediately by telephone, within one (1) working day or within seven (7) working days.

## **REPORT FORM:**

A proposed "report form" giving the name and address of the person filing the report, the name and address of the physician being reported, the violation and the history of non-reporting by the physician and the actions taken including the impact of non-reporting, the actions taken by the local health department to warn/educate the physician and the response by the physician.

Under the "violation" section, information may be included about any previous failure to comply with the reporting requirements and how the failure to report was determined, e.g., a community outbreak, laboratory report, etc.

## **SUGGESTED LETTERS TO BE SENT TO PHYSICIANS:**

A series of three letters to noncompliant physicians is included for your adaptation and use. These letters are merely suggestions to assist you in a progressive course of action. When sending out these letters, it is recommended that you enclose a Confidential Morbidity Report (CMR) form and a copy of the single-page Title 17, California Code of Regulations, Section 2500 list of Reportable Diseases and Conditions. The letters included are:

- 1) Letter to physicians after FIRST failure to report TB or an emergency condition
- 2) Letter to physicians after FIRST failure to report a non-emergency condition
- 3) Letter to physicians after SECOND failure to report a non-emergency condition

Also included is a draft (9/96) copy of the new CMR which is being pilot-tested in several counties and a copy of the single-page listing of Title 17, California Code of Regulations (CCR), Section 2500, Reportable Diseases and Conditions, which will be found on the reverse side of the CMR when it is finalized.

## **TRACKING SYSTEM:**

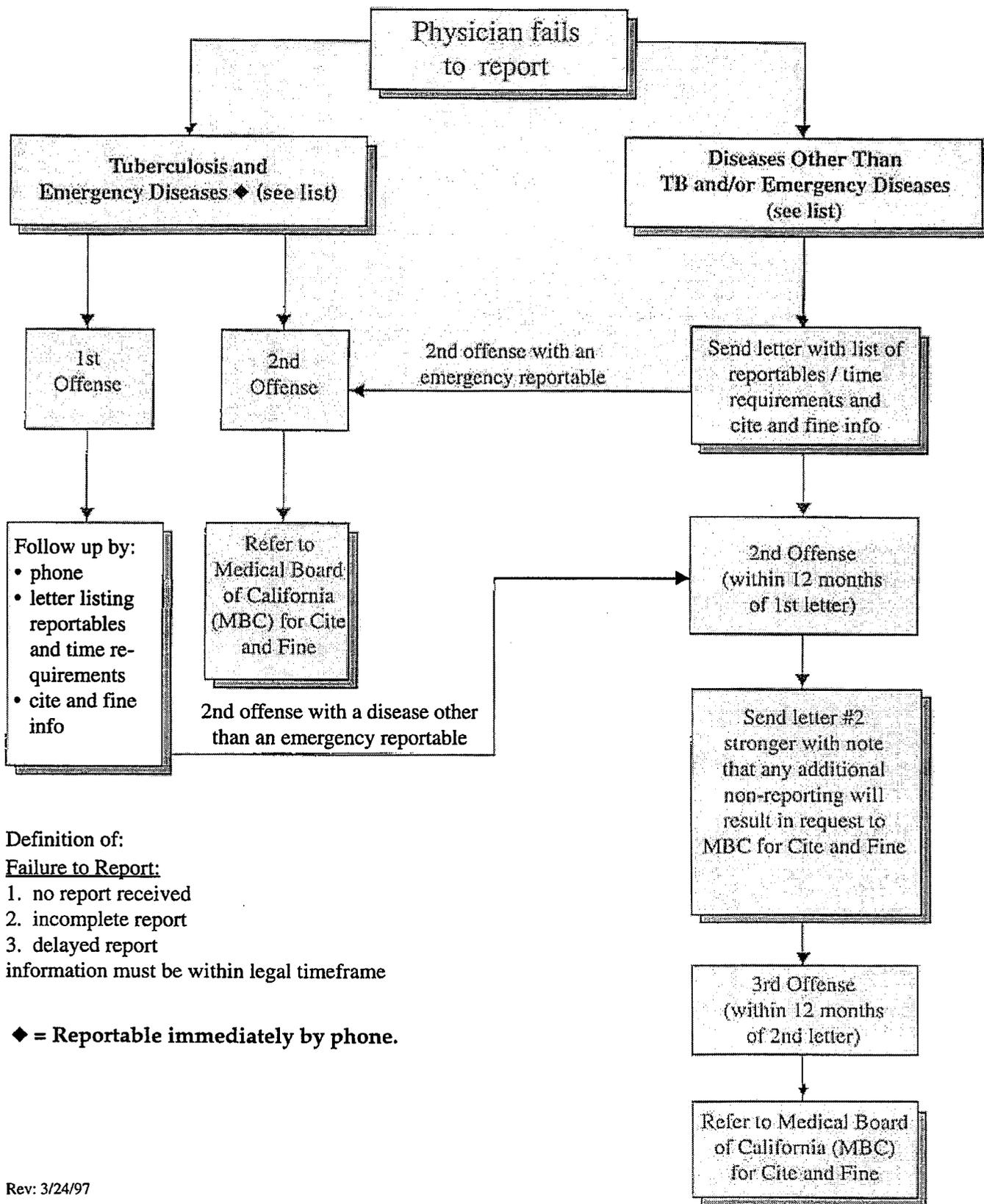
It is also suggested that you establish a tracking system or a simple file of letters sent to physicians who fail to report so you will find it easy to list all previous actions taken when reporting to the MBC.

## **OTHER:**

In order to educate the physicians in your community about the importance and value of reporting, it is also recommended that the Health Officer or Communicable Disease physician personally attend the local Medical Society meetings or other forums where physicians gather. This will provide an opportunity to explain what the local health department does with reports and that reporting is necessary to identify epidemics; interrupt transmission; establish risk factors for disease; track trends in communicable diseases at the local, state and national levels; and develop policies for prevention of disease.

# Citation and Fine

(a decision tree for non-reporting of a reportable disease)



Definition of:

**Failure to Report:**

1. no report received
  2. incomplete report
  3. delayed report
- information must be within legal timeframe

♦ = Reportable immediately by phone.

**Report to the Medical Board of California: Citation and Fine Program  
Failure to Comply with Required Disease Reporting**

❖ **Name of Person Filing Report:** \_\_\_\_\_

Title: \_\_\_\_\_

Jurisdiction: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

❖ **This is to notify the Medical Board of California that the physician named here has failed to comply with required disease reporting:**

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

❖ **Violation:**  No Report  Delayed  Incomplete  Refused on Request  Other

Disease: \_\_\_\_\_ Reportable:  Immediately  Within 1 day  Within 7 days

\_\_\_\_\_

\_\_\_\_\_

❖ **History of non-reporting and action(s) taken:**

Impact of non-reporting: \_\_\_\_\_

\_\_\_\_\_

Actions to warn/educate: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Response by physician: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\*\*\*\*\*

Health Officer: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature)

Send to: **Medical Board of California, Enforcement Program, Central Complaint Unit, Attn: Dave Thornton,  
1426 Howe Avenue, Suite 93, Sacramento, CA 95825**

**Referring Physicians to the Medical Board**

**Letter #1**

**Suggested letter to physicians after FIRST failure to report TB or an emergency condition**

Date

Address

Dear Dr. \_\_\_\_\_:

Your patient, \_\_\_\_\_, has \_\_\_\_\_, a communicable disease that is reportable to the health department by California law and regulation. Please provide the information requested on the enclosed form.

Many physicians are unaware of the laws and regulations of the State of California requiring that certain communicable diseases be reported to the local health department. Other physicians assume it is the laboratory's responsibility to report. California Health and Safety Code Section 120250 and California Code of Regulations, Title 17, Section 2500 clearly state that the physician is required to report the listed communicable diseases. Patient consent is not required for reporting purposes. All states in the United States have similar laws. The information generated by these requirements is used to identify epidemics; interrupt transmission; establish risk factors for disease; track trends in communicable diseases at the local, state and national levels; and develop policies for prevention of disease.

In December 1996, the Medical Board of California adopted a procedure for citing and fining physicians who fail to adhere to the reporting laws and regulations of the State of California. Failure to report this disease precludes any intervention by local public health to prevent transmission to others. Because of the public health significance of such actions, continued failure to report on your part in a complete and timely fashion as specified in the laws and regulations will result in a referral to the Medical Board. Such referral could result in a citation and fine from \$100 to \$2500. Citations issued shall be disclosed to any inquiring member of the public. The citation shall be purged five years from date of issuance.

I am enclosing materials that provide additional information on reporting and how to report to \_\_\_\_\_ Health Department. Please note that it is your responsibility to initiate reports to the health department and that there are time frames for reporting (for example, meningococcal infections must be reported immediately by telephone, and tuberculosis is to be reported within one working day of the identification of a case or a suspected case). Please call me at \_\_\_ - \_\_\_ if you have any questions about these materials.

Sincerely,

Enclosure

**Referring Physicians to the Medical Board**  
**Letter #2**  
**Suggested letter to physicians after FIRST failure to report a non-emergency condition**

Date

Address

Dear Dr. \_\_\_\_\_:

Your patient, \_\_\_\_\_, has \_\_\_\_\_, a communicable disease that is reportable to the health department by California law and regulation. Please provide the information requested on the enclosed form.

Many physicians are unaware of the laws and regulations of the State of California requiring that certain communicable diseases be reported to the local health department. Other physicians assume it is the laboratory's responsibility to report. California Health and Safety Code Section 120250 and California Code of Regulations, Title 17, Section 2500 clearly state that the physician is required to report the listed communicable diseases. Patient consent is not required for reporting purposes. All states in the United States have similar laws. The information generated by these requirements is used to identify epidemics; interrupt transmission; establish risk factors for disease; track trends in communicable diseases at the local, state and national levels; and develop policies for prevention of disease.

In December 1996, the Medical Board of California adopted a procedure for citing and fining physicians who fail to adhere to the reporting laws and regulations of the State of California. Local health departments may refer physicians to the Medical Board for failure to report these diseases, for incomplete reporting, and for lack of timeliness in reporting. Such referral could result in a citation and fine from \$100 to \$2500. Citations issued shall be disclosed to any inquiring member of the public. The citation shall be purged five years from date of issuance.

I am enclosing materials that provide additional information on reporting and how to report to \_\_\_\_\_ Health Department. Please note that it is your responsibility to initiate reports to the health department and that there are time frames for reporting (for example, meningococcal infections must be reported immediately by telephone, and tuberculosis is to be reported within one working day of the identification of a case or a suspected case). Please call me at \_\_\_\_-\_\_\_\_ if you have any questions about these materials.

Sincerely,

Enclosure

**Referring Physicians to the Medical Board  
Letter #3  
Suggested letter to physicians after SECOND failure to report a non-emergency condition**

Date

Address

Dear Dr. \_\_\_\_\_ :

Your patient, \_\_\_\_\_, has \_\_\_\_\_, a communicable disease that is reportable to the health department by California law and regulation. Please provide the information requested on the enclosed form.

As I explained in a previous letter to you, California laws and regulations (contained in California Health and Safety Code Section 120250 and California Code of Regulations, Title 17, Section 2500) require that physicians report certain communicable diseases to the local health department. This requirement is independent of any reporting by laboratories. Patient consent is not required for reporting purposes. The information generated by these requirements is used to identify epidemics; interrupt transmission; establish risk factors for disease; track trends in communicable diseases at the local, state and national levels; and develop policies for prevention of disease.

In December 1996, the Medical Board of California adopted a procedure for citing and fining physicians who fail to adhere to the reporting laws and regulations of the State of California. Continued failure to report in a complete and timely fashion as specified in the laws and regulations will result in a referral to the Medical Board. Such referral could result in a citation and fine from \$100 to \$2500. Citations issued shall be disclosed to any inquiring member of the public. The citation shall be purged five years from date of issuance.

I am again enclosing materials that provide additional information on reporting and how to report to \_\_\_\_\_ Health Department. Please note that it is your responsibility to initiate reports to the health department. Please call me at \_\_\_\_ - \_\_\_\_ if you have any questions about these materials.

Sincerely,

Enclosure



**Title 17, California Code of Regulations (CCR), §2500, §2593, §2641–2643, and §2800–2812  
Reportable Diseases and Conditions\***

**§2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.**

- **§2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or conditions listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§2500(c)** The administrator of each health facility, clinic or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local health officer.
- **§2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

**URGENCY REPORTING REQUIREMENTS [17 CCR §2500 (h) (i)]**

- ☎ = Report **immediately** by telephone (designated by a ♦ in regulations).
- † = Report **immediately** by telephone when **two or more cases** or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations).
- FAX ☎ ☒ = Report by FAX, telephone, or mail **within one working day of identification** (designated by a + in regulations).
- ☒ = All other diseases/conditions should be reported by FAX, telephone, or mail within seven calendar days of identification.

**REPORTABLE COMMUNICABLE DISEASES §2500(j)(1), §2641–2643**

- |   |  |
|---|--|
| <p>Acquired Immune Deficiency Syndrome (AIDS)<br/>(HIV infection only: see "Human Immunodeficiency Virus")</p> <p>FAX ☎ ☒ Amebiasis</p> <p>FAX ☎ ☒ Anisakiasis</p> <p>☎ Anthrax</p> <p>FAX ☎ ☒ Babesiosis</p> <p>☎ Botulism (Infant, Foodborne, Wound)</p> <p>☎ Brucellosis</p> <p>FAX ☎ ☒ Campylobacteriosis</p> <p>Chancroid</p> <p>Chlamydial Infections</p> <p>Cholera</p> <p>☎ Ciguatera Fish Poisoning</p> <p>Coccidioidomycosis</p> <p>FAX ☎ ☒ Colorado Tick Fever</p> <p>FAX ☎ ☒ Conjunctivitis, Acute Infectious of the Newborn, Specify Etiology</p> <p>FAX ☎ ☒ Cryptosporidiosis</p> <p>Cysticercosis</p> <p>☎ Dengue</p> <p>☎ Diarrhea of the Newborn, Outbreaks</p> <p>☎ Diphtheria</p> <p>☎ Domoic Acid Poisoning (Amnesic Shellfish Poisoning)</p> <p>Echinococcosis (Hydatid Disease)</p> <p>Ehrlichiosis</p> <p>FAX ☎ ☒ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic</p> <p>☎ <i>Escherichia coli</i> O157:H7 Infection</p> <p>† FAX ☎ ☒ Foodborne Disease</p> <p>Giardiasis</p> <p>Gonococcal Infections</p> <p>FAX ☎ ☒ <i>Haemophilus influenzae</i> Invasive Disease</p> <p>☎ Hantavirus Infections</p> <p>☎ Hemolytic Uremic Syndrome</p> <p>Hepatitis, Viral</p> <p>FAX ☎ ☒ Hepatitis A</p> <p>Hepatitis B (specify acute case or chronic)</p> <p>Hepatitis C (specify acute case or chronic)</p> <p>Hepatitis D (Delta)</p> <p>Hepatitis, other, acute</p> <p>Human Immunodeficiency Virus (HIV) (§2641–2643): reporting is NON-NAME (see <a href="http://www.dhs.ca.gov/aids">www.dhs.ca.gov/aids</a>)</p> <p>Kawasaki Syndrome (Mucocutaneous Lymph Node Syndrome)</p> <p>Legionellosis</p> <p>Leprosy (Hansen Disease)</p> <p>Leptospirosis</p> <p>FAX ☎ ☒ Listeriosis</p> <p>Lyme Disease</p> <p>FAX ☎ ☒ Lymphocytic Choriomeningitis</p> <p>FAX ☎ ☒ Malaria</p> <p>FAX ☎ ☒ Measles (Rubeola)</p> <p>FAX ☎ ☒ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic</p> <p>☎ Meningococcal Infections</p> <p>Mumps</p> <p>Non-Gonococcal Urethritis (Excluding Laboratory Confirmed Chlamydial Infections)</p> | <p>☎ Paralytic Shellfish Poisoning</p> <p>Pelvic Inflammatory Disease (PID)</p> <p>FAX ☎ ☒ Pertussis (Whooping Cough)</p> <p>☎ Plague, Human or Animal</p> <p>FAX ☎ ☒ Poliomyelitis, Paralytic</p> <p>FAX ☎ ☒ Psittacosis</p> <p>FAX ☎ ☒ Q Fever</p> <p>☎ Rabies, Human or Animal</p> <p>FAX ☎ ☒ Relapsing Fever</p> <p>Reye Syndrome</p> <p>Rheumatic Fever, Acute</p> <p>Rocky Mountain Spotted Fever</p> <p>Rubella (German Measles)</p> <p>Rubella Syndrome, Congenital</p> <p>FAX ☎ ☒ Salmonellosis (Other than Typhoid Fever)</p> <p>☎ Scombroid Fish Poisoning</p> <p>☎ Severe Acute Respiratory Syndrome (SARS)</p> <p>FAX ☎ ☒ Shigellosis</p> <p>☎ Smallpox (Variola)</p> <p>FAX ☎ ☒ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)</p> <p>FAX ☎ ☒ Swimmer's Itch (Schistosomal Dermatitis)</p> <p>FAX ☎ ☒ Syphilis</p> <p>Tetanus</p> <p>Toxic Shock Syndrome</p> <p>Toxoplasmosis</p> <p>FAX ☎ ☒ Trichinosis</p> <p>FAX ☎ ☒ Tuberculosis</p> <p>☎ Tularemia</p> <p>FAX ☎ ☒ Typhoid Fever, Cases and Carriers</p> <p>Typhus Fever</p> <p>☎ Varicella (deaths only)</p> <p>FAX ☎ ☒ <i>Vibrio</i> Infections</p> <p>☎ Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa and Marburg viruses)</p> <p>FAX ☎ ☒ Water-associated Disease</p> <p>FAX ☎ ☒ West Nile Virus (WNV) Infection</p> <p>☎ Yellow Fever</p> <p>FAX ☎ ☒ Yersiniosis</p> <p>☎ <b>OCCURRENCE of ANY UNUSUAL DISEASE</b></p> <p>☎ <b>OUTBREAKS of ANY DISEASE</b> (Including diseases not listed in §2500). Specify if institutional and/or open community.</p> |
|---|--|

**REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)**

Disorders Characterized by Lapses of Consciousness  
Cancer (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the cervix)  
Pesticide-related illness or injury (known or suspected cases)\*\*

**LOCALLY REPORTABLE DISEASES (If Applicable):**

\* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health and Safety Code §120295) and is a citable offense under the Medical Board of California's Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).  
\*\* Failure to report is a citable offense and subject to civil penalty (§250) (Health and Safety Code §105200).

**Title 17, California Code of Regulations (CCR), §2500, §2593, §2641–2643, and §2800–2812  
Reportable Diseases and Conditions\***

**§2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.**

- **§2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or conditions listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§2500(c)** The administrator of each health facility, clinic or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local health officer.
- **§2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

**URGENCY REPORTING REQUIREMENTS [17 CCR §2500 (h) (i)]**

- ☎ = Report **immediately** by **telephone** (designated by a ♦ in regulations).
- † = Report **immediately** by **telephone** when **two or more cases** or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations).
- FAX ☎ ☒ = Report by **FAX, telephone, or mail within one working day of identification** (designated by a + in regulations).
- ☒ = All other diseases/conditions should be reported by FAX, telephone, or mail within seven calendar days of identification.

**REPORTABLE COMMUNICABLE DISEASES §2500(j)(1), §2641–2643**

Acquired Immune Deficiency Syndrome (AIDS) (HIV infection only: see "Human Immunodeficiency Virus")		☎ Paralytic Shellfish Poisoning
FAX ☎ ☒ Amebiasis		☎ Pelvic Inflammatory Disease (PID)
FAX ☎ ☒ Anisakiasis		FAX ☎ ☒ Pertussis (Whooping Cough)
		☎ Plague, Human or Animal
		FAX ☎ ☒ Poliomyelitis, Paralytic
FAX ☎ ☒ Anthrax		FAX ☎ ☒ Psittacosis
FAX ☎ ☒ Babesiosis		FAX ☎ ☒ Q Fever
☎ Botulism (Infant, Foodborne, Wound)		☎ Rabies, Human or Animal
☎ Brucellosis		FAX ☎ ☒ Relapsing Fever
FAX ☎ ☒ Campylobacteriosis		☎ Reye Syndrome
Chancroid		☎ Rheumatic Fever, Acute
Chlamydial Infections		☎ Rocky Mountain Spotted Fever
Cholera		☎ Rubella (German Measles)
☎ Ciguatera Fish Poisoning		☎ Rubella Syndrome, Congenital
☎ Coccidioidomycosis		FAX ☎ ☒ Salmonellosis (Other than Typhoid Fever)
FAX ☎ ☒ Colorado Tick Fever		☎ Scombroid Fish Poisoning
FAX ☎ ☒ Conjunctivitis, Acute Infectious of the Newborn, Specify Etiology		☎ Severe Acute Respiratory Syndrome (SARS)
FAX ☎ ☒ Cryptosporidiosis		FAX ☎ ☒ Shigellosis
Cysticercosis		☎ Smallpox (Variola)
☎ Dengue		FAX ☎ ☒ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
☎ Diarrhea of the Newborn, Outbreaks		FAX ☎ ☒ Swimmer's Itch (Schistosomal Dermatitis)
☎ Diphtheria		FAX ☎ ☒ Syphilis
☎ Domoic Acid Poisoning (Amnesic Shellfish Poisoning)		☎ Tetanus
☎ Echinococcosis (Hydatid Disease)		☎ Toxic Shock Syndrome
Ehrlichiosis		☎ Toxoplasmosis
FAX ☎ ☒ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic		FAX ☎ ☒ Trichinosis
☎ <i>Escherichia coli</i> O157:H7 Infection		FAX ☎ ☒ Tuberculosis
† FAX ☎ ☒ Foodborne Disease		☎ Tularemia
Giardiasis		FAX ☎ ☒ Typhoid Fever, Cases and Carriers
Gonococcal Infections		☎ Typhus Fever
FAX ☎ ☒ <i>Haemophilus influenzae</i> Invasive Disease		☎ Varicella (deaths only)
☎ Hantavirus Infections		FAX ☎ ☒ <i>Vibrio</i> Infections
☎ Hemolytic Uremic Syndrome		☎ Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa and Marburg viruses)
Hepatitis, Viral		FAX ☎ ☒ Water-associated Disease
FAX ☎ ☒ Hepatitis A		FAX ☎ ☒ West Nile Virus (WNV) Infection
Hepatitis B (specify acute case or chronic)		☎ Yellow Fever
Hepatitis C (specify acute case or chronic)		FAX ☎ ☒ Yersiniosis
Hepatitis D (Delta)		☎ OCCURRENCE of ANY UNUSUAL DISEASE
Hepatitis, other, acute		☎ OUTBREAKS of ANY DISEASE (Including diseases not listed in §2500). Specify if institutional and/or open community.
Human Immunodeficiency Virus (HIV) (§2641–2643): reporting is NON-NAME (see <a href="http://www.dhs.ca.gov/aids">www.dhs.ca.gov/aids</a> )		
Kawasaki Syndrome (Mucocutaneous Lymph Node Syndrome)		
Legionellosis		
Leprosy (Hansen Disease)		
Leptospirosis		
FAX ☎ ☒ Listeriosis		
Lyme Disease		
FAX ☎ ☒ Lymphocytic Choriomeningitis		
FAX ☎ ☒ Malaria		
FAX ☎ ☒ Measles (Rubeola)		
FAX ☎ ☒ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic		
☎ Meningococcal Infections		
Mumps		
Non-Gonococcal Urethritis (Excluding Laboratory Confirmed Chlamydial Infections)		

**REPORTABLE NONCOMMUNICABLE DISEASES AND  
CONDITIONS §2800–2812 and §2593(b)**

Disorders Characterized by Lapses of Consciousness  
Cancer (except (1) basal and squamous skin cancer unless occurring on  
genitalia, and (2) carcinoma in-situ and CIN III of the cervix)  
Pesticide-related illness or injury (known or suspected cases)\*\*

**LOCALLY REPORTABLE DISEASES (If Applicable):**

\* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health and Safety Code §120295) and is a citable offense under the Medical Board of California's Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).

\*\* Failure to report is a citable offense and subject to civil penalty (§250) (Health and Safety Code §105200).

**APPENDICES:**

- A) The December 26, 1996 transmittal letter and amended regulations of Title 16 of the California Code of Regulations.
- B) A two-page excerpt from the original regulations package which explains the revisions to Section 1364.11.
- C) Business and Professions Code Section 2234, "Unprofessional Conduct."
- D) Health and Safety Code Sections 102795, 102800, 120250, 121362 and 121363.
- E) California Code of Regulations, Title 17, Section 2500.



MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
ENFORCEMENT PROGRAM  
1426 HOWE AVENUE, SUITE #93  
SACRAMENTO, CA 95825  
(916) 263-1647

JOHN C. LANCARA  
Chief of Enforcement

December 26, 1996

Eileen Eastman, Executive Secretary  
California Conference of Local Health Officers  
Department of Health Services  
P. O. Box 942732  
Sacramento, CA 94234-7320

Dear Eileen:

Enclosed is a copy of the changes impacting Sections 1364.10, 1364.11 and 1364.15 of Division 13 of Title 16 of the California Code of Regulations concerning the Board's Citation and Fine Program. They became effective on December 24, 1996.

If you have questions or would like further information, please contact me at (916) 263-1647.

Sincerely,

APRIL ROHDE

Staff Services Analyst  
Citation and Fine Program

Enclosure

The Medical Board of California of the Department of Consumer Affairs hereby amends Sections 1364.10 and 1364.11, and adopts Section 1364.15 in Division 13 of Title 16 of the California Code of Regulations to read as follows:

1364.10. Citations and Fines.

(a) For purposes of this article, "board official" shall mean the chief, deputy chief or ~~area supervisor~~ supervising investigator II of the enforcement program of the board or the program manager of the Division of Licensing of the board.

(b) A board official is authorized to determine when and against whom a citation will be issued and to issue citations containing orders of abatement and fines for violations by a licensed physician or surgeon of the statutes referred to in Section 1364.11.

(c) A citation shall be issued whenever any fine is levied or any order of abatement is issued. Each citation shall be in writing and shall describe with particularity the nature and facts of the violation, including a reference to the statute or regulations alleged to have been violated. The citation shall be served upon the individual personally or by certified mail.

NOTE: Authority cited: Sections 125.9, 148 and 2018, Business and Professions Code.  
Reference: Sections 125.9 and 148, Business and Professions Code.

1364.11. Citable Offenses.

The amount of any fine to be levied by a board official shall take into consideration the factors listed in subdivision (b)(3) of Section 125.9 of the code and shall be within the range set forth below.

(a) A board official may issue a citation under Section 1364.10 for a violation of the provisions listed in this section. The fine for a violation of the following code sections shall be from \$100 to \$2500:

- (1) Business and Professions Code Section 119
- (2) Business and Professions Code Section 125
- (3) Business and Professions Code Section 125.6
- (4) Business and Professions Code Section 475(a)(1)
- (5) Business and Professions Code Section 496
- (6) Business and Professions Code Section 650

- (7) Business and Professions Code Section 650.1
- (8) Business and Professions Code Section 651
- (9) Business and Professions Code Section 654
- (10) Business and Professions Code Section 654.1
- (11) Business and Professions Code Section 654.2
- (12) Business and Professions Code Section 655.5
- (13) Business and Professions Code Section 655.6
- (14) Business and Professions Code Section 702
- (15) Business and Professions Code Section 730
- (16) Business and Professions Code Section 732
- ~~(16)~~ (17) Business and Professions Code Section 810
- ~~(17)~~ (18) Business and Professions Code Section 2021
- ~~(18)~~ (19) Business and Professions Code Section 2052
- ~~(19)~~ (20) Business and Professions Code Section 2054
- ~~(20)~~ (21) Business and Professions Code Section 2065
- ~~(21)~~ (22) Business and Professions Code Section 2066
- ~~(22)~~ (23) Business and Professions Code Section 2072
- ~~(23)~~ (24) Business and Professions Code Section 2073
- ~~(24)~~ (25) Business and Professions Code Section 2097
- (26) Business and Professions Code Section 2221.1
- (27) Business and Professions Code Section 2234 only for a violation of one of the following:
  - (A) Business and Professions Code Section 802(b)
  - (B) Business and Professions Code Section 802.1
  - (C) Health and Safety Code Section 102795
  - (D) Health and Safety Code Section 102800
  - (E) Health and Safety Code Section 120250
  - (F) Health and Safety Code Section 121362
  - (G) Health and Safety Code Section 121363
  - (H) Title 17 California Code of Regulations Section 2500
- (28) Business and Professions Code Section 2236

- ~~(25)~~ (29) Business and Professions Code Section 2238
- ~~(30)~~ (30) Business and Professions Code Section 2243
- ~~(26)~~ (31) Business and Professions Code Section 2250
- ~~(27)~~ (32) Business and Professions Code Section 2255
- ~~(28)~~ (33) Business and Professions Code Section 2256
- ~~(29)~~ (34) Business and Professions Code Section 2257
- ~~(30)~~ (35) Business and Professions Code Section 2259
- ~~(31)~~ (36) Business and Professions Code Section 2261
- ~~(32)~~ (37) Business and Professions Code Section 2262
- ~~(33)~~ (38) Business and Professions Code Section 2263
- ~~(34)~~ (39) Business and Professions Code Section 2264
- ~~(35)~~ (40) Business and Professions Code Section 2265
- ~~(41)~~ (41) Business and Professions Code Section 2266
- ~~(36)~~ (42) Business and Professions Code Section 2271
- ~~(37)~~ (43) Business and Professions Code Section 2272
- ~~(38)~~ (44) Business and Professions Code Section 2273
- ~~(39)~~ (45) Business and Professions Code Section 2274
- ~~(40)~~ (46) Business and Professions Code Section 2285
- ~~(41)~~ (47) Business and Professions Code Section 2286
- ~~(42)~~ (48) Business and Professions Code Section 2305
- ~~(43)~~ (49) Business and Professions Code Section 2400
- ~~(44)~~ (50) Business and Professions Code Section 2415
- ~~(45)~~ (51) Business and Professions Code Section 2439
- ~~(46)~~ (52) Business and Professions Code Section 2440
- ~~(47)~~ (53) Business and Professions Code Section 2441
- ~~(48)~~ (54) Business and Professions Code Section 2630
- ~~(49)~~ (55) Business and Professions Code Section 3516
- ~~(50)~~ (56) Business and Professions Code Section 4231
- ~~(51)~~ (57) Business and Professions Code Section 4232
- ~~(52)~~ (58) Business and Professions Code Section 17500
- ~~(53)~~ (59) Title 16 California Code of Regulations Section 1338(c)

- ~~(54) (60) Health and Safety Code Section 123110(a)(b)~~
- ~~(55) Health and Safety Code Section 10203~~
- ~~(56) Health and Safety Code Section 10204~~
- ~~(57) Health and Safety Code Section 11167~~
- ~~(58) Health and Safety Code Section 11168~~
- ~~(59) Health and Safety Code Section 11190~~
- ~~(60) Health and Safety Code Section 11191~~
- (61) Penal Code Section 11166

(b) In his or her discretion, a board official may issue a citation with an order of abatement without levying a fine for the first violation of any provision set forth above.

NOTE: Authority cited: Sections 125.9, 148 and 2018, Business and Professions Code.

Reference: Sections 125.9, ~~and 148,~~ <sup>and 2234,</sup> Business and Professions Code.

1364.15. Public Disclosure; Record Retention.

Every citation that is issued pursuant to this article shall be disclosed to an inquiring member of the public. It shall be purged five (5) years from the date of issuance. A citation that has been withdrawn or dismissed shall be purged immediately upon being withdrawn or dismissed.

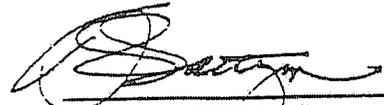
NOTE: Authority cited: Sections 125.9, 148 and 2018, Business and Professions Code.

Reference: Sections 125.9 and 148, Business and Professions Code.

DATED: August 19, 1996

  
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 RON JOSEPH, Executive Director  
 Medical Board of California

Approved this 9 day of OCTOBER, 1996.

  
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 RAY SAATJIAN, Deputy Director  
 Department of Consumer Affairs

## EXCERPT FROM ORIGINAL REGULATIONS PACKAGE, DATED JULY 26, 1996

Section 1364.11 lists the code sections for which the board could issue a citation for a violation. The board is proposing to add more citable offenses, and to make technical updates in the code section numbers. The added sections will improve the board's ability to ensure efficient public health, safety, and welfare by authorizing an administrative citation for these less egregious violations rather than pursuing prosecution through the administrative hearing process. Without the inclusion of the sections proposed in this amendment, the board would have no alternative but to close the case with no meaningful public protection or action, or pursue an administrative accusation for these minor violations. By adding the following sections as citable offenses, the board has the ability to use this enforcement option depending upon the circumstances of the violation:

- Add Business and Professions Code Section 732 - Refund of overpayments. This situation typically involves a partial or full payment made by the patient to the physician where the physician is subsequently paid in full by the insurance company. This section requires refund of that duplicate payment within certain time frames. In dealing with violations of this nature, it is the position of the board to assist the consumer in obtaining a refund of any monies owed to them. As with certain other minor violations, the board attempts to resolve complaints of failure to refund overpayment without the necessity of sending the case to investigation. In that endeavor, the use of a citation and fine with abatement would be a very effective tool.
- Add Business and Professions Code Section 2221.1 – Failure to Follow Infection Control Guidelines for Blood-Borne Diseases. The board has had increasing contact with state and local health agencies regarding the failure of physicians to follow proper protocol and guidelines to protect patients from the transmission of blood-borne infectious diseases from patient to patient or physician to patient. The addition of this section as a citable offense would provide the board with a method of dealing with these transgressions in an efficient and effective manner.
- Add Business and Professions Code Section 2234 – Unprofessional Conduct. The board is seeking the addition of this section to address ongoing problems of issuing citations for certain offenses not covered by the Medical Practice Act. For example, the Department of Health Services has statutes and regulations which impose a duty on health care providers (physicians are included in the list of providers) to notify local health authorities whenever they treat a patient that has certain communicable diseases (not blood-borne) such as tuberculosis. The issuing of a citation and fine provides an excellent means of effecting action in this area. The laws governing this reporting further state the health care provider is to instruct the patient and/or family on precautionary measures to be taken for preventing the spread of the disease. The board's medical consultants confirm that failure to make these reports is unprofessional conduct, therefore, a physician can be cited for Business and Professions Code Section 2234 with reference to the appropriate statute for regulation violated.

The board does not have current statistics from the local Health Officers on noncompliance with the reporting requirements for Blood-Borne diseases and communicable diseases. The board is informed by the local Health Officers that the noncompliance rate is on the rise and they have been informed by local prosecutors that these cases do not lend themselves to criminal prosecution. Therefore, the addition of these sections as citable offenses would provide the board with an effective option of dealing the less egregious violations.

The proposed subsections of Business and Professions Code Section 2234 are as follows:

- Add Business and Professions Code Section 802(b) (as a subsection of B&P 2234) – Failure of a physician to report malpractice settlements of \$30,000 or more when they have no malpractice insurance. This section carries criminal sanctions against the physician for failure to report settlements as required. The criminal sanctions are enhanced for knowing and intentional failure to report, or a conspiracy with another not to report the malpractice settlement. The addition of this section to the citation and fine regulations would give the board another option should the facts and circumstances of the case deem a citation an appropriate disposition. This has been recommended by the Attorney General's Office who agrees that many of these violations do not warrant an administrative accusation.
- Add Business and Professions Code Section 802.1 (as a subsection of B&P 2234) – Failure of a physician to report being charged and/or convicted of a felony. This section requires physicians to report to the Medical Board when they have been charged with, or convicted of a felony. Currently, a violation of this section is a criminal offense punishable by a fine of \$5,000. Adding this section to the list of citable offenses would give the board the option of issuing an administration citation in lieu of filing criminal charges.
- Health and Safety Code Sections 10203 and 10204 were already included in this regulation. The board is making a nonsubstantive, technical change, by moving these section in the regulation from the former (a)(55) and (a)(56) to the new subsections (a)(27)(C) and (D) (subsections of B&P 2234) so that they will be listed in numerical order.
- Add Health and Safety Code Sections 120250, duty to report persons with any infectious, contagious, or communicable disease to local health officer; 121362, failure to report persons with active tuberculosis; 121363, the duty to examine or refer for examination household contacts of persons with active tuberculosis; and, Title 17, Article 1, Section 2500, Code of Regulation, reporting requirements to local health officers, (as subsections to B&P 2234) – The board has had increasing contact with state and local health agencies regarding the failure of physicians who treat persons with infectious, contagious or communicable disease, or active tuberculosis to report these incidents to the local health officer. The addition of these sections as citable offenses would provide the board with a method of dealing with these violations in an efficient and effective manner.

## APPENDIX C

### BUSINESS AND PROFESSIONS CODE

#### 2234. Duty to act; unprofessional conduct; definition

The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

- (a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
- (b) Gross negligence.
- (c) Repeated negligent acts.
- (d) Incompetence.
- (e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.
- (f) Any action or conduct which would have warranted the denial of a certificate.

(Added by Stats. 1980, c. 1313, p. 4473, Section 2. Amended by Stats. 1983, c. 398, Section 2.)

The following now follows under section (c) Repeated negligent acts:

To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct which would have warranted the denial of a certificate.

(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

## HEALTH AND SAFETY CODE

## § 162795. Medical and health section data; completion and attestation

The medical and health section data and the time of death shall be completed and attested to by the physician and surgeon last in attendance, or in the case of a patient in a skilled nursing or intermediate care facility at the time of death, by the physician and surgeon last in attendance or by a licensed physician assistant under the supervision of the physician and surgeon last in attendance if the physician and surgeon or licensed physician assistant is legally authorized to certify and attest to these facts, and if the physician assistant has visited the patient within 72 hours of the patient's death. In the event the licensed physician assistant certifies the medical and health section data and the time of death, then the physician assistant shall also provide on the document the name of the last attending physician and surgeon and provide the coroner with a copy of the certificate of death. However, the medical health section data and the time of death shall be completed and attested to by the coroner in those cases in which he or she is required to complete the medical and health section data and certify and attest to these facts.

(Added by Stats.1995, c. 415 (S.B.1360), § 4.)

## Cross References

Chiropractors, duties and authority on death certificates, see Business and Professions Code § 1000-13.

## Library References

Health and Environment ¶34.  
WESTLAW Topic No. 199.  
C.J.S. Health and Environment § 41.

## Notes of Decisions

Evidence 2  
Physician 1

## 1. Physician

Christian Science practitioner is not a "physician" within Health and Safety Code provisions requiring attending physician or physician last in attendance to complete medical data section of death certificate. 34 Op.Atty.Gen. 151 (1959).

A drugless practitioner is a "physician" within meaning of this section and may sign death certificates. 1 Op.Atty.Gen. 574 (1943).

## 2. Evidence

It was not error, in an action on an accident insurance policy, to exclude a certified copy of a certificate stating

the cause of death of insured, where it was not shown that such certificate was made and signed by the physician last in attendance, as required by Stats.1917, pp. 717 to 723, and Stats.1905, pp. 115 to 122, as amended by Stats.1907, pp. 296 to 300, or that the certificate was made by a public officer or by any other person in the performance of a duty specially enjoined by law, as required by C.C.P. § 1920. *Mah See v. North American Acc. Ins. Co. of Chicago, Ill.* (1923) 190 Cal. 421, 213 P. 42.

In an action against hospital for the death of a child from negligent burning, where the defendant claimed the child died from pneumonia, the certificate of death of resident physician is prima facie evidence of the cause of death under Stats.1915, p. 575 (repealed 1943). *Longuy v. La Societe Francaise De Bienfaisance Mutuelle* (App. 1 Dist. 1921) 52 Cal.App. 370, 198 P. 1011.

§ 102800. Completion of certificate; time; delivery

The medical and health section data and the physician's or coroner's certification shall be completed by the attending physician within 15 hours after the death, or by the coroner within three days after examination of the body.

The physician shall within 15 hours after the death deposit the certificate at the place of death, or deliver it to the attending funeral director at his or her place of business or at the office of the physician.  
(Added by Stats.1995, c. 415 (S.B.1360), § 4.)

Cross References

Delivery of certificate by coroner, see Health and Safety Code § 102860.  
Duty to furnish information, see Health and Safety Code § 102135.

Failure to fill out and deliver certificate, offense, see Health and Safety Code § 103785.

Library References

Health and Environment ¶34.  
WESTLAW Topic No. 199.  
C.J.S. Health and Environment § 41.

Notes of Decisions

Physician 1

physician or physician last in attendance to complete medical data section of death certificate. 34 Op.Atty.Gen. 151 (1959).

1. Physician

Christian Science practitioner is not a "physician" within Health and Safety Code provisions requiring attending

## § 120250. Duty to report diseases to health officer

All physicians, nurses, clergymen, attendants, owners, proprietors, managers, employees, and persons living, or visiting any sick person, in any hotel, lodginghouse, house, building, office, structure, or other place where any person is ill of any infectious, contagious, or communicable disease, shall promptly report that fact to the health officer, together with the name of the person, if known, the place where he or she is confined, and the nature of the disease, if known.

(Added by Stats.1995, c. 415 (S.B.1360), § 7.)

### Law Review Commentaries

- California Public Records Act. (1974) 4 Golden Gate L.Rev. 203.      Physician-patient privilege: Absent patient. (1975) 27 Hast.L.J. 99.  
Confidentiality of genetic information. (1982) 30 U.C.L.A.Law Rev. 1283.

### Library References

- Health and Environment ¶34.  
WESTLAW Topic No. 199.  
C.J.S. Health and Environment § 41.

### Notes of Decisions

- In general 1  
Confidentiality 4  
Duty to report 3  
Malpractice 5  
Purpose 2

#### 1. In general

Where hospital patient had attending physician who had undertaken to treat her, it was his duty to advise her and her mother that she had contracted contagious, communicable disease, and hospital owed plaintiffs no duty to advise patient or her mother that patient had contracted contagious communicable disease. *Derrick v. Ontario Community Hospital* (App. 4 Dist. 1975) 120 Cal.Rptr. 566, 47 Cal.App.3d 145.

Under former §§ 2522, 2524, 2558, 2573 (repealed; see, now, §§ 3051, 3053, 3114 and this section) a physician who is acting under the direction of the county health officer may make examination of minor male or female persons applying at the clinic requesting diagnostic services for a suspected venereal disease, without knowledge or consent of parent or guardian. 1 Ops.Atty.Gen. 541.

#### 2. Purpose

Section 3110 requiring each health officer knowing or having reason to believe existence of a reportable disease or of a contagious infectious, or communicable disease to take necessary measures to prevent spread of diseases or occurrence of additional cases and this section requiring all physicians, etc., to report fact of illness from infectious or communicable disease to health officer together with name of person ill, etc., were enacted to protect public against spread of contagious, communicable diseases. *Derrick v. Ontario Community Hospital* (App. 4 Dist. 1975) 120 Cal.Rptr. 566, 47 Cal.App.3d 145.

#### 3. Duty to report

This section imposed on hospital a duty to plaintiff to report known infectious, contagious or communicable dis-

eases to local health officer. *Derrick v. Ontario Community Hospital* (App. 4 Dist. 1975) 120 Cal.Rptr. 566, 47 Cal.App.3d 145.

Regulation which requires clinical laboratories to report positive results of tests to detect communicable diseases may be promulgated. 28 Ops.Atty.Gen. 244, 10-29-56.

The Business and Professions Code and the Administrative Code permit promulgation of a regulation requiring the reporting by clinical laboratories of results of positive laboratory tests for reportable communicable diseases to local health authority, and such reporting does not constitute "diagnosis" within meaning of Bus. & Prof.C. § 2141 (repealed; see, now, § 2052), relating to practice of medicine without a license. 28 Ops.Atty.Gen. 244.

#### 4. Confidentiality

All venereal disease records compiled and kept by local health departments are confidential and a health officer receiving a subpoena for such record may assert a privilege pursuant to Evid.C. § 1040, 53 Ops.Atty.Gen. 10, 1-13-70.

The state board of public health may promulgate a regulation to disseminate the identities of persons known to be infected with viral hepatitis to licensed blood banks, for the sole purpose of screening donors, provided such regulation further directs that the information is to remain confidential and to be used only for such screening. 51 Ops.Atty.Gen. 217, 10-29-68.

#### 5. Malpractice

A private physician would not be liable in a medical malpractice suit for breach of the confidential physician-patient relationship if the physician reports to the director of the county of Sacramento, department of community health, the occurrence of a communicable disease in a patient who is a food handler even if the disease control section of the department of community health subsequently stops the patient from working during the communicable stage of his or her illness. 58 Ops.Atty.Gen. 904, 12-12-75.

**§ 121362. Treatment of persons with active tuberculosis disease; cessation of treatment; reports**

Each health care provider who treats a person for active tuberculosis disease, each person in charge of a health facility, or each person in charge of a clinic providing outpatient treatment for active tuberculosis disease shall promptly report to the local health officer at the times that the health officer requires, but no less frequently than when there are reasonable grounds to believe that a person has active tuberculosis disease, and when a person ceases treatment for tuberculosis disease. Situations in which the provider may conclude that the patient has ceased treatment include times when the patient fails to keep an appointment, relocates without transferring care, or discontinues care. The initial disease notification report shall include an individual treatment plan that includes the patient name, address, date of birth, tuberculin skin test results, pertinent radiologic, microbiologic, and pathologic reports whether final or pending, and any other information required by the local health officer. Subsequent reports shall provide updated clinical status and laboratory results, assessment of treatment adherence, name of current care provider if patient transfers care, and any other information required by the local health officer. A facility discharge, release, or transfer report shall include all pertinent and updated information required by the local health officer not previously reported on initial or subsequent reports, and shall specifically include verified patient address, the name of the medical provider who has specifically agreed to provide medical care, clinical information used to assess the current infectious state, and any other information required by the local health officer. Each health care provider who treats a person with active tuberculosis disease, and each person in charge of a health facility or a clinic providing outpatient treatment for active tuberculosis disease, shall maintain written documentation of each patient's adherence to his or her individual treatment plans. Nothing in this section shall authorize the disclosure of test results for human immunodeficiency virus (HIV) unless authorized by Chapter 7 (commencing with Section 120975) of, Chapter 8 (commencing with Section 121025) of, and Chapter 10 (commencing with Section 121075) of, Part 4, of Division 105.

In the case of a parolee under the jurisdiction of the Department of Corrections, the local health officer shall notify the medical officer of the parole region or the physician and surgeon designated by the Director of Corrections when there are reasonable grounds to believe that the parolee has active tuberculosis disease and when the parolee ceases treatment for tuberculosis. Situations where the local health officer may conclude that the parolee has ceased treatment include times when the parolee fails to keep an appointment, relocates without transferring care, or discontinues care.

(Added by Stats.1995, c. 415 (S.B.1360), § 7.)

**§ 121363. Examination or referral for examination; contacts of persons treated for active tuberculosis disease**

Each health care provider who treats a person for active tuberculosis disease shall examine, or cause to be examined, all household contacts or shall refer them to the local health officer for examination. Each health care provider shall promptly notify the local health officer of the referral. When required by the local health officer, nonhousehold contacts and household contacts not examined by a health care provider shall submit to examination by the local health officer or designee. If any abnormality consistent with tuberculosis disease is found, steps satisfactory to the local health officer shall be taken to refer the person promptly to a health care provider for further investigation, and if necessary, treatment. Contacts shall be reexamined at times and in a manner as the local health officer may require. When requested by the local health officer, a health care provider shall report the results of any examination related to tuberculosis of a contact.

(Added by Stats.1995, c. 415 (S.B.1360), § 7.)

**Law Review Commentaries**

Review of selected 1993 California legislation. 25 Pac.  
L.J. 731 (1994).

TITLE 17, CALIFORNIA CODE OF REGULATIONS  
REPORTABLE DISEASES AND CONDITIONS  
ARTICLE 1. REPORTING  
SECTIONS AMENDED AND EFFECTIVE ON FEBRUARY 2, 1996  
OFFICE OF ADMINISTRATIVE LAW FILE NO. 95-1219-09C

(1) Amend Section 2500 to read:

**2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.**

(a) The following definitions shall govern the interpretation of this Subchapter.

(1) 'CDC' means the Centers for Disease Control and Prevention, United States Department of Health and Human Services.

(2) 'CSTE' means the Council of State and Territorial Epidemiologists.

(3) 'MMWR' means the Morbidity and Mortality Weekly Report.

(4) 'Case' means (A) a person who has been diagnosed by a health care provider, who is lawfully authorized to diagnose, using clinical judgment or laboratory evidence, to have a particular disease or condition listed in subsection (j); or (B) a person who meets the definition of a case in Section 2564 - Diarrhea of the Newborn, Section 2574 - Food Poisoning, Section 2612 Salmonella Infections (Other than Typhoid Fever), Section 2628 - Typhoid Fever, or Section 2636 - Venereal Disease; or (C) a person who is considered a case of a disease or condition that satisfies the most recent communicable disease surveillance case definitions established by the CDC and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements; or (D) an animal that has been determined, by a person authorized to do so, to have rabies or plague.

(5) 'Clinical signs' means the objective evidence of disease.

(6) 'Clinical symptoms' means the subjective sensation of disease felt by the patient.

(7) 'Communicable disease' means an illness due to a specific microbiological or parasitic agent or its toxic products which arises through transmission of that agent or its products from an infected person, animal, or inanimate reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector, or the inanimate environment.

(8) 'Director' means State Director of Health Services.

(9) 'Drug susceptibility testing' means the process where at least one isolate from a culture of a patient's specimen is subjected to antimicrobial testing to determine if growth is inhibited by drugs commonly used to treat such infections.

(10) 'Epidemiological risk factors' means those attributes, behaviors, exposures, or other factors that alter the probability of disease.

(11) 'Epidemiologically linked case' means a case in which the patient has/had contact with one or more persons who have/had the disease, and transmission of the agent by the usual modes of transmission is plausible.

(12) 'Foodborne disease' means illness suspected by a health care provider to have resulted from consuming a contaminated food.

(13) 'Foodborne disease outbreak' means an incident in which two or more persons experience a similar illness after ingestion of a common food, and epidemiologic analysis implicates the food as the source of the illness. There are two exceptions: even one case of botulism or chemical poisoning constitutes an outbreak if laboratory studies identify the causative agent in the food.

(14) 'Health care provider' means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

(15) 'Health officer' and 'local health officer' as used in this subchapter includes county, city, and district health officers.

(16) 'In attendance' means the existence of the relationship whereby a health care provider renders those services which are authorized by the health care provider's licensure or certification.

(17) 'Infection control practitioner' means any person designated by a hospital, nursing home, clinic, or other health care facility as having responsibilities which include the detection, reporting, control and prevention of infections within the institution.

(18) 'Laboratory findings' means (A) the results of a laboratory examination of any specimen derived from the human body which yields microscopical, cultural, immunological, serological, or other evidence suggestive of a disease or condition made reportable by these regulations; or (B) the results of a laboratory examination of any specimen derived from an animal which yields evidence of rabies or plague.

(19) 'Multidrug-resistant *Mycobacterium tuberculosis*' means a laboratory culture or subculture of *Mycobacterium tuberculosis* which is determined by antimicrobial susceptibility testing to be resistant to at least isoniazid and rifampin.

(20) 'Outbreak' means the occurrence of cases of a disease (illness) above the expected or baseline level, usually over a given period of time, in a geographic area or facility, or in a specific population group. The number of cases indicating the presence of an outbreak will vary according to the disease agent, size and type of population exposed, previous exposure to the agent, and the time and place of occurrence. Thus, the designation of an outbreak is relative to the usual frequency of the disease in the same facility or community, among the specified population, over a comparable period of time. A single case of a communicable disease long absent from a population or the first invasion by a disease not previously recognized requires immediate reporting and epidemiologic investigation.

(21) 'Personal information' means any information that identifies or describes a person, including, but not limited to, his or her name, social security number, date of birth, physical description, home address, home telephone number, and medical or employment history.

(22) 'Sexually Transmitted Diseases' means Chancroid, Lymphogranuloma Venereum, Granuloma Inguinale, Syphilis, Gonorrhea, Chlamydia, Pelvic Inflammatory Disease, and Nongonococcal Urethritis.

(23) 'Suspected case' means (A) a person whom a health care provider believes, after weighing signs, symptoms, and/or laboratory evidence, to probably have a particular disease or condition listed in subsection (j); or (B) a person who is considered a probable case, or an epidemiologically-linked case, or who has supportive laboratory findings under the most recent communicable disease surveillance case definition established by CDC and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements; or (C) an animal which has been determined by a veterinarian to exhibit clinical signs or which has laboratory findings suggestive of rabies or plague.

(24) 'Unusual disease' means a rare disease or a newly apparent or emerging disease or syndrome of uncertain etiology which a health care provider has reason to believe could possibly be caused by a transmissible infectious agent or microbial toxin.

(25) 'Water-associated disease' means an illness in which there is evidence to suggest that the illness could possibly have resulted from physical contact with or swallowing water from a microbiologically or chemically contaminated water source. Examples of such potentially contaminated water sources are lakes, rivers, streams, irrigation water, wells, public and private drinking water, bottled water, reclaimed water, ocean and bay waters, hot springs, hot tubs, whirlpool spas, and swimming pools. Epidemiologic investigation by public health authorities is required to demonstrate that a suspected water-associated illness was likely to have been waterborne and related to the suspected source.

(26) 'Waterborne disease outbreak' means an incident in which two or more persons experienced a similar illness after consumption or use of the same water intended for drinking or after water contact such as by immersion, and epidemiologic investigation by public health authorities implicates the same water as the source of the waterborne illness. There is one exception: a single case of waterborne chemical poisoning constitutes an outbreak if laboratory studies indicate that the source water is contaminated by the chemical.

(b) It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or conditions listed in subsection (j) of this section, to report to the local health officer for the jurisdiction where the patient resides as required in subsection (h) of this section. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed in subsection (j) of this section may make such a report to the local health officer for the jurisdiction where the patient resides.

(c) The administrator of each health facility, clinic or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local health officer.

(d) Each report made pursuant to subsection (b) shall include all of the following information if known:

(1) name of the disease or condition being reported; the date of onset; the date of diagnosis; the name, address, telephone number, occupation, race/ethnic group, Social Security number, sex, age, and date of birth for the case or suspected case; the date of death if death has occurred; and the name, address and telephone number of the person making the report.

(2) If the disease reported pursuant to subsection (b) is hepatitis, a sexually transmitted disease or tuberculosis, then the report shall include the following applicable information, if known: (A) hepatitis information as to the type of hepatitis, type-specific laboratory findings, and sources of exposure, (B) sexually transmitted disease information as to the specific causative agent, syphilis-specific laboratory findings, and any complications of gonorrhea or chlamydia infections, or (C) tuberculosis information on the diagnostic status of the case or suspected case, bacteriologic, radiologic and tuberculin skin test findings, information regarding the risk of transmission of the disease to other persons, and a list of the anti-tuberculosis medications administered to the patient.

(e) Confidential Morbidity Report forms, PM 110 (1/90), are available from the local health department for reporting as required by this section.

(f) Information reported pursuant to this section is acquired in confidence and shall not be disclosed by the local health officer except as authorized by these regulations, as required by state or federal law, or with the written consent of the individual to whom the information pertains or the legal representative of the individual.

(g) Upon the Department of Health Services' request, a local health department shall provide to the Department the information reported pursuant to this section. Absent the individual's written consent, no information that would directly or indirectly identify the case or suspected case as an individual who has applied for or been given services for alcohol or other drug abuse by a federally assisted drug or alcohol abuse treatment program (as defined in federal law at 42 C.F.R. Section 2.11) shall be included.

(h) The urgency of reporting is identified by symbols in the list of diseases and conditions in subsection (j) of this section. Those diseases with a diamond (◆) are considered emergencies and shall be reported immediately by telephone. Those diseases and conditions with a cross (+) shall be reported by mailing, telephoning or electronically transmitting a report within one (1) working day of identification of the case or suspected case. Those diseases and conditions not otherwise identified by a diamond or a cross shall be reported by mailing a written report, telephoning, or electronically transmitting a report within seven (7) calendar days of the time of identification.

(i) For foodborne disease, the bullet (●) symbol indicates that, when two (2) or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness, they shall be reported immediately by telephone.

(j) Health care providers shall submit reports for the following diseases or conditions subdivided into two sections: communicable diseases and non-communicable diseases and conditions.

**(1) COMMUNICABLE DISEASES:**

Acquired Immune Deficiency Syndrome (AIDS)

+ Amebiasis

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- + Anisakiasis
- ◆ Anthrax
- + Babesiosis
- ◆ Botulism (Infant, Foodborne, Wound)
- Brucellosis
- + Campylobacteriosis
- Chancroid
- Chlamydial Infections
- ◆ Cholera
- ◆ Ciguatera Fish Poisoning
- Coccidioidomycosis
- + Colorado Tick Fever
- + Conjunctivitis, Acute Infectious of the Newborn, Specify Etiology
- + Cryptosporidiosis
- Cysticercosis
- ◆ Dengue
- ◆ Diarrhea of the Newborn, Outbreaks
- ◆ Diphtheria
- ◆ Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
- Echinococcosis (Hydatid Disease)
- Ehrlichiosis
- + Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
- ◆ *Escherichia coli* O157:H7 Infection
- + ● Foodborne Disease
- Giardiasis
- Gonococcal Infections
- + *Haemophilus influenzae*, Invasive Disease
- ◆ Hantavirus Infections
- ◆ Hemolytic Uremic Syndrome
- Hepatitis, Viral
- + Hepatitis A
- Hepatitis B (specify acute case or chronic)
- Hepatitis C (specify acute case or chronic)
- Hepatitis D (Delta)
- Hepatitis, other, acute
- Kawasaki Syndrome (Mucocutaneous Lymph Node Syndrome)
- Legionellosis
- Leprosy (Hansen Disease)
- Leptospirosis
- + Listeriosis
- Lyme Disease
- + Lymphocytic Choriomeningitis
- + Malaria
- + Measles (Rubeola)
- + Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
- ◆ Meningococcal Infections
- Mumps
- Non-Gonococcal Urethritis (Excluding Laboratory Confirmed Chlamydial Infections)
- ◆ Paralytic Shellfish Poisoning
- Pelvic Inflammatory Disease (PID)

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- + Pertussis (Whooping Cough)
- ◆ Plague, Human or Animal
- + Poliomyelitis, Paralytic
- + Psittacosis
- + Q Fever
- ◆ Rabies, Human or Animal
- + Relapsing Fever
- Reye Syndrome
- Rheumatic Fever, Acute
- Rocky Mountain Spotted Fever
- Rubella (German Measles)
- Rubella Syndrome, Congenital
- + Salmonellosis (Other than Typhoid Fever)
- ◆ Scombroid Fish Poisoning
- + Shigellosis
- + Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
- + Swimmer's Itch (Schistosomal Dermatitis)
- + Syphilis
- Tetanus
- Toxic Shock Syndrome
- Toxoplasmosis
- + Trichinosis
- + Tuberculosis
- Tularemia
- + Typhoid Fever, Cases and Carriers
- Typhus Fever
- + *Vibrio* Infections
- ◆ Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa and Marburg viruses)
- + Water-associated Disease
- ◆ Yellow Fever
- + Yersiniosis
- OCCURRENCE of ANY UNUSUAL DISEASE**
- ◆ **OUTBREAKS of ANY DISEASE** (Including diseases not listed in Section 2500).  
Specify if institutional and/or open community.
- (2) NON-COMMUNICABLE DISEASES OR CONDITIONS:**  
Alzheimer's Disease and Related Conditions  
Disorders Characterized by Lapses of Consciousness

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(◆) = to be reported immediately by telephone.

(+) = to be reported by mailing a report, telephoning, or electronically transmitting a report within one (1) working day of identification of the case or suspected case.

(No diamond or cross symbol) = to be reported within seven (7) calendar days by mail, telephone, or electronic report from the time of identification.

(●) when two (2) or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness, they should be reported immediately by telephone.

NOTE: Authority cited: Sections 200, 207, 208 and 3123, Health and Safety Code.  
Reference: Sections 200, 207, 211, 304.5, 410, 1603.1, 3053, 3110, 3123, 3124, 3125, 3131 and 3132, Health and Safety Code; Sections 551, 554 and 555, Business and Professions Code; Section 1798.3, Civil Code; 42 U.S.C. Sections 290ee-3 and 290dd-3; 42 C.F.R. Sections 2.11 and 2.12; Cal. Const., art. 1, Section 1; and Section 1040 of the Evidence Code.

(2) Amend Section 2501 to read:

**2501. INVESTIGATION OF A REPORTED CASE, UNUSUAL DISEASE, OR OUTBREAK OF DISEASE.**

(a) Upon receiving a report made pursuant to Section 2500 or 2505, the local health officer shall take whatever steps deemed necessary for the investigation and control of the disease, condition or outbreak reported. If the health officer finds that the nature of the disease and the circumstances of the case, unusual disease, or outbreak warrant such action, the health officer shall make or cause to be made an examination of any person who or animal which has been reported pursuant to Sections 2500 or 2505 in order to verify the diagnosis, or the existence of an unusual disease, or outbreak, make an investigation to determine the source of infection, and take appropriate steps to prevent or control the spread of the disease. Whenever requested to do so by the Department, the health officer shall conduct a special morbidity and mortality study under Health and Safety Code Section 211 for any of the diseases made reportable by these regulations.

(b) If a disease is one in which the local health officer determines identification of the source of infection is important, and the source of infection is believed to be outside the local jurisdiction, the health officer shall notify the Director or the health officer under whose jurisdiction the infection was probably contracted if known. Similar notification shall be given if there are believed to be exposed persons, living outside the jurisdiction of the health officer, who should be quarantined or evaluated for evidence of the disease.

NOTE: Authority cited: Sections 207, 208 and 3123, Health and Safety Code; and Section 555(b), Business and Professions Code. Reference: Sections 7, 200, 207, 211, 211.5, 304.5, 410, 1603.1, 3051, 3053, 3110, 3122, 3123, 3124, 3125, 3131, and 3132, Health and Safety Code; Sections 551, 554, and 555, Business and Professions Code.

(3) Repeal existing Section 2502:

NOTE: Authority cited: Sections 207, 208 and 3123, Health and Safety Code.  
Reference: Sections 200, 207, 3053, 3110, 3121, 3123 and 3124, Health and Safety Code.

(4) Adopt a new Section 2502 to read:

**2502. REPORTS BY LOCAL HEALTH OFFICER TO STATE DEPARTMENT OF HEALTH SERVICES.**

(a) Summary Reports: Each local health officer shall report at least weekly, on the Weekly Morbidity by Place of Report form (DHS 8245 (11/95)) to the Director the number of cases of those diseases, conditions, unusual diseases or outbreaks of disease reported pursuant to Section 2500. Copies of the form are available from the Department's Division of Communicable Disease Control.

(b) Individual Case and Outbreak Reports: For the diseases listed below, the local health officer shall prepare and send to the Department along with the summary report described in (a) above an individual case or outbreak report for each individual case/outbreak of those diseases which the Department has identified as requiring epidemiological analysis reported pursuant to Section 2500. At the discretion of the Director, the required individual case/outbreak report may be either a Confidential

Morbidity Report (PM-110 1/90), its electronic equivalent or a hard copy 8.5x11 inch individual case/outbreak report form. The Weekly Morbidity by Place of Report form (DHS 8245 (11/95)) indicates which format to use. Each individual case report shall include the following: (1) verification of information reported pursuant to Section 2500; (2) information on the probable source of infection, if known; (3) laboratory or radiologic findings, if any; (4) clinical signs and/or symptoms, if applicable; and (5) any known epidemiological risk factors. The Department or CDC has prepared forms that may be used for many of the diseases requiring individual case reports. Where a form exists, its identification number is listed in parentheses next to the diseases listed below. Copies of these case report forms are available from the Department's Division of Communicable Disease Control. An individual case report is required for the following diseases:

Acquired Immune Deficiency Syndrome (AIDS) (CDC 50.42B)  
 Anthrax (ACD-152)  
 Botulism (Infant, Foodborne, Wound) (ACD-153)  
 Brucellosis (262-101)  
 Cholera (CDC 52.79)  
 Cysticercosis (pending)  
 Diarrhea of the Newborn, Outbreaks (262-504)  
 Diphtheria (262-505)  
*Escherichia coli* O157:H7 Infection (pending)  
 Foodborne Disease Outbreak (CDC 52.13)  
*Haemophilus influenzae*, Invasive Disease (DHS 8449)  
 Hantavirus Infections (pending)  
 Hemolytic Uremic Syndrome (pending)  
 Hepatitis A (CDC 53.1)  
 Hepatitis B, acute only (CDC 53.1)  
 Hepatitis C, acute only (CDC 53.1)  
 Hepatitis D (Delta), acute only (CDC 53.1)  
 Hepatitis, any other acute viral type (CDC 53.1)  
 Kawasaki Syndrome (Mucocutaneous Lymph Node Syndrome) (DHS 8468)  
 Legionellosis (CDC 52.56)  
 Leprosy (Hansen Disease) (CDC 52.18)  
 Leptospirosis (262-102)  
 Listeriosis (DHS 8296)  
 Lyme Disease (DHS 8470)  
 Malaria (CDC 54.1)  
 Measles (Rubeola) (DHS 8345)  
 Meningococcal Infections (DHS 8469)  
 Outbreak of Disease Report (DHS 262-501)  
 Pelvic Inflammatory Disease (PID)  
 Pertussis (Whooping Cough) (DHS 8258)  
 Plague (CDC 56.37)  
 Poliomyelitis, Paralytic (DHS 8421)  
 Psittacosis (8023-005)  
 Q Fever (262-101)  
 Rabies, Human or Animal (Humans 262-105, Animals PM 102)  
 Relapsing Fever (262-107)  
 Reye Syndrome (CDC 55.8)  
 Rocky Mountain Spotted Fever (CDC 55.1)  
 Rubella (German Measles) (PM 358; for Congenital Rubella, CDC 71.17)  
 Streptococcal Outbreaks and Individual Cases in Food Handlers and Dairy Workers Only

Syphilis (for Congenital Syphilis, CDC 73.126)  
Tetanus (CDC 71.15)  
Toxic Shock Syndrome (CDC 52.3)  
Trichinosis (CDC 54.7)  
Tuberculosis (CDC 72.9 A, B, and C)  
Tularemia (262-101)  
Typhoid Fever, Cases and Carriers (Cases, CDC 52.5; Carriers, CDC 4.383)  
Typhus Fever (262-107)  
Unusual Disease Report (DHS 262-501)  
*Vibrio* Infections (CDC 52.79)  
Waterborne Disease Outbreak (CDC 52.12)  
Yellow Fever

(c) Immediate Reports: Cases and suspect cases of anthrax, botulism, cholera, diarrhea of the newborn (outbreaks), diphtheria, dengue, plague, human rabies and yellow fever are to be reported by the local health officer to the Director immediately by telephone.

(d) Upon request of the Department, the local health officer shall submit an individual case report for any disease not listed in subsection (b) above.

(e) During any special morbidity and mortality study requested under Section 2501, the local health officer shall be the Director's agent for purposes of carrying out the powers conferred under Government Code Section 11181.

(f) Confidentiality. Information reported pursuant to this section is acquired in confidence and shall not be disclosed by the local health officer except as authorized by these regulations, as required by state or federal law, or with the written consent of the individual to whom the information pertains or the legal representative of that individual.

(1) A health officer shall disclose any information, including personal information, contained in an individual case report to state, federal or local public health officials in order to determine the existence of a disease, its likely cause or the measures necessary to stop its spread.

(2) A health officer may for purposes of his or her investigation disclose any information contained in an individual case report, including personal information, as may be necessary to prevent the spread of disease or occurrence of additional cases.

(3) A health officer may disclose any information contained in an individual case report to any person or entity if the disclosure may occur without linking the information disclosed to the individual to whom it pertains, and the purpose of the disclosure is to increase understanding of disease patterns, to develop prevention and control programs, to communicate new knowledge about a disease to the community, or for research.

(4) Notwithstanding subsections (1), (2), and (3) above, no information that would directly or indirectly identify an individual as one who has applied for or been given services for alcohol or other drug abuse by a federally assisted drug or alcohol abuse treatment program (as defined in 42 C.F.R. §2.11) shall be included in an individual case report or otherwise disclosed absent the individual's written consent.

(g) Whenever the health officer collects personal information in order to prepare an individual case report required by subsection (b), the health officer shall notify the individual from whom the information is collected that: (1) supplying personal information related to the individual's disease is mandatory; (2) the only disclosure of personal information will be pursuant to subsections 2502(f)(1) and 2502(f)(2); and (3) non-personal information may be disclosed pursuant to subsection 2502(f)(3).

NOTE: Authority cited: Sections 207, 208 and 3123, Health and Safety Code; and Section 555(b), Business and Professions Code.

Reference: Sections 7, 200, 207, 211, 211.5, 304.5, 410, 1603.1, 3051, 3053, 3110, 3122, 3123, 3124, 3125, 3131 and 3132, Health and Safety Code; and Sections 551, 554 and 555, Business and Professions

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Code; Sections 11181 and 11182, Government Code; 42 U.S.C. Sections 290ee-3 and 290dd-3; 42 C.F.R. Sections 2.11 and 2.12; Cal. Const., art. 1, Section 1; Section 1040 of the Evidence Code; and Section 1798.3, Civil Code.

(5) Repeal Section 2503.

NOTE: Authority cited: Sections 207, 208 and 3123, Health and Safety Code.  
Reference: Sections 200, 207, 3053, 3110, 3123, 3124 and 3125, Health and Safety Code.

(6) Section 2504 unchanged:

**2504. REPORT BY HEALTH CARE PROVIDER OF OUT-OF-STATE LABORATORY FINDINGS.**

Whenever a health care provider's identification of a case or suspected case of tuberculosis includes laboratory findings from an out-of-state laboratory, the health care provider shall include those findings with the report made pursuant to Section 2500(b), and if the laboratory performed drug susceptibility testing, the results of such testing shall also be so reported.

NOTE: Authority cited: Sections 207, 208 and 3123, Health and Safety Code.  
Reference: Sections 200, 207, 3053, 3110, 3123, 3125 and 3285, Health and Safety Code.

(7) Amend Section 2505 to read:

**2505. NOTIFICATION BY LABORATORIES.**

(a) To assist the local health officer, the laboratory director, or the laboratory director's designee, of a clinical laboratory, an approved public health laboratory or a veterinary laboratory in which a laboratory examination of any specimen derived from the human body (or from an animal, in the case of rabies or plague testing) yields microscopical, cultural, immunological, serological, or other evidence suggestive of those diseases listed in subsection (e) below, shall report such findings to the health officer of the local health jurisdiction where the health care provider who first submitted the specimen is located within one working day from the time that the laboratory notifies that health care provider or other person authorized to receive the report. If the laboratory that makes the positive finding received the specimen from another laboratory, the laboratory making the positive finding shall notify the health officer of the jurisdiction in which the health care provider is located within one working day from the time the laboratory notifies the referring laboratory that submitted the specimen.

(b) To permit local health officer follow-up of laboratory findings, all specimens submitted for laboratory tests or examinations related to a disease or condition listed in subsection (e) shall be accompanied by a test requisition which includes the name, gender, and age or date of birth of the person from whom the specimen was obtained and the name, address and telephone number of the health care provider or other authorized person who submitted the specimen. Whenever the specimen, or an isolate therefrom, is transferred between laboratories, a test requisition with the above patient and submitter information shall accompany the specimen. The laboratory that first receives a specimen shall be responsible for obtaining the patient and submitter information at the time the specimen is received by that laboratory.

(c) Each notification to the local health officer shall be in writing and give the date the specimen was obtained, the patient identification number, the specimen accession number or other unique specimen identifier, the laboratory findings for the test performed, the date that any positive laboratory findings were identified, the name, gender, address and telephone number (if known), and age or date of birth of the person from whom the specimen was obtained, and the name, address, and telephone number of the

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health care provider for whom such examination or test was performed. A legible copy of a laboratory report containing all of the above information will satisfy the purpose of this regulation.

(d) The notification shall be submitted either by courier, mail, or electronic facsimile to the local health officer in the jurisdiction where the health care provider who submitted the specimen is located. When the specimen is from an out-of-state submitter, the state epidemiologist of the submitter shall be provided the same positive findings within one working day from the time the health care provider is notified. If the laboratory that finds evidence for any of those diseases listed in subsection (e) is an out-of-state laboratory, the California clinical laboratory that receives a report of such findings from the out-of-state laboratory shall notify the local health officer in the same way as if the finding had been made by the California laboratory.

(e) The diseases to which this section applies are:

- Chlamydial infections
- Cryptosporidiosis
- Diphtheria
- Encephalitis, arboviral
- Escherichia coli* O157:H7 infection
- Gonorrhea
- Hepatitis A, acute infection, by IgM antibody test or positive viral antigen test
- Hepatitis B, acute infection by IgM anti-HBc antibody test
- Hepatitis B surface antigen positivity (specify gender)
- Listeriosis
- Malaria
- Measles (Rubeola), acute infection, by IgM antibody test or positive viral antigen test
- Plague, animal or human
- Rabies, animal or human
- Syphilis
- Tuberculosis
- Typhoid
- Vibrio* species infections

(f) In addition to notifying the local health officer pursuant to subsection (a), any clinical laboratory or approved public health laboratory that isolates *Mycobacterium tuberculosis* from a patient specimen shall:

(1) Submit a culture as soon as available from the primary isolate on which a diagnosis of tuberculosis was established. Such a culture shall be submitted to the public health laboratory designated in Title 17, California Code of Regulations, Section 1075, for the local jurisdiction where the health care provider's office is located. The following information shall be submitted with the culture: the name, address, and the date of birth of the person from whom the specimen was obtained, the patient identification number, the specimen accession number or other unique specimen identifier, the date the specimen was obtained from the patient, and the name, address, and telephone number of the health care provider for whom such examination or test was performed. The public health laboratory shall retain the culture received (one culture from each culture-positive patient) in a viable condition for at least six months.

(2) Unless drug susceptibility testing has been performed by the clinical laboratory on a strain obtained from the same patient within the previous three months or the health care provider who submitted the specimen for laboratory examination informs the laboratory that such drug susceptibility testing has been performed by another laboratory on a culture obtained from that patient within the previous three months, the clinical laboratory shall:

(A) Perform or refer for drug susceptibility testing on at least one isolate from each patient from whom *Mycobacterium tuberculosis* was isolated; and

(B) Report the results of drug susceptibility testing to the local health officer of the city or county where the submitting physician's office is located within one working day from the time the health care provider or other authorized person who submitted the specimen is notified; and

(C) If the drug susceptibility testing determines the culture to be resistant to at least isoniazid and rifampin, in addition, submit one culture or subculture from each patient from whom multidrug-resistant *Mycobacterium tuberculosis* was isolated to the official public health laboratory designated in Title 17, California Code of Regulations, Section 1075, for the local health jurisdiction in which the health care provider's office is located. The local public health laboratory shall forward such cultures to the Department's Microbial Diseases Laboratory. The following information shall be submitted with the culture: the name, address, and the date of birth of the person from whom the specimen was obtained, the patient identification number, the specimen accession number or other unique specimen identifier, the date the specimen was obtained from the patient, and the name, address, and telephone number of the health care provider for whom such examination or test was performed.

(g) Whenever a clinical laboratory finds that a specimen from a patient with known or suspected tuberculosis tests positive for acid fast bacillus (AFB) staining and the patient has not had a culture which identifies that acid fast organism within the past 30 days, the clinical laboratory shall culture and identify the acid fast bacteria or refer a subculture to another laboratory for those purposes.

(h) In addition to notifying the local health officer pursuant to subsection (a), any clinical laboratory that makes a finding of malaria parasites in the blood film of a patient shall immediately submit one or more such blood film slides for confirmation to the public health laboratory designated in Title 17, California Code of Regulations, Section 1075, for the local health jurisdiction where the health care provider is located. When requested, all blood films shall be returned to the submitter.

(i) All laboratory notifications herein required are acquired in confidence and shall not be disclosed by the local health officer except (1) as authorized by these regulations; (2) as required by state or federal law; or (3) with the written consent of the individual to whom the information pertains or the legal representative of that individual.

(j) The local health officer shall disclose any information, including personal information, contained in a laboratory notification to state, federal or local public health officials in order to determine the existence of the disease, its likely cause, and the measures necessary to stop its spread.

NOTE: Authority cited: Sections 207, 208, 304.6 and 3123, Health and Safety Code.

Reference: Sections 200, 207, 304.7, 3053, 3110, 3123, 3194 and 3285, Health and Safety Code; Sections 1209, 1246.5 and 1288, Business and Professions Code; Cal. Const., art. 1, Section 1; and Section 1040 of the Evidence Code.

(8) Amend Section 2514 to read:

**2514. INSTRUCTIONS TO HOUSEHOLD.**

It shall be the duty of the health care provider in attendance on a case or suspected case of any disease or condition listed in Section 2500, or of any other disease considered to be communicable, to give detailed instructions to the members of the household in regard to precautionary measures to be taken for preventing the spread of the disease or condition. Such instructions shall conform to these regulations and local ordinances. It is the responsibility of each health care provider to be informed as to these regulations and the local ordinances which are in effect in the communities in which the health care provider practices.

NOTE: Authority cited: Sections 207, 208 and 3123, Health and Safety Code.

Reference: Sections 207, 208, 3123 and 3285, Health and Safety Code.