

CHAPTER 368a*

DEPARTMENT OF PUBLIC HEALTH

*Cited. 207 C. 346; 228 C. 651.

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Sec. 19a-106. (Formerly Sec. 19-62a). "Restroom" defined.

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Sec. 19a-111h. Review of lead poisoning data. Regulations.

Sec. 19a-111i. Report re lead poisoning prevention efforts.

Sec. 19a-111j. Financial assistance to local health departments for lead poisoning prevention and control.

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Sec. 19a-112a. Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations. Protocol. Sexual assault evidence collection kit. Electronic tracking, transfer, analysis and preservation of evidence. Costs. Training and sexual assault examiner programs. Victim access to information re evidence.

Sec. 19a-112b. Services to victims of sexual acts.

Sec. 19a-112c. Educational materials for sexual assault victims.

Sec. 19a-112d. Sexual assault victims account.

Sec. 19a-112e. Provision of emergency treatment to a victim of sexual assault. Standard of care. Title protection for sexual assault forensic examiners.

Sec. 19a-112f. Sexual Assault Forensic Examiners Advisory Committee. Membership. Recommendation of policies and procedures re sexual assault forensic examiners program. Consideration of recommendations by Office of Victim Services.

Sec. 19a-112g. Sexual assault forensic examiners. Responsibilities.

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Sec. 19a-115. (Formerly Sec. 19-66f). Regulation of medical test units.

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Sec. 19a-118a. Temporary nursing services agencies. Written agreement requirement. Discipline. Exemption from written agreement requirement.

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Secs. 19a-126 to 19a-127j. Transferred

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Sec. 19a-127l. Quality of care program. Quality of Care Advisory Committee.

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Sec. 19a-127r. Connecticut AIDS drug assistance program and Connecticut Insurance Premium Assistance Program. Policies and procedures. Rebates and refunds. Enrollment in or demonstration of ineligibility for Medicare Part D. Payment of premium and coinsurance costs of Medicare Part D.

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Sec. 19a-131k. Mandatory distribution of potassium iodide.

Sec. 19a-131l. Guidelines regarding provision of menstrual products by state agencies and emergency shelters operated by domestic violence agencies receiving state funding.

Sec. 19a-131m. Pandemic preparedness report.

Sec. 19a-132. Transferred

Sec. 19a-133. Declaration of racism as a public health crisis.

Sec. 19a-133a. Commission on Racial Equity in Public Health. Membership of advisory body.

Sec. 19a-133b. Commission on Racial Equity in Public Health. Strategic plan re elimination of health disparities and inequities.

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Sec. 19a-133d. Educational materials re pulse oximeters.

[Sec. 19a-133e. Declaration of homelessness as a public health crisis.](#)

[Sec. 19a-134. Regulations concerning the licensure of psychiatric residential facilities at Albert J. Solnit Children's Center.](#)

Sec. 19a-1. (Formerly Sec. 19-1a). Terms “Commissioner of Health”, “Health Commissioner”, “Department of Health”, or “state Department of Health”, deemed to mean Commissioner or Department of Health Services. Section [19a-1](#) is repealed, effective July 1, 1993.

(P.A. 77-614, S. 323, 610; P.A. 93-381, S. 38, 39.)

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Sec. 19a-1a. Department of Public Health. Successor department to Department of Public Health and Addiction Services. (a) There is established a Department of Public Health. The department head shall be the Commissioner of Public Health, who shall be appointed by the Governor in accordance with the provisions of sections [4-5](#) to [4-8](#), inclusive, with the powers and duties prescribed therein.

(b) The Department of Public Health shall constitute a successor department to the Department of Public Health and Addiction Services for the purposes of the chapters and sections listed in section [19a-1c](#), in accordance with sections [4-38d](#) and [4-39](#).

(c) Any order or regulation of the Department of Public Health and Addiction Services which is in force on July 1, 1995, shall continue in force and effect as an order or regulation of the Department of Public Health until amended, repealed or superseded pursuant to law. Where any order or regulation of said departments conflict, the Commissioner of Public Health may implement policies and procedures consistent with the provisions of public act 95-257* while in the process of adopting the policy or procedure in regulation form, provided notice of intention to adopt the regulations is printed in the Connecticut Law Journal within twenty days of implementation. The policy or procedure shall be valid until the time final regulations are effective.

(P.A. 93-381, S. 1, 39; P.A. 95-257, S. 12, 58.)

*Note: Public act 95-257 is entitled “An Act Concerning the Consolidation of State-Operated Programs at Fairfield Hills, Norwich and Connecticut Valley Hospitals, Transfer of Addiction Services to the Former Department of Mental Health, Medicaid Waiver and the Office of Health Care Access”. (See Reference Table captioned “Public Acts of 1995” in Volume 16 which lists the sections amended, created or repealed by the act.)

History: P.A. 93-381 effective July 1, 1993; P.A. 95-257 replaced Department of Public Health and Addiction Services with Department of Public Health, deleted reference to the department as successor to the Connecticut Alcohol and Drug Abuse Commission and transferred addiction services responsibilities to the Department of Mental Health and Addiction Services, effective July 1, 1995.

See Sec. 1-101aa re provider participation in informal committees, task forces and work groups of department not deemed to be lobbying.

Cited. 242 C. 152.

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Sec. 19a-1b. Department of Public Health and Addiction Services: Administration, operations and programs units. Agency goals. Section [19a-1b](#) is repealed, effective July 1, 1995.

(S.A. 92-20, S. 3 (b), (d); P.A. 93-262, S. 7, 87; P.A. 95-257, S. 57, 58.)

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Sec. 19a-1c. Department of Public Health: Successor department to Department of Public Health and Addiction Services. Terms Commissioner or Department of Public Health and Addiction Services deemed to mean Commissioner or Department of Public Health. Section [19a-1c](#) is repealed, effective October 1, 2002.

(P.A. 93-381, S. 9, 39, 58; P.A. 95-257, S. 21, 58; 95-264, S. 68; 95-360, S. 20, 32; P.A. 96-88, S. 6, 9; 96-185, S. 14, 16; P.A. 97-295, S. 9, 25; P.A. 98-262, S. 14, 22; P.A. 99-102, S. 51; 99-218, S. 15, 16; 99-284, S. 57, 60; P.A. 01-163, S. 29; P.A. 02-89, S. 90; 02-101, S. 14; 02-123, S. 9.)

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Sec. 19a-1d. (Formerly Sec. 19a-3). Commissioner of Public Health: Appointment and qualifications. (a) In accordance with the provisions of sections [4-5](#) to [4-8](#), inclusive, the Governor shall appoint a Commissioner of Public Health, who shall be the administrative head of the department. Said commissioner shall either (1) be a physician, graduated by an acceptable medical college, recognized by one of the medical examining boards of this state, experienced in actual practice of his profession, skilled in sanitary science and experienced in public health administration and shall have had a minimum of one year of university graduate instruction in public health administration as evidenced by a certificate of graduation or a degree in public health or (2) hold a graduate degree in public health. He shall not engage in any other occupation.

(b) Notwithstanding the educational requirements of subsection (a) of this section, a commissioner who has been appointed prior to July 1, 1998, may continue to serve as commissioner and may continue to be reappointed and confirmed for consecutive terms after July 1, 1998.

(1949 Rev., S. 3798; 1959, P.A. 148, S. 2; 1972, P.A. 113, S. 2; P.A. 77-614, S. 341, 610; P.A. 85-337; P.A. 93-381, S. 28, 39; P.A. 95-257, S. 12, 21, 22, 58; P.A. 98-250, S. 38, 39.)

History: 1959 act deleted requirement that commissioner have had at least five years' experience in practice and added provisions for deputy commissioners; 1972 act reduced number of deputy commissioners from three to two; P.A. 77-614 replaced commissioner and department of health with commissioner and department of health services, removed reference to appointment of chairman of public health council, made appointment of deputy commissioners optional rather than mandatory, deleted limit of two deputies, referred to "divisions" rather than "offices" of department and deleted provision whereby deputy commissioner for public health is acting commissioner during absence or disability of commissioner, effective January 1, 1979; Sec. 19-2 transferred to Sec. 19a-3 in 1983; P.A. 85-337 permitted the commissioner of health services to hold a graduate degree in public health as alternative qualification for the position; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; Sec. 19a-3 transferred to Sec. 19a-1d in 1995; P.A. 95-257 replaced Commissioner of Public Health and Addiction Services with Commissioner of Public Health and added Subdiv. (3) re degree and experience, effective July 1, 1995; P.A. 98-250 made existing language Subsec. (a), deleted former Subdiv. (3) re requalification option requiring master's degree in public administration, public policy or public health and at least 10 years' management experience in public health and added Subsec. (b) re exception for existing and reappointed commissioners, effective July 1, 1998.

See Sec. 19a-6 re commissioner's duties with respect to control and treatment of lung disease, chronic illness and medical rehabilitation.

Annotations to former section 19-2:

Cited. 140 C. 478; 165 C. 516.

Cited. 15 CS 468.

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Sec. 19a-2. (Formerly Sec. 19-1b). Department of Health Services. Commissioner. Successor department to Department of Health. Section [19a-2](#) is repealed, effective July 1, 1993.

(P.A. 77-614, S. 322, 610; P.A. 93-381, S. 38, 39.)

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Sec. 19a-2a. Powers and duties. The Commissioner of Public Health shall employ the most efficient and practical means for the prevention and suppression of disease and shall administer all laws under the jurisdiction of the Department of Public Health and the Public Health Code. The commissioner shall have responsibility for the overall operation and administration of the Department of Public Health. The commissioner shall have the power and duty to: (1) Administer, coordinate and direct the operation of the department; (2) adopt and enforce regulations, in accordance with chapter 54, as are necessary to carry out the purposes of the department as established by statute; (3) establish rules for the internal operation and administration of the department; (4) establish and develop programs and administer services to achieve the purposes of the department as established by statute; (5) enter into a contract, including, but not limited to, a contract with another state, for facilities, services and programs to implement the purposes of the department as established by statute; (6) designate a deputy commissioner or other employee of the department to sign any license, certificate or permit issued by said department; (7) conduct a hearing, issue subpoenas, administer oaths, compel testimony and render a final decision in any case when a hearing is required or authorized under the provisions of any statute dealing with the Department of Public Health; (8) with the health authorities of this and other states, secure information and data concerning the prevention and control of epidemics and conditions affecting or endangering the public health, and compile such information and statistics and shall disseminate among health authorities and the people of the state such information as may be of value to them; (9) annually issue a list of reportable diseases, emergency illnesses and health conditions and a list of reportable laboratory findings and amend such lists as the commissioner deems necessary and distribute such lists as well as any necessary forms to each licensed physician, licensed physician assistant, licensed advanced practice registered nurse and clinical laboratory in this state. The commissioner shall prepare printed forms for reports and returns, with such instructions as may be necessary, for the use of directors of health, boards of health and registrars of vital statistics; and (10) specify uniform methods of keeping statistical information by public and private agencies, organizations and individuals, including a client identifier system, and collect and make available relevant statistical information, including the number of persons treated, frequency of admission and readmission, and frequency and duration of treatment. The client identifier system shall be subject to the confidentiality requirements set forth in section [17a-688](#) and regulations adopted thereunder. The commissioner may designate any person to perform any of the duties listed in subdivision (7) of this section. The commissioner shall have authority over directors of health and may, for cause, remove any such director; but any person claiming to be aggrieved by such removal may appeal to the Superior Court which may affirm or reverse the action of the commissioner as the public interest requires. The commissioner shall assist and advise local directors of health and district directors of health in the performance of their duties, and may require the enforcement of any law, regulation or

ordinance relating to public health. In the event the commissioner reasonably suspects impropriety on the part of a local director of health or district director of health, or employee of such director, in the performance of his or her duties, the commissioner shall provide notification and any evidence of such impropriety to the appropriate governing authority of the municipal health authority, established pursuant to section [19a-200](#), or the district department of health, established pursuant to section [19a-244](#), for purposes of reviewing and assessing a director's or an employee's compliance with such duties. Such governing authority shall provide a written report of its findings from the review and assessment to the commissioner not later than ninety days after such review and assessment. When requested by local directors of health or district directors of health, the commissioner shall consult with them and investigate and advise concerning any condition affecting public health within their jurisdiction. The commissioner shall investigate nuisances and conditions affecting, or that he or she has reason to suspect may affect, the security of life and health in any locality and, for that purpose, the commissioner, or any person authorized by the commissioner, may enter and examine any ground, vehicle, apartment, building or place, and any person designated by the commissioner shall have the authority conferred by law upon constables. Whenever the commissioner determines that any provision of the general statutes or regulation of the Public Health Code is not being enforced effectively by a local health department or health district, he or she shall forthwith take such measures, including the performance of any act required of the local health department or health district, to ensure enforcement of such statute or regulation and shall inform the local health department or health district of such measures. In September of each year the commissioner shall certify to the Secretary of the Office of Policy and Management the population of each municipality. The commissioner may solicit and accept for use any gift of money or property made by will or otherwise, and any grant of or contract for money, services or property from the federal government, the state, any political subdivision thereof, any other state or any private source, and do all things necessary to cooperate with the federal government or any of its agencies in making an application for any grant or contract. The commissioner may establish state-wide and regional advisory councils. For purposes of this section, "employee of such director" means an employee of, a consultant employed or retained by or an independent contractor retained by a local director of health, a district director of health, a local health department or a health district.

(P.A. 93-381, S. 2, 39; P.A. 94-174, S. 10, 12; P.A. 95-257, S. 12, 21, 24, 58; P.A. 03-252, S. 1; P.A. 11-242, S. 20; P.A. 14-231, S. 30; P.A. 16-66, S. 41; P.A. 19-98, S. 19; P.A. 21-196, S. 24.)

History: P.A. 93-381 effective July 1, 1993; P.A. 94-174 required commissioner to certify the population of each municipality to the secretary of the office of policy and management in September of each year, effective June 6, 1994; P.A. 95-257 replaced Commissioner of Public Health and Addiction Services with Commissioner and Department of Public Health, deleted responsibilities for coordination of alcohol and drug abuse problems, replaced "complete" with "compel" in Subdiv. (7), deleted duties re alcohol and drug facilities in Subdiv. (10) and added designation authority in Subdiv. (11), effective July 1, 1995; P.A. 03-252 deleted former Subdiv. (11) re requirement that commissioner make annual inspection of hospitals, asylums, prisons, schools and other institutions; P.A. 11-242 amended Subdiv. (9) by requiring commissioner to annually issue a list of emergency illnesses and health conditions and made technical changes; P.A. 14-231 amended Subdiv. (5) by replacing "contract" with "enter into a contract, including, but not limited to, a contract with another state," added provision re commissioner's solicitation and acceptance of grant of or contract for money, service or property from any other state and made technical changes; P.A. 16-66 added provisions re commissioner to notify governing authority of municipal health authority or district department of health of suspected impropriety on part of local director of health, district director of health or employee of director, added provision re governing authority to report findings, added references to district directors of health, added provision defining "employee of such director" and made conforming changes; P.A. 19-98 amended Subdiv. (9) by adding "licensed advanced practice registered nurse"; P.A. 21-196 amended Subdiv. (9) by adding "licensed physician assistant,".

See Sec. 4b-31a re commissioner's role in development of plan for colocation of family resource centers and school-based health clinics.

See Sec. 7-136j re preliminary review of municipal petitions, applications or permit requests.

See Sec. 17b-277a re duty to establish informational program for applicants to Healthy Start Program.

See Sec. 22a-1i re environmental risk assessment duties.

Legislature has vested commissioner with expansive powers with respect to enacting and enforcing public health law, as well as overseeing implementation and coordination of state and municipal health regulations. 263 C. 558.

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Sec. 19a-2b. Commissioner may appear as intervenor for purpose of determining compliance with state health plan. Section [19a-2b](#) is repealed, effective October 1, 2010.

(P.A. 93-381, S. 4, 39; P.A. 95-257, S. 12, 21, 39, 58; Sept. Sp. Sess. P.A. 09-3, S. 27; P.A. 10-179, S. 161.)

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Sec. 19a-2c. Appointment of superintendents of alcohol and drug treatment facilities by the commissioner. Section [19a-2c](#) is repealed, effective July 1, 1995.

(P.A. 93-381, S. 5, 39; P.A. 95-257, S. 57, 58.)

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Secs. 19a-2d to 19a-2f. Transferred to Chapter 319j, Secs. [17a-670](#) to [17a-672](#), inclusive.

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Sec. 19a-2g. Transferred to Chapter 319j, Sec. [17a-679](#).

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Sec. 19a-3. Transferred to Sec. [19a-1d](#).

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Sec. 19a-4. (Formerly Sec. 19-2a). Commissioner to organize department and adopt regulations. Section [19a-4](#) is repealed, effective July 1, 1993.

(P.A. 77-614, S. 324, 325, 610; P.A. 93-381, S. 38, 39.)

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Secs. 19a-4a to 19a-4c. Transferred to Chapter 319j, Secs. [17a-674](#) to [17a-676](#), inclusive.

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Sec. 19a-4d. Transferred to Chapter 319j, Sec. [17a-712](#).

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Sec. 19a-4e. Transferred to Chapter 319j, Sec. [17a-673](#).

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Secs. 19a-4f and 19a-4g. Transferred to Chapter 319j, Secs. [17a-710](#) and [17a-711](#).

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Sec. 19a-4h. Transferred to Chapter 319j, Sec. [17a-713](#).

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Sec. 19a-4i. Office of Injury Prevention. There shall be, within the Department of Public Health, an Office of Injury Prevention, whose purpose shall be to coordinate and expand prevention and control activities related to intentional and unintentional injuries. The duties of said office shall include, but are not limited to, the following: (1) To serve as a data coordinator and analysis source of mortality and injury statistics for other state agencies; (2) to integrate an injury and violence prevention focus within the Department of Public Health; (3) to develop collaborative relationships with other state agencies and private and community organizations to establish programs promoting injury prevention, awareness and education to reduce automobile, motorcycle and bicycle injuries and interpersonal violence, including homicide, child abuse, youth violence, domestic violence, sexual assault and elderly abuse; (4) to support the development of comprehensive community-based injury and violence prevention initiatives within cities and towns of the state; and (5) to develop sources of funding to establish and continue programs to promote prevention of intentional and unintentional injuries.

(P.A. 93-269, S. 1, 4; 93-381, S. 9, 39; 93-435, S. 59, 95; P.A. 95-257, S. 12, 21, 58.)

History: P.A. 93-269 effective July 1, 1993 (Revisor's note: Pursuant to P.A. 93-381 and P.A. 93-435 department of health services was changed editorially by the Revisors to department of public health and addiction services); P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

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Sec. 19a-4j. Office of Health Equity. (a) There is established, within the Department of Public Health, an Office of Health Equity. The responsibility of the office is to improve the health of all Connecticut residents by working to eliminate differences in disease, disability and death rates among ethnic, racial and other population groups that are known to have adverse health status or outcomes. Such population groups may be based on race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, mental illness or geographic area of residence.

(b) The department may apply for, accept and expend such funds as may be available from federal, state or other sources and may enter into contracts to carry out the responsibilities of the office.

(c) The office shall assist the department in its efforts in the following areas:

(1) Monitor the health status of persons reporting membership in one of the following racial or ethnic groups: Hispanic or Latino, American Indian or Alaska Native, Asian, black or African American, Native Hawaiian or other Pacific Islander and persons reporting more than one race;

(2) Compare the results of the health status monitoring with the health status of persons reporting membership as white, non-Hispanic;

(3) Assess the effectiveness of state programs in eliminating differences in health status;

(4) Assess the health education and health resource needs of ethnic, racial and other population groups listed in subdivision (1) of this subsection; and

(5) Maintain a directory of, and promote culturally and linguistically appropriate health resources in Connecticut.

(d) The office may:

(1) Provide grants for culturally and linguistically appropriate health demonstration projects and may apply for, accept and expend public and private funding for such projects; and

(2) Recommend policies, procedures, activities and resource allocations to improve health among racial, ethnic and other population groups for which there may be health disparities.

(P.A. 98-250, S. 8, 39; P.A. 11-242, S. 31; P.A. 14-231, S. 5.)

History: P.A. 98-250 effective July 1, 1998; P.A. 11-242 deleted former Subsec. (e) re commissioner's annual report and office's responsibility to hold community workshops; P.A. 14-231 replaced "Office of Multicultural Health" with "Office of Health Equity", substantially revised Subsecs. (a) and (c) re responsibility of office, amended Subsec. (d) by inserting "and linguistically" and deleting "education" in Subdiv. (1) and by replacing "cultural populations in Connecticut" with "other population groups for which there may be health disparities" in Subdiv. (2).

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Sec. 19a-4k. Advisory Commission on Multicultural Health. Section [19a-4k](#) is repealed, effective June 12, 2008.

(P.A. 00-216, S. 11, 28; June Sp. Sess. P.A. 00-1, S. 14, 46; P.A. 08-171, S. 2.)

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Sec. 19a-4l. Office of Oral Public Health. There is established, within the Department of Public Health, an Office of Oral Public Health. The director of the Office of Oral Public Health shall be (1) a dental health professional with experience in public health and a license to practice under chapter 379 or 379a, (2) a person who holds the degree of doctor of medicine or doctor of osteopathy from an accredited institution of higher education, or (3) a public health professional with a graduate degree in public health, and shall:

(A) Coordinate and direct state activities with respect to state and national dental public health programs;

(B) Serve as the department's chief advisor on matters involving oral health; and

(C) Plan, implement and evaluate all oral health programs within the department.

(P.A. 07-252, S. 46; P.A. 10-117, S. 59; P.A. 12-197, S. 5; P.A. 18-168, S. 50.)

History: P.A. 07-252 effective July 1, 2007; P.A. 10-117 replaced “an experienced public health dentist licensed” with “a dental health professional with a graduate degree in public health and hold a license” and added “or 379a”; P.A. 12-197 replaced requirement for a graduate degree in public health with requirement for experience in public health and made a technical change; P.A. 18-168 designated existing provisions re dental health professional as new Subdiv. (1), added new Subdiv. (2) re person holding degree of doctor of medicine or doctor of osteopathy, and added new Subdiv. (3) re public health professional, and redesignated existing Subdivs. (1) to (3) as Subparas. (A) to (C).

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Sec. 19a-5. (Formerly Sec. 19-4). Powers and duties of commissioner. Section [19a-5](#) is repealed, effective July 1, 1993.

(1949, Rev., S. 3801; 1959, P.A. 148, S. 4; 1971, P.A. 282; 1972, P.A. 108, S. 4; P.A. 73-616, S. 14; P.A. 76-436, S. 374, 681; P.A. 77-614, S. 323, 342, 610; P.A. 85-149; 85-155; P.A. 88-362, S. 16; June Sp. Sess. P.A. 91-11, S. 12, 25; P.A. 93-49, S. 1, 3; 93-381, S. 38, 39.)

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Secs. 19a-5a and 19a-5b. Transferred to Chapter 319j, Secs. [17a-677](#) and [17a-678](#).

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Sec. 19a-5c. Transferred to Chapter 319i, Sec. [17a-465a](#).

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Sec. 19a-6. (Formerly Sec. 19-4a). Commissioner to plan and administer programs for control and treatment of lung disease and chronic illness and for medical rehabilitation. (a) The commissioner shall be responsible for planning state-wide programs for the control and treatment of lung diseases; the treatment of persons affected with other chronic illness, and the medical rehabilitation of persons who are chronically ill and persons with disabilities. The commissioner may provide and maintain facilities and personnel for the diagnosis or detection and treatment of such diseases or enter into contracts for the provision of diagnostic and treatment programs for such diseases with persons or organizations capable in the commissioner's judgment of providing such services.

(b) The commissioner shall be responsible for the administration of the department's programs as they relate to lung disease, other chronic illness and medical rehabilitation.

(1959, P.A. 148, S. 11, 12; 1972, P.A. 113, S. 3; P.A. 76-139, S. 2; P.A. 77-614, S. 323, 343, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 05-80, S. 2; P.A. 17-202, S. 66.)

History: 1972 act replaced office of tuberculosis control, hospital care and rehabilitation with office of public health and replaced provisions re appointment and qualifications of deputy commissioner of the former office with statement of duties of deputy commissioner for public health; P.A. 76-139 replaced references to tuberculosis with more general phrase “lung disease”, deleted provision specifically applicable to tuberculosis program with general statement of duty to maintain programs for lung diseases and removed provision excluding hospitals for the mentally retarded from consideration as “chronic

disease hospitals”; P.A. 77-614 transferred responsibilities of office and deputy commissioner of public health and of council on tuberculosis control, hospital care and rehabilitation to commissioner and replaced commissioner and department of health with commissioner and department of health services, effective January 1, 1979; Sec. 19-4a transferred to Sec. 19a-6 in 1983; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 05-80 amended Subsec. (a) to allow, rather than require, commissioner to provide and maintain facilities and personnel and to make a technical change, and amended Subsec. (b) by removing language requiring commissioner to administer and operate chronic disease hospitals and definitions of “chronic illness”, “chronic disease hospital” and “medical rehabilitation”; P.A. 17-202 amended Subsec. (a) by replacing “chronically ill, physically disabled and handicapped persons” with “persons who are chronically ill and persons with disabilities”.

See chapter 368g re lung disease, tuberculosis and other chronic illness.

Annotation to former section 19-4a:

Former statute cited. 138 C. 139.

Annotation to present section:

Cited. 33 CA 673.

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Sec. 19a-6a. Commissioner to implement outreach programs on chronic fatigue and immune dysfunction syndrome. The Commissioner of Public Health shall implement using existing structures, state-wide informational outreach programs on chronic fatigue and immune dysfunction syndrome. The programs shall include medical and patient education programs and public awareness campaigns.

(P.A. 93-211, S. 1; 93-381, S. 9, 39; 93-435, S. 59, 95; P.A. 95-257, S. 12, 21, 58.)

History: P.A. 93-381 and P.A. 93-435 authorized substitution of commissioner and department of public health and addiction services for commissioner and department of health services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

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Sec. 19a-6b. Commissioner to allow assisted living services in congregate housing pilot program. The Commissioner of Public Health shall allow state-funded congregate facilities to provide assisted living services pursuant to section [8-119n](#).

(June 18 Sp. Sess. P.A. 97-2, S. 153, 165.)

History: June 18 Sp. Sess. P.A. 97-2 effective July 1, 1997.

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Sec. 19a-6c. Assisted living services in state-funded congregate housing facilities. Regulations. (a) The Commissioner of Public Health shall allow state-funded congregate housing facilities to provide assisted living services through licensed assisted living services agencies, as defined in section [19a-490](#).

(b) In order to facilitate the development of assisted living services in state-funded congregate housing facilities, the Commissioner of Public Health may waive any provision of the regulations for assisted living services agencies, as defined in section [19a-490](#), which provide services in state-funded congregate housing facilities. No waiver of such regulations shall be made if the commissioner determines that the waiver would: (1) Endanger the life, safety or health of any resident receiving assisted living services in a state-funded congregate housing facility; (2) impact the quality or provision of services provided to a resident in a state-funded congregate housing facility; (3) revise or eliminate the requirements for an assisted living services agency's quality assurance program; (4) revise or eliminate the requirements for an assisted living services agency's grievance and appeals process; or (5) revise or eliminate the assisted living services agency's requirements relative to a client's bill of rights and responsibilities. The commissioner, upon the granting of a waiver of any provision of such regulations, may impose conditions which assure the health, safety and welfare of residents receiving assisted living services in a state-funded congregate housing facility. The commissioner may revoke such a waiver upon a finding (A) that the health, safety or welfare of any such resident is jeopardized, or (B) that such facility has failed to comply with such conditions as the commissioner may impose pursuant to this subsection.

(c) The provisions of sections [19a-693](#) to [19a-701](#), inclusive, shall not apply to any state-funded congregate housing facility.

(d) The Commissioner of Public Health may adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of this section. Said commissioner may implement the waiver of provisions as specified in subsection (b) of this section until January 1, 2002, while in the process of adopting criteria for the waiver process in regulation form, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal within twenty days after implementation.

(June Sp. Sess. P.A. 00-2, S. 8; June Sp. Sess. P.A. 07-2, S. 43.)

History: June Sp. Sess. P.A. 07-2 added new Subsec. (c) specifying that provisions of Secs. 19a-693 to 19a-701, inclusive, shall not apply to any state-funded congregate housing facility, and redesignated existing Subsec. (c) as Subsec. (d).

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Sec. 19a-6d. Tobacco abuse reduction and health plan. The Commissioner of Public Health and the Commissioner of Mental Health and Addiction Services shall, within available appropriations, develop a tobacco abuse reduction and health plan and shall submit such plan to the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations and the budgets of state agencies, not later than April 1, 2001. The plan shall consider and recommend actions to (1) reduce tobacco and substance abuse, and (2) address the unmet physical and mental health needs of the state, taking into account the most recent version of the state health plan prepared by the Department of Public Health pursuant to section [19a-7](#).

(P.A. 00-216, S. 16, 28.)

History: P.A. 00-216 effective June 1, 2000.

See Sec. 4-28f re Tobacco and Health Trust Fund.

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Sec. 19a-6e. Traumatic brain injury patient registry. The Department of Public Health shall establish a registry of data on traumatic brain injury patients. Each hospital, as defined in section [19a-490](#), shall make available to the registry such data concerning each traumatic brain injury patient admitted to such

hospital as the Commissioner of Public Health shall require by regulations adopted in accordance with chapter 54. The data contained in such registry may be used by the department and authorized researchers as specified in such regulations, provided personally identifiable information in such registry concerning any such traumatic brain injury patient shall be held confidential pursuant to section [19a-25](#). The data contained in the registry shall not be subject to disclosure under the Freedom of Information Act, as defined in section [1-200](#). The commissioner may enter into a contract with a nonprofit association in this state concerned with the prevention and treatment of brain injuries to provide for the implementation and administration of the registry established pursuant to this section.

(P.A. 01-90, S. 2; P.A. 05-272, S. 42.)

History: P.A. 05-272 replaced former provisions re disclosure of information with requirement that personally identifiable information in traumatic brain injury registry be held confidential pursuant to Sec. 19a-25, effective July 13, 2005.

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Sec. 19a-6f. Listing of certified medical assistants. Section [19a-6f](#) is repealed, effective October 1, 2022.

(P.A. 04-82, S. 1; P.A. 16-66, S. 43; P.A. 22-58, S. 78.)

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Sec. 19a-6g. HealthFirst Connecticut Authority. Members. Duties. Report. Application for financial assistance. Section [19a-6g](#) is repealed, effective July 1, 2013.

(P.A. 07-185, S. 30; June Sp. Sess. P.A. 07-2, S. 67; P.A. 08-184, S. 18; P.A. 13-299, S. 95.)

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Sec. 19a-6h. State-wide Primary Care Access Authority. Members. Duties. Consultants and assistants. Report. (a) There is established a State-wide Primary Care Access Authority. The authority shall consist of the Commissioners of Public Health and Social Services, the Comptroller and the following members: One each appointed by the Connecticut Primary Care Association, the Connecticut State Medical Society, the Connecticut Chapter of the American Academy of Pediatrics, the Connecticut Nurses Association, the Connecticut Association of School-Based Health Centers, the Connecticut State Dental Association, the Connecticut Community Providers Association and the Weitzman Center for Innovation In Community Health and Primary Care and two appointed by the Commissioner of Public Health. Members shall serve for a term of four years commencing on August 1, 2007. All initial appointments to the committee shall be made by July 15, 2007. Any vacancy shall be filled by the appointing authority.

(b) The members of the State-wide Primary Care Access Authority shall elect cochairpersons from among the members of the authority. Members shall serve without compensation but shall, within available appropriations, be reimbursed for expenses necessarily incurred in the performance of their duties.

(c) The chairpersons shall convene the first meeting of the State-wide Primary Care Access Authority not later than October 1, 2007. Any member who fails to attend three consecutive meetings or who fails to attend fifty per cent of all meetings held during any calendar year shall be deemed to have resigned from the committee.

(d) All members appointed to the authority shall be familiar with the criteria of the Institute of Medicine of the National Academies Principles for Healthcare Reform and shall be committed to making

recommendations about health care reform for the state of Connecticut that are consistent with said criteria.

(e) The State-wide Primary Care Access Authority shall:

(1) Determine what constitutes primary care services for purposes of subdivisions (2) to (4), inclusive, of this section;

(2) Inventory the state's existing primary care infrastructure, including, but not limited to, (A) the number of primary care providers practicing in the state, (B) the total amount of money expended on public and private primary care services during the last fiscal year, (C) the number of public and private buildings or offices used primarily for the rendering of primary care services, including, but not limited to, hospitals, mental health facilities, dental offices, school-based health clinics, community-based health centers and academic health centers. For the purposes of this subdivision, "primary care provider" means any physician, dentist, nurse, provider of services for persons with psychiatric disabilities or persons with intellectual disability, or other person involved in providing primary medical, nursing, counseling, or other health care, substance abuse or mental health service, including such services associated with, or under contract to, a health maintenance organization or medical services plan.

(3) Not later than December 31, 2008, develop a universal system for providing primary care services, including prescription drugs, to all residents of the state that maximizes federal financial participation in Medicaid and Medicare. The committee shall (A) estimate the cost of fully implementing such universal system, (B) identify any additional infrastructure or personnel that would be necessary in order to fully implement such universal system, (C) determine the state's role and the role of third party entities in administering such universal system, (D) identify funding sources for such universal system, and (E) determine the role of private health insurance in such universal system.

(4) Develop a plan for implementing by July 1, 2010, the universal primary care system developed pursuant to subdivision (3) of this section. Such plan shall (A) include a timetable for implementation of the universal primary care system, (B) establish benchmarks to assess the state's progress in implementing the system, and (C) establish mechanisms for assessing the effectiveness of the primary care system, once implemented.

(f) The State-wide Primary Care Access Authority may (1) retain and employ consultants or assistants on a contract or other basis for rendering professional, legal, financial, technical or other assistance or advice as may be required to carry out its duties or responsibilities, and (2) apply for grants or financial assistance from any person, group of persons or corporation or from any agency of the state or of the United States.

(g) On or before February 1, 2008, and annually thereafter on or before January first, the State-wide Primary Care Access Authority shall report to the joint standing committees of the General Assembly having cognizance of matters relating to public health, insurance and human services, in accordance with the provisions of section [11-4a](#), concerning its progress in developing the universal primary care services system and the implementation plan for such system.

(P.A. 07-185, S. 31; P.A. 08-184, S. 19; P.A. 13-139, S. 27; 13-299, S. 18.)

History: P.A. 07-185 effective July 10, 2007; P.A. 08-184 amended Subsec. (a) by authorizing Connecticut State Dental Society and Connecticut Community Providers Association to each appoint one member to the authority, effective June 12, 2008; P.A. 13-139 amended Subsec. (e)(2) by substituting "persons with psychiatric disabilities or persons with intellectual disability" for "the mentally ill or persons with mental retardation"; P.A. 13-299 amended Subsec. (a) to delete provision re chairpersons of HealthFirst Connecticut Authority as members and add provision re 2 members appointed by Commissioner of Public Health and amended Subsec. (b) to delete provision requiring chairpersons of HealthFirst Connecticut

Authority to act as cochairpersons and add provision re cochairpersons to be elected from among members, effective July 1, 2013.

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Sec. 19a-6i. School-based health center advisory committee. Members. Duties. Report. (a) There is established a school-based health center advisory committee for the purpose of advising the Commissioner of Public Health on matters relating to (1) statutory and regulatory changes to improve health care through access to school-based health centers and expanded school health sites, (2) minimum standards for the provision of services in school-based health centers and expanded school health sites to ensure that high quality health care services are provided in school-based health centers and expanded school health sites, as such terms are defined in section [19a-6r](#), and (3) other topics of relevance to the school-based health centers and expanded school sites, as requested by the commissioner.

(b) The committee shall be composed of the following members:

(1) One appointed by the speaker of the House of Representatives, who shall be a family advocate or a parent whose child utilizes school-based health center services;

(2) One appointed by the president pro tempore of the Senate, who shall be a school nurse;

(3) One appointed by the majority leader of the House of Representatives, who shall be a representative of a school-based health center that is sponsored by a community health center;

(4) One appointed by the majority leader of the Senate, who shall be a representative of a school-based health center that is sponsored by a nonprofit health care agency;

(5) One appointed by the minority leader of the House of Representatives, who shall be a representative of a school-based health center that is sponsored by a school or school system;

(6) One appointed by the minority leader of the Senate, who shall be a representative of a school-based health center that does not receive state funds;

(7) Two appointed by the Governor, one of whom shall be a representative of the Connecticut Chapter of the American Academy of Pediatrics and one of whom shall be a representative of a school-based health center that is sponsored by a hospital, a staff member of a children's hospital or a pediatric health care clinician;

(8) Three appointed by the Commissioner of Public Health, one of whom shall be a representative of a school-based health center that is sponsored by a local health department, one of whom shall be from a municipality that has a population of at least fifty thousand but less than one hundred thousand and that operates a school-based health center and one of whom shall be from a municipality that has a population of at least one hundred thousand and that operates a school-based health center;

(9) The Commissioner of Public Health, or the commissioner's designee;

(10) The Commissioner of Social Services, or the commissioner's designee;

(11) The Commissioner of Mental Health and Addiction Services, or the commissioner's designee;

(12) The Commissioner of Education, or the commissioner's designee;

(13) The Commissioner of Children and Families, or the commissioner's designee;

- (14) The executive director of the Commission on Women, Children, Seniors, Equity and Opportunity, or the executive director's designee; and
- (15) Three school-based health center providers, one of whom shall be the executive director of the Connecticut Association of School-Based Health Centers and two of whom shall be appointed by the board of directors of the Connecticut Association of School-Based Health Centers.
- (c) Any appointment that is vacant for one year or more shall be made by the Commissioner of Public Health. The Commissioner of Public Health shall notify the appointing authority of the commissioner's choice of member for appointment not less than thirty days before making such appointment.
- (d) The committee shall meet not less than quarterly. On or before January 1, 2020, and biennially thereafter, the committee shall report, in accordance with the provisions of section [11-4a](#), on its activities to the joint standing committees of the General Assembly having cognizance of matters relating to public health and education.
- (e) Administrative support for the activities of the committee may be provided by the Department of Public Health.

(P.A. 07-185, S. 32; P.A. 11-242, S. 44; P.A. 13-287, S. 1; P.A. 15-59, S. 2; May Sp. Sess. P.A. 16-3, S. 156; P.A. 17-146, S. 29; P.A. 18-168, S. 5; P.A. 19-117, S. 129; 19-118, S. 1; P.A. 24-68, S. 4.)

History: P.A. 07-185 effective July 10, 2007; P.A. 11-242 replaced former provisions with Subsecs. (a) to (d) re school-based health center advisory committee, effective July 13, 2011; P.A. 13-287 amended Subsec. (a) by replacing “assisting the Commissioner of Public Health in developing recommendations for” with “advising the Commissioner of Public Health on matters relating to”, designating existing provision re statutory and regulatory changes as Subdiv. (1), and adding Subdiv. (2) re minimum standards, amended Subsec. (b) by adding new Subdiv. (1) re appointment by speaker of the House of Representatives, new Subdiv. (2) re appointment by president pro tempore of the Senate, new Subdiv. (3) re appointment by majority leader of the House of Representatives, new Subdiv. (4) re appointment by majority leader of the Senate, new Subdiv. (5) re appointment by minority leader of the House of Representatives, Subdiv. (6) re appointment by minority leader of the Senate, Subdiv. (7) re appointments by Governor, Subdiv. (8) re appointment by Commissioner of Public Health and Subdiv. (13) re executive director of Commission on Children, redesignating existing Subdivs. (1) to (4) and (5) as Subdivs. (9) to (12) and (14), respectively, and amending redesignated Subdiv. (14) to add provision re executive director of Connecticut Association of School-Based Health Centers and make a technical change, amended Subsec. (c) by substituting “January 1, 2014,” for “January 1, 2012,” and amended Subsec. (d) by substituting “Department of Public Health” for “Connecticut Association of School-Based Health Centers”; P.A. 15-59 amended Subsec. (a) by adding references to expanded school health sites and definitions in Sec. 19a-6r; May Sp. Sess. P.A. 16-3 amended Subsec. (b)(13) by substituting “Commission on Women, Children and Seniors” for “Commission on Children”, effective July 1, 2016; P.A. 17-146 amended Subsec. (a) by adding Subdiv. (3) re other topics of relevance to school-based health centers and expanded school sites, and made a conforming change, effective June 30, 2017; P.A. 18-168 amended Subsec. (b) by adding provisions re appointments of representatives of a municipality with population of at least 50,000 but less than 100,000 that operates a school-based health center and a representative of a municipality with population of at least 100,000 that operates a school-based health center, adding new Subdiv. (13) re Commissioner of Children and Families, and redesignating existing Subdivs. (13) and (14) as Subdivs. (14) and (15); P.A. 19-117 amended Subsec. (b)(14) by replacing “Commission on Women, Children and Seniors” with “Commission on Women, Children, Seniors, Equity and Opportunity”, effective July 1, 2019; P.A. 19-118 added new Subsec. (c) re vacant appointments, redesignated existing Subsec. (c) as new Subsec. (d) and amended same to replace “2014” with “2020” and replace “annually” with “biennially” re reports, and redesignated existing Subsec. (d) as Subsec. (e), effective July 1, 2019; P.A. 24-68 amended Subsec. (b)(7) by deleting “each” and requiring second Governor's appointment to comply with existing provision re representative of school-based health center sponsored by hospital or new provisions re staff member of children's hospital and pediatric health care clinician, effective May 28, 2024.

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Secs. 19a-6j to 19a-6l. Interagency and Partnership Advisory Panel on Lupus; membership. Interagency and Partnership Advisory Panel on Lupus; duties. Assistance to the Interagency and Partnership Advisory Panel on Lupus from the Department of Public Health. Sections [19a-6j](#) to [19a-6l](#), inclusive, are repealed, effective October 1, 2017.

(P.A. 11-23, S. 1–3; P.A. 12-197, S. 17; May Sp. Sess. P.A. 16-3, S. 157; P.A. 17-146, S. 48.)

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Sec. 19a-6m. Advisory council on organ and tissue donation education and awareness. Members. Duties. Report. (a) There is established an advisory council on organ and tissue donation education and awareness. The advisory council shall consist of the following members: The Commissioner of Motor Vehicles, or the commissioner's designee; the Commissioner of Public Health, or the commissioner's designee; the executive director of Donate Life Connecticut, or the executive director's designee; a representative of each of the organizations in the state that are members of the Association of Organ Procurement Organizations; a health care professional representing each transplant center located in the state that is a member of the federal Organ Procurement and Transplantation Network; the chief executive officer of the Connecticut Hospital Association, or the chief executive officer's designee; five persons experienced in issues involving organ and tissue donation or transplants, one of whom shall be a recipient of a donated organ or donated tissue, one of whom shall be a living donor, and one of whom shall be a family member of a deceased donor. One each of such persons experienced in issues involving organ and tissue donation or transplants shall be appointed by the Governor, the president pro tempore of the Senate, the speaker of the House of Representatives, jointly by the majority leader of the House of Representatives and the majority leader of the Senate, and jointly by the minority leader of the House of Representatives and the minority leader of the Senate.

(b) Appointed council members shall serve for a term of three years and no such member shall serve more than two consecutive terms. Any vacancy of an appointed council member shall be filled by the appointing authority. The Governor shall appoint the chairperson from among the members of the council. The council shall have its first meeting not later than December 1, 2012, and shall meet not less than four times per year and as requested by the chairperson or upon the request of a majority of the members of the council. Council members shall serve without compensation.

(c) The council shall: (1) Analyze education on organ tissue donation in the state; (2) determine the rate of organ and tissue donation registration in the state and establish periodic goals for increasing such rate; and (3) advise the Commissioners of Public Health and Motor Vehicles on methods to increase organ and tissue donation rates in the state. The Commissioner of Motor Vehicles shall, on a quarterly basis, provide the council with data concerning registered organ donors.

(d) Not later than July 1, 2013, and annually thereafter, the council shall report, in accordance with the provisions of section [11-4a](#), to the joint standing committees of the General Assembly having cognizance of matters relating to public health and transportation concerning organ and tissue donation awareness in the state. Such report shall include, but not be limited to, actions taken by the council to increase organ and tissue donations and recommendations to increase organ and tissue donation rates in the state.

(P.A. 12-197, S. 44.)

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Sec. 19a-6n. Advisory council on pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections and pediatric acute neuropsychiatric syndrome. Report. Section [19a-6n](#) is repealed, effective October 1, 2017.

(P.A. 13-187, S. 2; 13-208, S. 71; P.A. 14-231, S. 59; P.A. 15-242, S. 25; P.A. 17-146, S. 48.)

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Sec. 19a-6o. Palliative Care Advisory Council. Duties. Members. Report. (a) There is established, within available appropriations, within the Department of Public Health, a Palliative Care Advisory Council. The advisory council shall: (1) Analyze the current state of palliative care in the state; and (2) advise the department on matters relating to the improvement of palliative care and the quality of life for persons with serious or chronic illnesses.

(b) The advisory council shall consist of the following members:

(1) Two appointed by the Governor, one of whom shall be a physician certified by the American Board of Hospice and Palliative Medicine and one of whom shall be a registered nurse or advanced practice registered nurse certified by the National Board for Certification of Hospice and Palliative Nurses;

(2) Seven appointed by the Commissioner of Public Health, each of whom shall be a licensed health care provider, with each appointee having experience or expertise in the provision of one of the following: (A) Inpatient palliative care in a hospital; (B) inpatient palliative care in a nursing home facility; (C) palliative care in the patient's home or a community setting; (D) pediatric palliative care; (E) palliative care for young adults; (F) palliative care for adults or elderly persons; and (G) inpatient palliative care in a psychiatric facility;

(3) One appointed by the speaker of the House of Representatives, who shall be a licensed social worker experienced in working with persons with serious or chronic illness and their family members;

(4) One appointed by the president pro tempore of the Senate, who shall be a licensed pharmacist experienced in working with persons with serious or chronic illness;

(5) One appointed by the minority leader of the House of Representatives, who shall be a spiritual counselor experienced in working with persons with serious or chronic illness and their family members; and

(6) One appointed by the minority leader of the Senate, who shall be a representative of the American Cancer Society or a person experienced in advocating for persons with serious or chronic illness and their family members.

(c) All initial appointments to the advisory council shall be made not later than December 31, 2013. Advisory council members shall serve three-year terms. Except as provided in subsection (d) of this section, any vacancy shall be filled by the appointing authority.

(d) Any appointment that is vacant for one year or more shall be made by the Commissioner of Public Health. The commissioner shall notify the appointing authority of the identity of the commissioner's choice for appointment not later than thirty days before making such appointment.

(e) Members shall receive no compensation except for reimbursement for necessary expenses incurred in performing their duties.

(f) The members shall elect the chairperson of the advisory council from among the members of the advisory council. A majority of the advisory council members shall constitute a quorum. Any action taken

by the advisory council shall require a majority vote of those present. The first meeting of the advisory council shall be held not later than December 31, 2013. The advisory council shall meet biannually and at other times upon the call of the chairperson, upon the request of the Commissioner of Public Health or upon the request of a majority of the advisory council members.

(g) Not later than January 1, 2022, and biennially thereafter, the advisory council shall submit a report on its findings and recommendations to the Commissioner of Public Health and the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section [11-4a](#).

(P.A. 13-55, S. 1; P.A. 21-121, S. 33; P.A. 22-92, S. 13.)

History: P.A. 21-121 added new Subsec. (d) re commissioner appointments for vacancies of 1 year or more, redesignated existing Subsecs. (d) and (e) as Subsecs. (e) and (f), redesignated existing Subsec. (f) as Subsec. (g) and amended same to replace “January 1, 2015” with “January 1, 2022” and “annually” with “biennially”, effective July 1, 2021; P.A. 22-92 amended Subsec. (c) by making technical changes, effective May 24, 2022.

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Sec. 19a-6p. School-based health centers. Hours. Services. Reimbursement for services. Any school-based health center may (1) extend its hours of operation, (2) provide services to students who do not reside in the school district that such school-based health center is located, (3) provide behavioral health services, (4) expand the health care services provided by such school-based health center, (5) conduct community outreach relating to services provided by such school-based health center, and (6) receive reimbursement for services from private insurance. Any services provided by a school-based health center under this section shall be provided in accordance with the terms of any license issued by the Department of Public Health to such school-based health center.

(P.A. 13-247, S. 193.)

History: P.A. 13-247 effective July 1, 2013.

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Sec. 19a-6q. Chronic disease plan. The Commissioner of Public Health, in consultation with the Commissioner of Health Strategy and local and regional health departments, shall, within available resources, develop a plan that is consistent with the Department of Public Health's Healthy Connecticut 2020 health improvement plan and the state healthcare innovation plan developed pursuant to the State Innovation Model Initiative by the Centers for Medicare and Medicaid Services Innovation Center. The Commissioner of Public Health shall develop and implement such plan to: (1) Reduce the incidence of tobacco use, high blood pressure, health care associated infections, asthma, unintended pregnancy and diabetes; (2) improve chronic disease care coordination in the state; and (3) reduce the incidence and effects of chronic disease and improve outcomes for conditions associated with chronic disease in the state. The Commissioner of Public Health shall post such plan on the Department of Public Health's Internet web site.

(P.A. 14-148, S. 1; P.A. 18-91, S. 61; P.A. 19-118, S. 21; P.A. 21-121, S. 34; P.A. 24-81, S. 185.)

History: P.A. 18-91 replaced references to Lieutenant Governor, or Lieutenant Governor's designee, with references to executive director of the Office of Health Strategy, effective May 14, 2018; P.A. 19-118 amended Subsec. (a)(1) by replacing provision re chronic disease with “tobacco use, high blood pressure, health care associated infections, asthma, unintended pregnancy and diabetes”, effective July 1, 2019; P.A.

21-121 deleted Subsec. (a) designator, added provision re commissioner to post plan on department's Internet web site and deleted former Subsec. (b) re biennial report, effective July 6, 2021; P.A. 24-81 replaced references to executive director of the Office of Health Strategy with references to Commissioner of Health Strategy and made a conforming change, effective May 30, 2024.

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Sec. 19a-6r. School-based health centers and expanded school health sites. Definitions. Use of title. Regulations. (a) As used in sections [19a-6i](#), [19a-7d](#) and [19a-638](#):

(1) “School-based health center” means a health center that: (A) Is located in, or on the grounds of, a school facility of a school district or school board or of an Indian tribe or tribal organization; (B) is organized through school, community and health provider relationships; (C) is administered by a sponsoring facility; and (D) provides comprehensive on-site medical and behavioral health services to children and adolescents in accordance with state and local law, including laws relating to licensure and certification.

(2) “Expanded school health site” means a health center that: (A) Is located in, or on the grounds of, a school facility of a school district or school board; (B) is organized through school, community and health provider relationships; (C) is administered by a sponsoring facility; and (D) provides medical or behavioral services, including, but not limited to, dental services, counseling, health education, health screening and prevention services, to children and adolescents in accordance with state and local law, including laws relating to licensure and certification.

(3) “Sponsoring facility” means a: (A) Hospital; (B) public health department; (C) community health center; (D) nonprofit health or human services agency; (E) school or school system; or (F) program administered by the Indian Health Service or the Bureau of Indian Affairs or operated by an Indian tribe or a tribal organization.

(b) No person or entity shall use the term “school-based health center” to describe a facility or make use of any words, letters or abbreviations that may reasonably be confused with said term unless the facility meets the definition of a school-based health center in subsection (a) of this section.

(c) The Department of Public Health may adopt regulations, in accordance with the provisions of chapter 54, to establish minimum quality standards for school-based health centers, as defined in subsection (a) of this section.

(P.A. 15-59, S. 1.)

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Sec. 19a-6s. Provision of vaccines by clinical medical assistants under supervision. (a) For purposes of this section, “clinical medical assistant” means a person who (1) (A) is certified by the American Association of Medical Assistants, the National Healthcareer Association, the National Center for Competency Testing, the American Medical Technologists or the American Medical Certification Association, and (B) has graduated from a postsecondary medical assisting program (i) that is accredited by the Commission on Accreditation of Allied Health Education Programs, the Accrediting Bureau of Health Education Schools or another accrediting organization recognized by the United States Department of Education, or (ii) offered by an institution of higher education accredited by an accrediting organization recognized by the United States Department of Education and that includes a total of seven hundred twenty hours, including one hundred sixty hours of clinical practice skills, including, but not limited to, administering injections, or (2) has completed relevant medical assistant training provided by any branch of the armed forces of the United States.

(b) A clinical medical assistant may administer a vaccine under the supervision, control and responsibility of a physician licensed pursuant to chapter 370, a physician assistant licensed pursuant to chapter 370 or an advanced practice registered nurse licensed pursuant to chapter 378 to any person in any setting other than a hospital setting. Prior to administering a vaccine, a clinical medical assistant shall complete not less than twenty-four hours of classroom training and not less than eight hours of training in a clinical setting regarding the administration of vaccines. Nothing in this section shall be construed to permit an employer of a physician, a physician assistant or an advanced practice registered nurse to require the physician, physician assistant or advanced practice registered nurse to oversee a clinical medical assistant in the administration of a vaccine without the consent of the physician, physician assistant or advanced practice registered nurse.

(c) On or before January first annually, the Commissioner of Public Health shall obtain from the American Association of Medical Assistants, the National Healthcareer Association, the National Center for Competency Testing, the American Medical Technologists and the American Medical Certification Association a listing of all state residents maintained on said organizations' registries of certified medical assistants. The commissioner shall make such listings available for public inspection.

(P.A. 22-58, S. 47; 22-92, S. 25; 22-93, S. 1; P.A. 24-68, S. 37.)

History: P.A. 22-92 amended Subsec. (a) to change “January 1, 2024” to “January 1, 2023”; P.A. 22-93 amended Subsec. (a) to delete “on and after January 1, 2023,”; P.A. 24-68 amended Subsecs. (a)(1)(A) and (c) to add reference to the American Medical Certification Association, effective May 28, 2024.

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Sec. 19a-6t. Connecticut Rare Disease Advisory Council. Duties. Members. Report. (a) On and after July 1, 2023, there is established a Connecticut Rare Disease Advisory Council. The council shall advise and make recommendations to the Department of Public Health and other state agencies, as appropriate, regarding the needs of persons in the state living with a rare disease and such persons' caregivers. The council may perform the following functions:

- (1) Hold public hearings and otherwise make inquiries of and solicit comments from the general public to assist with a study or survey of persons living with a rare disease and such persons' caregivers and health care providers;**
- (2) Consult with experts on rare diseases to develop policy recommendations for improving patient access to quality medical care in the state, affordable and comprehensive insurance coverage, medications, medically necessary diagnostics, timely treatment and other necessary services and therapies;**
- (3) Research and make recommendations to the department, other state agencies, as necessary, and health carriers that provide services to persons living with a rare disease regarding the adverse impact that changes to health insurance coverage, drug formularies and utilization review, as defined in section [38a-591a](#), may have on the provision of treatment or care to persons living with a rare disease;**
- (4) Research and identify priorities related to treatments and services provided to persons living with a rare disease and develop policy recommendations regarding (A) safeguards and legal protections against discrimination and other practices that limit access to appropriate health care, services or therapies, and (B) planning for natural disasters and other public health emergencies;**
- (5) Research and make recommendations regarding improving the quality and continuity of care for persons living with a rare disease who are transitioning from pediatric to adult health care services;**
- (6) Research and make recommendations regarding the development of educational materials on rare diseases, including, but not limited to, online educational materials and a list of reliable resources for the**

department, other state agencies, as necessary, the public, persons living with a rare disease, such persons' families and caregivers, medical school students and health care providers; and

(7) Research and make recommendations for support and training resources for caregivers and health care providers of persons living with a rare disease.

(b) The council shall consist of the following members:

(1) The Commissioner of Public Health, or the commissioner's designee;

(2) The Commissioner of Social Services, or the commissioner's designee;

(3) The Insurance Commissioner, or the commissioner's designee, who may be the representative of a health carrier;

(4) Two appointed by the Governor, one of whom shall be a representative of an association of hospitals in the state or an administrator of a hospital that provides health care to persons living with a rare disease, and one of whom shall be a physician licensed under chapter 370 who has expertise in the field of medical genetics;

(5) Two appointed by the Senate chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to public health, one of whom shall be a representative of a patient advocacy group in the state representing all rare diseases, and one of whom shall be the family member or caregiver of a pediatric patient living with a rare disease;

(6) Two appointed by the House chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to public health, one of whom shall be a representative of the biopharmaceutical industry who is involved in rare disease research and therapy development, and one of whom shall be an adult living with a rare disease;

(7) Two appointed by the Senate ranking member of the joint standing committee of the General Assembly having cognizance of matters relating to public health, one of whom shall be a member of the scientific community in the state who is engaged in rare disease research, and one of whom shall be the caregiver of a child or adult living with a rare disease; and

(8) Two appointed by the House ranking member of the joint standing committee of the General Assembly having cognizance of matters relating to public health, one of whom shall be a physician licensed to practice under chapter 370 who treats persons living with a rare disease, and one of whom shall be a representative, family member or caregiver of a person living with a rare disease.

(c) All initial appointments to the council shall be made not later than October 31, 2023. Any vacancy shall be filled by the appointing authority. Except for members of the council who represent state agencies, five of the members first appointed shall serve for a term of two years, five of such members shall serve for a term of three years and, thereafter, members shall serve for a term of two years. The Commissioner of Public Health shall determine which of the members first appointed shall serve for a term of two years and which of such members shall serve for a term of three years. The members of the council shall receive no compensation for their services but may be reimbursed for any necessary expenses incurred in the performance of their duties. The commissioner shall select an acting chairperson of the council from its members for the purpose of organizing the first council meeting. Such chairperson shall schedule and convene the first meeting, which shall be held not later than November 30, 2023. The members of the council shall appoint, by majority vote, a permanent chairperson and vice-chairperson during the first meeting of the council. Nothing in this subsection shall prohibit the reappointment of the chairperson, vice-chairperson or any member of the council to their position on the council.

(d) The council shall meet in person or on a remote platform not less than six times between November 30, 2023, and October 31, 2024, as determined by the chairperson. Thereafter, the council shall meet quarterly in person or on a remote platform, as determined by the chairperson.

(e) The council shall provide opportunities at council meetings for the general public to make comments, hear updates from the council and provide input on council activities. The council shall create an Internet web site where meeting minutes, notices of upcoming meetings and feedback may be posted.

(f) The council shall be within the Department of Public Health for administrative purposes only.

(g) Not later than one year after the date of its first meeting, and annually thereafter, the council shall report to the Governor and, in accordance with the provisions of section [11-4a](#), to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding its findings and recommendations, including, but not limited to, (1) the council's activities, research findings and any recommendations for proposed legislative changes, and (2) any potential sources of funding for the council's activities, including, but not limited to, grants, donations, sponsorships or in-kind donations.

(P.A. 22-58, S. 48.)

History: P.A. 22-58 effective July 1, 2022.

See Sec. 4-38f for definition of “administrative purposes only”.

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Sec. 19a-6u. School-based health center expansion grant program. For the fiscal year ending June 30, 2023, the Department of Public Health shall administer a school-based health center expansion grant program to provide grants to certain operators of school-based health centers for the expansion of school-based health centers and services provided by such centers. The following operators of school-based health centers shall be eligible for a grant under this section: (1) The operator of a school-based health center for any of the thirty-six recommended sites for expanded mental health services contained in the final report of the School-Based Health Center Expansion Working Group, established pursuant to section 16 of public act 21-35*, and (2) the operator of a school-based health center for any of the one hundred twenty-four recommended schools for expanded school-based health center medical and mental health services contained in the final report of the School-Based Health Center Expansion Working Group, established pursuant to section 16 of public act 21-35*. The department shall give priority to awarding a grant to those operators of a school-based health center that will provide services after regular school hours. Each such operator shall submit, in collaboration with the local or regional board of education for the school district in which the school-based health center is located, an application for a grant under this section at such time and in such manner as prescribed by the department.

(P.A. 22-80, S. 12.)

*Note: Section 16 of public act 21-35 is special in nature and therefore has not been codified but remains in full force and effect according to its terms.

History: P.A. 22-80 effective July 1, 2022.

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Sec. 19a-6v. Report from department re work on the Healthy Brain Initiative. Not later than January 1, 2025, and annually thereafter, the Department of Public Health shall report, within available appropriations and in accordance with the provisions of section [11-4a](#), to the joint standing committee of

the General Assembly having cognizance of matters relating to public health regarding the department's work on the Healthy Brain Initiative. As used in this section, “Healthy Brain Initiative” means the National Centers for Disease Control and Prevention’s collaborative approach to fully integrate cognitive health into public health practice and reduce the risk and impact of Alzheimer’s disease and other dementias.

(P.A. 24-19, S. 25.)

History: P.A. 24-19 effective May 21, 2024.

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Sec. 19a-6w. Men's health public awareness and educational campaign. (a) The Commissioner of Public Health shall develop a public awareness and educational campaign to promote community-based screening and education for common diseases affecting high-risk male populations, including, but not limited to, colorectal cancer, prostate cancer, hypertension, diabetes, high cholesterol, chronic obstructive pulmonary disease, asthma, infectious diseases, depression and anxiety.

(b) Not later than January 1, 2025, and annually thereafter, the commissioner shall report to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding the public awareness and educational campaign.

(P.A. 24-81, S. 106.)

History: P.A. 24-81 effective July 1, 2024.

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Sec. 19a-7. (Formerly Sec. 19-3a). Public health planning. State health plan. Access to certain health care data. Regulations. (a) The Department of Public Health shall be the lead agency for public health planning and shall assist communities in the development of collaborative health planning activities which address public health issues on a regional basis or which respond to public health needs having state-wide significance. The department shall prepare a multiyear state health plan which will provide an assessment of the health of Connecticut's population and the availability of health facilities. The plan shall include: (1) Policy recommendations regarding allocation of resources; (2) public health priorities; (3) quantitative goals and objectives with respect to the appropriate supply, distribution and organization of public health resources; and (4) evaluation of the implications of new technology for the organization, delivery and equitable distribution of services. In the development of the plan the department shall consider the recommendations of any advisory bodies which may be established by the commissioner.

(b) For the purposes of establishing a state health plan as required by subsection (a) of this section and consistent with state and federal law on patient records, the department is entitled to access hospital discharge data, emergency room and ambulatory surgery encounter data, data on home health care agency client encounters and services, data from community health centers on client encounters and services and all data collected or compiled by the Health Systems Planning Unit of the Office of Health Strategy pursuant to section [19a-613](#).

(c) The Commissioner of Public Health shall adopt regulations in accordance with the provisions of chapter 54 to assure the confidentiality of personal data and patient-identifiable data collected or compiled pursuant to this section.

(P.A. 75-562, S. 7, 8; P.A. 77-614, S. 323, 610; P.A. 78-109, S. 4–6; P.A. 80-66; P.A. 84-163; P.A. 87-420, S. 1, 14; P.A. 93-381, S. 3, 39; P.A. 95-257, S. 12, 21, 25, 58; P.A. 98-87, S. 1; June Sp. Sess. P.A. 98-1, S. 86, 121;

June Sp. Sess. P.A. 99-2, S. 33; P.A. 10-179, S. 103; P.A. 18-91, S. 74.)

History: P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; P.A. 78-109 restated Subsec. (d) and added Subsec. (g) re regulations; P.A. 80-66 removed limit on nominations submitted by health systems agencies but provided that the number be at least twice the number of representatives allotted to the agency in Subsec. (a), changed proportion of direct providers of health care from one-third to one-half and added provision re representatives of consumers of health care in Subsec. (c), specified that veterans' representative be nonvoting member in Subsec. (d), transferred primary responsibility for chairman selection from council to governor in Subsec. (e), added provision re assistance provided council by department in Subsec. (f) and changed reference to federal act; Sec. 19-3a transferred to Sec. 19a-7 in 1983; P.A. 84-163 added Subsec. (h) concerning the council's duty to annually submit a health status update, submit recommendations for legislation and review the governor's recommended block grant allocations; P.A. 87-420 deleted Subsecs. (b) through (h), deleted references to the state-wide health coordinating council and restated Subsec. (a) re the designation of the department of health services as the lead agency for public health planning; P.A. 93-381 replaced commissioner and department of health services with commissioner and department of public health and addiction services, amended Subsec. (a) to add provisions re multiyear state health plan and added Subsec. (b) re developing and implementing comprehensive plan for prevention and treatment of alcohol and drug abuse problems, effective July 1, 1993; P.A. 95-257 replaced Department of Public Health and Addiction Services with Department of Public Health and deleted former Subsec. (b) re developing and implementing comprehensive plan for prevention and treatment of alcohol and drug problems, effective July 1, 1995; P.A. 98-87 made existing language Subsec. (a) and added Subsec. (b) granting department access to Office of Health Care Access data and Subsec. (c) requiring regulations on confidentiality; June Sp. Sess. P.A. 98-1 made a technical change in Subsec. (b) re the correct name of the Office of Health Care Access; June Sp. Sess. P.A. 99-2 amended Subsec. (b) by deleting reference to Office of Health Care Access regulations; P.A. 10-179 amended Subsec. (b) by replacing "Office of Health Care Access" with "Office of Health Care Access division of the Department of Public Health"; P.A. 18-91 amended Subsec. (b) by replacing reference to Office of Health Care Access with reference to Health Systems Planning Unit, effective May 14, 2018.

See Sec. 19a-73a re state comprehensive cancer plan.

See Sec. 19a-630 for applicable definitions.

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Sec. 19a-7a. State goal to assure the availability of appropriate health care to all state residents. The General Assembly declares that it shall be the goal of the state to assure the availability of appropriate health care to all Connecticut residents, regardless of their ability to pay. In achieving this goal, the state shall work to create the means to assure access to a single standard of care for all residents of Connecticut, on an equitable financing basis and with effective cost controls. In meeting the objective of such access, the state shall ensure that mechanisms are adopted to assure that care is provided in a cost effective and efficient manner.

(P.A. 90-134, S. 1, 28.)

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Sec. 19a-7b. Health Care Access Commission. Section [19a-7b](#) is repealed, effective July 1, 2019.

(P.A. 90-134, S. 2, 28; June Sp. Sess. P.A. 91-11, S. 16, 25; P.A. 93-262, S. 55, 87; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 39, 58; P.A. 96-227, S. 16; June Sp. Sess. P.A. 98-1, S. 16, 121; P.A. 01-195, S. 137, 181;

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Sec. 19a-7c. Subsidized nongroup health insurance product for pregnant women. (a) The Commissioner of Public Health, in consultation with the Department of Social Services, may contract, within available appropriations, to provide a subsidized nongroup health insurance product for pregnant women who are not eligible for Medicaid and have incomes under two hundred fifty per cent of the federal poverty level. The product shall be available to such pregnant women (1) for whom employer-based insurance is not available or (2) who have employer-based insurance (A) to cover the cost of the premiums, copayments and deductibles of the employer-based plan provided the cost of the employer-based plan is less than the nongroup product and (B) to provide coverage for benefits not covered by the employer-based plan which are covered under the subsidized nongroup product. The Department of Public Health may make such product available to limited populations, as pilot programs, initially to test the impact of program design and administration. The Department of Social Services shall assist in the administration of the programs. The contract may include, but not be limited to, provisions for coinsurance and copayment and a sliding scale based on income for premiums and shall provide for the use of mechanisms to control costs.

(b) The contract for pregnant women shall include coverage for: (1) Physician visits for diagnosis and treatment; (2) prenatal and postnatal care; and (3) outpatient hospital care; and may include coverage for: (A) Labor and delivery; (B) laboratory and diagnostic tests; (C) prescription drugs; (D) physical therapy; (E) mental health and substance abuse visits; and (F) inpatient care, including mental health and substance abuse treatment, subject to eighty per cent coinsurance on the first two thousand five hundred dollars of expenses.

(c) The commissioner shall establish an outreach program to ensure that eligible persons are aware of the health insurance available pursuant to this section.

(d) The commissioner may adopt regulations, in accordance with the provisions of chapter 54, for purposes of this section.

(P.A. 90-134, S. 7, 28; June Sp. Sess. 91-11, S. 17, 25; P.A. 93-262, S. 1, 87; 93-381, S. 9, 39; P.A. 95-205, S. 1, 2; 95-257, S. 12, 21, 58; P.A. 96-187, S. 1, 2; June 18 Sp. Sess. P.A. 97-2, S. 90, 165; P.A. 98-8, S. 4, 5.)

History: June Sp. Sess. P.A. 91-11 amended Subsec. (a) to require consultation with the department of income maintenance to contract for health insurance and to permit the department to offer products as pilot programs, amended Subsec. (b) and added Subsec. (c) to list separate specifications for a children's insurance product and a pregnant woman's product, and made technical changes; P.A. 93-262 authorized substitution of commissioner and department of social services for commissioner and department of income maintenance, effective July 1, 1993; P.A. 93-381 replaced department and commissioner of health services with department and commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-205 amended Subsec. (a) to require extension of the program to currently enrolled children up to age 17, effective July 1, 1995; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 96-187 amended Subsec. (a) to specify that eligibility applied to children enrolled as of December 31, 1994, effective May 31, 1996; June 18 Sp. Sess. P.A. 97-2 amended Subsec. (a) to make a technical change, effective July 1, 1997; P.A. 98-8 eliminated all references throughout the section to the provision of a subsidized nongroup health insurance product for children under 18 years of age who are not eligible for medical assistance and whose families have incomes under 200% of the federal poverty level and relettered the remaining Subsecs. accordingly, effective April 7, 1998.

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Sec. 19a-7d. Primary care direct services program. Section [19a-7d](#) is repealed, effective July 1, 2024.

(P.A. 90-134, S. 10, 28; P.A. 91-274; P.A. 93-381, S. 9, 39; P.A. 95-203, S. 1, 2; 95-257, S. 12, 21, 58; June Sp. Sess. P.A. 01-4, S. 46; P.A. 06-195, S. 84; P.A. 07-252, S. 4; P.A. 15-59, S. 3; June Sp. Sess. P.A. 21-2, S. 28; P.A. 22-81, S. 28; 22-118, S. 231; P.A. 24-81, S. 87.)

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Sec. 19a-7e. Health care for uninsured pregnant women demonstration project. The Department of Public Health, in consultation with the Department of Social Services, shall establish a three-year demonstration program to improve access to health care for uninsured pregnant women under two hundred fifty per cent of the poverty level. Services to be covered by the program shall include, but not be limited to, the professional services of obstetricians, dental care providers, physician assistants or midwives on the staff of the sponsoring hospital and community-based providers; services of pediatricians for purposes of assistance in delivery and postnatal care; dietary counseling; dental care; substance abuse counseling, and other ancillary services which may include substance abuse treatment and mental health services, as required by the patient's condition, history or circumstances; necessary pharmaceutical and other durable medical equipment during the prenatal period; and postnatal care, as well as preventative and primary care for children up to age six in families in the eligible income level. The program shall encourage the acquisition, sponsorship and extension of existing outreach activities and the activities of mobile, satellite and other outreach units. The Commissioner of Public Health shall issue a request for proposals to Connecticut hospitals. Such request shall require: (1) An interactive relationship between the hospital, community health centers, community-based providers and the healthy start program; (2) provisions for case management; (3) provisions for financial eligibility screening, referrals and enrollment assistance where appropriate to the medical assistance program, the healthy start program or private insurance; and (4) provisions for a formal liaison function between hospitals, community health centers and other health care providers. Hospitals participating in the program shall report monthly to the Departments of Public Health and Social Services or their designees and annually to the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services such information as the departments and the committees deem necessary.

(June Sp. Sess. P.A. 91-11, S. 18, 25; P.A. 93-262, S. 1, 87; 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 39, 58; P.A. 03-278, S. 71; Sept. Sp. Sess. P.A. 09-3, S. 29; P.A. 12-170, S. 4.)

History: P.A. 93-262 authorized substitution of commissioner and department of social services for commissioner and department of income maintenance, effective July 1, 1993; P.A. 93-381 replaced department and commissioner of health services with department and commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health and replaced Commission on Hospitals and Health Care with Office of Health Care Access, effective July 1, 1995; P.A. 03-278 made technical changes, effective July 9, 2003; Sept. Sp. Sess. P.A. 09-3 deleted references to Office of Health Care Access and Commissioner of Health Care Access or designee re consultative role in establishment and administration of demonstration program, effective October 6, 2009; P.A. 12-170 deleted provisions re additions to hospital budgets re fiscal years 1992 to 1994.

See Sec. 19a-490a for definition of “community health center”.

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Sec. 19a-7f. Child immunization standard of care and programs. Provision of vaccines by department. Vaccine policy and reporting. (a) The Commissioner of Public Health shall determine the standard of care for immunization for the children of this state. The standard of care for immunization shall be based on

the recommended schedules for active immunization for normal infants and children published by the National Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, the American Academy of Pediatrics and the American Academy of Family Physicians. The commissioner shall establish, within available appropriations, an immunization program which shall: (1) Provide vaccine at no cost to health care providers in Connecticut to administer to children so that cost of vaccine will not be a barrier to age-appropriate vaccination in this state; (2) with the assistance of hospital maternity programs, provide all parents in this state with the recommended immunization schedule for normal infants and children, a booklet to record immunizations at the time of the infant's discharge from the hospital nursery and a list of sites where immunization may be provided; (3) inform in a timely manner all health care providers of changes in the recommended immunization schedule; (4) assist hospitals, local health providers and local health departments to develop and implement record-keeping and outreach programs to identify and immunize those children who have fallen behind the recommended immunization schedule or who lack access to regular preventative health care and have the authority to gather such data as may be needed to evaluate such efforts; (5) assist in the development of a program to assess the vaccination status of children who are clients of state and federal programs serving the health and welfare of children and make provision for vaccination of those who are behind the recommended immunization schedule; (6) access available state and federal funds including, but not limited to, any funds available through the federal Childhood Immunization Reauthorization or any funds available through the Medicaid program; (7) solicit, receive and expend funds from any public or private source; and (8) develop and make available to parents and health care providers public health educational materials about the benefits of timely immunization.

(b) (1) Commencing October 1, 2011, one group health care provider located in Bridgeport and one group health care provider located in New Haven, as identified by the Commissioner of Public Health, and any health care provider located in Hartford who administers vaccines to children under the federal Vaccines For Children immunization program that is operated by the Department of Public Health under authority of 42 USC 1396s may select under said federal program, and the department shall provide, any vaccine licensed by the federal Food and Drug Administration, including any combination vaccine and dosage form, that is (A) recommended by the National Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, and (B) made available to the department by the National Centers for Disease Control and Prevention.

(2) Not later than June 1, 2012, the Commissioner of Public Health shall provide an evaluation of the vaccine program established in subdivision (1) of this subsection to the joint standing committee of the General Assembly having cognizance of matters relating to public health. Such evaluation shall include, but not be limited to, an assessment of the program's impact on child immunization rates, an assessment of any health or safety risks posed by the program, and recommendations regarding future expansion of the program.

(3) (A) Provided the evaluation submitted pursuant to subdivision (2) of this subsection does not indicate a significant reduction in child immunization rates or an increased risk to the health and safety of children, commencing October 1, 2012, (i) any health care provider who administers vaccines to children under the federal Vaccines For Children immunization program that is operated by the Department of Public Health under authority of 42 USC 1396s may select, and the department shall provide, any vaccine licensed by the federal Food and Drug Administration, including any combination vaccine and dosage form, that is (I) recommended by the National Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, and (II) made available to the department by the National Centers for Disease Control and Prevention, and (ii) any health care provider who administers vaccines to children may select, and the department shall provide, subject to inclusion in such program due to available appropriations, any vaccine licensed by the federal Food and Drug Administration, including any combination vaccine and dosage form, that is (I) recommended by the National Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, (II) made available to the department by the National Centers for Disease Control and Prevention, and (III) equivalent, as

determined by the commissioner, to the cost for vaccine series completion of comparable available licensed vaccines.

(B) Commencing January 1, 2013, (i) any health care provider who administers vaccines to children under the federal Vaccines For Children immunization program that is operated by the Department of Public Health under authority of 42 USC 1396s shall utilize, and the department shall provide, any vaccine licensed by the federal Food and Drug Administration, including any combination vaccine and dosage form, that is (I) recommended by the National Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, and (II) made available to the department by the National Centers for Disease Control and Prevention, and (ii) any health care provider who administers vaccines to children shall utilize, and the department shall provide, subject to inclusion in such program due to available appropriations, any vaccine licensed by the federal Food and Drug Administration, including any combination vaccine and dosage form, that is (I) recommended by the National Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, (II) made available to the department by the National Centers for Disease Control and Prevention, and (III) equivalent, as determined by the commissioner, to the cost for vaccine series completion of comparable available licensed vaccines.

(C) For purposes of subparagraphs (A)(ii) and (B)(ii) of this subdivision, “comparable” means a vaccine (i) protects a recipient against the same infection or infections, (ii) has similar safety and efficacy profiles, (iii) requires the same number of doses, and (iv) is recommended for similar populations by the National Centers for Disease Control and Prevention.

(D) On and after July 1, 2022, any health care provider that administers vaccines to children under the immunization program described in subparagraph (B) of this subdivision shall order such vaccines using the immunization information system in a form and manner prescribed by the Commissioner of Public Health.

(4) (A) The provisions of this subsection shall not apply in the event of a public health emergency, as defined in section [19a-131](#), or an attack, major disaster, emergency or disaster emergency, as those terms are defined in section [28-1](#).

(B) Nothing in this subsection shall require a health care provider to procure a vaccine from the Department of Public Health when such provider is directed by said department to procure such vaccine from another source, including, but not limited to, during a declared national or state vaccine shortage.

(C) Nothing in this subsection shall require a health care

provider to utilize or administer a vaccine provided by said department if, based upon such provider's medical judgment, (i) administration of such vaccine is not medically appropriate, or (ii) the administration of another vaccine that said department is not authorized to supply under subdivision (3) of this subsection is more medically appropriate.

(5) No health care provider shall seek or receive remuneration for or sell any vaccine serum provided by said department under this section. Nothing in this section shall prohibit a health care provider from charging or billing for administering a vaccine.

(6) Not later than January 1, 2014, said department shall submit a report to the General Assembly, in accordance with section [11-4a](#), evaluating the effectiveness of implementing expanded vaccine choice and universal health care provider participation.

(c) Not later than October 1, 2012, the Department of Public Health shall (1) post on its Internet web site its most current policy regarding vaccine wastage. Such policy shall include a statement of the factors said department used to determine such policy and shall be updated as necessary to reflect the most current policy in effect, and (2) make a form available to health care providers for the purpose of reporting to said

department instances when a health care provider does not receive a full order of a requested vaccine. Not later than January 1, 2013, and biannually thereafter, said department shall, within available resources, track, record and investigate all such reported instances and shall post aggregate findings of such instances and the reasons for such findings on said department's Internet web site.

(P.A. 91-327, S. 1, 8; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; June 18 Sp. Sess. P.A. 97-8, S. 23, 88; P.A. 10-117, S. 79; P.A. 11-242, S. 81; June 12 Sp. Sess. P.A. 12-1, S. 211, 212; P.A. 22-118, S. 494.)

History: P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; June 18 Sp. Sess. P.A. 97-8 added reference to state funds in Subdiv. (6), added new Subdiv. (7) re soliciting funds and redesignated existing Subdiv. (7) as Subdiv. (8), effective July 1, 1997; P.A. 10-117 added provision re determination by commissioner and replaced provision requiring standard of care to be schedule published by committee on infectious diseases of American Academy of Pediatrics or by National Immunization Practices Advisory Committee with provision requiring standard of care for immunization to be based on schedules published by National Centers for Disease Control and Prevention Advisory Committee, American Academy of Pediatrics and American Academy of Family Physicians, effective June 8, 2010; P.A. 11-242 designated existing provisions as Subsec. (a) and amended same by deleting “as determined by the Commissioner of Public Health” and added Subsec. (b) establishing a vaccine program that allows certain health care providers located in Bridgeport, New Haven and Hartford access to any vaccine licensed by federal Food and Drug Administration, effective July 1, 2011; June 12 Sp. Sess. P.A. 12-1 added Subsec. (c) re vaccine wastage policy and reporting when full order of vaccine is not received, effective June 15, 2012, and amended Subsec. (b) to redesignate Subdiv. (3) as Subdiv. (3)(A) and amend same to change commencement date of voluntary vaccine program from July 1, 2012, to October 1, 2012, add provision re vaccine program for health care providers who administer vaccines to children and make conforming changes, add Subdiv. (3)(B) and (C) re mandatory vaccine program, redesignate Subdiv. (4) as Subdiv. (4)(A), add Subdiv. (4)(B) and (C) re exceptions for mandatory vaccine program, and add Subdivs. (5) and (6) re prohibition on remuneration or selling of vaccine serum and department report to General Assembly, effective October 1, 2012; P.A. 22-118 amended Subsec. (b) by adding Subdiv. (3)(D) re ordering of vaccines through immunization information system, effective July 1, 2022.

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Sec. 19a-7g. Childhood Immunization Advisory Council. Section [19a-7g](#) is repealed, effective October 1, 2008.

(P.A. 91-327, S. 2, 8; P.A. 93-262, S. 56, 87; 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 08-184, S. 63.)

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Sec. 19a-7h. Immunization information system. Regulations. (a) As used in this section, “health care provider” means a person who has direct or supervisory responsibility for the administration of a vaccine or assessment of immunization status, including a physician or physician assistant licensed pursuant to chapter 370, a nurse-midwife licensed pursuant to chapter 377, an advanced practice registered nurse or registered nurse licensed pursuant to chapter 378, a pharmacist licensed pursuant to chapter 400j, or an individual authorized under the general statutes or federal law to administer a vaccine.

(b) The Commissioner of Public Health or the commissioner's designee shall establish and maintain an immunization information system for the purpose of assuring vaccine recipient's access to their immunization records. The immunization information system shall include such information as is

necessary to accurately identify a vaccine recipient and to assess such recipient's current immunization status.

(c) Each health care provider who has administered a vaccine to a person in the state shall report, in a form and manner prescribed by the commissioner, or the commissioner's designee, information, which shall include, but need not be limited to, (1) the name and date of birth of the vaccine recipient, (2) the name and date of each vaccine dose given to the vaccine recipient, (3) any other information deemed necessary by the commissioner, and (4) when appropriate, contraindications or exemptions to administration of each vaccine dose. Each health care provider shall provide to a vaccine recipient, a vaccine recipient's court-appointed guardian or conservator, if applicable, or, in the case of a child who received a vaccine, such child's parent or guardian information regarding how such vaccine recipient or such child may decline enrollment in the immunization information system.

(d) Each health care provider intending to administer vaccines to any person may use the immunization information system to determine current information on the immunization status of such person for the purposes of determining whether such person requires immunizations, or to officially document immunization status to meet state child care, school or higher education immunization entry requirements pursuant to sections [10-204a](#), [10a-155](#), [19a-79](#) and [19a-87b](#) and regulations adopted thereunder.

(e) Each school nurse who is required to verify the immunization status for children enrolled in prekindergarten to grade twelve, inclusive, at a public or private school in any town, city or school district pursuant to section [10-204a](#) shall be provided with sufficient information on the children who live in the school nurse's jurisdiction and who are listed on the immunization information system to enable determination of which children are overdue for scheduled immunizations and to enable provision of outreach to assist in getting each such child vaccinated.

(f) The commissioner, or the commissioner's designee, shall provide the director of health of any municipality or health district with sufficient information on the persons who live in such director's jurisdiction and who are listed on the immunization information system in order to address undervaccinated communities and improve health equity.

(g) The commissioner may use the information in the immunization information system for the purposes set forth in sections [19a-25](#) and [19a-215](#) and the regulations promulgated pursuant to said sections. The commissioner, or the commissioner's designee, may exchange information in the immunization information system with federal agencies providing health care services and other states' immunization information systems for the purposes described in this section.

(h) The commissioner shall provide to a vaccine recipient, a vaccine recipient's court-appointed guardian or conservator, if applicable, or, in the case of a child who received a vaccine, such child's parent or guardian access to any information that was provided by a health care provider to the Department of Public Health through the immunization information system regarding such person's vaccination status upon request by such recipient, guardian, conservator, parent or guardian.

(i) Except as specified in subsections (b) to (h), inclusive, of this section, all personal information including vaccination status and dates of vaccination of persons shall be confidential pursuant to section [19a-25](#) and shall not be further disclosed without the authorization of the vaccine recipient, the vaccine recipient's court-appointed guardian or conservator, if applicable, or, in the case of a child who received a vaccine, such child's parent or guardian.

(j) The immunization information system shall comply with the National Centers for Disease Control and Prevention's Immunization Information System Functional Standards, as amended from time to time.

(k) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of this section, including, but not limited to, regulations specifying (1) how information on vaccinations and, when appropriate, contraindications or exemptions to administration of

each vaccine dose, is reported in a timely manner to the immunization information system, (2) how information on the immunization information system is made available to persons authorized to receive such information pursuant to subsections (b) to (h), inclusive, of this section, and (3) how a vaccine recipient, a vaccine recipient's court-appointed guardian or conservator, if applicable, or, in the case of a child who received a vaccine, such child's parent or guardian may decline enrollment in the immunization information system.

(l) The commissioner shall, in consultation with the Office of Health Strategy, adopt regulations, in accordance with the provisions of chapter 54, to facilitate interoperability between the immunization information system and the State-wide Health Information Exchange established pursuant to section [17b-59d](#). The commissioner may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulations, provided the department posts such policies and procedures on the eRegulations System prior to adopting them. Policies and procedures implemented pursuant to this section shall be valid until regulations are adopted in accordance with the provisions of chapter 54.

(P.A. 94-90, S. 1; P.A. 95-257, S. 12, 21, 58; P.A. 98-252, S. 35, 80; P.A. 08-184, S. 11; P.A. 14-231, S. 4; P.A. 22-118, S. 493.)

History: P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 98-252 made a technical change in Subsec. (b), effective July 1, 1998; P.A. 08-184 amended Subsec. (c) by eliminating requirement that commissioner consult with state Childhood Immunization Advisory Council prior to adoption of regulations; P.A. 14-231 amended Subsecs. (b) and (c) by adding provisions re school nurse and making technical changes; P.A. 22-118 added new Subsec. (a) defining “health care provider”, substantially revised existing Subsecs. (a) to (c), including adding provisions re establishment of immunization information system, redesignated existing Subsec. (a) as Subsec. (b), redesignated existing Subsec. (b) as Subsec. (c), designated existing provisions re health care provider use of information in existing Subsec. (b) as Subsec. (d), designated existing provisions re school nurse use of information in existing Subsec. (b) as Subsec. (e), added Subsec. (f) re commissioner's duty to provide information to directors of health, added Subsec. (g) re commissioner's use of information, added Subsec. (h) re commissioner's duty to provide information to vaccine recipient, guardian, conservator or parent, redesignated existing Subsec. (c) as Subsec. (i), added Subsec. (j) re compliance with National Centers for Disease Control and Prevention's Immunization Information System Functional Standards, designated existing provisions in existing Subsec. (c) re regulations as Subsec. (k), added Subsec. (l) re regulations to facilitate interoperability between immunization information system and State-wide Health Information Exchange and made technical and conforming changes, effective July 1, 2022.

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Sec. 19a-7i. Extension of coverage under the maternal and child health block grant. Within available appropriations, the Commissioner of Public Health shall extend coverage under Title V of the Social Security Act for families up to three hundred per cent of the federal poverty level to cover underinsured children with family incomes between two hundred per cent and three hundred per cent of the federal poverty level. If allowed by federal regulations, such expansion may be included for reimbursement under Title XXI of the Social Security Act.

(Oct. 29 Sp. Sess. P.A. 97-1, S. 21, 23.)

History: Oct. 29 Sp. Sess. P.A. 97-1 effective October 30, 1997.

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Sec. 19a-7j. Vaccines and antibiotic purchase and childhood immunization registry. Health and welfare fee assessment. Appeal. Penalties. Overpayment. (a) Not later than September first, annually, the Secretary of the Office of Policy and Management, in consultation with the Commissioner of Public Health, shall (1) determine the amount appropriated for the following purposes: (A) To purchase, store and distribute vaccines for routine immunizations included in the schedule for active immunization required by section [19a-7f](#); (B) to purchase, store and distribute (i) vaccines to prevent hepatitis A and B in persons of all ages, as recommended by the schedule for immunizations published by the National Advisory Committee for Immunization Practices, (ii) antibiotics necessary for the treatment of tuberculosis and biologics and antibiotics necessary for the detection and treatment of tuberculosis infections, and (iii) antibiotics to support treatment of patients in communicable disease control clinics, as defined in section [19a-216a](#); (C) to administer the immunization program described in section [19a-7f](#); and (D) to provide services needed to collect up-to-date information on childhood immunizations for all children enrolled in Medicaid who reach two years of age during the year preceding the current fiscal year, to incorporate such information into the immunization information system, established pursuant to section [19a-7h](#), (2) calculate the difference between the amount expended in the prior fiscal year for the purposes set forth in subdivision (1) of this subsection and the amount of the appropriation used for the purpose of the health and welfare fee established in subparagraph (A) of subdivision (2) of subsection (b) of this section in that same year, and (3) inform the Insurance Commissioner of such amounts.

(b) (1) As used in this subsection, (A) “health insurance” means health insurance of the types specified in subdivisions (1), (2), (4), (11) and (12) of section [38a-469](#), and (B) “exempt insurer” means a domestic insurer that administers self-insured health benefit plans and is exempt from third-party administrator licensure under subparagraph (C) of subdivision (11) of section [38a-720](#) and section [38a-720a](#).

(2) (A) Each domestic insurer or domestic health care center doing health insurance business in this state shall annually pay to the Insurance Commissioner, for deposit in the Insurance Fund established under section [38a-52a](#), a health and welfare fee assessed by the Insurance Commissioner pursuant to this section.

(B) Each third-party administrator licensed pursuant to section [38a-720a](#) that provides administrative services for self-insured health benefit plans and each exempt insurer shall, on behalf of the self-insured health benefit plans for which such third-party administrator or exempt insurer provides administrative services, annually pay to the Insurance Commissioner, for deposit in the Insurance Fund established under section [38a-52a](#), a health and welfare fee assessed by the Insurance Commissioner pursuant to this section.

(3) Not later than September first, annually, each such insurer, health care center, third-party administrator and exempt insurer shall report to the Insurance Commissioner, on a form designated by said commissioner, the number of insured or enrolled lives in this state as of May first immediately preceding for which such insurer, health care center, third-party administrator or exempt insurer is providing health insurance or administering a self-insured health benefit plan that provides coverage of the types specified in subdivisions (1), (2), (4), (11) and (12) of section [38a-469](#). Such number shall not include lives enrolled in Medicare, any medical assistance program administered by the Department of Social Services, workers' compensation insurance or Medicare Part C plans.

(4) Not later than November first, annually, the Insurance Commissioner shall determine the fee to be assessed for the current fiscal year against each such insurer, health care center, third-party administrator and exempt insurer. Such fee shall be calculated by multiplying the number of lives reported to said commissioner pursuant to subdivision (3) of this subsection by a factor, determined annually by said commissioner as set forth in this subdivision, to fully fund the amount determined under subsection (a) of this section, adjusted for a health and welfare fee, by subtracting, if the amount appropriated was more than the amount expended or by adding, if the amount expended was more than the amount appropriated, the amount calculated under subdivision (2) of subsection (a) of this section. The Insurance Commissioner shall determine the factor by dividing the adjusted amount by the total number of lives reported to said commissioner pursuant to subdivision (3) of this subsection.

(5) (A) Not later than December first, annually, the Insurance Commissioner shall submit a statement to each such insurer, health care center, third-party administrator and exempt insurer that includes the proposed fee, identified on such statement as the “Health and Welfare fee”, for the insurer, health care center, third-party administrator or exempt insurer calculated in accordance with this subsection. Each such insurer, health care center, third-party administrator and exempt insurer shall pay such fee to the Insurance Commissioner not later than February first, annually.

(B) Any such insurer, health care center, third-party administrator or exempt insurer aggrieved by an assessment levied under this subsection may appeal therefrom in the same manner as provided for appeals under section [38a-52](#).

(6) Any insurer, health care center, third-party administrator or exempt insurer that fails to file the report required under subdivision (3) of this subsection shall pay a late filing fee of one hundred dollars per day for each day from the date such report was due. The Insurance Commissioner may require an insurer, health care center, third-party administrator or exempt insurer subject to this subsection to produce the records in its possession, and may require any other person to produce the records in such person's possession, that were used to prepare such report, for said commissioner's or said commissioner's designee's examination. If said commissioner determines there is other than a good faith discrepancy between the actual number of insured or enrolled lives that should have been reported under subdivision (3) of this subsection and the number actually reported, such insurer, health care center, third-party administrator or exempt insurer shall pay a civil penalty of not more than fifteen thousand dollars for each report filed for which said commissioner determines there is such a discrepancy.

(7) (A) The Insurance Commissioner shall apply an overpayment of the health and welfare fee by an insurer, health care center, third-party administrator or exempt insurer for any fiscal year as a credit against the health and welfare fee due from such insurer, health care center, third-party administrator or exempt insurer for the succeeding fiscal year, subject to an adjustment under subdivision (4) of this subsection, if: (i) The amount of the overpayment exceeds five thousand dollars; and (ii) on or before June first of the calendar year of the overpayment, the insurer, health care center, third-party administrator or exempt insurer (I) notifies the commissioner of the amount of the overpayment, and (II) provides the commissioner with evidence sufficient to prove the amount of the overpayment.

(B) Not later than ninety days following receipt of notice and supporting evidence under subparagraph (A) of this subdivision, the commissioner shall (i) determine whether the insurer, health care center, third-party administrator or exempt insurer made an overpayment, and (ii) notify the insurer, health care center, third-party administrator or exempt insurer of such determination.

(C) Failure of an insurer, health care center, third-party administrator or exempt insurer to notify the commissioner of the amount of an overpayment within the time prescribed in subparagraph (A) of this subdivision constitutes a waiver of any demand of the insurer, health care center, third-party administrator or exempt insurer against the state on account of such overpayment.

(D) Nothing in this subdivision shall be construed to prohibit or limit the right of an insurer, health care center, third-party administrator or exempt insurer to appeal pursuant to subparagraph (B) of subdivision (5) of this section.

(June 30 Sp. Sess. P.A. 03-3, S. 6; P.A. 11-242, S. 82; June 12 Sp. Sess. P.A. 12-1, S. 213; P.A. 13-234, S. 142; P.A. 14-217, S. 66; P.A. 16-213, S. 8; P.A. 17-198, S. 33; P.A. 22-118, S. 495.)

History: June 30 Sp. Sess. P.A. 03-3 effective August 20, 2003; P.A. 11-242 amended Subsec. (b) by deleting provision re fee assessed for fiscal year ending June 30, 2004, and deleted former Subsec. (d) re aggregate assessment limits for fiscal years ending June 30, 2004, and June 30, 2005, effective July 1, 2011; June 12 Sp. Sess. P.A. 12-1 redesignated Subsecs. (b) and (c) as Subsec. (b)(2)(A) and (5)(B), amended Subsec. (b)(2)(A) to delete former assessment methodology and delete life insurance companies from health and welfare fee requirement, added Subsec. (b)(1), (2)(B), (3), (4) and (5)(A) re assessment methodology, added

Subsec. (b)(6) re late filing fee and civil penalty for other than good faith discrepancy in number of lives reported, and made technical and conforming changes, effective July 1, 2012; P.A. 13-234 amended Subsec. (a)(1) by adding new Subpara. (C) re immunization program described in Sec. 19a-7f and redesignating existing Subpara. (C) as Subpara. (D), effective July 1, 2013; P.A. 14-217 amended Subsec. (a) to add new Subdiv. (2) re calculation of difference in amount expended and amount appropriated for health and welfare fee, redesignate existing Subdiv. (2) as Subdiv. (3) and make a conforming change, and amended Subsec. (b) to substitute Insurance Fund for General Fund in Subdiv. (2)(A) and (B), add provision re adjustment re difference calculated under Subsec. (a)(2) and make a technical change in Subdiv. (4), and add health and welfare fee identification requirement in Subdiv. (5)(A), effective July 1, 2014; P.A. 16-213 amended Subsec. (b)(2)(A) by adding “domestic” in provision re health care center, effective July 1, 2016; P.A. 17-198 added Subsec. (b)(7) re overpayment of health and welfare fee, effective June 30, 2017, and applicable to any health and welfare fee due on or after February 1, 2017; P.A. 22-118 amended Subsec. (a)(1)(D) by replacing reference to childhood immunization registry with reference to immunization information system, effective July 1, 2022.

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Sec. 19a-7k. Preventive dental care pilot program. Section [19a-7k](#) is repealed, effective October 1, 1999.
(P.A. 97-239; P.A. 99-197, S. 3.)

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Sec. 19a-7l. Department of Public Health to provide information concerning meningococcal meningitis to local and regional boards of education. On or before September 1, 2008, the Department of Public Health, in collaboration with the Department of Education, shall contact each local and regional board of education to make such boards aware of information concerning meningococcal meningitis. Such information shall include, but not necessarily be limited to, information related to the causes, symptoms and spread of meningococcal meningitis and vaccination information that reflects the current recommendations from the United States Centers for Disease Control and Prevention. On and after September 1, 2008, the department shall periodically update the information provided to such boards concerning meningococcal meningitis.

(P.A. 08-184, S. 55; P.A. 09-11, S. 4.)

History: P.A. 08-184 effective July 1, 2008; P.A. 09-11 made technical changes.

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Sec. 19a-7m. Provision of charitable health care services by out-of-state health care practitioners. No provision of this title or title 20 shall be construed to prohibit an out-of-state health care practitioner who holds a current unrestricted health care practitioner license or certificate issued in another state, territory of the United States or the District of Columbia from providing uncompensated health care services in this state in association with: (1) A free clinic or other similar charitable medical event that provides health care services to persons at no cost; or (2) the Special Olympics or any other similar athletic competition held in the state that attracts a large number of out-of-state participants, provided the out-of-state health care practitioner: (A) Does not represent himself or herself to be a Connecticut licensed or certified health care practitioner; (B) only provides health care services to patients seeking health care services at a charitable medical event or athletes participating in the Special Olympics or other similar athletic competition; (C) only provides health care services authorized pursuant to state law while under the supervision of a Connecticut licensed or certified health care practitioner within the same professional

licensure or certification category; and (D) maintains professional liability insurance or other indemnity against liability for professional malpractice either personally or through the sponsoring organization in an amount that is equal to or greater than that required for similarly licensed or certified Connecticut practitioners. Any organization conducting a free clinic, charitable medical event or athletic competition shall be responsible for ensuring that an out-of-state health care practitioner participating in such event fully complies with the requirements of this section.

(P.A. 10-23, S. 1.)

History: P.A. 10-23 effective July 1, 2010.

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Sec. 19a-7n. Childhood immunization budget account reconciliation and expenditure projection process. Not later than October 1, 2013, the Department of Public Health, in consultation with the Office of Policy and Management, shall develop and thereafter annually implement a reconciliation and expenditure projection process relative to the state's childhood immunization budget account which includes, but is not limited to: (1) An accounting of the previous year's expenditures; (2) the process and factors to be used in determining each future year's assessment; and (3) the establishment of an appropriate notification process for the entities assessed under the account.

(P.A. 13-234, S. 143.)

History: P.A. 13-234 effective July 1, 2013.

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Sec. 19a-7o. Hepatitis C and HIV-related testing. (a) For purposes of this section:

- (1) "Hepatitis C screening test" means a laboratory test that detects the presence of hepatitis C virus antibodies in the blood;
 - (2) "Hepatitis C diagnostic test" means a laboratory test that detects the presence of hepatitis C virus in the blood and provides confirmation of whether the person whose blood is being tested has a hepatitis C virus infection;
 - (3) "HIV infection" means infection with the human immunodeficiency virus or any other related virus identified as a probable causative agent of acquired immune deficiency syndrome, as defined by the Centers for Disease Control and Prevention of the United States Public Health Service;
 - (4) "HIV-related test" means any laboratory test or series of tests for any virus, antibody, antigen or etiologic agent whatsoever thought to cause or indicate the presence of HIV infection;
 - (5) "Primary care provider" means a physician, advanced practice registered nurse or physician assistant who provides primary care services and is licensed by the Department of Public Health pursuant to title 20; and
 - (6) "Primary care" means the medical fields of family medicine, general pediatrics, primary care, internal medicine, primary care obstetrics or primary care gynecology, without regard to board certification.
- (b) A primary care provider shall offer to provide to, or order for, each patient eighteen years of age and older, and each pregnant woman a hepatitis C screening test or hepatitis C diagnostic test at the time the primary care provider provides services to such patient, except a primary care provider is not required to

offer to provide to, or order for, such patient a hepatitis C screening test or hepatitis C diagnostic test when the primary care provider reasonably believes: (1) Such patient is being treated for a life-threatening emergency; (2) such patient has previously been offered or has received a hepatitis C screening test; or (3) such patient lacks the capacity to consent to a hepatitis C screening test.

(c) On and after January 1, 2023, a primary care provider, or such provider's designee, shall offer to provide to, order for, or arrange for the order for, each patient who is thirteen years of age or older, an HIV-related test, except a primary care provider, or such provider's designee, is not required to offer to provide to, or order for, such patient an HIV-related test when the primary care provider reasonably believes: (1) Such patient is being treated for a life-threatening emergency; (2) such patient has previously been offered or has received an HIV-related test; or (3) such patient lacks the capacity to consent to an HIV-related test. The primary care provider, or such provider's designee, shall comply with all requirements concerning HIV-related testing and HIV-related information prescribed in chapter 368x.

(P.A. 14-203, S. 1; P.A. 22-58, S. 68; P.A. 23-31, S. 11; 23-195, S. 9.)

History: P.A. 22-58 amended Subsec. (a) by adding new Subdivs. (3) and (4) defining “HIV infection” and “HIV-related test”, redesignated existing Subdivs. (3) and (4) as Subdivs. (5) and (6), amended Subsec. (b) by deleting “On and after October 1, 2014, a” and making a technical change and added Subsec. (c) re provision of HIV-related tests to patients 13 years of age or older; P.A. 23-31 amended Subsec. (b) by replacing “who was born between 1945 to 1965, inclusive,” with “eighteen years of age and older, and each pregnant woman”; P.A. 23-195 amended Subsec. (a)(3) by making a technical change.

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Sec. 19a-7p. Public health fee. Annual reporting requirement. Appeal. Penalties. Overpayment. (a) Not later than September first, annually, the Secretary of the Office of Policy and Management, in consultation with the Commissioner of Public Health, shall (1) determine the amounts appropriated for the syringe services program, AIDS services, breast and cervical cancer detection and treatment, x-ray screening and tuberculosis care, sexually transmitted disease control and children's health initiatives; and (2) inform the Insurance Commissioner of such amounts.

(b) (1) As used in this section: (A) “Health insurance” means health insurance of the types specified in subdivisions (1), (2), (4), (11) and (12) of section [38a-469](#); and (B) “health care center” has the same meaning as provided in section [38a-175](#).

(2) Each domestic insurer or domestic health care center doing health insurance business in this state shall annually pay to the Insurance Commissioner, for deposit in the Insurance Fund established under section [38a-52a](#), a public health fee assessed by the Insurance Commissioner pursuant to this section.

(3) (A) Not later than September first, annually, each such insurer or health care center shall report to the Insurance Commissioner, in the form and manner prescribed by the commissioner, the number of insured or enrolled lives in this state as of May first immediately preceding the date for which such insurer or health care center is providing health insurance that provides coverage of the types specified in subdivisions (1), (2), (4), (11) and (12) of section [38a-469](#). Such number shall not include lives enrolled in Medicare, any medical assistance program administered by the Department of Social Services, workers' compensation insurance or Medicare Part C plans. The commissioner may require each such insurer or health care center or any other person to submit to the commissioner any records that are in such insurer's, health care center's or other person's possession if such records were used to prepare such insurer's or health care center's annual report submitted pursuant to this subparagraph.

(B) Each such insurer or health care center that fails to timely submit an annual report pursuant to subparagraph (A) of this subdivision shall pay to the Insurance Commissioner, in the form and manner

prescribed by the commissioner, a late filing fee of one hundred dollars per day for each day from the date that the annual report was due.

(C) If the Insurance Commissioner determines that there is a discrepancy, other than a good faith discrepancy, between the number of insured or enrolled lives that the insurer or health care center reported to the commissioner pursuant to subparagraph (A) of this subdivision and the number of such lives that the insurer or health care center should have reported to the commissioner pursuant to said subparagraph (A), the insurer or health care center shall be liable for a civil penalty of not more than fifteen thousand dollars.

(c) Not later than November first, annually, the Insurance Commissioner shall determine the fee to be assessed for the current fiscal year against each such insurer and health care center. Such fee shall be calculated by multiplying the number of lives reported to said commissioner pursuant to subparagraph (A) of subdivision (3) of subsection (b) of this section by a factor, determined annually by said commissioner as set forth in this subsection, to fully fund the aggregate amount determined under subsection (a) of this section. The Insurance Commissioner shall determine the factor by dividing the aggregate amount by the total number of lives reported to said commissioner pursuant to subparagraph (A) of subdivision (3) of subsection (b) of this section.

(d) Not later than December first, annually, the Insurance Commissioner shall submit a statement to each such insurer and health care center that includes the proposed fee, identified on such statement as the "Public Health fee", for the insurer or health care center, calculated in accordance with this section. Not later than December twentieth, annually, any insurer or health care center may submit an objection to the Insurance Commissioner concerning the proposed public health fee. The Insurance Commissioner, after making any adjustment that said commissioner deems necessary, shall, not later than January first, annually, submit a final statement to each insurer and health care center that includes the final fee for the insurer or health care center. Each such insurer and health care center shall pay such fee to the Insurance Commissioner not later than February first, annually.

(e) Any such insurer or health care center aggrieved by an assessment levied under this section may appeal therefrom in the same manner as provided for appeals under section [38a-52](#).

(f) (1) The Insurance Commissioner shall apply an overpayment of the public health fee by an insurer or health care center for any fiscal year as a credit against the public health fee due from such insurer or health care center for the succeeding fiscal year, subject to an adjustment under subsection (c) of this section, if: (A) The amount of the overpayment exceeds five thousand dollars; and (B) on or before June first of the calendar year of the overpayment, the insurer or health care center (i) notifies the commissioner of the amount of the overpayment, and (ii) provides the commissioner with evidence sufficient to prove the amount of the overpayment.

(2) Not later than ninety days following receipt of notice and supporting evidence under subdivision (1) of this subsection, the commissioner shall (A) determine whether the insurer or health care center made an overpayment, and (B) notify the insurer or health care center of such determination.

(3) Failure of an insurer or health care center to notify the commissioner of the amount of an overpayment within the time prescribed in subdivision (1) of this subsection constitutes a waiver of any demand of the insurer or health care center against the state on account of such overpayment.

(4) Nothing in this subsection shall be construed to prohibit or limit the right of an insurer or health care center to appeal pursuant to subsection (e) of this section.

(June Sp. Sess. P.A. 15-5, S. 345; P.A. 16-213, S. 9; P.A. 17-6, S. 4; 17-198, S. 32; P.A. 18-168, S. 26; P.A. 19-117, S. 72; P.A. 21-157, S. 1.)

History: June Sp. Sess. P.A. 15-5 effective July 1, 2015; P.A. 16-213 amended Subsec. (b)(2) by adding “domestic” in provision re health care center, effective July 1, 2016; P.A. 17-6 amended Subsec. (a) by replacing “needle and syringe exchange program” with “syringe services program”, effective July 1, 2017; P.A. 17-198 added Subsec. (f) re overpayment of public health fee, effective June 30, 2017, and applicable to any public health fee due on or after February 1, 2017; P.A. 18-168 amended Subsec. (a) by replacing “venereal” with “sexually transmitted” in Subdiv. (1); P.A. 19-117 amended Subsec. (a)(1) by adding reference to children's health initiatives, effective July 1, 2019; P.A. 21-157 amended Subsec. (b)(3) by designating existing provisions as Subpara. (A) and amended same to add provision re commissioner may require submission of records used to prepare annual report and adding Subpara. (B) re late filing fee and Subpara. (C) re civil penalty, amended Subsec. (c) by adding “subparagraph (A) of” and made a technical change, effective July 1, 2021.

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Sec. 19a-7q. Certificate for use by physician, physician assistant or advanced practice registered nurse stating required vaccination is medically contraindicated. On or before October 1, 2021, the Commissioner of Public Health shall develop and make available on the Internet web site of the Department of Public Health a certificate for use by a physician, physician assistant or advanced practice registered nurse stating that, in the opinion of such physician, physician assistant or advanced practice registered nurse, a vaccination required by the general statutes is medically contraindicated for a person because of the physical condition of such person. The certificate shall include (1) definitions of the terms “contraindication” and “precaution”, (2) a list of contraindications and precautions recognized by the National Centers for Disease Control and Prevention for each of the statutorily required vaccinations, from which the physician, physician assistant or advanced practice registered nurse may select the relevant contraindication or precaution on behalf of such person, (3) a section in which the physician, physician assistant or advanced practice registered nurse may record a contraindication or precaution that is not recognized by the National Centers for Disease Control and Prevention, but in his or her discretion, results in the vaccination being medically contraindicated, including, but not limited to, any autoimmune disorder, family history of any autoimmune disorder, family history of any reaction to a vaccination, genetic predisposition to any reaction to a vaccination as determined through genetic testing and a previous documented reaction of a person that is correlated to a vaccination, (4) a section in which the physician, physician assistant or advanced practice registered nurse may include a written explanation for the exemption from any statutorily required vaccinations, (5) a section requiring the signature of the physician, physician assistant or advanced practice registered nurse, (6) a requirement that the physician, physician assistant or advanced practice registered nurse attach such person's most current immunization record, and (7) a synopsis of the grounds for any order of quarantine or isolation pursuant to section [19a-131b](#).

(P.A. 21-6, S. 7.)

History: P.A. 21-6 effective April 28, 2021.

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Sec. 19a-7r. Advisory Committee on Medically Contraindicated Vaccinations. Duties. Membership. Report. (a) There is established an Advisory Committee on Medically Contraindicated Vaccinations within the Department of Public Health for the purpose of advising the Commissioner of Public Health on issues concerning exemptions from state or federal requirements for vaccinations that result from a physician, physician assistant or advanced practice registered nurse stating that a vaccination is medically contraindicated for a person due to the medical condition of such person. Said advisory committee shall not be responsible for confirming or denying any determination by a physician, physician assistant or advanced practice registered nurse that a vaccination is medically contraindicated for a specific

individual. In order to carry out its duties, the advisory committee shall (1) have access to the immunization information system established by the department pursuant to section [19a-7h](#), (2) evaluate the process used by the department in collecting data concerning exemptions resulting from a vaccination being medically contraindicated and whether the department should have any oversight over such exemptions, (3) examine whether enrollment of an unvaccinated child into a program operated by a public or nonpublic school, institution of higher education, child care center or group child care home should be conditioned upon the child meeting certain criteria, (4) calculate the ratio of school nurses to students in each public and nonpublic school in the state and the funding issues surrounding such ratio, (5) assess whether immunizations should be required more frequently than prior to enrollment into a program operated by a public or nonpublic school and prior to entering seventh grade, and (6) determine whether (A) there are any discrepancies in the issuance of certificates stating that a vaccine is medically contraindicated, and (B) to recommend continuing education of physicians, physician assistants or advanced practice registered nurses in vaccine contraindications and precautions. All information obtained by the advisory committee from such registry shall be confidential pursuant to section [19a-25](#).

(b) The advisory committee shall consist of the following members:

- (1) Two appointed by the speaker of the House of Representatives, one of whom shall be a physician licensed pursuant to chapter 370 who is a pediatrician, and one of whom shall be a member of the public;**
- (2) Two appointed by the president pro tempore of the Senate, one of whom shall be a physician licensed pursuant to chapter 370 who has expertise in the efficacy of vaccines, and one of whom shall be a member of the public;**
- (3) One appointed by the majority leader of the House of Representatives, who shall be a school nurse;**
- (4) One appointed by the majority leader of the Senate, who shall be a physician assistant licensed pursuant to chapter 370 who has experience in the administration of vaccines;**
- (5) One appointed by the minority leader of the House of Representatives, who shall be an advanced practice registered nurse licensed pursuant to chapter 378 who has experience in the administration of vaccines;**
- (6) One appointed by the minority leader of the Senate, who shall be a representative of the Connecticut Chapter of the American Academy of Pediatrics;**
- (7) The Commissioner of Public Health, or the commissioner's designee;**
- (8) The Commissioner of Education, or the commissioner's designee; and**
- (9) The Commissioner of Early Childhood, or the commissioner's designee.**

(c) The members of the advisory committee shall elect a chairperson of the advisory committee from among its members. Such chairperson shall schedule the first meeting of the advisory committee, which shall be held not later than October 1, 2021. The advisory committee shall meet not less than biannually. On or before January 1, 2022, and annually thereafter, the committee shall report, in accordance with the provisions of section [11-4a](#), on its activities and findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health.

(P.A. 21-6, S. 8; P.A. 22-118, S. 496.)

History: P.A. 21-6 effective April 28, 2021; P.A. 22-118 amended Subsec. (a)(1) by replacing reference to childhood immunization registry with reference to immunization information system, effective July 1, 2022.

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Sec. 19a-7s. Evaluation of data re exemptions from immunization requirements. Report. The Department of Public Health, in collaboration with the state Department of Education and the Office of Early Childhood, shall evaluate all of the data collected by said departments concerning exemptions from immunization requirements. Not later than January 1, 2022, and annually thereafter, the Commissioners of Public Health, Education and Early Childhood shall jointly report, in accordance with the provisions of section [11-4a](#), to the joint standing committees of the General Assembly having cognizance of matters relating to public health and education regarding the evaluation of such data.

(P.A. 21-6, S. 9.)

History: P.A. 21-6 effective April 28, 2021.

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Sec. 19a-7t. Provision by department of COVID-19 vaccination status to recipient of vaccine or recipient's fiduciary, parent or guardian. The Department of Public Health shall provide to any person who has received a COVID-19 vaccination or such person's court-appointed fiduciary, or, if such person is a minor child, such person's parent or guardian, information that was provided by a COVID-19 vaccination provider to the department regarding such person's COVID-19 vaccination status upon request by such person, fiduciary, parent or guardian. The department shall not disclose such person's COVID-19 vaccination status to any other person or entity unless such person, fiduciary, parent or guardian authorizes such disclosure in a form and manner prescribed by the Commissioner of Public Health.

(June Sp. Sess. P.A. 21-2, S. 145; P.A. 22-129, S. 1.)

History: June Sp. Sess. P.A. 21-2 effective June 23, 2021; P.A. 22-129 added reference re provision of information to “such person's court-appointed fiduciary” and made conforming changes, effective July 1, 2022.

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Sec. 19a-7u. Pilot program to expand behavioral health care. Grants. (a) Not later than July 1, 2023, the Commissioner of Public Health, in consultation with the Commissioner of Social Services, shall establish a pilot grant program to expand behavioral health care offered to children by providers of pediatric care in private practices.

(b) The Commissioner of Public Health, within available appropriations, shall establish a grant program to provide such providers with a fifty per cent match for costs associated with paying the salaries of licensed social workers providing counseling and other services to children receiving primary health care from such providers. The commissioner shall (1) prescribe forms and criteria for such providers to apply and qualify for grant funds; and (2) require such providers to report to the commissioner on use of the funds to expand behavioral health care for children.

(P.A. 22-81, S. 17.)

History: P.A. 22-81 effective July 1, 2022.

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Sec. 19a-8. (Formerly Sec. 19-4i). Boards and commissions within the department: Public members. Not less than one-third of the members of each board and commission identified in subsection (b) of section [19a-14](#) shall be public members. As used in this section and in the sections listed in said subsection, “public member” means an elector of the state who has no substantial financial interest in, is not employed in or by, and is not professionally affiliated with, any industry, profession, occupation, trade or institution regulated or licensed by the board or commission to which he or she is appointed, and who has had no professional affiliation with any such industry, profession, occupation, trade or institution for three years preceding his appointment to the board or commission.

(P.A. 77-614, S. 346, 610; P.A. 82-472, S. 58, 183.)

History: P.A. 82-472 substituted reference to Sec. 19-4o (19a-14) for obsolete reference to Sec. 19-4b; Sec. 19-4i transferred to Sec. 19a-8 in 1983.

Cited. 211 C. 508.

Cited. 22 CA 181.

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Sec. 19a-9. (Formerly Sec. 19-4j). Boards and commissions within the department: Regulations re hearings, proceedings and subjects within the jurisdiction of such boards and commissioners. (a) The Commissioner of Public Health shall adopt uniform rules of procedure, consistent with chapter 54, for hearings and other proceedings to be conducted by the boards and commissions identified in subsection (b) of section [19a-14](#), and for the giving of notice to persons affected by such proceedings.

(b) The Commissioner of Public Health may, where authorized by statute, adopt rules and regulations regarding any subject within the jurisdiction of a board or commission.

(c) Any rules and regulations adopted pursuant to this section shall be adopted as provided in chapter 54. No regulation shall be adopted pursuant to this section until the appropriate board has had reasonable opportunity to review the proposed regulation and to offer comments thereon.

(P.A. 77-614, S. 331, 610; P.A. 81-472, S. 128, 159; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: P.A. 81-472 substituted reference to Sec. 19-4o for reference to Sec. 19-4b in Subsec. (a); Sec. 19-4j transferred to Sec. 19a-9 in 1983; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

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Sec. 19a-10. (Formerly Sec. 19-4k). Boards and commissions within the department: Hearings. Oaths and subpoenas. The boards and commissions listed in subsection (b) of section [19a-14](#) may conduct hearings on any matter within their statutory jurisdiction. Such hearings shall be conducted in accordance with chapter 54 and the regulations established by the Commissioner of Public Health. In connection with any such hearing, any member of a board or commission, upon being designated by the board or commission, may administer oaths, issue subpoenas, compel testimony and order the production of books, records and documents. If any person refuses to appear, to testify or to produce any book, record or document when so ordered, a judge of the Superior Court may make such order as may be appropriate to aid in the enforcement of this section.

(P.A. 77-614, S. 328, 610; P.A. 81-472, S. 129, 159; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: P.A. 81-472 substituted reference to Sec. 19-4o for reference to Sec. 19-4b; Sec. 19-4k transferred to Sec. 19a-10 in 1983; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

Cited. 207 C. 346; Id., 674; 208 C. 492; 223 C. 618; 231 C. 391.

Cited. 4 CA 307.

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Sec. 19a-11. (Formerly Sec. 19-4l). Boards and commissions: Orders for discontinuance; injunctive or other relief. Any board or commission listed in subsection (b) of section [19a-14](#) may, in its discretion, issue an appropriate order to any person found to be violating an applicable statute or regulation, providing for the immediate discontinuance of the violation. The board or commission may, through the Attorney General, petition the superior court for the judicial district wherein the violation occurred, or wherein the person committing the violation resides or transacts business, for the enforcement of any order issued by it and for appropriate temporary relief or a restraining order. Such board or commission shall certify and file in such court a transcript of the entire record of the hearing or hearings, including all testimony upon which such order was made and the findings and orders made by such board or commission. The court may grant such relief by injunction or otherwise, including temporary relief, as it deems equitable and may make and enter a decree enforcing, modifying and enforcing as so modified, or setting aside, in whole or in part, any order of the board or commission.

(P.A. 77-614, S. 329, 610; P.A. 78-331, S. 51, 58; P.A. 82-472, S. 59, 183.)

History: P.A. 78-331 replaced “county” with “judicial district”; P.A. 82-472 substituted reference to Sec. 19-4o (19a-14) for obsolete reference to Sec. 19-4b; Sec. 19-4l transferred to Sec. 19a-11 in 1983.

Cited. 207 C. 674.

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Sec. 19a-12. (Formerly Sec. 19-4m). Boards and commissions: Appeals from orders and decisions by aggrieved persons. Any person aggrieved by any order or decision of a board or commission listed in subsection (b) of section [19a-14](#) may appeal therefrom as provided in section [4-183](#).

(P.A. 77-614, S. 330, 610; P.A. 82-472, S. 60, 183.)

History: P.A. 82-472 substituted reference to Sec. 19-4o (19a-14) for obsolete reference to Sec. 19-4b; Sec. 19-4m transferred to Sec. 19a-12 in 1983.

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Sec. 19a-12a. Professional assistance program for regulated professions. Definitions. Program requirements. Referrals to Department of Public Health. Notification of disciplinary action against program participants. Annual reporting requirements. Confidentiality. Annual audit. (a) As used in this section and section [19a-12b](#):

(1) “Assistance program” means the program established pursuant to subsection (b) of this section to provide education, prevention, intervention, referral assistance, rehabilitation or support services to health care professionals, pharmacists and pharmacy interns who have a chemical dependency, emotional or behavioral disorder or physical or mental illness;

(2) “Chemical dependency” means abusive or excessive use of drugs, including alcohol, narcotics or chemicals, that results in physical or psychological dependence;

(3) “Health care professionals” includes any person licensed or who holds a permit pursuant to chapter 370, 372, 373, 375, 375a, 376, 376a, 376b, 376c, 377, 378, 379, 379a, 380, 381, 381a, 382a, 383, 383a, 383b, 383c, 384, 384a, 384b, 384c, 384d, 385, 398 or 399;

(4) “Medical review committee” means any committee that reviews and monitors participation by health care professionals, pharmacists or pharmacy interns in the assistance program, including a medical review committee described in section [19a-17b](#);

(5) “Pharmacist” has the same meaning as provided in section [20-571](#); and

(6) “Pharmacy intern” has the same meaning as provided in section [20-571](#).

(b) State or local professional societies or membership organizations of health care professionals, pharmacists and pharmacy interns, or any combination thereof, may establish a single assistance program to serve all health care professionals, pharmacists and pharmacy interns, provided the assistance program (1) operates in compliance with the provisions of this section and sections [20-638](#) to [20-638b](#), inclusive, and (2) includes one or more medical review committees that comply with the applicable provisions of (A) subsections (c) to (f), inclusive, of this section, and (B) subsections (b) to (h), inclusive, of section [20-638a](#). The program shall (i) be an alternative, voluntary and confidential opportunity for the rehabilitation of health care professionals, persons who have applied to become health care professionals, pharmacists and pharmacy interns, and (ii) include mandatory, periodic evaluations of each participant's ability to practice with skill and safety and without posing a threat to the health and safety of any person or patient in the health care or pharmacy setting.

(c) Prior to admitting a health care professional into the assistance program, a medical review committee shall (1) determine if the health care professional is an appropriate candidate for rehabilitation and participation in the program, and (2) establish the participant's terms and conditions for participating in the program. No action taken by the medical review committee pursuant to this subsection shall be construed as the practice of medicine or mental health care.

(d) A medical review committee shall not admit into the assistance program any health care professional who has pending disciplinary charges, prior history of disciplinary action or a consent order by any professional licensing or disciplinary body or has been charged with or convicted of a felony under the laws of this state, or of an offense that, if committed within this state, would constitute a felony. A medical review committee shall refer such health care professional to the Department of Public Health and shall submit to the department all records and files maintained by the assistance program concerning such health care professional. Upon such referral, the Department of Public Health shall determine if the health care professional is eligible to participate in the assistance program and whether such participation should be treated as confidential pursuant to subsection (h) of this section. The Department of Public Health may seek the advice of professional health care societies or organizations and the assistance program in determining what intervention, referral assistance, rehabilitation or support services are appropriate for such health care professional. If the Department of Public Health determines that the health care professional is an appropriate candidate for confidential participation in the assistance program, the entire record of the referral and investigation of the health care professional shall be confidential and shall not be disclosed, except at the request of the health care professional, for the duration of the health care professional's participation in and upon successful completion of the program, provided such

participation is in accordance with terms agreed upon by the department, the health care professional and the assistance program.

(e) Any health care professional participating in the assistance program shall immediately notify the assistance program upon (1) being made aware of the filing of any disciplinary charges or the taking of any disciplinary action against such health care professional by a professional licensing or disciplinary body, or (2) being charged with or convicted of a felony under the laws of this state, or of an offense that, if committed within this state, would constitute a felony. The assistance program shall regularly review available sources to determine if disciplinary charges have been filed, or disciplinary action has been taken, or felony charges have been filed or substantiated against any health care professional who has been admitted to the assistance program. Upon such notification, the assistance program shall refer such health care professional to the Department of Public Health and shall submit to the department all records and files maintained by the assistance program concerning such health care professional. Upon such referral, the Department of Public Health shall determine if the health care professional is eligible to continue participating in the assistance program and whether such participation should be treated as confidential in accordance with subsection (h) of this section. The Department of Public Health may seek the advice of professional health care societies or organizations and the assistance program in determining what intervention, referral assistance, rehabilitation or support services are appropriate for such health care professional. If the Department of Public Health determines that the health care professional is an appropriate candidate for confidential participation in the assistance program, the entire record of the referral and investigation of the health care professional shall be confidential and shall not be disclosed, except at the request of the health care professional, for the duration of the health care professional's participation in and upon successful completion of the program, provided such participation is in accordance with terms agreed upon by the department, the health care professional and the assistance program.

(f) A medical review committee shall not admit into the assistance program any health care professional who is alleged to have harmed a patient. Upon being made aware of such allegation of harm a medical review committee and the assistance program shall refer such health care professional to the Department of Public Health and shall submit to the department all records and files maintained by the assistance program concerning such health care professional. Such referral may include recommendations as to what intervention, referral assistance, rehabilitation or support services are appropriate for such health care professional. Upon such referral, the Department of Public Health shall determine if the health care professional is eligible to participate in the assistance program and whether such participation should be provided in a confidential manner in accordance with the provisions of subsection (h) of this section. The Department of Public Health may seek the advice of professional health care societies or organizations and the assistance program in determining what intervention, referral assistance, rehabilitation or support services are appropriate for such health care professional. If the Department of Public Health determines that the health care professional is an appropriate candidate for confidential participation in the assistance program, the entire record of the referral and investigation of the health care professional shall be confidential and shall not be disclosed, except at the request of the health care professional, for the duration of the health care professional's participation in and upon successful completion of the program, provided such participation is in accordance with terms agreed upon by the department, the health care professional and the assistance program.

(g) The assistance program shall report annually to the appropriate professional licensing board or commission or, in the absence of such board or commission, to the Department of Public Health on the number of health care professionals participating in the assistance program who are under the jurisdiction of such board or commission or in the absence of such board or commission, the Department of Public Health, the purposes for participating in the assistance program and whether participants are practicing health care with skill and safety and without posing a threat to the health and safety of any person or patient in the health care setting. Annually, on or before December thirty-first, the assistance program shall report such information to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section [11-4a](#).

(h) (1) All information given or received in connection with any intervention, rehabilitation, referral assistance or support services provided by the assistance program pursuant to this section, including the identity of any health care professional seeking or receiving such intervention, rehabilitation, referral assistance or support services shall be confidential and shall not be disclosed (A) to any third person or entity, unless disclosure is reasonably necessary for the accomplishment of the purposes of such intervention, rehabilitation, referral assistance or support services or for the accomplishment of an audit in accordance with subsection (l) of this section, or (B) in any civil or criminal case or proceeding or in any legal or administrative proceeding, unless the health care professional seeking or obtaining intervention, rehabilitation, referral assistance or support services waives the confidentiality privilege under this subsection or unless disclosure is otherwise required by law. Unless a health care professional waives the confidentiality privilege under this subsection or disclosure is otherwise required by law, no person in any civil or criminal case or proceeding or in any legal or administrative proceeding may request or require any information given or received in connection with the intervention, rehabilitation, referral assistance or support services provided pursuant to this section.

(2) The proceedings of a medical review committee shall not be subject to discovery or introduced into evidence in any civil action for or against a health care professional arising out of matters that are subject to evaluation and review by such committee, and no person who was in attendance at such proceedings shall be permitted or required to testify in any such civil action as to the content of such proceedings. Nothing in this subdivision shall be construed to preclude (A) in any civil action, the use of any writing recorded independently of such proceedings; (B) in any civil action, the testimony of any person concerning such person's knowledge, acquired independently of such proceedings, about the facts that form the basis for the instituting of such civil action; (C) in any civil action arising out of allegations of patient harm caused by health care services rendered by a health care professional who, at the time such services were rendered, had been requested to refrain from practicing or whose practice of medicine or health care was restricted, the disclosure of such request to refrain from practicing or such restriction; or (D) in any civil action against a health care professional, disclosure of the fact that a health care professional participated in the assistance program, the dates of participation, the reason for participation and confirmation of successful completion of the program, provided a court of competent jurisdiction has determined that good cause exists for such disclosure after (i) notification to the health care professional of the request for such disclosure, and (ii) a hearing concerning such disclosure at the request of any party, and provided further, the court imposes appropriate safeguards against unauthorized disclosure or publication of such information.

(3) Nothing in this subsection shall be construed to prevent the assistance program from disclosing information in connection with administrative proceedings related to the imposition of disciplinary action against any health care professional referred to the Department of Public Health by the assistance program pursuant to subsection (d), (e), (f) or (i) of this section or by the Professional Assistance Oversight Committee pursuant to subsection (e) of section [19a-12b](#).

(i) If at any time, (1) the assistance program determines that a health care professional is not able to practice with skill and safety or poses a threat to the health and safety of any person or patient in the health care setting and the health care professional does not refrain from practicing health care or fails to participate in a recommended program of rehabilitation, or (2) a health care professional who has been referred to the assistance program fails to comply with terms or conditions of the program or refuses to participate in the program, the assistance program shall refer the health care professional to the Department of Public Health and shall submit to the department all records and files maintained by the assistance program concerning such health care professional. Upon such referral, the Department of Public Health shall determine if the health care professional is eligible to participate in the assistance program and whether such participation should be provided in a confidential manner in accordance with the provisions of subsection (h) of this section. The Department of Public Health may seek the advice of professional health care societies or organizations and the assistance program in determining what intervention, rehabilitation, referral assistance or support services are appropriate for such health care professional. If the Department of Public Health determines that the health care professional is an

appropriate candidate for confidential participation in the assistance program, the entire record of the referral and investigation of the health care professional shall be confidential and shall not be disclosed, except at the request of the health care professional, for the duration of the health care professional's participation in and upon successful completion of the program, provided such participation is in accordance with terms agreed upon by the department, the health care professional and the assistance program.

(j) (1) Any physician, hospital or state or local professional society or organization of health care professionals that refers a physician for intervention to the assistance program shall be deemed to have satisfied the obligations imposed on the person or organization pursuant to subsection (a) of section [20-13d](#), with respect to a physician's inability to practice medicine with reasonable skill or safety due to chemical dependency, emotional or behavioral disorder or physical or mental illness.

(2) Any physician, physician assistant, hospital or state or local professional society or organization of health care professionals that refers a physician assistant for intervention to the assistance program shall be deemed to have satisfied the obligations imposed on the person or organization pursuant to subsection (a) of section [20-12e](#), with respect to a physician assistant's inability to practice with reasonable skill or safety due to chemical dependency, emotional or behavioral disorder or physical or mental illness.

(k) The assistance program established pursuant to subsection (b) of this section shall meet with the Professional Assistance Oversight Committee established under section [19a-12b](#) on a regular basis, but not less than four times each year.

(l) (1) On or before November first, annually, the assistance program shall select a person determined to be qualified by the assistance program and the Department of Public Health to conduct an audit on the premises of the assistance program for the purpose of examining quality control of the program and compliance with all requirements of this section. The Department of Public Health may waive the audit requirement, provided (A) the Professional Assistance Oversight Committee established under section [19a-12b](#) has agreed to such waiver, in writing, and (B) the Department of Public Health has notified the Department of Consumer Protection of such waiver, in writing.

(2) Any audit conducted pursuant to this subsection shall consist of a random sampling of at least twenty per cent of the assistance program's files or ten files, whichever is greater. Prior to conducting the audit, the auditor shall agree in writing (A) not to copy any program files or records, (B) not to remove any program files or records from the premises, (C) to destroy all personally identifying information about health care professionals participating in the assistance program upon the completion of the audit, (D) not to disclose personally identifying information about health care professionals participating in the program to any person or entity other than a person employed by the assistance program who is authorized by such program to receive such disclosure, and (E) not to disclose in any audit report any personally identifying information about health care professionals participating in the assistance program.

(3) Upon completion of the audit conducted pursuant to this subsection, the auditor shall submit a written audit report to the assistance program, the Department of Public Health, the Professional Assistance Oversight Committee established under section [19a-12b](#) and the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section [11-4a](#).

(P.A. 07-103, S. 1; P.A. 08-184, S. 23; P.A. 21-121, S. 26; P.A. 23-204, S. 255.)

History: P.A. 07-103 effective June 11, 2007; P.A. 08-184 made a technical change in Subsec. (e); P.A. 21-121 amended Subsec. (a)(3) by adding reference to Ch. 382a, effective July 1, 2021; P.A. 23-204 amended Subsec. (a) by adding Subdiv. (1) defining “assistance program”, redesignating existing Subdiv. (1) as Subdiv. (2), deleting former Subdiv. (2) defining “department”, redefining “medical review committee” in Subdiv. (4), deleting former Subdiv. (5) defining “assistance program,” adding new Subdiv. (5) defining “pharmacist” and adding Subdiv. (6) defining “pharmacy intern”, amended Subsec. (b) by adding

references to pharmacists and pharmacy interns, Subdiv. (1) by adding references to Secs. 20-638 to 20-638b and Subdiv. (2) by designating existing provision re applicable provisions of Subsecs. (c) to (f) of section as Subpara. (A), adding Subpara. (B) re applicable provisions of Sec. 20-638a(b) to (h), redesignating existing Subparas. (A) and (B) as Subparas. (B)(i) and (B)(ii), adding reference to pharmacists and pharmacy interns in Subpara. (B)(i) and reference to pharmacy setting in Subpara. (B)(ii), substantially amended Subsec. (l) by dividing existing provisions into new Subdivs. (1) to (3), adding Subparas. (A) and (B) in Subdiv. (1) re waiver and redesignating former Subdivs. (1) to (5) as Subdivs. (2) (A) to (E), and made technical and conforming changes throughout.

See Secs. 20-638 to 20-638c, inclusive, for similar provisions re pharmacists and pharmacy interns.

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Sec. 19a-12b. Professional Assistance Oversight Committee. Duties. Access to professional assistance program records. Corrective action plans. Confidentiality of records and proceedings. (a) The Department of Public Health shall establish a Professional Assistance Oversight Committee for the assistance program. Such committee's duties shall include, but not be limited to, overseeing quality assurance. The oversight committee shall consist of the following members: (1) Three members selected by the Department of Public Health, who are health care professionals with training and experience in mental health or addiction services, (2) three members selected by the assistance program, who are not employees, board or committee members of the assistance program and who are health care professionals with training and experience in mental health or addiction services, and (3) one member selected by the Department of Mental Health and Addiction Services who is a health care professional.

(b) The assistance program shall provide administrative support to the oversight committee.

(c) Beginning January 1, 2008, the oversight committee shall meet with the assistance program on a regular basis, but not fewer than four times each year.

(d) The oversight committee may request and shall be entitled to receive copies of files or such other assistance program records it deems necessary, provided all information pertaining to the identity of any health care professional shall first be redacted by the assistance program. No member of the oversight committee may copy, retain or maintain any such redacted records. If the oversight committee determines that a health care professional is not able to practice with skill and safety or poses a threat to the health and safety of any person or patient in the health care setting, and the health care professional has not refrained from practicing health care or has failed to comply with terms or conditions of participation in the assistance program, the oversight committee shall notify the assistance program to refer the health care professional to the Department of Public Health. Upon such notification, the assistance program shall refer the health care professional to the Department of Public Health, in accordance with the provisions of subsection (i) of section [19a-12a](#).

(e) (1) If, at any time, the oversight committee determines that the assistance program (A) has not acted in accordance with the provisions of this section, section [19a-12a](#) or sections [20-638](#) and [20-638a](#), or (B) requires remedial action based upon the audit performed under subsection (l) of section [19a-12a](#) or subsection (j) of section [20-638a](#), the oversight committee shall notify the assistance program of such determination, in writing, not later than thirty days after such determination.

(2) The assistance program shall develop and submit to the oversight committee a corrective action plan addressing such determination not later than thirty days after the date of such notification. The assistance program may seek the advice and assistance of the oversight committee in developing the corrective action plan. Upon approval of the corrective action plan by the oversight committee, the oversight committee shall provide a copy of the approved plan to the assistance program, the Department of Public Health and, if the approved plan addresses pharmacists or pharmacy interns, the Department of Consumer Protection.

(3) (A) If the assistance program fails to comply with the corrective action plan, the oversight committee may (i) amend the plan, or (ii) direct the assistance program to refer some or all of the records of (I) the health care professionals in the assistance program to the Department of Public Health for a determination under subparagraph (B) of this subdivision, or (II) the pharmacists and pharmacy interns in the assistance program to the Department of Consumer Protection for a determination under subsection (f) of section [20-638a](#).

(B) Upon such referral, the Department of Public Health shall determine if each referred health care professional is eligible for continued intervention, rehabilitation, referral assistance or support services and whether participation in such intervention, rehabilitation, referral assistance or support services should be treated as confidential in accordance with subsection (h) of section [19a-12a](#). If the Department of Public Health determines that a health care professional is an appropriate candidate for confidential participation in continued intervention, referral assistance, rehabilitation or support services, the entire record of the referral and investigation of the health care professional shall be confidential and shall not be disclosed, except at the request of the health care professional, for the duration of the health care professional's participation in and upon successful completion of the program, provided such participation is in accordance with terms agreed upon by the department and the health care professional.

(4) Upon written notice to the Department of Public Health by the oversight committee that the assistance program is in compliance with a corrective action plan developed pursuant to subdivision (2) of this subsection, the department may refer health care professionals to the assistance program for continued intervention, rehabilitation, referral assistance or support services and shall submit to the assistance program all records and files concerning such health care professionals.

(f) Records created for, by or on behalf of the oversight committee shall not be deemed public records and shall not be subject to the provisions of section [1-210](#). Such records shall be treated as confidential in accordance with the provisions of subsection (h) of section [19a-12a](#) and subsection (h) of section [20-638a](#).

(g) The proceedings of the oversight committee shall not be subject to discovery or introduced into evidence in any civil action for or against a health care professional, pharmacist or pharmacy intern arising out of matters that are subject to evaluation and review by such committee, and no person who was in attendance at such proceedings shall be permitted or required to testify in any such civil action as to the content of such proceedings. Nothing in this subdivision shall be construed to preclude (1) in any civil action, the use of any writing recorded independently of such proceedings; (2) in any civil action, the testimony of any person concerning such person's knowledge, acquired independently of such proceedings, about the facts that form the basis for the instituting of such civil action; (3) in any civil action arising out of allegations of patient harm caused by health care or pharmacy services rendered by a health care professional, pharmacist or pharmacy intern who, at the time such services were rendered, had been requested to refrain from practicing or whose practice of medicine, health care or pharmacy was restricted, the disclosure of such request to refrain from practicing or such restriction; or (4) in any civil action against a health care professional, pharmacist or pharmacy intern, disclosure of the fact that a health care professional, pharmacist or pharmacy intern participated in the assistance program, the dates of participation, the reason for participation and confirmation of successful completion of the program, provided a court of competent jurisdiction has determined that good cause exists for such disclosure after (A) notification to the health care professional, pharmacist or pharmacy intern of the request for such disclosure, and (B) a hearing concerning such disclosure at the request of any party, and provided further, the court imposes appropriate safeguards against unauthorized disclosure or publication of such information.

(P.A. 07-103, S. 2; P.A. 23-204, S. 256.)

History: P.A. 07-103 effective June 11, 2007; P.A. 23-204 amended Subsec. (e) by adding reference to Secs. 20-638 and 20-638a in Subdiv. (1)(A) and Sec. 20-638a(j) in Subdiv. (1)(B), adding provision re pharmacists, pharmacy interns and Department of Consumer Protection in Subdiv. (2), dividing Subdiv. (3) into Subparas. (A) and (B), dividing Subdiv. (3)(A) into clauses (i), (ii) and (ii)(I) and adding Subdiv. (3)

(A)(ii)(II) re pharmacists, pharmacy interns and Department of Consumer Protection, amended Subsec. (f) by adding reference to Sec. 20-638a(h), amended Subsec. (g) by adding provisions re pharmacists, pharmacy interns, pharmacy services and practice of pharmacy, and made technical and conforming changes throughout.

See Secs. 20-638 to 20-638c, inclusive, for similar provisions re pharmacists and pharmacy interns.

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Sec. 19a-12c. Professional assistance program account. There is established an account to be known as the “professional assistance program account” which shall be a separate, nonlapsing account within the General Fund. The account shall contain any moneys required by law to be deposited in the account. Moneys in the account shall be paid by the Commissioner of Public Health to the assistance program for health care professionals established pursuant to section [19a-12a](#) for the provision of education, prevention, intervention, referral assistance, rehabilitation or support services to health care professionals who have a chemical dependency, emotional or behavioral disorder or physical or mental illness.

(P.A. 15-244, S. 137; June Sp. Sess. P.A. 15-5, S. 474.)

History: P.A. 15-244 effective July 1, 2015; June Sp. Sess. P.A. 15-5 changed effective date of P.A. 15-244, S. 137, from July 1, 2015, to October 1, 2015, and applicable to the renewal of a license or certificate that expires on or after that date, effective June 30, 2015.

See Secs. 20-638 to 20-638c, inclusive, for similar provisions re pharmacists and pharmacy interns.

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Sec. 19a-12d. Commissioner of Public Health to transfer certain revenue to professional assistance program account. (a) On or before the last day of January, April, July and October in each year, the Commissioner of Public Health shall certify the amount of revenue received as a result of any fee increase in the amount of five dollars (1) that took effect October 1, 2015, pursuant to sections [19a-88](#), [19a-515](#), [20-65k](#), [20-74bb](#), [20-74h](#), [20-74s](#), [20-149](#), [20-162o](#), [20-162bb](#), [20-191a](#), [20-195c](#), [20-195o](#), [20-195cc](#), [20-201](#), [20-206b](#), [20-206n](#), [20-206r](#), [20-206bb](#), [20-206ll](#), [20-222a](#), [20-275](#), [20-395d](#), [20-398](#) and [20-412](#), (2) that took effect October 1, 2021, pursuant to section [20-185k](#), and (3) that took effect July 1, 2021, pursuant to section [20-12j](#), and transfer such amount to the professional assistance program account established in section [19a-12c](#).

(b) On and after October 1, 2025, until January 1, 2028, in addition to the transfers made pursuant to subsection (a) of this section, the commissioner shall transfer an additional two dollars from each license renewed pursuant to subdivision (1) or (3) of subsection (c) of section [19a-88](#) to the professional assistance program account established pursuant to section [19a-12c](#). Transfers made pursuant to this subsection shall occur at the same times and frequency as the transfers made pursuant to subsection (a) of this section.

(P.A. 15-244, S. 136; June Sp. Sess. P.A. 15-5, S. 474, 479; P.A. 21-121, S. 27; June Sp. Sess. P.A. 21-2, S. 200; P.A. 24-83, S. 4.)

History: P.A. 15-244 effective July 1, 2015; June Sp. Sess. P.A. 15-5 changed effective date of P.A. 15-244, S. 136, from July 1, 2015, to October 1, 2015, and applicable to the renewal of a license or certificate that expires on or after that date, effective June 30, 2015, and changed “July 1, 2015,” to “October 1, 2015,” re fee increase and substituted reference to Sec. 20-74h for reference to Sec. 20-74f, effective October 1, 2015; P.A. 21-121 designated existing provision re fee increases that took effect October 1, 2015, as Subdiv. (1) and added Subdiv. (2) re fee increases that took effect October 1, 2021, effective July 1, 2021; June Sp.

Sess. P.A. 21-2 designated existing provision re fee increases that took effect October 1, 2015, as Subdiv. (1) and added Subdiv. (2), codified by the Revisors as Subdiv. (3), re fee increases that took effect July 1, 2021, effective July 1, 2021; P.A. 24-83 designated existing provisions as Subsec. (a) and added Subsec. (b) requiring transfer of additional 2 dollars from licenses renewed pursuant to Sec. 19a-88(c)(1) or (3) to the professional assistance program, effective May 30, 2024.

See Secs. 20-638 to 20-638c, inclusive, for similar provisions re pharmacists and pharmacy interns.

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Sec. 19a-12e. Petition re inability of health care professional to practice with reasonable skill or safety. Report re arrest or disciplinary action. Investigation. Disclosure. Procedure. (a) As used in this section:

(1) “Assistance program” has the same meaning as provided in subsection (a) of section [19a-12a](#);

(2) “Health care professional” means any individual licensed or who holds a permit pursuant to chapter 368v, 370, 372, 373, 375 to 378, inclusive, 379 to 381b, inclusive, 382a, 383 to 385, inclusive, 388 or 397a to 399, inclusive; and

(3) “Hospital” has the same meaning as provided in section [19a-490](#).

(b) (1) Any health care professional or hospital shall, and any other person may, file a petition when such health care professional, hospital or person has any information that appears to show that a health care professional is, or may be, unable to practice his or her profession with reasonable skill or safety for any of the following reasons: (A) Physical illness or loss of motor skill, including, but not limited to, deterioration through the aging process; (B) emotional disorder or mental illness; (C) abuse or excessive use of drugs, including alcohol, narcotics or chemicals; (D) illegal, incompetent or negligent conduct in the practice of the profession of the health care professional; (E) possession, use, prescription for use or distribution of controlled substances or legend drugs, except for therapeutic or other medically proper purposes; (F) misrepresentation or concealment of a material fact in the obtaining or reinstatement of a license to practice the profession of the health care professional; or (G) violation of any provision of the chapter of the general statutes under which the health care professional is licensed or any regulation established under such chapter.

(2) A health care professional or hospital shall, and any other person may, file a petition described in this subsection not later than thirty days after obtaining information to support such petition. Each petition shall be filed with the Department of Public Health on forms supplied by the department, shall be signed and sworn and shall set forth in detail the matters complained of.

(c) Any health care professional or hospital that refers a health care professional for intervention to the assistance program shall be deemed to have satisfied the obligations imposed on the health care professional or hospital pursuant to this section with respect to a health care professional's inability to practice with reasonable skill or safety due to chemical dependency, emotional or behavioral disorder or physical or mental illness.

(d) A health care professional who has been the subject of an arrest arising out of an allegation of the possession, use, prescription for use or distribution of a controlled substance or legend drug or alcohol shall, not less than thirty days after such arrest, notify the Department of Public Health. The health care professional shall be deemed to satisfy this obligation if the health care professional seeks intervention with the assistance program.

(e) A health care professional shall report to the department any disciplinary action similar to an action specified in subsection (a) of section [19a-17](#) taken against the health care professional by a duly authorized professional disciplinary agency of any state, the District of Columbia, a United States possession or

territory or a foreign jurisdiction, not later than thirty days after such action. Failure to report in accordance with the provisions of this subsection may constitute a ground for disciplinary action under section [19a-17](#).

(f) No health care professional, hospital or person filing a petition in accordance with the provisions of this section or providing information to the department or the assistance program shall, without a showing of malice, be liable for damage or injury to the health care professional. The assistance program shall not be liable for damage or injury to the health care professional without a showing of malice.

(g) The department shall investigate each petition filed pursuant to this section in accordance with the provisions of subdivisions (10) and (11) of subsection (a) of section [19a-14](#), to determine if probable cause exists to issue a statement of charges and to institute proceedings against the health care professional under subsection (j) of this section. Such investigation shall be concluded not later than eighteen months after the date the petition is filed with the department and, unless otherwise specified by this subsection, the record of such investigation shall be deemed a public record, in accordance with section [1-210](#), at the conclusion of such eighteen-month period. Any such investigation shall be confidential prior to the conclusion of such eighteen-month period and no person shall disclose his or her knowledge of such investigation to a third party unless the health care professional requests that such investigation and disclosure be open, except the department shall provide information to the person who filed the petition as provided in subdivision (12) of subsection (a) of section [19a-14](#). If the department determines that probable cause exists to issue a statement of charges, the entire record of such proceeding shall be public unless the department determines that the health care professional is an appropriate candidate for participation in the assistance program. If at any time subsequent to the filing of a petition and during the eighteen-month period following the filing of the petition, the department makes a finding of no probable cause, the petition and the entire record of such investigation shall remain confidential, except as provided in subdivision (12) of subsection (a) of section [19a-14](#), unless the health care professional requests that such petition and record be open.

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

(i) If the health care professional fails to obey a department order to submit to examination or attend a hearing, the department may petition the superior court for the judicial district of Hartford to order such examination or attendance, and said court or any judge assigned to said court shall have jurisdiction to issue such order.

(j) Subject to the provisions of section [4-182](#), no license shall be restricted, suspended or revoked by the Department of Public Health, and no health care professional's right to practice shall be limited by the department, until the health care professional has been given notice and opportunity for hearing in accordance with said section.

(June Sp. Sess. P.A. 15-5, S. 480; P.A. 16-39, S. 16; 16-66, S. 3; P.A. 17-178, S. 1; P.A. 21-121, S. 28; P.A. 23-204, S. 257.)

History: P.A. 16-39 amended Subsec. (h) by adding references to advanced practice registered nurse; P.A. 16-66 amended Subsec. (a)(1) by replacing “person” with “individual” and adding references to Chs. 368v, 370, 381b, 388 and 397a to 399; P.A. 17-178 amended Subsec. (d) by deleting provision re notice to department when diagnosed with mental illness or behavioral or emotional disorder and making a conforming change; P.A. 21-121 amended Subsec. (a)(1) by adding reference to Ch. 382a; P.A. 23-204 amended Subsec. (a) by adding Subdiv. (1) defining “assistance program”, redesignating existing Subdiv.

(1) as new Subdiv. (2), deleting former Subdiv. (2) defining “assistance program” and made a conforming change in Subdiv. (2).

See Secs. 20-638 to 20-638c, inclusive, for similar provisions re pharmacists and pharmacy interns.

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Sec. 19a-13. (Formerly Sec. 19-4n). Regulated professions; definitions. As used in this chapter and chapters 368v, 369 to 375, inclusive, 378 to 381, inclusive, 383 to 388, inclusive, 398 and 399 unless the context otherwise requires:

(1) “Certificate” includes the whole or part of any Department of Public Health permit which the department is authorized by the general statutes to issue and which further: (A) Authorizes practice of the profession by certified persons but does not prohibit the practice of the profession by others, not certified; (B) prohibits a person from falsely representing that he is certified to practice the profession unless the person holds a certificate issued by the department; (C) requires as a condition to certification that a person submit specified credentials to the department which attest to qualifications to practice the profession;

(2) “Emerging occupation or profession” means a group of health care providers whose actual or proposed duties, responsibilities and services include functions which are not presently regulated or licensed or which are presently performed within the scope of practice of an existing licensed or otherwise regulated health occupation or profession;

(3) “License” includes the whole or part of any Department of Public Health permit, approval or similar form of permission required by the general statutes and which further requires: (A) Practice of the profession by licensed persons only; (B) that a person demonstrate competence to practice through an examination or other means and meet certain minimum standards; (C) enforcement of standards by the department or regulatory board or commission;

(4) “Public member” means an elector of the state who has no substantial financial interest in, is not employed in or by, and is not professionally affiliated with, any industry, profession, occupation, trade or institution regulated or licensed by the board or commission to which he is appointed, and who has had no professional affiliation with any such industry, profession, occupation, trade or institution for three years preceding his appointment to the board or commission;

(5) “Registration” means the required entry upon a list maintained by the Department of Public Health of the name of a practitioner or the address of a place where a practice or profession subject to the provisions of this chapter and chapters 368v, 369 to 375, inclusive, 378 to 381, inclusive, 383 to 388, inclusive, 398 and 399 may be engaged in;

(6) “Complaint” means a formal statement of charges issued by the Department of Public Health.

(P.A. 80-484, S. 1, 174, 176; P.A. 81-471, S. 1, 71; P.A. 85-613, S. 35, 154; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 12-143, S. 9.)

History: P.A. 81-471 added Subdiv. (6) defining “complaint”; Sec. 19-4n transferred to Sec. 19a-13 in 1983; P.A. 85-613 made technical changes, substituting references to Sec. 2c-2b(a) for references to Sec. 2c-2(f); P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 12-143 deleted references to Sec. 2c-2b(a), effective July 1, 2012.

Cited. 207 C. 674.

Sec. 19a-14. (Formerly Sec. 19-4o). Powers of department concerning regulated professions. (a) The Department of Public Health shall have the following powers and duties with regard to the boards and commissions listed in subsection (b) of this section which are within the Department of Public Health. The department shall:

- (1) Control the allocation, disbursement and budgeting of funds appropriated to the department for the operation of the boards and commissions;**
- (2) Employ and assign such personnel as the commissioner deems necessary for the performance of the functions of the boards and commissions;**
- (3) Perform all management functions including purchasing, bookkeeping, accounting, payroll, secretarial, clerical and routine housekeeping functions;**
- (4) Adopt, with the advice and assistance of the appropriate board or commission, and in accordance with chapter 54, any regulations which are consistent with protecting the public health and safety and which are necessary to implement the purposes of this chapter and chapters 368v, 369 to 375, inclusive, 378 to 381, inclusive, 383 to 388, inclusive, 398 and 399;**
- (5) Develop and perform all administrative functions necessary to process applications for licenses and certificates;**
- (6) Determine the eligibility of all applicants for permits, licensure, certification or registration, based upon compliance with the general statutes and administrative regulations. The department may deny the eligibility of an applicant for a permit or for licensure by examination, endorsement, reciprocity or for reinstatement of a license voided pursuant to subsection (f) of section [19a-88](#), voluntarily surrendered or, by agreement, not renewed or reinstated pursuant to subsection (d) of section [19a-17](#), or may issue a license pursuant to a consent order containing conditions that must be met by the applicant if the department determines that the applicant:**
 - (A) Has failed to comply with the general statutes and administrative regulations governing the applicant's profession;**
 - (B) Has been found guilty or convicted as a result of an act which constitutes a felony under (i) the laws of this state, (ii) federal law, or (iii) the laws of another jurisdiction and which, if committed within this state, would have constituted a felony under the laws of this state, except any applicant for licensure as a barber under chapter 386, a hairdresser and cosmetician under chapter 387 or an embalmer and funeral director under chapter 385;**
 - (C) Is subject to a pending disciplinary action or unresolved complaint before the duly authorized professional disciplinary agency of any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction;**
 - (D) Has been subject to disciplinary action similar to an action specified in subsection (a) of section [19a-17](#) by a duly authorized professional disciplinary agency of any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction;**
 - (E) Has committed an act which, if the applicant were licensed, would not conform to the accepted standards of practice of the profession, including, but not limited to, incompetence, negligence, fraud or deceit; illegal conduct; procuring or attempting to procure a license, certificate or registration by fraud or deceit; or engaging in, aiding or abetting unlicensed practice of a regulated profession, provided the commissioner, or the commissioner's designee, gives notice and holds a hearing, in accordance with the**

provisions of chapter 54, prior to denying an application for a permit or a license based on this subparagraph; or

(F) Has a condition which would interfere with the practice of the applicant's profession, including, but not limited to, physical illness or loss of skill or deterioration due to the aging process, emotional disorder or mental illness, abuse or excessive use of drugs or alcohol, provided the commissioner, or the commissioner's designee, gives notice and holds a hearing in accordance with the provisions of chapter 54, prior to denying an application for a permit or a license based on this subparagraph;

(7) Administer licensing examinations under the supervision of the appropriate board or commission;

(8) Develop and perform all administrative functions necessary to process complaints against persons licensed by the department;

(9) Consent to the approval or disapproval by the appropriate boards or commissions of schools at which educational requirements shall be met;

(10) Conduct any necessary review, inspection or investigation regarding qualifications of applicants for licenses or certificates, possible violations of statutes or regulations, and disciplinary matters. In connection with any investigation, the Commissioner of Public Health or the commissioner's authorized agent may administer oaths, issue subpoenas, compel testimony and order the production of books, records and documents. If any person refuses to appear, to testify or to produce any book, record or document when so ordered, a judge of the Superior Court may make such order as may be appropriate to aid in the enforcement of this section;

(11) Conduct any necessary investigation and follow-up in connection with complaints regarding persons subject to regulation or licensing by the department. In connection with any such investigation, the department may restrict, suspend or otherwise limit the license or permit of any person subject to regulation or licensing by the department pursuant to an interim consent order entered during the pendency of such investigation;

(12) With respect to any complaint filed with the department on or after October 1, 2010, alleging incompetence, negligence, fraud or deceit by a person subject to regulation or licensing by any board or commission described in subdivision (1) to (8), inclusive, (12) to (14), inclusive, or subdivision (16) of subsection (b) of this section:

(A) Upon request of the person who filed the complaint, provide such person with information on the status of the complaint;

(B) Upon request of the person who filed the complaint, provide such person with an opportunity to review, at the department, records compiled as of the date of the request pursuant to any investigation of the complaint, including, but not limited to, the respondent's written response to the complaint, except that such person shall not be entitled to copy such records and the department (i) shall not disclose (I) information concerning a health care professional's referral to, participation in or completion of an assistance program in accordance with sections [19a-12a](#) and [19a-12b](#), that is confidential pursuant to section [19a-12a](#), (II) information not related to such person's specific complaint, including, but not limited to, information concerning patients other than such person, or (III) personnel or medical records and similar files the disclosure of which would constitute an invasion of personal privacy pursuant to section [1-210](#), except for such records or similar files solely related to such person; (ii) shall not be required to disclose any other information that is otherwise confidential pursuant to federal law or state statute, except for information solely related to such person; and (iii) may require up to ten business days written notice prior to providing such opportunity for review;

(C) Prior to resolving the complaint with a consent order, provide the person who filed the complaint with not less than ten business days to submit a written statement as to whether such person objects to

resolving the complaint with a consent order;

(D) If a hearing is held with respect to such complaint after a finding of probable cause, provide the person who filed the complaint with a copy of the notice of hearing issued pursuant to section [4-177](#), which shall include information concerning the opportunity to present oral or written statements pursuant to subsection (b) of section [4-177c](#); and

(E) Notify the person who filed the complaint of the final disposition of such complaint not later than seven business days after such final disposition;

(13) Perform any other function necessary to the effective operation of a board or commission and not specifically vested by statute in the board or commission;

(14) Contract with a third party, if the commissioner deems necessary, to administer licensing examinations and perform all attendant administrative functions in connection with such examination; and

(15) With respect to any investigation of a person subject to regulation, licensing or certification by the department and in any disciplinary proceeding regarding such person, except as required by federal law:

(A) Not be denied access to or use of copies of patient medical records on the grounds that privilege or confidentiality applies to such records; and

(B) Not further disclose patient medical records received pursuant to the provisions of this subdivision or personnel records received during the course of the investigation. Patient records received pursuant to this subdivision or personnel records received during the course of the investigation shall not be subject to disclosure under section [1-210](#).

(b) The department shall have the powers and duties indicated in subsection (a) of this section with regard to the following professional boards and commissions:

(1) The Connecticut Medical Examining Board, established under section [20-8a](#);

(2) The Connecticut State Board of Examiners for Optometrists, established under subsections (a) to (c), inclusive, of section [20-128a](#);

(3) The Connecticut State Board of Examiners for Nursing, established under section [20-88](#);

(4) The Dental Commission, established under section [20-103a](#);

(5) The Board of Examiners of Psychologists, established under section [20-186](#);

(6) The Connecticut Board of Veterinary Medicine, established under section [20-196](#);

(7) Repealed by P.A. [13-208](#), S. 79;

(8) The Connecticut State Board of Examiners for Opticians, established under subsections (a) to (c), inclusive, of section [20-139a](#);

(9) The Connecticut State Board of Examiners for Barbers and Hairdressers and Cosmeticians, established under section [20-235a](#);

(10) The Connecticut Board of Examiners of Embalmers and Funeral Directors, established under section [20-208](#);

(11) Repealed by P.A. 99-102, S. 51;

- (12) The State Board of Naturopathic Examiners, established under section [20-35](#);**
- (13) The State Board of Chiropractic Examiners, established under section [20-25](#);**
- (14) The Connecticut Board of Examiners in Podiatry, established under section [20-51](#);**
- (15) The Board of Examiners of Electrologists, established under section [20-268](#); and**
- (16) The Connecticut State Board of Examiners for Physical Therapists.**

(c) No board shall exist for the following professions that are licensed or otherwise regulated by the Department of Public Health:

- (1) Speech and language pathologist and audiologist;**
- (2) Hearing instrument specialist;**
- (3) Nursing home administrator;**
- (4) Environmental health specialist;**
- (5) Subsurface sewage system installer or cleaner;**
- (6) Marital and family therapist and marriage and family therapist associate;**
- (7) Nurse-midwife;**
- (8) Licensed clinical social worker;**
- (9) Respiratory care practitioner;**
- (10) Asbestos contractor, asbestos consultant and asbestos training provider;**
- (11) Massage therapist;**
- (12) Registered nurse's aide;**
- (13) Radiographer;**
- (14) Dental hygienist;**
- (15) Dietitian-Nutritionist;**
- (16) Asbestos abatement worker;**
- (17) Asbestos abatement site supervisor;**
- (18) Licensed or certified alcohol and drug counselor;**
- (19) Professional counselor and professional counselor associate;**
- (20) Acupuncturist;**
- (21) Occupational therapist and occupational therapist assistant;**
- (22) Lead abatement contractor, lead consultant contractor, lead consultant, lead abatement supervisor, lead abatement worker, lead training provider, lead inspector, lead inspector risk assessor and lead**

planner-project designer;

(23) Emergency medical technician, advanced emergency medical technician, emergency medical responder and emergency medical services instructor;

(24) Paramedic;

(25) Athletic trainer;

(26) Perfusionist;

(27) Master social worker subject to the provisions of section [20-195v](#);

(28) Radiologist assistant, subject to the provisions of section [20-74tt](#);

(29) Homeopathic physician;

(30) Certified water treatment plant operator, certified distribution system operator, certified small water system operator, certified backflow prevention device tester and certified cross connection survey inspector, including certified limited operators, certified conditional operators and certified operators in training;

(31) Tattoo technician;

(32) Genetic counselor;

(33) Behavior analyst;

(34) Art therapist;

(35) Esthetician;

(36) Eyelash technician; and

(37) Nail technician.

The department shall assume all powers and duties normally vested with a board in administering regulatory jurisdiction over such professions. The uniform provisions of this chapter and chapters 368v, 369 to 381a, inclusive, 383 to 388, inclusive, 393a, 395, 398, 399, 400a and 400c, including, but not limited to, standards for entry and renewal; grounds for professional discipline; receiving and processing complaints; and disciplinary sanctions, shall apply, except as otherwise provided by law, to the professions listed in this subsection.

(d) Except as provided in subdivision (15) of subsection (a) of this section and section [20-13e](#), all records obtained by the department in connection with any investigation of a person or facility over which the department has jurisdiction under this chapter, other than a physician as defined in subdivision (5) of section [20-13a](#), shall not be subject to disclosure under section [1-210](#) for a period of one year from the date of the petition or other event initiating such investigation, or until such time as the investigation is terminated pursuant to a withdrawal or other informal disposition or until a hearing is convened pursuant to chapter 54, whichever is earlier. A complaint, as defined in subdivision (6) of section [19a-13](#), shall be subject to the provisions of section [1-210](#) from the time that it is served or mailed to the respondent. Records that are otherwise public records shall not be deemed confidential merely because they have been obtained in connection with an investigation under this chapter. Records disclosed to a person who files a complaint pursuant to subdivision (12) of subsection (a) of this section that are otherwise confidential shall not be deemed public records merely because they have been disclosed pursuant to said subdivision (12).

(e) The department shall not issue a license to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint with the professional licensing authority in another jurisdiction.

(f) (1) Upon the issuance of a complaint under this chapter concerning any board or commission listed in subsection (b) of this section, or upon the filing of a petition for a declaratory ruling with, or the initiation of a proceeding for declaratory ruling by, any such board or commission pursuant to section [4-176](#), such board or commission shall notify the department of such complaint, petition or initiation of a proceeding.

(2) The Commissioner of Public Health or his or her designee may, not later than fifteen calendar days after receipt of the notice described in subdivision (1) of this subsection, notify such board or commission that the decision rendered by such board or commission in such matter shall be a proposed decision and that the commissioner or his or her designee shall render the final determination of the matter. The board or commission in making any such proposed decision shall comply with the requirements set forth in section [4-179](#). The commissioner or his or her designee may approve, modify or reject the proposed decision or remand the proposed decision for further review or for the taking of additional evidence. Any party to the matter may file written exceptions to the proposed decision not later than thirty days after the proposed decision is issued by the board or commission. The decision of the commissioner or his or her designee shall be the final decision in accordance with section [4-180](#) and for purposes of reconsideration in accordance with section [4-181a](#) or appeal to the Superior Court pursuant to section [4-183](#).

(P.A. 80-484, S. 2, 174, 176; P.A. 81-473, S. 11, 43; P.A. 82-156, S. 1, 2; P.A. 83-352, S. 3, 5; 83-441, S. 6, 10; P.A. 85-531, S. 6; 85-585, S. 1; 85-613, S. 36, 154; P.A. 86-123, S. 8; 86-365, S. 1, 5; 86-376, S. 5; P.A. 87-537, S. 1, 13; P.A. 88-362, S. 9; P.A. 93-121, S. 1, 8; 93-249, S. 5; 93-381, S. 9, 39; P.A. 94-149, S. 15; 94-210, S. 1, 30; P.A. 95-116, S. 8; 95-196, S. 1; 95-257, S. 12, 21, 58; P.A. 96-47, S. 1; P.A. 97-186, S. 11; 97-311, S. 7; P.A. 98-166, S. 3, 9; 98-247, S. 10; P.A. 99-102, S. 51; 99-249, S. 2, 10; June Sp. Sess. P.A. 99-2, S. 60, 72; P.A. 00-226, S. 8, 20; P.A. 01-109, S. 3; June Sp. Sess. P.A. 01-4, S. 2, 3, 58; P.A. 05-66, S. 2, 3; 05-272, S. 14, 15; 05-280, S. 72, 73; P.A. 06-195, S. 2; P.A. 09-232, S. 25, 89; P.A. 10-38, S. 8; 10-117, S. 19, 20; 10-122, S. 3; P.A. 11-242, S. 3; P.A. 12-143, S. 10; P.A. 13-208, S. 17, 79; 13-234, S. 137; P.A. 15-242, S. 17; June Sp. Sess. P.A. 15-5, S. 366, 493; P.A. 17-60, S. 15; 17-66, S. 7; 17-112, S. 3; June Sp. Sess. P.A. 17-2, S. 187; P.A. 18-48, S. 4; 18-168, S. 2; P.A. 19-117, S. 173, 181, 201; P.A. 21-121, S. 20; P.A. 22-88, S. 1; P.A. 24-68, S. 18.)

History: P.A. 81-473 deleted a reference to the now abolished board of registration for sanitarians, added a reference to the board of examiners for physical therapists and provided that the department of health services perform the functions of a board with respect to the professions of sanitarian and subsurface sewage system installer or cleaner; P.A. 82-156 added Subdiv. (13) authorizing department of health services to contract with a third party to administer licensing examinations for the boards and commissions under its jurisdiction; Sec. 19-40 transferred to Sec. 19a-14 in 1983; P.A. 83-352 amended Subsec. (c) to include marital and family therapists; P.A. 83-441 amended Subsec. (c) to include nurse-midwives; P.A. 85-531 amended Subsec. (c) to include reference to certified independent social workers; P.A. 85-585 added Subsec. (d) regarding confidentiality of records obtained by the department in connection with an investigation of a person or facility over which the department has jurisdiction; P.A. 85-613 made technical changes, substituting reference to Sec. 2c-2b(a) for reference to Sec. 2c-2(f); P.A. 86-123 amended Subsec. (b)(6) by changing the name of the board from the state board of veterinary registration and examination to the Connecticut board of veterinary medicine; P.A. 86-365 added Subdivs. (A) to (F), inclusive, in Subsec. (a)(6) detailing grounds for denying applicants' eligibility for permits; P.A. 86-376 added "respiratory care practitioner" in Subsec. (c) as profession which has no board; P.A. 87-537 added asbestos contractor and asbestos consultant in Subsec. (c) as profession which has no board; P.A. 88-362 applied Subsec. (c) to massage therapists; P.A. 93-121 added Subsec. (c)(12) re registered nurse's aides, effective June 14, 1993; P.A. 93-249 amended Subsec. (c) to add new Subdiv. re radiographers; P.A. 93-381 replaced department and commissioner of health services with department and commissioner of public health and addiction services, effective July 1, 1993; P.A. 94-149 added Subsec. (c)(14) re dental hygienists; P.A. 94-210 added Subsec. (c)(15) re dietitian-nutritionists, effective July 1, 1994; P.A. 95-116 amended Subsec. (c)(8) to change "certified independent" to "licensed clinical" social worker; P.A. 95-196 added Subsec. (c)(16) and (17) re asbestos abatement workers and supervisors; P.A. 95-257 replaced

Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 96-47 amended Subsec. (a)(6) to allow issue of a license pursuant to a consent order; P.A. 97-186 amended Subsec. (c) by adding new Subdiv. re alcohol and drug counselors; P.A. 97-311 amended Subsec. (c) by adding new Subdiv. re professional counselors; P.A. 98-166 amended Subsec. (d) to add reference to the Sec. 20-13e exception and change “the provisions of” to “disclosure under” Sec. 1-19 (now 1-210), effective June 4, 1998; P.A. 98-247 amended Subdiv. (18) to change “associate licensed” to “certified”; P.A. 99-102 repealed Subsec. (b)(11) re Connecticut Osteopathic Examining Board; P.A. 99-249 added Subsec. (c)(20) re acupuncturists, effective June 29, 1999; June Sp. Sess. P.A. 99-2 added Subsec. (c)(20) to (23), inclusive, re acupuncturists, occupational therapists, lead abatement contractors and nail technicians and by making technical changes, effective June 29, 1999; P.A. 00-226 added Subsec. (c)(24) re athletic trainers, effective the later of October 1, 2000, or the date notice is published by the Commissioner of Public Health in the Connecticut Law Journal indicating that the licensing of athletic trainers and physical therapist assistants is being implemented by the commissioner, i.e. April 11, 2006; P.A. 01-109 amended Subsec. (b)(15) by changing “Hypertrichologists” to “Electrologists”; June Sp. Sess. P.A. 01-4 amended Subsec. (c) by changing hearing aid dealer to hearing instrument specialist in Subdiv. (2), adding occupational therapist assistant in Subdiv. (21), adding lead consultant contractor, lead consultant, lead abatement supervisor, lead abatement worker, inspector and planner-project designer in Subdiv. (22), deleting nail technician and adding emergency medical technician, emergency medical technician-intermediate, medical response technician and emergency medical services instructor in Subdiv. (23) and adding paramedic as Subdiv. (24), effective July 1, 2001; P.A. 05-66 added Subsec. (c)(25) re dialysis patient care technicians; P.A. 05-272 amended Subsec. (c)(1) by replacing “speech pathologist” with “speech and language pathologist”; P.A. 05-280 added Subsec. (c)(26) re perfusionists; P.A. 06-195 deleted Subsec. (c)(26) re dialysis patient care technician and redesignating existing Subdiv. (27) as Subdiv. (26); P.A. 09-232 amended Subsec. (c) (23) by substituting “advanced emergency medical technician” for “emergency medical technician-intermediate” and substituting “emergency medical responder” for “medical response technician”, effective January 1, 2010, and added Subsec. (c)(27) re radiologist assistants, effective July 1, 2009; P.A. 10-38 amended Subsec. (c) to add new Subdiv. (27) re master social workers and redesignate existing Subdiv. (27) as Subdiv. (28); P.A. 10-117 amended Subsec. (a) by adding provisions, codified by the Revisors as Subdiv. (15), re department's access to and disclosure of patient medical records in connection with an investigation or disciplinary action, amended Subsec. (d) by adding reference to Subsec. (a)(15) and added Subsec. (e) re nonissuance of a license to a person against whom professional disciplinary action is pending or who is the subject of an unresolved complaint in another jurisdiction; P.A. 10-122 amended Subsec. (a) by making technical changes, by adding new Subdiv. (12) re complainant's right to access information and records re complaints filed with department on or after October 1, 2010, and by redesignating existing Subdivs. (12) and (13) as Subdivs. (13) and (14) and amended Subsec. (d) by making a technical change and adding provision specifying that confidential records disclosed to complainant pursuant to Subsec. (a)(12) are not deemed public records; P.A. 11-242 amended Subsec. (a)(11) by allowing department to restrict, suspend or limit a license or permit pursuant to interim consent order entered during pendency of an investigation, effective July 1, 2011; P.A. 12-143 amended Subsec. (a)(4) to replace reference to Sec. 2c-2b(a) with reference to Sec. 2c-2h, effective July 1, 2012; P.A. 13-208 repealed Subsec. (b)(7) and amended Subsec. (c) by adding Subdiv. (29) re homeopathic physician and Subdiv. (30) re water professionals; P.A. 13-234 amended Subsec. (c) by deleting “On and after July 1, 2011, a” in Subdiv. (28) and adding provision, codified by the Revisors as Subdiv. (31), re tattoo technician; P.A. 15-242 amended Subsec. (a)(6) by adding provision re denial of eligibility for voluntary surrender of license or for license that is not renewed or reinstated; June Sp. Sess. P.A. 15-5 added Subsec. (f) re notice to department of a complaint concerning board or commission or a declaratory ruling petition or proceeding, effective June 30, 2015, and amended Subsec. (c) by adding Subdiv. (32) re genetic counselors, effective October 1, 2015; P.A. 17-60 amended Subsec. (a)(4) by deleting reference to Sec. 2c-2h, and making a technical change, effective July 1, 2017; P.A. 17-66 amended Subsec. (c) by adding reference to “asbestos training provider” in Subdiv. (10), adding references to “lead training provider” and “lead inspector risk assessor” in Subdiv. (22), and making technical changes, effective July 1, 2017; P.A. 17-112 amended Subsec. (a)(6)(B) by adding “Except any applicant for licensure as a barber under chapter 386 or a hairdresser and cosmetician under chapter 387”, and making technical changes; June Sp. Sess. P.A. 17-2

amended Subsec. (c) by adding Subdiv. (33) re behavior analyst, effective July 1, 2018; P.A. 18-48 amended Subsec. (b)(10) by making a technical change, effective May 29, 2018; P.A. 18-168 amended Subsec. (a)(15)(B) by adding provisions re personnel records received during course of an investigation; P.A. 19-117 amended Subsec. (c) by adding reference to marriage and family therapist associate in Subdiv. (6), adding reference to professional counselor associate in Subdiv. (19), adding Subdiv. (34) re art therapist, and making technical changes, effective October 1, 2019, and further amended Subsec. (c) by adding Subdiv. (34) re esthetician, adding Subdiv. (35) re eyelash technician and adding Subdiv. (36) re nail technician, codified by the Revisors as Subdivs. (35), (36) and (37), respectively, and making technical changes, effective January 1, 2020; P.A. 21-121 amended Subsec. (a)(12) by replacing “subdivision (1) to (5), inclusive, (7), (8)” with “subdivision (1) to (8), inclusive,” and made a technical change; P.A. 22-88 amended Subsec. (a)(6)(B) by adding provisions re felony conviction and adding “or an embalmer and funeral director under chapter 385”; P.A. 24-68 amended Subsec. (c)(4) by replacing “sanitarian” with “environmental health specialist”, effective July 1, 2024.

Cited. 207 C. 674; 208 C. 492; Id., 709; 225 C. 700; 240 C. 658.

Cited. 4 CA 544; 17 CA 577; 22 CA 181. Sanctions imposed on defendant were civil and subsequent criminal prosecution does not constitute double jeopardy. 48 CA 71.

Cited. 40 CS 188.

Subsec. (a):

Subdiv. (10): Provisions of statute do not override psychiatrist-patient privilege of Sec. 52-146e(a). 14 CA 552.

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Sec. 19a-14a. Professional licenses. Investigations and disciplinary action. Any person who is the subject of an investigation pursuant to subdivision (10) or (11) of subsection (a) of section [19a-14](#) or disciplinary action pursuant to section [19a-17](#), while holding a professional license issued by the Department of Public Health or having held such a license within eighteen months of the commencement of such investigation or disciplinary action shall be considered to hold a valid license for purposes of such investigation or disciplinary action.

(P.A. 89-91, S. 2, 3; P.A. 90-211, S. 22; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: P.A. 90-211 applied provisions to persons investigated pursuant to Sec. 19a-14(11) and to those under disciplinary action pursuant to Sec. 19a-17; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

Cited. 37 CA 694.

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Sec. 19a-14b. Radon mitigators, diagnosticians and testing companies. Regulations. (a) For the purposes of this section and sections [20-420](#) and [20-432](#), the following terms shall have the following meanings unless the context clearly denotes otherwise:

(1) “Radon diagnosis” means evaluating buildings found to have levels of radon gas that are higher than the guidelines promulgated by this state or the United States Environmental Protection Agency and

recommending appropriate remedies to eliminate radon.

(2) “Radon mitigation” means taking steps including, but not limited to, installing ventilation systems, sealing entry routes for radon gas and installing subslab depressurization systems to reduce radon levels in buildings.

(3) “Analytical measurement service providers” means companies or individuals that have their own analysis capability for radon measurement but may or may not offer measurement services directly to the public.

(4) “Residential measurement service providers” means individuals that offer services that include, but are not limited to, detector placement and home inspection and consultation but do not have their own analysis capability and utilize the services of an analytical measurement service provider for their detector analysis.

(5) “Residential mitigation service providers” means individuals that offer services that include, but are not limited to, radon diagnosis or radon mitigation.

(b) The Department of Public Health shall maintain a list of companies or individuals that are included in current lists of national radon proficiency programs that have been approved by the Commissioner of Public Health.

(c) The Department of Public Health may adopt regulations, in accordance with chapter 54, concerning radon in drinking water that are consistent with the provisions contained in 40 CFR 141 and 142.

(P.A. 90-321, S. 1, 2, 4; P.A. 92-6; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 03-252, S. 2; P.A. 09-220, S. 4; P.A. 19-118, S. 13.)

History: P.A. 92-6 amended Subsec. (b) to require supervisors and people or companies doing diagnostic evaluation to be included in the current proficiency report of the U.S. Environmental Protection Agency; P.A. 93-381 replaced department and commissioner of health services with department and commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 03-252 defined “residential mitigation service providers” in new Subdiv. (5), changed “primary testing companies” to “analytical measurement service providers” in Subdiv. (3), adding “or individuals” therein, redefined “secondary testing companies” as “residential measurement service providers” in Subdiv. (4), and replaced former Subsec. (b) with new Subsec. (b) re method of compiling list; P.A. 09-220 amended Subsec. (c) by replacing “establishing safe levels of radon in potable water” with “concerning radon in drinking water that are consistent with the provisions contained in 40 CFR 141 and 142”; P.A. 19-118 amended Subsec. (c) by replacing “shall” with “may”, effective July 1, 2019.

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Sec. 19a-14c. Provision of outpatient mental health treatment to minors. (a) For the purposes of this section, “outpatient mental health treatment” means the treatment of mental disorders, emotional problems or maladjustments with the object of (1) removing, modifying or retarding existing symptoms; (2) improving disturbed patterns of behavior; and (3) promoting positive personality growth and development. Treatment shall not include prescribing or otherwise dispensing any medication which is a legend drug as defined in section [20-571](#).

(b) A psychiatrist licensed pursuant to chapter 370, a psychologist licensed pursuant to chapter 383, a clinical social worker licensed pursuant to chapter 383b or a marital and family therapist licensed pursuant to chapter 383a may provide outpatient mental health treatment to a minor without the consent

or notification of a parent or guardian at the request of the minor if (1) requiring the consent or notification of a parent or guardian would cause the minor to reject such treatment; (2) the provision of such treatment is clinically indicated; (3) the failure to provide such treatment would be seriously detrimental to the minor's well-being; (4) the minor has knowingly and voluntarily sought such treatment; and (5) in the opinion of the provider of treatment, the minor is mature enough to participate in treatment productively. The provider of such treatment shall document the reasons for any determination made to treat a minor without the consent or notification of a parent or guardian and shall include such documentation in the minor's clinical record, along with a written statement signed by the minor stating that (A) the minor is voluntarily seeking such treatment; (B) the minor has discussed with the provider the possibility of involving his or her parent or guardian in the decision to pursue such treatment; (C) the minor has determined it is not in his or her best interest to involve his or her parent or guardian in such decision; and (D) the minor has been given adequate opportunity to ask the provider questions about the course of his or her treatment.

(c) (1) Except as otherwise provided in subdivision (2) of this subsection, a minor may request and receive as many outpatient mental health treatment sessions as necessary without the consent or notification of a parent or guardian. No provider shall notify a parent or guardian of treatment provided pursuant to this section or disclose any information concerning such treatment to a parent or guardian without the consent of the minor.

(2) A provider may notify a parent or guardian of treatment provided pursuant to this section or disclose certain information concerning such treatment without the consent of the minor who receives such treatment provided (A) such provider determines such notification or disclosure is necessary for the minor's well-being, (B) the treatment provided to the minor is solely for mental health and not for a substance use disorder, and (C) the minor is provided an opportunity to express any objection to such notification or disclosure. The provider shall document his or her determination concerning such notification or disclosure and any objections expressed by the minor in the minor's clinical record. A provider may disclose to a minor's parent or guardian the following information concerning such minor's outpatient mental health treatment: (i) Diagnosis; (ii) treatment plan and progress in treatment; (iii) recommended medications, including risks, benefits, side effects, typical efficacy, dose and schedule; (iv) psychoeducation about the minor's mental health; (v) referrals to community resources; (vi) coaching on parenting or behavioral management strategies; and (vii) crisis prevention planning and safety planning. A provider shall release a minor's entire clinical record to another provider upon the request of the minor or such minor's parent or guardian.

(d) A parent or guardian who is not informed of the provision of outpatient mental health treatment for his or her minor child pursuant to this section shall not be liable for the costs of the treatment provided.

(P.A. 92-129, S. 1; P.A. 95-289, S. 8; P.A. 21-46, S. 10; P.A. 22-58, S. 19.)

History: P.A. 95-289 changed marital and family therapists from “certified” to “licensed”; P.A. 21-46 amended Subsec. (b) by replacing “he” with “the minor” and adding “or her”, amended Subsec. (c) by deleting provision re notification to minor after 6th session that consent, notification or involvement of parent or guardian required, designating existing provision re prohibiting notification of parent or guardian re treatment or disclosure of information without consent of minor as Subdiv. (1) and amended same by adding provision re minor to request and receive sessions without parental or guardian consent or notification and adding Subdiv. (2) re parental or guardian notification or disclosure without consent of minor, documentation and information that may be disclosed, and amended Subsec. (d) by adding “or her”, effective July 1, 2021; P.A. 22-58 amended Subsec. (b) by replacing “an independent social worker certified pursuant to chapter 383b” with “a clinical social worker licensed pursuant to chapter 383b”, effective May 23, 2022.

Sec. 19a-14d. Issuance of occupational or professional license, permit, certification or registration to certain persons with license, permit, certification or registration from another United States jurisdiction. Requirements. Recognition of covered licenses. (a) An occupational or professional license, permit, certification or registration issued by the Department of Public Health pursuant to chapter 368v, 370, 372, 373, 375, 375a, 376, 376a, 376b, 376c, 377, 378, 378a, 379, 379a, 380, 381, 381a, 381b, 382a, 382b, 382c, 383, 383a, 383b, 383c, 383d, 383e, 383f, 383g, 383h, 384, 384a, 384b, 384c, 384d, 385, 386, 387, 387a, 388, 388a, 393a, 395, 397a, 398, 399, 400a, 400c or 474 shall be issued, in the occupation or profession applied for and at a practice level determined by the department, to a person, including, but not limited to, an active duty member of the armed forces of the United States or such person's spouse, if:

(1) The person holds a valid license, permit, certification or registration in at least one other jurisdiction in the United States in the occupation or profession applied for;

(2) The person has practiced under such license, permit, certification or registration for not less than four years;

(3) The person is in good standing in all jurisdictions in the United States in which he or she holds a license, permit, certification or registration and has not had a license, permit, certification or registration revoked or discipline imposed by any jurisdiction in the United States, does not have a complaint, allegation or investigation related to unprofessional conduct pending in any jurisdiction, and has not voluntarily surrendered a license, permit, certification or registration while under investigation for unprofessional conduct in any jurisdiction;

(4) The person satisfies any background check or character and fitness check required of other applicants for the license, permit, certification or registration; and

(5) The person pays all fees required of other applicants for the license, permit, certification or registration.

(b) In addition to the requirements set forth in subsection (a) of this section, the department may require a person applying for a license, permit, certification or registration under this section to take and pass all, or a portion of, any examination required of other persons applying for such license, permit, certification or registration.

(c) Any person issued a license, permit, certification or registration pursuant to this section shall be subject to the laws of this state and the jurisdiction of the department.

(d) Notwithstanding the provisions of this section and pursuant to section [19a-14](#), the Commissioner of Public Health may deny an occupational or professional license, permit, certification or registration if he or she finds such denial is in the best interest of the state.

(e) Not later than July 1, 2024, the commissioner shall publish, in a form and manner prescribed by the commissioner, an application for each occupational or professional license, permit, certification and registration issued by the department that collects the applicant information necessary for the department to recognize a covered license, as defined in 50 USC 4025a, as amended from time to time. The department shall not charge a fee to any covered license holder that submits such an application to the department. After determining that an applicant is eligible for license recognition pursuant to 50 USC 4025a, as amended from time to time, the department shall issue to the applicant a specially designated license, permit, certification, registration or similar credential for the occupation or profession for which the covered licensed is considered valid that shall (1) be recorded by the department in the department's registry of the occupational or professional license, permit, certification, registration or other similar credential relevant to the scope of practice and discipline, (2) be subject to the provisions of section [19a-17](#), and (3) expire when the covered license holder's residency in the state is no longer required by military orders for military service, except when the covered license holder has submitted a complete application to the department for an appropriate license, registration or permit to practice the occupation and profession

of the covered license in which case said expiration will occur upon the final determination of said application by the department.

(P.A. 21-152, S. 1; P.A. 22-47, S. 2; P.A. 24-68, S. 34.)

History: P.A. 22-47 amended Subsec. (a) by deleting Subdivs. (1) and (2) and adding reference to “an active duty member of the armed forces of the United States or such person's spouse” and redesignating existing Subparas. (A) to (E) as Subdivs. (1) to (5), and amended Subsec. (b) by deleting Subdiv. (1) designator, permitting the department to require a person to take and pass an examination, making a technical change and deleting Subdiv. (2); P.A. 24-68 amended Subsecs. (b) and (c) by replacing “Department of Public Health” with “department” and added Subsec. (e) re recognition of covered licenses, effective May 28, 2024.

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Sec. 19a-14e. Need-based program for waiver of application costs and licensure fees for persons applying for licensure as a mental or behavioral health care provider who will provide mental or behavioral health care services to children. The Commissioner of Public Health shall establish, within available appropriations, a need-based program pursuant to which the commissioner may waive application costs and licensure fees for persons who are applying to the Department of Public Health for licensure as a mental or behavioral health care provider pursuant to chapter 370, 382a, 383, 383a, 383b or 383c, or section [20-195mmm](#), and who will provide mental or behavioral health care services to children. The Commissioner of Public Health shall develop eligibility requirements based on financial need for recipients of a waiver of such costs and fees and give priority to each applicant (1) who is a member of a racial or ethnic minority, (2) for whom English is a second language, (3) who identifies as lesbian, gay, bisexual, transgender or queer, or (4) who has a disability. The Department of Public Health may accept private donations for the program.

(P.A. 22-47, S. 6.)

History: P.A. 22-23 effective May 23, 2022.

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Sec. 19a-15. (Formerly Sec. 19-4p). Review of certain statutes and regulations; report to General Assembly. Section [19a-15](#) is repealed, effective October 1, 2002.

(P.A. 80-484, S. 4, 176; P.A. 85-613, S. 37, 154; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; S.A. 02-12, S. 1.)

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Sec. 19a-16. (Formerly Sec. 19-4q). Emerging occupations or professions; requests for regulation. In order to provide a systematic and uniform legislative review process to limit the proliferation of additional regulatory entities and programs, requests for regulation of emerging occupations or professions as defined by section [19a-13](#), shall be received first by the joint standing committee of the General Assembly having cognizance of matters relating to public health and then referred to the joint standing committee of the General Assembly having cognizance of matters relating to government administration, organization and reorganization. Requests for regulation may be initiated by the department, a board or commission, any group or individual or by said committee.

(P.A. 80-484, S. 5, 176; P.A. 82-314, S. 38, 63.)

History: P.A. 82-314 changed official name of government administration and elections committee; Sec. 19-4q transferred to Sec. 19a-16 in 1983.

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Secs. 19a-16a to 19a-16c. Athletic training. Certification of athletic trainers by the National Athletic Trainers' Association; restrictions; exemptions. Referrals by athletic trainers. Sections [19a-16a](#) to [19a-16c](#), inclusive, are repealed, effective the later of October 1, 2000, or the date notice is published by the Commissioner of Public Health in the Connecticut Law Journal indicating that the licensing of athletic trainers and physical therapist assistants is being implemented by the commissioner, i.e. April 11, 2006.

(P.A. 90-211, S. 18–20; P.A. 00-226, S. 19, 20.)

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Sec. 19a-16d. Submission of scope of practice requests and written impact statements to Department of Public Health. Requests for exemption. Notification and publication of requests. (a) Any person or entity, acting on behalf of a health care profession that seeks to establish a new scope of practice or change a profession's scope of practice, shall submit a written scope of practice request to the Department of Public Health not later than August fifteenth of the year preceding the commencement of the next regular session of the General Assembly.

(b) (1) Any written scope of practice request submitted to the Department of Public Health pursuant to subsection (a) of this section shall include the following information:

(A) A plain language description of the request;

(B) Public health and safety benefits that the requestor believes will be achieved should the request be implemented and, if applicable, a description of any harm to public health and safety should the request not be implemented;

(C) The impact that the request will have on public access to health care;

(D) A brief summary of state or federal laws that govern the health care profession making the request;

(E) The state's current regulatory oversight of the health care profession making the request;

(F) All current education, training and examination requirements and any relevant certification requirements applicable to the health care profession making the request;

(G) A summary of known scope of practice changes either requested or enacted concerning the health care profession in the five-year period preceding the date of the request;

(H) The extent to which the request directly impacts existing relationships within the health care delivery system;

(I) The anticipated economic impact of the request on the health care delivery system;

(J) Regional and national trends concerning licensure of the health care profession making the request and a summary of relevant scope of practice provisions enacted in other states;

(K) Identification of any health care professions that can reasonably be anticipated to be directly impacted by the request, the nature of the impact and efforts made by the requestor to discuss the request with such health care professions; and

(L) A description of how the request relates to the health care profession's ability to practice to the full extent of the profession's education and training.

(2) In lieu of submitting a scope of practice request as described in subdivision (1) of this subsection, any person or entity acting on behalf of a health care profession may submit a request for an exemption from the processes described in this section and section [19a-16e](#). A request for exemption shall include a plain language description of the request and the reasons for the request for exemption, including, but not limited to: (A) Exigent circumstances which necessitate an immediate response to the scope of practice request, (B) the lack of any dispute concerning the scope of practice request, or (C) any outstanding issues among health care professions concerning the scope of practice request can easily be resolved. Such request for exemption shall be submitted to the Department of Public Health not later than August fifteenth of the year preceding the commencement of the next regular session of the General Assembly.

(c) In any year in which a scope of practice request is received pursuant to this section, not later than September first of the year preceding the commencement of the next regular session of the General Assembly, the Department of Public Health, within available appropriations, shall: (1) Provide written notification to the joint standing committee of the General Assembly having cognizance of matters relating to public health of any health care profession that has submitted a scope of practice request, including any request for exemption, to the department pursuant to this section; and (2) post any such request, including any request for exemption, and the name and address of the requestor on the department's Internet web site.

(d) Any person or entity, acting on behalf of a health care profession that may be directly impacted by a scope of practice request submitted pursuant to this section, may submit to the department a written statement identifying the nature of the impact not later than September fifteenth of the year preceding the next regular session of the General Assembly. Any such person or entity directly impacted by a scope of practice request shall indicate the nature of the impact taking into consideration the criteria set forth in subsection (b) of this section and shall provide a copy of the written impact statement to the requestor. Not later than October first of such year, the requestor shall submit a written response to the department and any person or entity that has provided a written impact statement. The requestor's written response shall include, but not be limited to, a description of areas of agreement and disagreement between the respective health care professions.

(P.A. 11-209, S. 1; P.A. 22-58, S. 16, 55.)

History: P.A. 11-209 effective July 1, 2011; P.A. 22-58 amended Subsec. (a) by replacing “may” with “shall”, amended Subsec. (c) by replacing “September fifteenth” with “September first” and making a technical change and amended Subsec. (d) by replacing “October first” with “September fifteenth” and “October fifteenth” with “October first”, effective May 23, 2022.

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Sec. 19a-16e. Scope of practice review committees. Membership. Duties. (a) On or before October fifteenth of the year preceding the commencement of the next regular session of the General Assembly, the Commissioner of Public Health shall select from the timely scope of practice requests submitted to the department pursuant to section [19a-16d](#) the requests on which the department will act and, within available appropriations allocated to the department, establish and appoint members to a scope of practice review committee for each such request. Committees established pursuant to this section shall consist of the following members: (1) Two members recommended by the requestor to represent the health care profession making the scope of practice request; (2) two members recommended by each person or

entity that has submitted a written impact statement pursuant to subsection (d) of section [19a-16d](#) to represent the health care professions directly impacted by the scope of practice request; and (3) the Commissioner of Public Health or the commissioner's designee, who shall serve as an ex-officio, nonvoting member of the committee. The Commissioner of Public Health or the commissioner's designee shall serve as the chairperson of any such committee. The Commissioner of Public Health may appoint additional members to any committee established pursuant to this section to include representatives from health care professions having a proximate relationship to the underlying request if the commissioner or the commissioner's designee determines that such expansion would be beneficial to a resolution of the issues presented. Any member of such committee shall serve without compensation.

(b) Any committee established pursuant to this section shall review and evaluate the scope of practice request, subsequent written responses to the request and any other information the committee deems relevant to the scope of practice request. Such review and evaluation shall include, but not be limited to, an assessment of any public health and safety risks that may be associated with the request, whether the request may enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training. The committee, when carrying out the duties prescribed in this section, may seek input on the scope of practice request from the Department of Public Health and such other entities as the committee determines necessary in order to provide its written findings as described in subsection (c) of this section.

(c) The committee, upon concluding its review and evaluation of the scope of practice request, shall provide its findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The committee shall provide the written findings to said joint standing committee not later than the February first following the date of the committee's establishment. The committee shall include with its written findings all materials that were presented to the committee for review and consideration during the review process. The committee shall terminate on the date that it submits its written findings to said joint standing committee.

(P.A. 11-209, S. 2; P.A. 22-58, S. 17.)

History: P.A. 11-209 effective July 1, 2011; P.A. 22-58 amended Subsec. (a) by replacing “November first” with “October fifteenth”, adding provision re selection of timely scope of practice requests and made technical and conforming changes, effective May 23, 2022.

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Sec. 19a-16f. Report to General Assembly on scope of practice review processes. On or before January 1, 2013, the Commissioner of Public Health shall evaluate the processes implemented pursuant to sections [19a-16d](#) and [19a-16e](#) and report to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section [11-4a](#), on the effectiveness of such processes in addressing scope of practice requests. Such report may also include recommendations from the committee concerning measures that could be implemented to improve the scope of practice review process.

(P.A. 11-209, S. 3.)

History: P.A. 11-209 effective July 1, 2011.

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Sec. 19a-17. (Formerly Sec. 19-4s). Disciplinary action by department, boards and commissions. (a) Each board or commission established under chapters 369 to 376, inclusive, 378 to 381, inclusive, and 383 to 388, inclusive, and the Department of Public Health with respect to professions under its jurisdiction that

have no board or commission may take any of the following actions, singly or in combination, based on conduct that occurred prior or subsequent to the issuance of a permit or a license upon finding the existence of good cause:

- (1) Revoke a practitioner's license or permit;**
- (2) Suspend a practitioner's license or permit;**
- (3) Censure a practitioner or permittee;**
- (4) Issue a letter of reprimand to a practitioner or permittee;**
- (5) Restrict or otherwise limit practice to those areas prescribed by the board, commission or department;**
- (6) Place a practitioner or permittee on probationary status and require the practitioner or permittee to:**
 - (A) Report regularly to such board, commission or department upon the matters which are the basis of probation;**
 - (B) Limit practice to those areas prescribed by such board, commission or department; and**
 - (C) Continue or renew professional education until a satisfactory degree of skill has been attained in those areas which are the basis for the probation;**
- (7) Assess a civil penalty of up to ten thousand dollars;**
- (8) In those cases involving persons or entities licensed or certified pursuant to sections [20-341d](#), [20-435](#), [20-436](#), [20-437](#), [20-438](#), [20-475](#) and [20-476](#), require that restitution be made to an injured property owner; or**
- (9) Summarily take any action specified in this subsection against a practitioner's license or permit upon receipt of proof that such practitioner has been:**
 - (A) Found guilty or convicted as a result of an act which constitutes a felony under (i) the laws of this state, (ii) federal law, or (iii) the laws of another jurisdiction and which, if committed within this state, would have constituted a felony under the laws of this state, except for a practitioner who is a social worker under chapter 383b, an art therapist under chapter 383g, a dietitian-nutritionist under chapter 384b, an embalmer or funeral director under chapter 385, a barber under chapter 386, a hairdresser, cosmetician, esthetician, eyelash technician or nail technician under chapter 387; or**
 - (B) Subject to disciplinary action similar to that specified in this subsection by a duly authorized professional agency of any state, the federal government, the District of Columbia, a United States possession or territory or a foreign jurisdiction. The applicable board or commission, or the department shall promptly notify the practitioner or permittee that his license or permit has been summarily acted upon pursuant to this subsection and shall institute formal proceedings for revocation within ninety days after such notification.**
- (b) Such board or commission or the department may withdraw the probation if it finds that the circumstances that required action have been remedied.**
- (c) Such board or commission or the department where appropriate may summarily suspend a practitioner's license or permit in advance of a final adjudication or during the appeals process if such board or commission or the department finds that a practitioner or permittee represents a clear and immediate danger to the public health and safety if he is allowed to continue to practice.**

(d) In addition to the authority provided to the Department of Public Health in subsection (a) of this section, the department may resolve any disciplinary action with respect to a practitioner's license or permit in any profession by voluntary surrender or agreement not to renew or reinstate.

(e) Such board or commission or the department may reinstate a license that has been suspended or revoked if, after a hearing, such board or commission or the department is satisfied that the practitioner or permittee is able to practice with reasonable skill and safety to patients, customers or the public in general. As a condition of reinstatement, the board or commission or the department may impose disciplinary or corrective measures authorized under this section.

(f) Such board or commission or the department may take disciplinary action against a practitioner's license or permit as a result of the practitioner having been subject to disciplinary action similar to an action specified in subsection (a) or (d) of this section by a duly authorized professional disciplinary agency of any state, the federal government, the District of Columbia, a United States possession or territory or a foreign jurisdiction. Such board or commission or the department may rely upon the findings and conclusions made by a duly authorized professional disciplinary agency of any state, the federal government, the District of Columbia, a United States possession or territory or foreign jurisdiction in taking such disciplinary action.

(g) As used in this section, the term "license" shall be deemed to include the following authorizations relative to the practice of any profession listed in subsection (a) of this section: (1) Licensure by the Department of Public Health; (2) certification by the Department of Public Health; (3) certification by a national certification body; and (4) a covered license, as defined in 50 USC 4025a, as amended from time to time, that is considered valid by the Department of Public Health.

(h) As used in this chapter, the term "permit" includes any authorization issued by the department to allow the practice, limited or otherwise, of a profession which would otherwise require a license; and the term "permittee" means any person who practices pursuant to a permit.

(P.A. 80-484, S. 137, 176; P.A. 81-473, S. 12, 43; P.A. 82-179; P.A. 83-261; P.A. 86-365, S. 2, 5; P.A. 93-381, S. 9, 39; P.A. 94-174, S. 1, 12; P.A. 95-257, S. 12, 21, 58; P.A. 07-252, S. 5, 39; P.A. 08-137, S. 3; P.A. 11-242, S. 1; P.A. 15-242, S. 16; P.A. 17-10, S. 1; 17-146, S. 7; P.A. 19-118, S. 7; P.A. 22-88, S. 2; P.A. 24-68, S. 33, 35.)

History: P.A. 81-473 added a reference to safety of "customers or the public in general"; P.A. 82-179 allowed boards or commissions under the jurisdiction of the department of health services, and the department of health services with respect to professions under its jurisdiction which have no board or commission, to assess civil penalties of up to \$1,000; Sec. 19-4s transferred to Sec. 19a-17 in 1983; P.A. 83-261 amended Subsec. (a) to authorize summary revocation of a practitioner's license for conviction of a felony or of improper professional practice in another state and added Subsec. (e) to include certain certifications in the definition of a license; P.A. 86-365 provided for disciplinary action "based on conduct which occurred prior or subsequent to the issuance of a permit or a license", added references to "permits" and "permittees", and changed wording of Subsec. (a)(7) and added Subsec. (f) defining "permit" and "permittee"; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 94-174 amended Subsec. (a)(6) to increase civil penalty from \$1,000 to \$10,000, effective June 6, 1994; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 07-252 made technical changes in Subsecs. (a) and (b), added new Subsec. (d) authorizing department to resolve any disciplinary action with respect to a practitioner's license or permit by voluntary surrender or agreement not to renew or reinstate, redesignated existing Subsecs. (d), (e) and (f) as Subsecs. (e), (f) and (g), respectively, and made a technical change in redesignated Subsec. (e), effective July 12, 2007, and amended Subsec. (a)(6) to increase maximum civil penalty that boards, commissions and department may assess from \$10,000 to \$25,000; P.A. 08-137 amended Subsec. (a) by adding new Subdiv. (7) requiring restitution to injured property owners from the specified licensed or certified professionals and by redesignating existing Subdiv. (7) as Subdiv. (8); P.A.

11-242 added new Subsec. (f) re authority to rely upon findings and conclusions of out-of-state disciplinary agencies when taking disciplinary action against practitioner's license or permit and redesignated existing Subsecs. (f) and (g) as Subsecs. (g) and (h), effective July 1, 2011; P.A. 15-242 amended Subsec. (f) by adding "a federal governmental agency"; P.A. 17-10 amended Subsec. (a) by adding new Subdiv. (5) re restricting or otherwise limiting practice to areas prescribed by board, commission or department, and redesignating existing Subdivs. (5) to (8) as Subdivs. (6) to (9); P.A. 17-146 amended Subsec. (a)(8)(B) to add "the federal government," and amended Subsec. (f) to replace "a federal governmental agency" with "the federal government"; P.A. 19-118 amended Subsec. (f) by adding reference to Subsec. (d), effective July 1, 2019; P.A. 22-88 amended Subsec. (a)(9)(A) by adding ", except for a practitioner who is a social worker under chapter 383b, an art therapist under chapter 383g, a dietitian-nutritionist under chapter 384b, an embalmer or funeral director under chapter 385, a barber under chapter 386, a hairdresser, cosmetician, esthetician, eyelash technician or nail technician under chapter 387"; P.A. 24-68 amended Subsec. (a)(7) by replacing \$25,000 with \$10,000, and amended Subsec. (g) by adding Subdiv. (4) re covered licenses and making a conforming change, effective July 1, 2024.

Cited. 207 C. 674; 208 C. 492; 211 C. 508; 223 C. 618; 242 C. 1. Standard of proof in cases involving physician discipline before the Connecticut Medical Examining Board is by a preponderance of the evidence. 309 C. 727.

Cited. 6 CA 473; 15 CA 205; 24 CA 662; judgment reversed, see 223 C. 618; 34 CA 343; 37 CA 694. It is neither arbitrary nor irrational for legislature to permit board to take disciplinary action against practitioners whom it finds to have acted negligently or unskillfully, and such action does not violate substantive due process. 60 CA 775. Physician disciplinary proceedings, unlike attorney discipline proceedings, are governed by the Uniform Administrative Procedure Act in Ch. 54, and the preponderance of the evidence standard is the appropriate standard of proof in Ch. 54 proceedings. 129 CA 575.

Cited. 41 CS 211.

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Sec. 19a-17a. Review of medical malpractice awards and certain settlements. Upon entry of any medical malpractice award or upon entering a settlement of a malpractice claim against an individual licensed pursuant to chapter 370 to 373, inclusive, 379 or 383, the entity making payment on behalf of a party or, if no such entity exists, the party, shall notify the Department of Public Health of the terms of the award or settlement and shall provide to the department a copy of the award or settlement and the underlying complaint and answer, if any. The department shall review all medical malpractice awards and all settlements to determine whether further investigation or disciplinary action against the providers involved is warranted. Any document received pursuant to this section shall not be considered a petition and shall not be subject to the provisions of section [1-210](#) unless the department determines, following completion of its review, that further investigation or disciplinary action is warranted.

(P.A. 86-365, S. 3, 5; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 96-133, S. 1.)

History: P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 96-133 required the entity or party to notify the department, eliminated notification to state and county medical associations and added the section 1-19 exemption.

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Sec. 19a-17b. (Formerly Sec. 38-19a). Peer review: Definitions; immunity; discovery permissible re proceedings. (a) For the purposes of this section:

(1) “Health care provider” means any person, corporation, limited liability company, facility or institution operated, owned or licensed by this state to provide health care or professional services, or an officer, employee or agent thereof acting in the course and scope of his employment.

(2) “Peer review” means the procedure for evaluation by health care professionals of the quality and efficiency of services ordered or performed by other health care professionals, including practice analysis, inpatient hospital and extended care facility utilization review, medical audit, ambulatory care review and claims review.

(3) “Professional society” includes medical, psychological, nursing, dental, naturopathic, osteopathic, optometric, pharmaceutical, chiropractic, podiatric, physical therapy and occupational therapy organizations as well as individual practice associations as defined in Section 300e-1(5) of the Public Health Service Act, 42 USC 300e-1(5), as amended, having as members at least a majority of the eligible licentiates in the area or health care facility or agency served by the particular society or, in the case of physical therapy organizations, at least twenty-five per cent of the eligible licentiates in the state.

(4) “Medical review committee” includes any committee of a state or local professional society or a committee of any health care institution established pursuant to written bylaws, and any utilization review committee established pursuant to Public Law 89-97, and a professional standards review organization or a state-wide professional standards review council, established pursuant to Public Law 92-603, engaging in peer review, to gather and review information relating to the care and treatment of patients for the purposes of (A) evaluating and improving the quality of health care rendered; (B) reducing morbidity or mortality; or (C) establishing and enforcing guidelines designed to keep within reasonable bounds the cost of health care. “Medical review committee” also means any hospital board or committee reviewing the professional qualifications or activities of its medical staff or applicants for admission thereto.

(b) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person who provides testimony, information, records, documents, reports, proceedings, minutes or conclusions to any hospital, hospital medical staff, professional society, medical or dental school, professional licensing board or medical review committee when such communication is intended to aid in the evaluation of the qualifications, fitness or character of a health care provider and does not represent as true any matter not reasonably believed to be true.

(c) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any member of a medical review committee for any act or proceeding undertaken or performed within the scope of any such committee's functions provided that such member has taken action or made recommendations without malice and in the reasonable belief that the act or recommendation was warranted.

(d) The proceedings of a medical review committee conducting a peer review shall not be subject to discovery or introduction into evidence in any civil action for or against a health care provider arising out of the matters which are subject to evaluation and review by such committee, and no person who was in attendance at a meeting of such committee shall be permitted or required to testify in any such civil action as to the content of such proceedings; provided the provisions of this subsection shall not preclude (1) in any civil action, the use of any writing which was recorded independently of such proceedings; (2) in any civil action, the testimony of any person concerning the facts which formed the basis for the institution of such proceedings of which he had personal knowledge acquired independently of such proceedings; (3) in any health care provider proceedings concerning the termination or restriction of staff privileges, other than peer review, the use of data discussed or developed during peer review proceedings; or (4) in any civil action, disclosure of the fact that staff privileges were terminated or restricted, including the specific restriction imposed, if any.

(P.A. 76-413, S. 1-4; 76-435, S. 80, 82; P.A. 80-446; P.A. 82-40; P.A. 93-112, S. 1, 2; P.A. 95-79, S. 57, 189; 95-299, S. 1; P.A. 96-57, S. 1, 3; P.A. 14-122, S. 116.)

History: P.A. 76-435 redefined “professional society” to include optometric organizations; Sec. 52-197a transferred to Sec. 38-19a in 1979; P.A. 80-446 rephrased provisions, substituting references to proceedings re conduct of peer review for references to opinions and added proviso re situations where disclosure is allowed; P.A. 82-40 amended the definition of “professional society” in Subsec. (a) to include individual practice associations; Sec. 38-19a transferred to Sec. 19a-17b in 1991; P.A. 93-112 amended Subsec. (a) by redefining “health care provider” to include facilities or institutions operated or owned by the state and by revising Subdiv. and Subpara. indicators to conform with standard general statute style, effective June 3, 1993; P.A. 95-79 amended Subsec. (a) by redefining “health care provider” to include a limited liability company, effective May 31, 1995; P.A. 95-299 redefined “professional society” in Subsec. (a) to include physical therapy organizations having as members at least 25% of eligible licentiates in state; P.A. 96-57 redefined “professional society” to include occupational therapy organizations and substituted “area” for “state”, effective May 7, 1996; P.A. 14-122 made technical changes in Subsec. (a)(4).

Annotations to former section 38-19a:

Statute is designed not to disqualify a physician from testifying but to prevent him from disclosing confidential matters. 180 C. 314.

Department investigation not a “civil action” for purposes of privilege under statute. 40 CS 188.

Annotations to present section:

Cited. 242 C. 1. The privilege afforded by section applies to substantive exchanges that transpire during the course of a peer review meeting and confidentiality is provided for such exchanges but not for any knowledge gained by a committee member independent of that meeting. 251 C. 790. Section abrogates the common-law absolute immunity applicable to statements made to medical examining board of department in connection with proceedings of the board. 272 C. 776.

Where statutory immunity provided by Sec. 19a-20 and this section overlaps with common-law provision of absolute immunity to those who make statements in connection with quasi-judicial proceedings, statutes are in derogation of common law and must prevail over common-law grant of absolute immunity, and examination of the plain language and legislative history of statutes clearly and unambiguously demonstrated legislature's intent to provide only a qualified immunity to defendants. 77 CA 104.

Subsec. (d):

Provision which prohibits disclosure of proceedings of a medical review committee conducting peer review is not applicable to proceedings before Freedom of Information Commission and commission properly ordered disclosure of requested records; the term “discovery” is confined to discovery in a court action in a civil matter and use of the terms “discovery”, “introduction into evidence” and “civil action” signify that the legislature intended that the privilege apply within the context of a court action in a civil matter that does not include proceedings before commission. 293 C. 164.

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Sec. 19a-17c. Peer review materials not subject to disclosure pursuant to Freedom of Information Act. Access to peer review materials by Department of Public Health. (a) Notwithstanding any provision of the general statutes or any regulation adopted thereunder, peer review materials or information produced in conformance with section [19a-17b](#), in any format or media, shall not be subject to disclosure pursuant to the Freedom of Information Act.

(b) The provisions of subsection (a) of this section shall not preclude the Department of Public Health from accessing such peer review materials or information in connection with any investigation or review by the department regarding the license of a health care provider, as defined in subsection (a) of section [19a-17b](#), provided the department does not disclose such materials or information to any person outside of the department, except as may be necessary to take disciplinary action against such health care provider, and any such materials or information shall be exempt from disclosure under the Freedom of Information Act.

(c) The provisions of this section shall not limit the protections afforded pursuant to section [19a-17b](#).

(Sept. Sp. Sess. P.A. 09-3, S. 58.)

History: Sept. Sp. Sess. P.A. 09-3 effective October 6, 2009.

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Sec. 19a-17d. Prohibition on automatic reciprocal discipline based solely on the termination of a pregnancy. If a health care professional who is currently licensed or was previously licensed in another state or jurisdiction is subject to automatic reciprocal discipline for a disciplinary action in such state or jurisdiction, such automatic reciprocal discipline shall be automatically rescinded and shall not be entered into the licensing record of the health care professional if the discipline was based solely on the termination of pregnancy under conditions that would not violate the general statutes or the regulations of Connecticut state agencies. The provisions of this section shall not preclude or affect the ability of an agency or board of the state to seek or impose any discipline pursuant to the general statutes against a health care professional licensed by the state.

(P.A. 23-31, S. 18; P.A. 24-80, S. 5.)

History: P.A. 23-31 effective July 1, 2023; P.A. 24-80 deleted references to pharmacist, effective May 30, 2024.

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Sec. 19a-17e. Adverse permit or licensure eligibility action based on provision of reproductive health care services prohibited. (a) As used in this section, “reproductive health care services” has the same meaning as provided in section [52-571m](#).

(b) Notwithstanding the provisions of subsection (a) of section [19a-14](#), the Department of Public Health shall not deny the eligibility of an applicant for a (1) permit, (2) license by examination, endorsement or reciprocity, or (3) reinstatement of a license (A) voided pursuant to the provisions of subsection (f) of section [19a-88](#), (B) voluntarily surrendered, or (C) by agreement, not renewed or reinstated pursuant to the provisions of subsection (d) of section [19a-17](#) based on pending disciplinary action, an unresolved complaint or the imposition of disciplinary action against the applicant by a duly authorized professional disciplinary agency of another state, the District of Columbia or a commonwealth, territory or possession of the United States that is based solely on the alleged provision of, receipt of, assistance in provision or receipt of, material support for, or any theory of vicarious, joint, several or conspiracy liability derived therefrom, reproductive health care services that are permitted under the laws of this state and were provided in accordance with the standard of care applicable to such services, regardless of whether the patient receiving such services was a resident of this state. The provisions of this subsection shall not apply where the underlying conduct of the applicant would constitute the basis of disciplinary action against the applicant under the laws of this state if the applicant had been licensed or permitted in this state and the conduct had occurred in this state.

(c) Notwithstanding the provisions of section [19a-17](#), a board or commission established under title 20 that has jurisdiction over persons licensed, certified or registered under said title who provide reproductive health care services, and the Department of Public Health, with respect to professions under the department's jurisdiction that are not subject to discipline by such a board or commission, shall not impose disciplinary action against a licensed, certified or registered person based on pending disciplinary action, an unresolved complaint or the imposition of disciplinary action against such persons before or by a duly authorized professional disciplinary agency of another state, the District of Columbia, or a commonwealth, territory or possession of the United States that is based solely on the alleged provision of, receipt of, assistance in provision or receipt of, material support for, or any theory of vicarious, joint, several or conspiracy liability derived therefrom, reproductive health care services that are permitted under the laws of this state and were provided in accordance with the standard of care applicable to such services, regardless of whether the patient receiving such services was a resident of this state. The provisions of this subsection shall not apply where the underlying conduct of the licensed, certified or registered person would constitute the basis of disciplinary action against such person under the laws of this state if the conduct had occurred in this state.

(P.A. 23-128, S. 1.)

History: P.A. 23-128 effective June 27, 2023.

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Secs. 19a-17f to 19a-17l. Reserved for future use.

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Sec. 19a-17m. Malpractice insurance purchase program. (a) The Department of Public Health shall, within available appropriations, establish a program to purchase and maintain malpractice liability insurance for the following professionals and retired professionals who have been licensed by the state of Connecticut for a minimum of one year, whose licenses are in good standing and who provide primary health care services at community health centers and at other locations authorized by the department: Physicians, dentists, chiropractors, optometrists, podiatrists, naturopaths, psychologists, dental hygienists, physician assistants and nurse practitioners. The following conditions shall apply to the program:

- (1) Primary health care services shall only be provided at community health centers or at other locations as determined by the department, located in public investment communities, as defined in subdivision (9) of subsection (a) of section [7-545](#);
- (2) Primary health care services provided shall be offered to low-income patients based on their ability to pay;
- (3) Professionals providing health care services shall not receive compensation for their services;
- (4) Professionals must provide not less than one hundred fifty hours per year of such primary health care services; and
- (5) The department shall contract with a liability insurer authorized to offer malpractice liability insurance in this state or with the Connecticut Primary Care Association or other eligible primary health care providers to purchase insurance for professionals working in primary health care settings. The Connecticut Primary Care Association may subcontract with community health centers to purchase malpractice liability insurance for eligible professionals providing primary care services at the community health centers. Liability insurance shall be purchased only from a provider authorized to offer malpractice liability insurance in this state.

(b) Nothing in this section shall be interpreted to require a liability insurer to provide coverage to a professional should the insurer determine that coverage should not be offered to a professional because of past claims experience or for other appropriate reasons.

(c) The department may provide liability insurance under this section only to the extent funds are appropriated for this purpose by the General Assembly.

(May Sp. Sess. P.A. 94-3, S. 22, 28; P.A. 95-257, S. 12, 21, 58; 95-271, S. 35, 40; P.A. 06-196, S. 146; P.A. 14-187, S. 31.)

History: May Sp. Sess. P.A. 94-3 effective July 1, 1994; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 95-271 limited the department's mandate to provide a program to be within available appropriations, deleted limitation to “retired” professionals and the requirement that the department maintain a portion of malpractice insurance, changed applicability from just physicians to all listed medical professionals and expanded Subdiv. (5) beyond malpractice liability insurers to include the Connecticut Primary Care Association and subcontracting, and deleted former Subsec. (c), which allowed monitoring of claims; P.A. 06-196 made a technical change in Subsec. (a), effective June 7, 2006; P.A. 14-187 amended Subsec. (b) to delete reference to Sec. 19a-17n, effective June 11, 2014.

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Sec. 19a-17n. Malpractice insurance purchase program. Regulations. Limitations. Section [19a-17n](#) is repealed, effective June 11, 2014.

(May Sp. Sess. P.A. 94-3, S. 23, 28; P.A. 95-257, S. 12, 21, 58; P.A. 00-27, S. 8, 24; P.A. 14-187, S. 55.)

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Sec. 19a-18. (Formerly Sec. 19-4t). Meaning of term “licensed” for insurance purposes. Whenever the term “licensed” is used in any individual or group hospital or medical expense insurance policy or hospital or medical services plan contract delivered, issued for delivery or renewed in this state on or after July 1, 1980, with respect to services performed by any practitioner subject to the provisions of chapter 368v, chapters 369 to 375, inclusive, 376b, 377 to 381, inclusive, 383 to 388, inclusive, 398 and 399, and the provisions of sections [20-195m](#) to [20-195q](#), inclusive, it shall be deemed to include persons licensed or certified under said provisions.

(P.A. 80-484, S. 138, 176; P.A. 83-352, S. 4, 5; 83-441, S. 7, 10; 83-557, S. 4, 5; P.A. 85-531, S. 7.)

History: Sec. 19-4t transferred to Sec. 19a-18 in 1983; P.A. 83-352 included marital and family therapists; P.A. 83-441 included nurse-midwives; P.A. 83-557 included alcoholism counselors under chapter 376b; P.A. 85-531 added reference to certified independent social workers, i.e. practitioners subject to Secs. 20-195m to 20-195q, inclusive.

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Sec. 19a-19. (Formerly Sec. 19-4u). Regulation of business practices. The Department of Public Health shall not adopt any regulation concerning business practices. Regulations directed at the business practices of persons licensed or otherwise regulated under the provisions of sections [19a-511](#) to [19a-520](#), inclusive, chapters 369 to 376, inclusive, 378 to 381, inclusive, 383 to 388, inclusive, 393a, 395, 398 and 399, may be adopted by the Department of Consumer Protection in accordance with chapter 54.

Notwithstanding any provision of the general statutes to the contrary, all complaints concerning business practices shall be adjudicated by said department. As used in this section, the term “business practices” includes but is not limited to ownership of a regulated practice; number of offices or sites of a regulated practice; practice in an association, partnership, corporation or other lawful entity; practice with other health professionals in an association, partnership, corporation or other lawful entity; practice under the name of “clinic”, “center”, or other descriptive term; advertising related to a regulated practice; number of assistants, auxiliaries or other paraprofessionals employed by a regulated practitioner; and the hours or days a regulated practice is open for business.

(P.A. 80-484, S. 139, 176; P.A. 81-471, S. 2, 71; 81-473, S. 37, 43; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; June 30 Sp. Sess. P.A. 03-6, S. 146(d); P.A. 04-169, S. 17; 04-189, S. 1.)

History: P.A. 81-471 inserted provision requiring that complaints concerning business practices be adjudicated by department of consumer protection as of July 1, 1981; P.A. 81-473 transferred authority to adopt regulations concerning business practices of physical therapists, sanitarians and subsurface sewage disposal system installers and cleaners from the department of health services to the department of consumer protection; Sec. 19-4u transferred to Sec. 19a-19 in 1983; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; June 30 Sp. Sess. P.A. 03-6 and P.A. 04-169 replaced Department of Consumer Protection with Department of Agriculture and Consumer Protection, effective July 1, 2004; P.A. 04-189 repealed Sec. 146 of June 30 Sp. Sess. P.A. 03-6, thereby reversing the merger of the Departments of Agriculture and Consumer Protection, effective June 1, 2004.

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Sec. 19a-20. (Formerly Sec. 19-4v). Nonliability of complainants and board and commission members. Indemnification and defense. No member of any board or commission subject to the provisions of chapter 368v, chapters 369 to 375, inclusive, 378 to 381, inclusive, 383 to 388, inclusive, 398 and 399, including a member of a medical hearing panel established pursuant to subsection (g) of section [20-8a](#), and no person making a complaint or providing information to any of such boards or commissions or the Department of Public Health as part of an investigation pursuant to section [19a-14](#), or a disciplinary action pursuant to section [19a-17](#), shall, without a showing of malice, be personally liable for damage or injury to a practitioner arising out of any proceeding of such boards and commissions or department. A person making a complaint or providing information to any of such boards or commissions or to the Department of Public Health as part of an investigation pursuant to section [19a-14](#) or a disciplinary action pursuant to section [19a-17](#) shall be entitled to indemnification and defense in the manner set forth in section [5-141d](#) with respect to a state officer or employee.

(P.A. 80-484, S. 144, 176; P.A. 94-174, S. 2, 12; P.A. 95-71, S. 2; P.A. 95-257, S. 12, 21, 58.)

History: Sec. 19-4v transferred to Sec. 19a-20 in 1983; P.A. 94-174 extended nonliability for complainants to investigations by the department and disciplinary action pursuant to Sec. 19a-17 and provided for indemnification and defense for complainants, effective June 6, 1994; P.A. 95-71 added members of medical hearing panels to those exempt from liability; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

Section abrogates common-law absolute immunity applicable to statements made to medical examining board of department in connection with proceedings of the board. 272 C. 776.

Malice required by section is actual malice. 75 CA 819. Where statutory immunity provided by this section and Sec. 19a-17b overlaps with common-law provision of absolute immunity to those who make statements in connection with quasi-judicial proceedings, statutes are in derogation of common law and

must prevail over common-law grant of absolute immunity, and examination of the plain language and legislative history of statutes clearly and unambiguously demonstrated legislature's intent to provide only a qualified immunity to defendants. 77 CA 104.

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Sec. 19a-21. (Formerly Sec. 19-4w). Disposition of licensing fees. All moneys collected by the Department of Public Health in connection with the issuance or renewal of any professional license shall be paid into the State Treasury to the credit of the General Fund.

(P.A. 80-484, S. 158, 176; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: Sec. 19-4w transferred to Sec. 19a-21 in 1983; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

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Sec. 19a-22. (Formerly Sec. 19-4x). Actions by department, boards and commissions; appeals. Any practitioner aggrieved by any final decision of a board or commission or the department may appeal therefrom in accordance with the provisions of section [4-183](#).

(P.A. 80-484, S. 172, 176; P.A. 96-47, S. 2.)

History: Sec. 19-4x transferred to Sec. 19a-22 in 1983; P.A. 96-47 changed “decision or order” to “final decision”.

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Sec. 19a-23. (Formerly Sec. 19-4y). Boards and commissions; records. Each board or commission subject to the provisions of this chapter and chapters 368v, 369 to 375, inclusive, 378 to 381, inclusive, 383 to 388, inclusive, 398 and 399 shall perform its own record-keeping functions and shall provide the Department of Public Health with a copy of the record of all of its meetings.

(P.A. 80-484, S. 173, 176; P.A. 85-613, S. 38, 154; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: Sec. 19-4y transferred to Sec. 19a-23 in 1983; P.A. 85-613 made technical changes, deleting reference to repealed Sec. 2c-2; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

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Sec. 19a-24. (Formerly Sec. 19-5a). Claims for damages against Commissioners of Public Health and Developmental Services and certain officials, employees, council members and trustees. Immunity. Indemnification. Section [19a-24](#) is repealed, effective October 1, 2014.

(1957, P.A. 244, S. 1; September, 1957, P.A. 11, S. 31; 1959, P.A. 148, S. 18; P.A. 73-643, S. 1; P.A. 75-567, S. 74, 80; 75-638, S. 11, 23; P.A. 76-153, S. 12; 76-371, S. 3, 5; P.A. 77-614, S. 323, 610; P.A. 78-303, S. 59, 93, 136; P.A. 83-587, S. 71, 96; P.A. 86-41, S. 1, 11; P.A. 88-111; P.A. 90-230, S. 28, 101; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 99-60; P.A. 07-73, S. 2(b); P.A. 08-7, S. 4; P.A. 13-225, S. 8; P.A. 14-231, S. 72.)

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Sec. 19a-25. (Formerly Sec. 19-6a). Confidentiality of records procured by the Department of Public Health or directors of health of towns, cities or boroughs. (a) All information, records of interviews, written reports, statements, notes, memoranda or other data, including personal data as defined in subdivision (9) of section [4-190](#), procured by: (1) The Department of Public Health, by staff committees of facilities accredited by the Department of Public Health, the maternity mortality review committee, established pursuant to section [19a-59i](#), or the infant mortality review committee, established pursuant to section [19a-59k](#), in connection with studies of morbidity and mortality conducted by the Department of Public Health, such staff committees, the maternal mortality review committee or the infant mortality review committee, or carried on by said department, such staff committees or the maternal mortality review committee jointly with other persons, agencies or organizations, (2) the directors of health of towns, cities or boroughs or the Department of Public Health pursuant to section [19a-215](#), or (3) the Department of Public Health or such other persons, agencies or organizations, for the purpose of reducing the morbidity or mortality from any cause or condition, shall be confidential and shall be used solely for the purposes of medical or scientific research and, for information obtained pursuant to section [19a-215](#), disease prevention and control by the local director of health and the Department of Public Health and reducing the morbidity or mortality from any cause or condition. Such information, records, reports, statements, notes, memoranda or other data shall not be admissible as evidence in any action of any kind in any court or before any other tribunal, board, agency or person, nor shall it be exhibited or its contents disclosed in any way, in whole or in part, by any officer or representative of the Department of Public Health or of any such facility, by any person participating in such a research project or by any other person, except as may be necessary for the purpose of furthering the research project or public health use to which it relates.

(b) Notwithstanding the provisions of chapter 55, the Department of Public Health may exchange personal data for the purpose of medical or scientific research, with any other governmental agency or private research organization; provided such state, governmental agency or private research organization shall not further disclose such personal data. The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, consistent with the purposes of this section to establish the procedures to ensure the confidentiality of such disclosures. The furnishing of such information to the Department of Public Health or its authorized representative, or to any other agency cooperating in such a research project, shall not subject any person, hospital, behavioral health facility, rest home, nursing home or other person or agency furnishing such information to any action for damages or other relief because of such disclosure.

(c) The provisions of this section shall not affect: (1) Disclosure of regular hospital and medical records made in the course of the regular notation of the care and treatment of any patient, but only records or notations by the staff committees described in subsection (a) of this section pursuant to their work, or (2) release by the Department of Public Health of annual immunization rates for each public and nonpublic school in the state pursuant to section [10-204a](#).

(1961, P.A. 358; 1971, P.A. 811; P.A. 77-346; 77-614, S. 323, 587, 610; P.A. 78-303, S. 85, 136; P.A. 84-380, S. 3; P.A. 93-291, S. 1; 93-381, S. 9, 39; 93-435, S. 59, 95; P.A. 95-257, S. 12, 21, 58; P.A. 18-150, S. 1; P.A. 21-6, S. 2; P.A. 23-147, S. 12.)

History: 1971 act made provisions applicable to data procured by staff committees of accredited facilities, excluded studies of “maternal and perinatal” morbidity and rewrote provision re effect of provisions on disclosure of regular hospital and medical records; P.A. 77-346 specifically included as confidential records “personal data as defined in subsection (i) of section 4-190” and added provision re exchange of personal data for research purposes between health department and other agencies and organizations; P.A. 77-614 and P.A. 78-303 replaced commissioner and department of health with commissioner and department of health services, effective January 1, 1979; Sec. 19-6a transferred to Sec. 19a-25 in 1983; P.A. 84-380 made technical change to reflect numbering of Subdivs. in Sec. 4-190; P.A. 93-291 applied provisions to records and information procured by the department or local health directors concerning communicable diseases; P.A. 93-381 and P.A. 93-435 replaced department and commissioner of health services with department and commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 18-150 added references to maternal mortality review committee, and made technical changes; P.A. 21-6 designated existing provisions as Subsecs. (a), (b) and (c) and amended same by making technical changes and further amended Subsec. (a) by adding Subdiv. designators (1) to (3), Subsec. (b) by replacing “sanitarium” with “behavioral health facility” and Subsec. (c) by designating existing provision as Subdiv. (1) and adding Subdiv. (2) re release of annual school immunization rates, effective April 28, 2021; P.A. 23-147 amended Subsec. (a) by adding references to infant mortality review committee and making conforming changes in Subdiv. (1), adding “the Department of Public Health or” and “and reducing the morbidity or mortality from any cause or condition” in Subdiv. (3), and adding “or public health use”.

Statute is designed not to disqualify a physician from testifying but to prevent him from disclosing confidential matters. 180 C. 314. The privilege afforded by section is limited to designated materials of a hospital staff committee generated primarily for the purpose of studying morbidity and mortality, undertaken specifically for the purpose of reducing the incidence of patient deaths. 251 C. 790.

Cited. 40 CS 188.

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Sec. 19a-25a. Regulations re electronic signatures for medical records. The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, if he deems such regulations are necessary to implement the use of electronic signatures for medical records maintained in hospitals as defined in section [19a-490](#). Until such regulations are promulgated, hospitals shall submit to the Department of Public Health for review and approval, any current or proposed protocol for the use of electronic signatures for medical records including, but not limited to, protections for patient confidentiality and medical record security.

(P.A. 93-317; 93-381, S. 9, 39; 93-435, S. 59, 95; P.A. 95-257, S. 12, 21, 58.)

History: P.A. 93-381 and P.A. 93-435 authorized substitution of commissioner and department of public health and addiction services for commissioner and department of health services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

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Sec. 19a-25b. Electronic prescribing systems authorized. Each health care provider licensed in this state with prescriptive authority may generate prescriptions in this state utilizing an electronic prescribing system. The Department of Consumer Protection may, within available appropriations, advise and assist health care providers in such utilization.

(P.A. 05-168, S. 1.)

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Sec. 19a-25c. Medical records systems: Electronic and paper formats authorized. A health care institution licensed by the Department of Public Health pursuant to chapter 368v may create, maintain or utilize medical records or a medical records system in electronic format, paper format or both, provided such records or system is designed to store medical records or patient health information in a medium that is reproducible and secure.

(P.A. 05-168, S. 3; P.A. 06-196, S. 241.)

History: P.A. 06-196 made a technical change, effective June 7, 2006.

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Sec. 19a-25d. State-wide health information technology plan. Designation of lead health information exchange organization. Section [19a-25d](#) is repealed, effective October 1, 2015.

(June Sp. Sess. P.A. 07-2, S. 68; P.A. 09-232, S. 77; P.A. 15-146, S. 41.)

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Sec. 19a-25e. Connecticut Health Information Network plan. (a) The Department of Public Health and The University of Connecticut Health Center may, within available appropriations, develop a Connecticut Health Information Network plan to securely integrate state health and social services data, consistent with state and federal privacy laws, within and across The University of Connecticut Health Center and the Departments of Public Health, Developmental Services and Children and Families. Data from other state agencies may be integrated into the network as funding permits and as permissible under federal law.

(b) The Department of Public Health and The Center for Public Health and Health Policy at The University of Connecticut Health Center shall collaborate with the Departments of Administrative Services, Developmental Services, and Children and Families to develop the Connecticut Health Information Network plan.

(c) The plan shall: (1) Include research in and describe existing health and human services data; (2) inventory the various health and human services data aggregation initiatives currently underway; (3) include a framework and options for the implementation of a Connecticut Health Information Network, including query functionality to obtain aggregate data on key health indicators within the state; (4) identify and comply with confidentiality, security and privacy standards; and (5) include a detailed cost estimate for implementation and potential sources of funding.

(P.A. 07-73, S. 2(a); June Sp. Sess. P.A. 07-2, S. 66; Sept. Sp. Sess. P.A. 09-3, S. 30; P.A. 11-51, S. 89.)

History: June Sp. Sess. P.A. 07-2 effective July 1, 2007; pursuant to P.A. 07-73 “Department of Mental Retardation” was changed editorially by the Revisors to “Department of Developmental Services”, effective October 1, 2007; Sept. Sp. Sess. P.A. 09-3 amended Subsecs. (a) and (b) by deleting references to Office of Health Care Access re establishment and development of Connecticut Health Information Network plan, effective October 6, 2009; P.A. 11-51 amended Subsec. (b) to change “Department of Information Technology” to “Department of Administrative Services”, effective July 1, 2011.

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Sec. 19a-25f. Disclosure of personally identifiable information by state agencies to the Connecticut Health Information Network. Notwithstanding any provision of this chapter or chapter 14, 319, 319b, 319o, 319t, 319v or 368z, or any regulation adopted pursuant to said chapters, the state agencies that participate in the Connecticut Health Information Network, subject to federal restrictions on disclosure or redisclosure of information, may disclose personally identifiable information held in agency databases to the administrator of the Connecticut Health Information Network and its subcontractors for the purposes of (1) network development and verification, and (2) data integration and aggregation to enable response to network queries. No state agency that participates in the Connecticut Health Information Network shall disclose personally identifiable information to the Connecticut Health Information Network if such disclosure would constitute a violation of federal law, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) (HIPAA), as amended from time to time, and the Family Educational Rights and Privacy Act of 1974, 20 USC 1232g, (FERPA), as amended from time to time, and any regulations promulgated thereunder at 34 CFR Part 99. The administrator of the Connecticut Health Information Network and its subcontractors shall not disclose personally identifiable information.

(P.A. 09-95, S. 1.)

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Sec. 19a-25g. Provision of electronic copy of medical records by one health care institution to another at the request of the patient. (a) Each institution, as defined in section [19a-490](#), except a facility operated by the Department of Mental Health and Addiction Services and the hospital and psychiatric residential treatment facility units of the Albert J. Solnit Children's Center, shall, upon receipt of a medical records request directed by the patient or the patient's representative, provide an electronic copy of such patient's medical records to another such institution (1) as soon as feasible, but not later than six days after such request is received by the institution, if such request is urgent, or (2) not later than seven business days after such request is received, if such request is not urgent. Notwithstanding any other provision of the general statutes, an institution providing an electronic copy of a patient's medical records pursuant to the provisions of this section shall not be required to obtain specific written consent from such patient before providing such electronic copy.

(b) The provisions of subsection (a) of this section shall not be construed to require an institution to provide records (1) in violation of the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, or 45 CFR 160.101 to 45 CFR 164.534, inclusive, as amended from time to time, (2) in response to a direct request from another health care provider, unless such provider can validate that such provider has a health provider relationship with the patient whose records are being requested, or (3) in response to a third-party request.

(P.A. 23-97, S. 43.)

History: P.A. 23-97 effective January 1, 2024.

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Sec. 19a-26. (Formerly Sec. 19-7). State laboratories. Services provided. Schedule of fees. Construction of state public health laboratory. Permissible activities. (a) The Department of Public Health may establish, maintain and control state laboratories to perform examinations of supposed morbid tissues, other laboratory tests for the diagnosis and control of preventable diseases, and laboratory work in the field of

sanitation, environmental and occupational testing and research studies for the protection and preservation of the public health. Such laboratory services shall be performed upon the application of licensed physicians, other laboratories, licensed dentists, licensed podiatrists, licensed physician assistants, licensed advanced practice registered nurses, local directors of health, public utilities or state departments or institutions, subject to regulations prescribed by the Commissioner of Public Health, and upon payment of any applicable fee as provided in this subsection. For such purposes the department may provide necessary buildings and apparatus, employ, subject to the provisions of chapter 67, administrative and scientific personnel and assistants and do all things necessary for the conduct of such laboratories. The Commissioner of Public Health may establish a schedule of fees, provided the commissioner waives the fees for local directors of health and local law enforcement agencies. If the commissioner establishes a schedule of fees, the commissioner may waive (1) the fees, in full or in part, for others if the commissioner determines that the public health requires a waiver, and (2) fees for chlamydia and gonorrhea testing for nonprofit organizations and institutions of higher education if the organization or institution provides combination chlamydia and gonorrhea test kits. The commissioner shall also establish a fair handling fee which a client of a state laboratory may charge a person or third party payer for arranging for the services of the laboratory. Such client shall not charge an amount in excess of such handling fee.

(b) The Department of Public Health shall ensure that the new state public health laboratory, to be constructed in the town of Rocky Hill, and authorized in accordance with the provisions of subsection (e) of section 2 of special act [01-2](#) of the June special session, subsection (g) of section 2 of special act [04-2](#) of the May special session and subsection (o) of section 2 of public act 07-7 of the June special session* is constructed and thereafter operates in accordance with all applicable biosafety level criteria as prescribed by the National Centers for Disease Control and Prevention Office of Health and Safety. The construction of such laboratory shall facilitate the operation and administration of a laboratory that conforms with biosafety level 3 criteria as prescribed by the National Centers for Disease Control and Prevention Office of Health and Safety. The design or construction of such laboratory shall not permit biosafety level 4 activities to be conducted at such laboratory. No activity shall be conducted at the new state public health laboratory that exceeds biosafety level 3, nor shall any person, entity or state agency make application or seek permission to convert the public health laboratory into a facility that engages in biosafety level 4 activities.

(1949 Rev., S. 3807; 1949, S. 2037d; P.A. 76-396, S. 1, 3; P.A. 77-496; 77-614, S. 19, 323, 587, 610; P.A. 78-303, S. 85, 136; P.A. 84-77; P.A. 90-13, S. 1; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; June 18 Sp. Sess. P.A. 97-8, S. 24, 88; P.A. 98-250, S. 12, 39; P.A. 99-125, S. 1, 6; P.A. 07-252, S. 6; P.A. 08-184, S. 54; P.A. 10-117, S. 74; P.A. 19-98, S. 20; P.A. 21-196, S. 25.)

*Note: Section 2 of public act 07-7 of the June special session is special in nature and therefore has not been codified but remains in full force and effect according to its terms.

History: P.A. 76-396 replaced “examinations” with “laboratory services”, required adherence to regulations of health commissioner and added provision re imposition of schedule of fees, replacing previous requirement that services be performed free of charge; P.A. 77-496 added Subdiv. (3) allowing no charge for services where public health requires that no charge be made; P.A. 77-614 and P.A. 78-303 replaced commissioner of finance and control with secretary of the office of policy and management and, effective January 1, 1979, replaced commissioner and department of health with commissioner and department of health services; Sec. 19-7 transferred to Sec. 19a-26 in 1983; P.A. 84-77 deleted the authority of the secretary of the office of policy and management to establish a schedule of fees for laboratory services performed by state laboratories and deleted obsolete provision which had allowed performance of lab services without charge for state agencies until July 1, 1977; P.A. 90-13 added language on environmental and occupational testing, other laboratories, public utilities, fair market value and the handling fee; P.A. 93-381 replaced department and commissioner of health services with department and commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; June 18 Sp. Sess. P.A. 97-8 exempted local law enforcement agencies from charge for laboratory services, effective July 1, 1997; P.A. 98-250 authorized

commissioner to waive fees for chlamydia and gonorrhea for nonprofit organizations providing kits, effective July 1, 1998; P.A. 99-125 changed fees from “directly related to operating costs or fair market value” to “based upon nationally recognized standards and performance measures for analytic work effort”, and changed provision allowing services “without charge” to required waiver of charges in Subdiv. (1) and permissive waiver in full or in part in Subdiv. (2), effective July 1, 1999; P.A. 07-252 made establishment of a fee schedule for state laboratory services discretionary rather than mandatory, eliminated requirement that fees be based upon nationally recognized standards and performance measures and made technical changes; P.A. 08-184 amended Subdiv. (2) to expand fee waiver for chlamydia and gonorrhea testing to institutions of higher education, effective July 1, 2008; P.A. 10-117 designated existing provisions as Subsec. (a), made a technical change therein and added Subsec. (b) re construction and subsequent operation of new state public health laboratory, effective June 8, 2010; P.A. 19-98 amended Subsec. (a) by adding “licensed advanced practice registered nurses,”; P.A. 21-196 amended Subsec. (a) by adding “licensed physician assistants,”.

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Sec. 19a-27. (Formerly Sec. 19-7a). Test for rubella immunity. Regulations. Section [19a-27](#) is repealed, effective October 1, 2003.

(P.A. 78-165, S. 3–5; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 03-188, S. 6.)

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Sec. 19a-28. (Formerly Sec. 19-8). Toxicology laboratory. Section [19a-28](#) is repealed, effective July 1, 1999.

(November, 1949, S. 2039d; 1959, P.A. 148, S. 7; 1969, P.A. 699, S. 22; 1971, P.A. 412, S. 10; P.A. 77-614, S. 323, 610; P.A. 80-190, S. 6; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; June 18 Sp. Sess. P.A. 97-8, S. 25, 88; P.A. 99-218, S. 15, 16.)

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Sec. 19a-29. (Formerly Sec. 19-9). Special laboratories. The Department of Public Health may establish and maintain district or special laboratories to perform laboratory examinations and studies as specified in section [19a-26](#). To provide for laboratory services as herein authorized, said department may join with municipalities or institutions in establishing or maintaining laboratories.

(1949 Rev., S. 3808; 1949, S. 2038d; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; Sec. 19-9 transferred to Sec. 19a-29 in 1983; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

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Sec. 19a-29a. Environmental laboratories. (a) As used in this section:

(1) “Environmental laboratory” means any facility or other area, including, but not limited to, an outdoor area where testing occurs, used for microbiological, chemical, radiological or other analyte testing of drinking waters, ground waters, sea waters, rivers, streams and surface waters, recreational waters, fresh water sources, wastewaters, swimming pools, construction, renovation and demolition building materials, soil, solid waste, animal and plant tissues, sewage, sewage effluent, sewage sludge or any other matrix for the purpose of providing information on the sanitary quality or the amount of pollution or any substance prejudicial to health or the environment. “Environmental laboratory” does not include a publicly-owned treatment works, as defined in section [22a-521](#), that performs only physical, residue, microbiological and biological oxygen demand tests for its own facility for which results are required by or submitted to the Department of Energy and Environmental Protection to comply with permits or authorizations issued pursuant to section [22a-6k](#), [22a-430](#) or [22a-430b](#), or a pollution abatement facility, as defined in either section [22a-423](#) or [22a-475](#), that tests for pH, turbidity, conductivity, salinity and oxidation-reduction potential, and tests for residual chlorine for its own facility for which results are required by or submitted to the Department of Energy and Environmental Protection to comply with permits or authorizations issued pursuant to section [22a-6k](#), [22a-430](#) or [22a-430b](#);

(2) “Analyte” means a microbiological, chemical, radiological or other component of a matrix being measured by an analytical test; and

(3) “Matrix” means the substance or medium in which an analyte is contained, that may include drinking water or wastewater.

(b) The Department of Public Health shall (1) adopt regulations, in accordance with the provisions of chapter 54, to establish reasonable standards governing environmental laboratory operations and facilities, personnel qualifications, certification for testing, levels of acceptable proficiency in testing programs approved by the department, the collection, acceptance and suitability of samples for analysis and such other pertinent laboratory functions, including the establishment of advisory committees, as may be necessary to ensure environmental quality, public health and safety, and (2) establish one or more schedules of the amounts of civil penalties that may be imposed under this section. Each registered environmental laboratory shall comply with all standards for environmental laboratories established by the department and shall be subject to inspection by said department, including inspection of all records necessary to carry out the purposes of this section. The Commissioner of Public Health may revoke or otherwise limit the license of any environmental laboratory that fails to comply with the provisions of this section or regulations adopted under this section.

(c) The Commissioner of Public Health shall determine whether it is necessary for the protection of the public health or the environment for an environmental laboratory to be registered and to have certification to conduct a test for an analyte in a matrix. If the commissioner determines that it is necessary for the environmental laboratory to be registered, such environmental laboratory shall obtain from the commissioner a certification to conduct such tests for analytes. No person shall operate, manage or control an environmental laboratory that tests for analytes for the purpose of providing information on the sanitary quality or the amount of pollution of any substance prejudicial to health or the environment for which the commissioner has determined registration and certification is required without having first registered and obtained such certification.

(d) The commissioner shall, annually, publish a list setting forth all analytes and matrices for which a certification for testing is required.

(e) Each application for registration of an environmental laboratory and for certification for testing any analyte shall be made on forms provided by said department, shall be accompanied by a fee of one thousand two hundred fifty dollars and shall be executed by the owner or owners or by a responsible officer authorized to do so by the agency, firm or corporation owning the environmental laboratory. Upon receipt of any such application, the department shall make such inspections and investigations as are necessary and shall deny registration when operation of the environmental laboratory would be

prejudicial to the health of the public. Registration shall not be in force until notice of its effective date and term has been sent to the applicant.

(f) Each registration or certification shall be issued for a period of not less than twenty-four or more than twenty-seven months from any deadline for applications established by the commissioner. Renewal applications shall be made (1) biennially within the twenty-fourth month of the current registration; (2) before any change in ownership is made; and (3) prior to any major expansion or alteration in, or changing of, quarters.

(g) This section shall not apply to any environmental laboratory that only provides laboratory services or information for the agency, person, firm or corporation which owns or operates such laboratory.

(h) If, upon review, investigation or inspection, the Commissioner of Public Health determines an environmental laboratory has violated any provision of this section or regulations adopted under this section, the commissioner may impose a civil penalty not to exceed five thousand dollars per violation per day and issue such other orders as the commissioner determines necessary to protect the public health. Upon notice of imposition of the civil penalty, the commissioner shall provide the environmental laboratory with an opportunity for a hearing. Governmental immunity shall not be a defense against the imposition of any civil penalty imposed pursuant to this section. In determining the amount of the civil penalty to be imposed on an environmental laboratory, the commissioner shall consider the degree of the threat to public health or the environment, the amount necessary to achieve compliance, and the history of compliance of the environmental laboratory. Any order issued under this provision may be appealed in accordance with the provisions of section [4-183](#).

(i) The failure of an environmental laboratory to pay a civil penalty imposed by the commissioner shall be grounds for revocation of the environmental laboratory's registration and certification for testing.

(j) The commissioner may order an unregistered environmental laboratory to cease operations.

(k) The commissioner may request the Attorney General to petition the Superior Court for an order to aid in enforcement of any provision of this section.

(P.A. 94-47; P.A. 95-257, S. 12, 21, 58; 95-317, S. 1; June 18 Sp. Sess. P.A. 97-8, S. 40, 88; P.A. 05-175, S. 1; P.A. 06-196, S. 147; June Sp. Sess. P.A. 09-3, S. 163; P.A. 14-231, S. 42; P.A. 15-242, S. 21, 45.)

History: P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 95-317 added a \$1,000 fee for application for registration or approval; June 18 Sp. Sess. P.A. 97-8 amended Subsec. (e) by exempting state agency laboratories from fee, effective July 1, 1997; P.A. 05-175 deleted “dairy and dairy products” from definition of “environmental laboratory” in Subsec. (a); P.A. 06-196 made a technical change in Subsec. (d), effective June 7, 2006; June Sp. Sess. P.A. 09-3 amended Subsec. (c) to increase fee from \$1,000 to \$1,250; P.A. 14-231 amended Subsec. (a) by redefining “environmental laboratory” and adding Subdiv. (1) defining “analyte” and Subdiv. (2) defining “matrix”, substantially revised Subsec. (b) re regulations and commissioner's authority to revoke or limit license, added new Subsec. (c) re registration of environmental laboratory, added new Subsec. (d) re publication of list of analytes and matrices, redesignated existing Subsec. (c) as Subsec. (e) and amended same by replacing provision re application for approval with provision re certification for testing analyte and adding provision re officer authorization, redesignated existing Subsec. (d) as Subsec. (f) and amended same by deleting reference to certificate of approval in Subdiv. (1), deleting reference to change in director in Subdiv. (2) and adding “or changing of” in Subdiv. (3), redesignated existing Subsec. (e) as Subsec. (g) and amended same by deleting provision re fee required, added Subsec. (h) re civil penalty, added Subsec. (i) re failure to pay civil penalty, added Subsec. (j) re order for unregistered laboratory to cease operations, added Subsec. (k) re request for Attorney General to petition Superior Court, and made technical and conforming changes; P.A. 15-242 amended Subsec. (a) by designating existing definition of “environmental laboratory” as

Subdiv. (1) and redefining same, redesignating existing Subdivs. (1) and (2) as Subdivs. (2) and (3) and making technical changes, and amended Subsec. (f) by making a technical change.

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Secs. 19a-30 to 19a-31. Transferred to Chapter 368v, Secs. [19a-565](#) to [19a-565b](#), inclusive.

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Sec. 19a-31a. Microbiological and biomedical biosafety laboratories. (a) For purposes of this section:

(1) “Microbiological and biomedical biosafety laboratory” means a laboratory that (A) utilizes any living agent capable of causing a human infection or reportable human disease, or (B) is used to secure evidence of the presence or absence of a living agent capable of causing a human infection or reportable human disease, for the purposes of teaching, research or quality control of the infection or disease;

(2) “Biolevel-two microbiological and biomedical biosafety laboratory” means a microbiological and biomedical biosafety laboratory that presents a moderate hazard to personnel of exposure to an infection or disease and utilizes agents that are associated with human infection or disease;

(3) “Biolevel-three microbiological and biomedical biosafety laboratory” means a microbiological and biomedical biosafety laboratory operated by an institution of higher education, or any other research entity, that (A) handles agents that (i) have a known potential for aerosol transmission, (ii) may cause serious and potentially lethal human infections or diseases, and (iii) are either indigenous or exotic in origin, and (B) is designed and equipped under guidelines issued by the National Institutes of Health and the National Centers for Disease Control as a biolevel-three laboratory; and

(4) “Biolevel-three agent” means an agent classified as a biolevel-three agent by the National Institutes of Health and the National Centers for Disease Control.

(b) No biolevel-two microbiological and biomedical biosafety laboratory or biolevel-three microbiological and biomedical biosafety laboratory shall operate unless such laboratory has registered with the Department of Public Health and paid the registration fee required under subsection (c) of this section.

(c) The biennial registration fee for a biolevel-two microbiological and biomedical biosafety laboratory and a biolevel-three microbiological and biomedical biosafety laboratory shall be four hundred dollars.

(d) Microbiological and biomedical biosafety laboratories that are state or federally operated entities shall be exempt from the registration fee requirements set forth in subsection (c) of this section.

(e) If an institution that operates a biolevel-three microbiological and biomedical biosafety laboratory establishes a biosafety committee pursuant to the National Institutes of Health or the National Centers for Disease Control guidelines, such committee shall (1) forward the minutes of its meetings to the Department of Public Health and (2) meet at least annually with a representative of the Department of Public Health to review safety procedures and discuss health issues relating to the operation of the laboratory.

(f) Each such institution shall report to the Department of Public Health any infection or injury relating to work at the laboratory with biolevel-three agents and any incidents relating to such work which result in a recommendation by the institution that employees or members of the public be tested or monitored for potential health problems because of the possibility of infection or injury or incidents which pose a threat to public health.

(g) Each such institution shall report to the Department of Public Health any sanctions imposed on the laboratory or on the institution for incidents occurring at the laboratory by the National Institutes of Health, the National Centers for Disease Control, the United States Department of Defense or any other government agency.

(P.A. 96-149; P.A. 17-146, S. 20.)

History: P.A. 17-146 amended Subsec. (a) by adding new Subdivs. (1) and (2) defining “microbiological and biomedical biosafety laboratory” and “biolevel-two microbiological and biomedical biosafety laboratory”, respectively, redesignated existing Subdiv. (1) as Subdiv. (3) and amended same by replacing “biolevel-three laboratory” with “biolevel-three microbiological and biomedical biosafety laboratory” and adding provisions re other research entities, redesignated existing Subdiv. (2) re biolevel-three agent as Subdiv. (4), added new Subsec. (b) re laboratory registration with department, added new Subsec. (c) re biennial registration fee, added new Subsec. (d) re exemption from registration fee, redesignated existing Subsecs. (b) to (d) as Subsecs. (e) to (g), and made technical and conforming changes.

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Sec. 19a-31b. Transferred to Chapter 368v, Sec. [19a-565c](#).

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Sec. 19a-32. (Formerly Sec. 19-10). Department authorized to receive gifts. The Department of Public Health is authorized to receive, hold and use real estate and to receive, hold, invest and disburse money, securities, supplies or equipment offered it for the protection and preservation of the public health and welfare by the federal government, another state or by any person, corporation or association, provided such real estate, money, securities, supplies or equipment shall be used only for the purposes designated by the federal government or such state, person, corporation or association.

(1949 Rev., S. 3820; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 14-231, S. 31; P.A. 18-168, S. 15.)

History: P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; Sec. 19-10 transferred to Sec. 19a-32 in 1983; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 14-231 added references to another state; P.A. 18-168 deleted provision re inclusion of information in annual report.

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Sec. 19a-32a. AIDS research education account. Regulations. (a) There is established an AIDS research education account which shall be a separate, nonlapsing account within the General Fund. Any moneys collected under the contribution system established under section [12-743](#) shall be deposited by the Commissioner of Revenue Services into the account. This account may also receive moneys from public and private sources or from the federal government. All moneys deposited in the account shall be used by the Department of Public Health or persons acting under a contract with the department, (1) to assist AIDS research, education and AIDS-related community service programs or (2) the promotion of the income tax contribution system and the AIDS research education account. Expenditures from the account in any fiscal year for the promotion of the contribution system or the account shall not exceed ten per cent of the amount of moneys raised during the previous fiscal year provided such limitation shall not apply to

an expenditure of not more than fifteen thousand dollars from the account on or before July 1, 1994, to reimburse expenditures made on or before said date, with prior written authorization of the Commissioner of Public Health, by private organizations to promote the contribution system and the AIDS research education account.

(b) The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, to provide for the distribution of funds available pursuant to this section and section [12-743](#).

(P.A. 93-233, S. 6; 93-381, S. 9, 39; 93-435, S. 59, 95; P.A. 94-175, S. 17, 32; May Sp. Sess. P.A. 94-4, S. 80, 85; P.A. 95-160, S. 64, 69; 95-257, S. 12, 21, 58.)

History: P.A. 93-381 and P.A. 93-435 authorized substitution of commissioner and department of public health and addiction services for commissioner and department of health services, effective July 1, 1993; P.A. 94-175 in Subsec. (a) changed account name from “AIDS research education fund account” to “AIDS research education account”, effective June 2, 1994; May Sp. Sess. P.A. 94-4 and P.A. 95-160 revised effective date of P.A. 94-175 but without affecting this section; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995 (Revisor's note: Erroneous reference to “Commission” of Public Health was changed editorially by the Revisors to “Commissioner” of Public Health).

See chapter 368x re AIDS testing and medical information.

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Sec. 19a-32b. Breast cancer research and education account. There is established a breast cancer research and education account which shall be a separate, nonlapsing account within the General Fund. Any moneys collected under the contribution system established under section [12-743](#) shall be deposited by the Commissioner of Revenue Services into the account. This account may also receive moneys from public and private sources or from the federal government. All moneys deposited in the account shall be used by the Department of Public Health or persons acting under a contract with the department, (1) to assist breast cancer research, education and breast cancer related community service programs or (2) the promotion of the income tax contribution system and the breast cancer research and education account. Expenditures from the account in any fiscal year for the promotion of the contribution system or the account shall not exceed ten per cent of the amount of moneys raised during the previous fiscal year provided such limitation shall not apply to an expenditure of not more than fifteen thousand dollars from the account on or before July 1, 1998, to reimburse expenditures made on or before said date, with prior written authorization of the Commissioner of Public Health, by private organizations to promote the contribution system and the breast cancer research and education account.

(P.A. 97-286, S. 6, 8; P.A. 14-187, S. 26.)

History: P.A. 97-286 effective June 26, 1997, and applicable to taxable years commencing on or after January 1, 1997; P.A. 14-187 deleted former Subsec. (b) re regulations to provide for distribution of funds and deleted Subsec. (a) designator, effective June 11, 2014.

See Sec. 19a-266 re breast and cervical cancer screening.

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Sec. 19a-32c. (Note: This section is repealed, effective July 1, 2025.) Biomedical Research Trust Fund. Transfers from Tobacco Settlement Fund. Grants-in-aid. There is created a Biomedical Research Trust Fund which shall be a separate nonlapsing fund. The trust fund may contain any moneys required or permitted by law to be deposited in the fund, may accept transfers from the Tobacco Settlement Fund and

may apply for and accept gifts, grants or donations from public or private sources to enable the account to carry out its objectives. The Commissioner of Public Health may make grants-in-aid from the trust fund to eligible institutions for the purpose of funding biomedical research in the fields of heart disease, cancer and other tobacco-related diseases, Alzheimer's disease, stroke and diabetes. Each fiscal year, the total amount of moneys deposited in the account shall be used by the Commissioner of Public Health for such grants-in-aid, provided such grants-in-aid shall not exceed fifty per cent of the total amount held in the trust fund as of the date such grants-in-aid are approved. Not more than two per cent of the total available amount held in the trust fund shall be made available to the Department of Public Health for administration expenses relating to the trust fund and making the grants-in-aid. The Commissioner of Public Health shall develop an application for grants-in-aid under this section and may receive applications from eligible institutions for such grants-in-aid. For purposes of this section, "eligible institution" means an entity that has its principal place of business located in the state and is (1) a nonprofit, tax-exempt academic institution of higher education, or (2) a hospital that conducts biomedical research.

(P.A. 00-216, S. 17, 28; P.A. 10-136, S. 1; P.A. 13-18, S. 1; 13-208, S. 1; May Sp. Sess. P.A. 16-4, S. 250; P.A. 24-81, S. 97.)

History: P.A. 00-216 effective June 1, 2000; P.A. 10-136 permitted grants from trust fund to be used for Alzheimer's disease and diabetes research, effective July 1, 2010; P.A. 13-18 added reference to stroke research eligible for grants-in-aid, effective July 1, 2013; P.A. 13-208 deleted provisions re amount of grants-in-aid for fiscal years ending June 30, 2002, and June 30, 2003, and reference to "On and after July 1, 2001," added provision re amount available for administration expenses and deleted obsolete date, redefined "eligible institution" to require principal place of business to be located in state, and made technical changes; May Sp. Sess. P.A. 16-4 added "may contain any moneys required or permitted by law to be deposited in the fund," effective July 1, 2016; P.A. 24-81 repealed section, effective July 1, 2025.

See Sec. 4-28e re Tobacco Settlement Fund.

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Secs. 19a-32d to 19a-32g. Transferred to Chapter 581, Secs. [32-41jj](#) to [32-41mm](#), inclusive.

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Secs. 19a-32h to 19a-32l. Reserved for future use.

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Sec. 19a-32m. Information request concerning establishment of public cord blood collection operation. (a) On or before October 1, 2007, the Commissioner of Public Health shall request information from one or more umbilical cord blood banks concerning the establishment of a public cord blood collection operation within this state to collect, transport, process and store cord blood units from Connecticut residents for therapeutic and research purposes. Any such request for information shall contain provisions inquiring about the ability of the umbilical cord blood bank to: (1) Establish and operate one or more collection sites within the state to collect a targeted number of cord blood units; (2) implement collection procedures designed to collect cord blood units that reflect the state's racial and ethnic diversity; (3) set up public cord blood collection operations not later than six months after execution of a contract with the state, provided the umbilical cord blood bank is able to negotiate any necessary contracts related to the collection sites within that time frame; (4) participate in the National Cord Blood Coordinating Center or similar national cord blood inventory center by listing cord blood units in a manner that assures

maximum opportunity for use; (5) have a program that provides cord blood units for research and agree to provide cord blood units that are unsuitable for therapeutic use to researchers located within the state at no charge; and (6) maintain national accreditation by an accrediting organization recognized by the federal Health Resources and Services Administration.

(b) On or before January 1, 2008, the Commissioner of Public Health shall submit, in accordance with section [11-4a](#), a summary of the responses to the request for information, along with any recommendations, to the Governor and the joint standing committee of the General Assembly having cognizance of matters relating to public health.

(P.A. 07-252, S. 77.)

History: P.A. 07-252 effective July 12, 2007.

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Sec. 19a-32n. Information re umbilical cord blood collection programs. A physician or other health care provider who provides health care services to a pregnant woman during the last trimester of her pregnancy, which health care services are directly related to her pregnancy, shall provide the woman with timely, relevant and appropriate information sufficient to allow her to make an informed and voluntary choice regarding options to bank or donate umbilical cord blood following the delivery of a newborn child.

(P.A. 09-232, S. 21; P.A. 11-160, S. 9; P.A. 23-204, S. 238.)

History: P.A. 09-232 effective July 1, 2009; P.A. 11-160 designated existing provision as Subsec. (a) and added Subsec. (b) re Connecticut Umbilical Cord Blood Collection Board's public education and marketing activities, effective July 13, 2011; P.A. 23-204 deleted former Subsec. (b) re Connecticut Umbilical Cord Blood Collection Board's public education and marketing activities and deleted Subsec. (a) designator, effective July 1, 2023.

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Secs. 19a-32o to 19a-32v. Short title: Connecticut Umbilical Cord Blood Collection Program Act. Legislative findings and declaration of policy. Connecticut Umbilical Cord Blood Collection Board; membership; meetings. Board to establish and administer umbilical cord blood collection program. Board's authority to enter into contracts re collection and transportation of umbilical cord blood units. Umbilical cord blood collection account. Copies of independent audits to be submitted to General Assembly. Reports to Governor and General Assembly. Sections [19a-32o](#) to [19a-32v](#), inclusive, are repealed, effective July 1, 2023.

(P.A. 11-160, S. 1–8; P.A. 23-204, S. 444.)

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Sec. 19a-33. (Formerly Sec. 19-10a). Regulation of traffic at department facilities. The superintendent or director of any state-operated facility within the Department of Public Health, subject to the approval of the Commissioner of Public Health and the Office of the State Traffic Administration, may: (1) Prohibit, limit, restrict or regulate the parking of vehicles; (2) determine speed limits; (3) install stop signs; (4) restrict roads or portions thereof to one-way traffic; (5) designate the location of crosswalks on any portion of any road or highway upon the grounds of the respective facilities; and (6) erect and maintain signs designating such prohibitions or restrictions. Security officers or institutional patrolmen appointed

to act as state policemen on state institution grounds under the provisions of section [29-18](#) may arrest or issue summons for violation of such restrictions or prohibitions. Any person who fails to comply with any such prohibition or restriction shall be fined not more than twenty-five dollars, and the court or traffic or parking authority having jurisdiction of traffic or parking violations in the town in which such facility is located shall have jurisdiction over violations of this section.

(P.A. 80-49, S. 1; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 11-256, S. 6; P.A. 12-132, S. 45.)

History: Sec. 19-10a transferred to Sec. 19a-33 in 1983; P.A. 93-381 replaced department and commissioner of health services with department and commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 11-256 added provision re installation of stop signs, inserted numeric Subdiv. designators and made technical changes; P.A. 12-132 replaced “State Traffic Commission” with “Office of the State Traffic Administration”, effective July 1, 2012.

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Sec. 19a-34. (Formerly Sec. 19-11). Administration of federal funds for hospital survey and construction. The Department of Public Health is designated as the state agency to administer the Hospital Survey and Construction Act authorized under Title VI, Construction of Hospitals, of the Public Health Service Act, as amended, and shall receive and distribute federal, state and other funds which may become available for such services.

(1949 Rev., S. 4198; 1955, S. 2138d; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; Sec. 19-11 transferred to Sec. 19a-34 in 1983; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

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Sec. 19a-35. (Formerly Sec. 19-12). Federal funds for health services to children. Advisory board. (a) The Department of Public Health is designated as the state agency to receive and administer federal funds which may become available for health services to children.

(b) The Commissioner of Public Health may create an advisory board composed of representatives of public departments and private agencies concerned with welfare and educational interests and individuals to assist him in making plans and allotting funds.

(1949 Rev., S. 3826; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: P.A. 77-614 replaced commissioner and department of health with commissioner and department of health services, effective January 1, 1979; Sec. 19-12 transferred to Sec. 19a-35 in 1983; P.A. 93-381 replaced department and commissioner of health services with department and commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

See Sec. 19a-50 re crippled children and those with cardiac defects.

Sec. 19a-35a. Alternative on-site sewage treatment systems with capacities of five thousand gallons or less per day. Jurisdiction. Establishment and definition of categories. Minimum requirements. Permits and approvals. Appeals. (a) Notwithstanding the provisions of chapter 439 and sections [22a-430](#) and [22a-430b](#), the Commissioner of Public Health shall, within available appropriations, pursuant to section [19a-36](#), establish and define categories of discharge that constitute alternative on-site sewage treatment systems with capacities of five thousand gallons or less per day. After the establishment of such categories, said commissioner shall have jurisdiction, within available appropriations, to issue or deny permits and approvals for such systems and for all discharges of domestic sewage to the groundwaters of the state from such systems. Said commissioner shall, pursuant to section [19a-36](#), and within available appropriations, establish minimum requirements for alternative on-site sewage treatment systems under said commissioner's jurisdiction, including, but not limited to: (1) Requirements related to activities that may occur on the property; (2) changes that may occur to the property or to buildings on the property that may affect the installation or operation of such systems; and (3) procedures for the issuance of permits or approvals by said commissioner, a local director of health or an environmental health specialist licensed pursuant to chapter 395. A permit or approval granted by said commissioner, such local director of health or such environmental health specialist for an alternative on-site sewage treatment system pursuant to this section shall: (A) Not be inconsistent with the requirements of the federal Water Pollution Control Act, 33 USC 1251 et seq., the federal Safe Drinking Water Act, 42 USC 300f et seq., and the standards of water quality adopted pursuant to section [22a-426](#), as such laws and standards may be amended from time to time, (B) not be construed or deemed to be an approval for any other purpose, including, but not limited to, any planning and zoning or municipal inland wetlands and watercourses requirement, and (C) be in lieu of a permit issued under section [22a-430](#) or [22a-430b](#). For purposes of this section, “alternative on-site sewage treatment system” means a sewage treatment system serving one or more buildings on a single parcel of property that utilizes a method of treatment other than a subsurface sewage disposal system and that involves a discharge of domestic sewage to the groundwaters of the state.

(b) In establishing and defining categories of discharge that constitute alternative on-site sewage treatment systems pursuant to subsection (a) of this section, and in establishing minimum requirements for such systems pursuant to section [19a-36](#), said commissioner shall consider all relevant factors, including, but not limited to: (1) The impact that such systems or discharges may have individually or cumulatively on public health and the environment, (2) the impact that such systems and discharges may have individually or cumulatively on land use patterns, and (3) recommendations regarding responsible growth made to said commissioner by the Secretary of the Office of Policy and Management through the Office of Responsible Growth established by Executive Order No. 15 of Governor M. Jodi Rell.

(c) The Commissioner of Energy and Environmental Protection shall retain jurisdiction over any alternative on-site sewage treatment system not under the jurisdiction of the Commissioner of Public Health. The provisions of title 22a shall apply to any such system not under the jurisdiction of the Commissioner of Public Health. The provisions of this section shall not affect any permit issued by the Commissioner of Energy and Environmental Protection prior to July 1, 2007, and the provisions of title 22a shall continue to apply to any such permit until such permit expires.

(d) A permit or approval denied by the Commissioner of Public Health, a local director of health or an environmental health specialist pursuant to subsection (a) of this section shall be subject to an appeal in the manner provided in section [19a-229](#).

(P.A. 07-231, S. 1; June Sp. Sess. P.A. 07-1, S. 155; P.A. 08-124, S. 7; P.A. 09-220, S. 3; P.A. 11-80, S. 1; P.A. 24-68, S. 19.)

History: P.A. 07-231 effective July 1, 2007; June Sp. Sess. P.A. 07-1 amended Subsec. (a) to add “within available appropriations”, effective July 1, 2007; P.A. 08-124 made technical changes in Subsec. (a),

effective June 2, 2008; P.A. 09-220 amended Subsec. (a) by removing December 31, 2008, deadline for commissioner to establish and define categories of discharge that constitute alternative on-site sewage treatment systems, effective July 8, 2009; pursuant to P.A. 11-80, “Commissioner of Environmental Protection” was changed editorially by the Revisors to “Commissioner of Energy and Environmental Protection” in Subsec. (c), effective July 1, 2011; P.A. 24-68 replaced references to sanitarian with references to environmental health specialist throughout and made a technical change, effective July 1, 2024.

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Sec. 19a-35b. Expiration of permit or approval for on-site sewage disposal system with design flows of less than five thousand gallons per day. For any permit or approval issued prior to July 1, 2011, for any on-site sewage disposal system with design flows of less than five thousand gallons per day, such on-site sewage disposal system permit or approval shall expire nine years after the date of approval, provided such on-site sewage disposal system permit or approval has not expired prior to July 11, 2013, and further provided none of the following changes has occurred since such permit or approval was issued: (1) A change in ownership of the property on which the on-site sewage disposal system is to be installed, (2) a change to an approved site or building plan issued in conjunction with such permit or approval, or (3) a change in the property on which the on-site sewage system is to be installed or adjacent property that is deemed by the municipal health authority or district department of health from which the permit or approval was issued to prevent the effective operation of such on-site sewage disposal system. If the on-site sewage disposal system permit or approval was issued in conjunction with a site plan approved pursuant to section [8-3](#), a plan of subdivision approved pursuant to section [8-26](#), or a permit to conduct a regulated activity issued pursuant to section [22a-42a](#) and the applicant has received one or more extensions of time in which to complete all or part of the work in connection with such approved site plan, plan of subdivision or permit to conduct a regulated activity, the on-site sewage disposal system permit or approval shall not expire until the latest date on which such site plan, subdivision or permit to conduct a regulated activity expires.

(P.A. 13-257, S. 1.)

History: P.A. 13-257 effective July 11, 2013.

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Sec. 19a-36. (Formerly Sec. 19-13). Public Health Code. Fees. Public pools. Wells: Use, replacement and mitigation. (a) The Commissioner of Public Health shall establish a Public Health Code and, from time to time, amend the same. The Public Health Code may provide for the preservation and improvement of the public health.

(1) Drainage and toilet systems to be installed in any house or building arranged or designed for human habitation, or field sanitation provided for agricultural workers or migratory farm laborers, shall conform to minimum requirements prescribed in said code.

(2) Said code may include regulations requiring toilets and handwashing facilities in large stores, as defined in such regulations, in shopping centers and in places dispensing food or drink for consumption on the premises, for the use of patrons of such establishments, except that the provisions of such regulations shall not apply to such establishments constructed or altered pursuant to plans and specifications approved or building permits issued prior to October 1, 1977.

(3) Each regulation adopted by the Commissioner of Public Health shall state the date on which it shall take effect, and a copy of the regulation, signed by the Commissioner of Public Health, shall be filed in the

office of the Secretary of the State and a copy sent by said commissioner to each director of health, and such regulation shall be published in such manner as the Commissioner of Public Health may determine.

(4) Any person who violates any provision of the Public Health Code shall be guilty of a class C misdemeanor.

(b) The Commissioner of Public Health shall charge the following fees for the following services: (1) Review of each small flow plan for subsurface sewage disposal, two hundred dollars; and (2) review of each large flow plan for subsurface sewage disposal, six hundred twenty-five dollars. The commissioner shall amend the regulations adopted pursuant to this section as necessary to implement the provisions of this subsection.

(c) (1) For purposes of this subsection, “public pool” means an artificial basin constructed of concrete, steel, fiberglass or other impervious material and equipped with a controlled water supply that is intended for recreational bathing, swimming, diving or therapeutic purposes and includes, but is not limited to, any related equipment, structure, area or enclosure intended for the use of any person using or staffing such pool. “Public pool” does not include an artificial basin provided with a controlled water supply that is intended for use at a single-family residence, except when such basin is used for commercial or business purposes at such residence.

(2) The Department of Public Health shall classify public pools into one of the following categories:

(A) Public swimming pool, which is a pool used or intended to be used for recreational bathing, swimming or water recreation activities;

(B) Public wading pool, which is a pool principally used or intended to be used for wading and recreational bathing by small children;

(C) Public spa, which is a pool used for recreational bathing in conjunction with a high-velocity air system, a high-velocity water recirculation system, hot water, cold water, a mineral bath or any combination thereof;

(D) Public diving pool, which is a pool used solely for diving or the instruction and practicing of diving techniques; or

(E) Special purpose public pool, which is a pool used for a specialized purpose, including, but not limited to, a splash pad or spray park where the water is recirculated, water flume, pool used for scuba diving instruction, therapeutic pool, hydrotherapy pool or a pool used in an aquatics program for persons with disabilities. Special purpose public pool does not include a flotation vessel, which shall not be subject to review by the Department of Public Health. For purposes of this subparagraph, “flotation vessel” means a tank devoid of light and sound and containing salt water in which a person floats for purposes including, but not limited to, meditation, relaxation and alternative medicine.

(3) The commissioner shall charge the following fees for the following services: (A) Review of plans for a public pool, seven hundred fifty dollars; (B) review of a resubmitted plan for a public pool, two hundred fifty dollars; (C) initial inspection of a public pool, two hundred dollars; and (D) any subsequent inspection of a public pool, one hundred fifty dollars. The commissioner shall amend the regulations adopted pursuant to this section as necessary to implement the provisions of this subsection.

(4) Notwithstanding subsection (a) of this section, regulations governing the safety of public pools shall not require fences around (A) naturally formed ponds subsequently converted to public pool use, provided the converted ponds (i) retain sloping sides common to natural ponds, and (ii) are on property surrounded by a fence, or (B) a splash pad or spray park.

(d) The local director of health may authorize the use of an existing private well, consistent with all applicable sections of the regulations of Connecticut state agencies, the installation of a replacement well at a single-family residential premises on property whose boundary is located within two hundred feet of an approved community water supply system, measured along a street, alley or easement, where (1) a premises that is not connected to the public water supply may replace a well used for domestic purposes if water quality testing is performed at the time of the installation, and for at least every ten years thereafter, or for such time as requested by the local director of health, that demonstrates that the replacement well meets the water quality standards for private wells established in the Public Health Code, and provided there is no service to the premises by a public water supply, or (2) a premises served by a public water supply may utilize or replace an existing well or install a new well solely for irrigation purposes or other outdoor water uses provided such well is permanently and physically separated from the internal plumbing system of the premises and a reduced pressure device is installed to protect against a cross connection with the public water supply. Upon a determination by the local director of health that an irrigation well creates an unacceptable risk of injury to the health or safety of persons using the water, to the general public, or to any public water supply, the local director of health may issue an order requiring the immediate implementation of mitigation measures, up to and including permanent abandonment of the well, in accordance with the provisions of the Connecticut Well Drilling Code adopted pursuant to section [25-128](#). In the event a cross connection with the public water system is found, the owner of the system may terminate service to the premises.

(1949 Rev., S. 3800; 1959, P.A. 628, S. 2; 1961, P.A. 140; P.A. 77-282; 77-614, S. 345, 610; May Sp. Sess. P.A. 92-6, S. 6, 117; P.A. 93-381, S. 9, 39; P.A. 95-44, S. 2; 95-257, S. 12, 21, 58; P.A. 97-278; P.A. 98-75, S. 2; P.A. 02-102, S. 2; P.A. 03-252, S. 3; P.A. 05-122, S. 1; P.A. 07-244, S. 2; P.A. 08-184, S. 5; P.A. 09-11, S. 5; June Sp. Sess. P.A. 09-3, S. 165; Sept. Sp. Sess. P.A. 09-7, S. 177; P.A. 12-80, S. 66; P.A. 15-148, S. 1; P.A. 16-75, S. 1; P.A. 17-93, S. 1; 17-202, S. 67.)

History: 1959 act added provision re field sanitation; 1961 act substituted public health code for sanitary code; P.A. 77-282 provided that code may include regulations requiring restroom facilities in large stores, shopping centers etc.; P.A. 77-614 replaced public health council with commissioner of health services, effective January 1, 1979; Sec. 19-13 transferred to Sec. 19a-36 in 1983; May Sp. Sess. P.A. 92-6 added new Subsec. (b) to establish fees for public swimming pool plan review and resubmitted plan review, public swimming pool inspection and reinspection and review of small and large flow plan for subsurface sewage disposal; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-44 amended Subsec. (a) to prohibit the regulations from prohibiting the sale of food at noncommercial functions and to define “noncommercial function”; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 97-278 added Subsec. (c) re naturally formed ponds converted to swimming pool use; P.A. 98-75 amended Subsec. (a) to provide that provisions of regulations with respect to requirement of employing a qualified food operator and any reporting requirements re such operator shall not apply to soup kitchens that rely exclusively on volunteer services; P.A. 02-102 added Subsec. (d) to permit a local director of health to authorize the use of an existing private well or the installation of a replacement well at a single-family residential premises located within 200 feet of an approved community water supply system, subject to certain safeguards; P.A. 03-252 amended Subsec. (a) by allowing code to regulate retail food establishments; P.A. 05-122 amended Subsec. (a) by adding provision requiring testing of qualified food operator's knowledge of food allergies, redesignating existing Subdivs. (1) and (2) as Subparas. (A) and (B), adding new Subdiv. designators and making technical changes; P.A. 07-244 amended Subsec. (d) to subject local health directors' decisions re use of existing private wells to applicable state regulations, to add provisions re mitigation or abandonment of irrigation wells that create an unacceptable risk of injury to health or safety and to make technical changes; P.A. 08-184 amended Subsec. (a)(1) by providing that code may include “the required permitting from local health departments or districts to operate said establishments”; P.A. 09-11 made a technical change in Subsec. (a)(1); June Sp. Sess. P.A. 09-3 amended Subsec. (b) to increase fees; Sept. Sp. Sess. P.A. 09-7 amended Subsec. (a)(4) to expand exemption to include persons distributing food and to provide that distribution or sale of food at a “noncommercial function” is by a person not normally engaged in the

business of selling such food for profit, effective October 5, 2009; P.A. 12-80 amended Subsec. (a)(7) to replace penalty of a fine of not more than \$100 or imprisonment of not more than 3 months or both with a class C misdemeanor; P.A. 15-148 amended Subsec. (b) to delete “Notwithstanding any regulations to the contrary”, delete former Subdivs. (1) to (4) re public swimming pools, redesignate existing Subdivs. (5) and (6) as Subdivs. (1) and (2) and add provision re commissioner to amend regulations to implement provisions of Subsec., added new Subsec. (c)(1) to (3) re definition and classification of public pools and fees for services, and redesignated existing Subsec. (c) as Subsec. (c)(4) and made technical and conforming changes therein; P.A. 16-75 amended Subsec. (c)(4) by redesignating existing Subparas. (A) and (B) as clauses (i) and (ii), designating existing provision re naturally formed ponds converted to public pool use as Subpara. (A) and adding new Subpara. (B) re splash pad or spray park; P.A. 17-93 amended Subsec. (a) by deleting former Subdiv. (1) re regulations pertaining to retail food establishments, redesignating existing Subdivs. (2) and (3) as Subdivs. (1) and (2), deleting former Subdiv. (4) re qualified food operators and sale or distribution of food at noncommercial function, deleting Subdiv. (5) re qualified food operators, and redesignating existing Subdivs. (6) and (7) as Subdivs. (3) and (4), effective July 1, 2018; P.A. 17-202 amended Subsec. (c)(2)(E) by replacing “handicapped persons” with “persons with disabilities”.

See Sec. 19a-207 re duties of local health officials in enforcing Public Health Code.

See Sec. 19a-495 re regulation of health care institutions.

See Sec. 21a-62a re regulations pertaining to preparation of food in private residential dwelling for sale for human consumption.

Annotations to former section 19-13:

Cited. 166 C. 337; 172 C. 88.

Cited. 12 CA 57.

Annotation to present section:

Cited. 32 CA 409.

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Sec. 19a-36a. Regulations concerning food operators. The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, to assure that food service establishments employ as food operators persons who have a knowledge of safe food handling techniques and to set requirements for the employment of food operators by such establishments. Such regulations shall include, but not be limited to, responsibilities of food service establishments and their employees, exemptions for certain classes of food establishments and responsibilities of local health departments in monitoring compliance of food establishments.

(P.A. 89-308; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

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Sec. 19a-36b. Persons exempt from examination requirement for qualified food operators. Regulations. (a) Any person who serves meals to individuals at registered congregate meal sites funded under Title III of the Older Americans Act of 1965, as amended, which were prepared under the supervision of a qualified food operator, shall be exempt from the examination requirement for qualified food operators.

(b) Any volunteer who serves meals for a nonprofit organization shall be exempt from the examination requirement for qualified food operators.

(c) The Commissioner of Public Health, in conjunction with the Commissioner of Social Services, shall adopt regulations in accordance with the provisions of chapter 54 to establish training procedures for persons exempt from the examination requirement for qualified food operators under the provisions of subsections (a) and (b) of this section.

(P.A. 98-75, S. 1.)

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Secs. 19a-36c to 19a-36e. Display of sign re signs of choking by food service establishments. Sous vide processing by food service establishments. Acidification of sushi rice. Sections [19a-36c](#) to [19a-36e](#), inclusive, are repealed, effective October 1, 2017.

(P.A. 05-134, S. 1; P.A. 15-140, S. 1; P.A. 15-220, S. 1; P.A. 17-93, S. 16.)

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Sec. 19a-36f. Prohibition on use of disposable natural rubber latex gloves at retail food establishments. (a) No person shall use or require the use of disposable, nonsterile or sterile natural rubber latex gloves at a retail food establishment.

(b) Any person who violates subsection (a) of this section shall be fined not less than two hundred fifty dollars nor more than five hundred dollars.

(P.A. 15-242, S. 31; P.A. 17-93, S. 13; P.A. 18-168, S. 23.)

History: P.A. 15-242 effective July 1, 2016; P.A. 17-93 amended Subsec. (a) by replacing “food service establishment” with “food establishment”; P.A. 18-168 amended Subsec. (a) by deleting reference to the types of retail food establishments.

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Sec. 19a-36g. Food code. Definitions. As used in this section and sections [19a-36h](#) to [19a-36o](#), inclusive:

(1) “Catering food service establishment” means a business that is involved in the (A) sale or distribution of food and drink prepared in bulk in one geographic location for retail service in individual portions in another location, or (B) preparation and service of food in a public or private venue that is not under the ownership or control of the operator of such business;

(2) “Certified food protection manager” means a food employee that has supervisory and management responsibility and the authority to direct and control food preparation and service;

(3) “Class 1 food establishment” means a retail food establishment that does not serve a population that is highly susceptible to food borne illnesses and only offers (A) commercially packaged food in its original

commercial package that is time or temperature controlled for safety, or (B) commercially prepackaged, precooked food that is time or temperature controlled for safety and heated, hot held and served in its original commercial package not later than four hours after heating, or (C) food prepared in the establishment that is not time or temperature controlled for safety;

(4) “Class 2 food establishment” means a retail food establishment that does not serve a population that is highly susceptible to food-borne illnesses and offers a limited menu of food that is prepared or cooked and served immediately, or that prepares or cooks food that is time or temperature controlled for safety and may require hot or cold holding, but that does not involve cooling;

(5) “Class 3 food establishment” means a retail food establishment that (A) does not serve a population that is highly susceptible to food-borne illnesses, and (B) offers food that is time or temperature controlled for safety and requires complex preparation, including, but not limited to, handling of raw ingredients, cooking, cooling and reheating for hot holding;

(6) “Class 4 food establishment” means a retail food establishment that serves a population that is highly susceptible to food-borne illnesses, including, but not limited to, preschool students, hospital patients and nursing home patients or residents, or that conducts specialized food processes, including, but not limited to, smoking, curing or reduced oxygen packaging for the purposes of extending the shelf life of the food;

(7) “Cold holding” means maintained at a temperature of forty-one degrees Fahrenheit or below;

(8) “Commissioner” means the Commissioner of Public Health or the commissioner's designee;

(9) “Contact hour” means a minimum of fifty minutes of a training activity;

(10) “Department” means the Department of Public Health;

(11) “Director of health” means the director of a local health department or district health department appointed pursuant to section [19a-200](#) or [19a-242](#);

(12) “Food code” means the food code administered under section [19a-36h](#);

(13) “Food establishment” means an operation that (A) stores, prepares, packages, serves, vends directly to the consumer or otherwise provides food for human consumption, including, but not limited to, a restaurant, catering food service establishment, food service establishment, temporary food service establishment, itinerant food vending establishment, market, conveyance used to transport people, institution or food bank, or (B) relinquishes possession of food to a consumer directly, or indirectly through a delivery service, including, but not limited to, home delivery of grocery orders or restaurant takeout orders or a delivery service that is provided by common carriers. “Food establishment” does not include a vending machine, as defined in section [21a-34](#), a private residential dwelling in which food is prepared under section [21a-62a](#) or a food manufacturing establishment, as defined in section [21a-151](#);

(14) “Food inspector” means a director of health, or his or her authorized agent, or a registered environmental health specialist who has been certified as a food inspector by the commissioner;

(15) “Food inspection training officer” means a certified food inspector who has received training developed or approved by the commissioner and been authorized by the commissioner to train candidates for food inspector certification;

(16) “Food-borne illness” means illness, including, but not limited to, illness due to heavy metal intoxications, staphylococcal food poisoning, botulism, salmonellosis, shigellosis, *Clostridium perfringens* intoxication and hepatitis A, acquired through the ingestion of a common-source food or water contaminated with a chemical, infectious agent or the toxic products of a chemical or infectious agent;

(17) “Food-borne outbreak” means illness, including, but not limited to, illness due to heavy metal intoxications, staphylococcal food poisoning, botulism, salmonellosis, shigellosis, *Clostridium perfringens* intoxication and hepatitis A, in two or more individuals, acquired through the ingestion of common-source food or water contaminated with a chemical, infectious agent or the toxic products of a chemical or infectious agent;

(18) “Hot holding” means maintained at a temperature of one hundred thirty-five degrees Fahrenheit or above;

(19) “Itinerant food vending establishment” means a vehicle-mounted, self-contained, mobile food establishment;

(20) “Permit” means a written document issued by a director of health that authorizes a person to operate a food establishment;

(21) “Temporary food service establishment” means a food establishment that operates for a period of not more than fourteen consecutive days in conjunction with a single event or celebration;

(22) “Time or temperature controlled for safety” means maintained at a certain temperature or maintained for a certain length of time, or both, to prevent microbial growth and toxin production; and

(23) “Variance” means a written document issued by the commissioner that authorizes a modification or waiver of one or more requirements of the food code.

(P.A. 17-93, S. 2; P.A. 18-168, S. 20; P.A. 19-118, S. 3; P.A. 24-68, S. 20.)

History: P.A. 18-168 amended Subdiv. (3) by redefining “Class 1 food establishment”, and amended Subdiv. (5)(B) by replacing “has an extensive menu of foods, many of which are” with “offers food that is”, and making a technical change; P.A. 19-118 amended Subdiv. (4) by redefining “Class 2 food establishment”, effective July 1, 2019; P.A. 24-68 amended Subdiv. (14) by replacing “sanitarian” with “environmental health specialist”, effective July 1, 2024.

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Sec. 19a-36h. Adoption by reference of United States Food and Drug Administration's Food Code. Regulations. (a) Not later than January 1, 2023, the commissioner shall adopt and administer by reference the United States Food and Drug Administration's Food Code, as amended from time to time, and any Food Code Supplement published by said administration as the state's food code for the purpose of regulating food establishments.

(b) The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of this section and sections [19a-36i](#) to [19a-36m](#), inclusive.

(P.A. 17-93, S. 3; P.A. 18-168, S. 46; P.A. 19-118, S. 23; P.A. 21-121, S. 61.)

History: P.A. 18-168 amended Subsec. (a) by replacing “July 1, 2018” with “January 1, 2019”, effective June 13, 2018; P.A. 19-118 amended Subsec. (a) by replacing “January 1, 2019” with “January 1, 2020”, effective July 1, 2019; P.A. 21-121 amended Subsec. (a) by replacing “January 1, 2020” with “January 1, 2023”, effective July 6, 2021.

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Sec. 19a-36i. Food establishments. Permit. Inspections. Food protection managers. Reciprocal licensing of itinerant food vending establishment. (a) No person, firm or corporation shall operate or maintain any food establishment where food or beverages are served or sold to the public in any town, city or borough without obtaining a valid permit to operate from the director of health of such town, city or borough, in a form and manner prescribed by the director of health. The director of health shall issue a permit to operate a food establishment upon receipt of an application if the food establishment meets the requirements of this section. All food establishments shall comply with the food code.

(b) All food establishments shall be inspected by a certified food inspector in a form and manner prescribed by the commissioner. The Commissioner of Public Health may, after notifying the Commissioner of Consumer Protection, grant a variance for the requirements of the food code if the Commissioner of Public Health determines that such variance would not result in a health hazard or nuisance.

(c) Each class 2 food establishment, class 3 food establishment and class 4 food establishment shall employ a certified food protection manager. No person shall serve as a certified food protection manager unless such person has satisfactorily passed a test as part of a food protection manager certification program that is evaluated and approved by an accrediting agency recognized by the Conference for Food Protection as conforming to its standards for accreditation of food protection manager certification programs. A certified food inspector shall verify that the food protection manager is certified upon inspection of the food establishment. The owner or manager of the food service establishment shall designate an alternate person or persons to be in charge at all times when the certified food protection manager cannot be present. The alternate person or persons in charge shall be responsible for ensuring the following: (1) All employees are in compliance with the requirements of this section; (2) foods are safely prepared in accordance with the requirements of the food code; (3) emergencies are managed properly; (4) a food inspector is admitted into the food establishment upon request; and (5) he or she receives and signs inspection reports.

(d) The commissioner shall collaborate with the directors of health to develop a process that allows for the reciprocal licensing of an itinerant food vending establishment that has obtained a valid permit or license under subsection (a) of this section and seeks to operate as an itinerant food vending establishment in another town, city or borough. Not later than December 1, 2021, the commissioner shall submit a report, in accordance with the provisions of section [11-4a](#), to the joint standing committee of the General Assembly having cognizance of matters relating to public health, of the process developed pursuant to this subsection. Not later than January 1, 2022, the commissioner and each director of health shall implement such process.

(P.A. 17-93, S. 4; P.A. 18-168, S. 49; 18-169, S. 5; P.A. 19-56, S. 4; P.A. 21-26, S. 8; P.A. 22-92, S. 5; P.A. 24-68, S. 5.)

History: P.A. 18-168 amended Subdiv. (4) by adding provisions re alternate person or persons in charge when certified food protection manager cannot be present, effective July 1, 2018; P.A. 18-169 redesignated existing Subdivs. (1) to (4) as Subsecs. (a) to (d) and added Subsec. (e) re development of process that allows reciprocal licensing of itinerant food vending establishment and submission of report, effective June 14, 2018; P.A. 19-56 amended Subsec. (d) by redesignating existing Subparas. (A) to (E) as Subdivs. (1) to (5), effective June 28, 2019; P.A. 21-26 amended Subsec. (a) by deleting “or license” and amended Subsec. (e) by replacing “January 1, 2019” with “December 1, 2021” and “February 1, 2019” with “January 1, 2022”, effective June 7, 2021; P.A. 22-92 amended Subsec. (a) by deleting reference to “license”, effective May 24, 2022; P.A. 24-68 amended Subsec. (b) by replacing “in consultation with” with “after notifying”, deleted Subsec. (c) prohibiting directors of health from issuing permits without proof of registration with department and written application and redesignating existing Subsecs. (d) and (e) as Subsecs. (c) and (d), effective July 1, 2024.

Sec. 19a-36j. Food inspectors. Certification. Employment restrictions. Inspections. (a) No person shall engage in the practice of a food inspector unless such person has obtained a certification from the commissioner in accordance with the provisions of this section. The commissioner shall develop a training and verification program for food inspector certification that shall be administered by the food inspection training officer at a local health department.

(1) Each person seeking certification as a food inspector shall submit an application to the department on a form prescribed by the commissioner and present to the department satisfactory evidence that such person (A) possesses a bachelor's degree or three years of experience in a regulatory food protection program, (B) has successfully completed a training and verification program prescribed by the commissioner, and (C) has successfully completed the field standardization inspection prescribed by the commissioner.

(2) Certifications issued under this section shall be subject to renewal once every three years. A food inspector applying for renewal of his or her certification shall demonstrate successful completion of twenty contact hours in food protection training, as approved by the commissioner, and reassessment by the food inspection training officer.

(b) No person shall be employed as a certified food inspector if such person, such person's immediate family, as defined in section [1-79](#), or a business with which such person is associated, as described in subdivision (2) of section [1-79](#), (1) has any financial or ownership interest in a food establishment located in the jurisdiction in which such person is employed as a food inspector, (2) engages in any business, employment or management of a food establishment located in such jurisdiction, or (3) owns the property on which a food establishment is located in such jurisdiction.

(c) Each director of health employing a food inspector shall certify, on a form prescribed by the commissioner, that such food inspector is not prohibited from employment as a food inspector pursuant to the provisions of subsection (b) of this section.

(d) A certified food inspector shall conduct an inspection of a food establishment in a form and manner prescribed by the commissioner to determine compliance with the food code. The director of health shall ensure all food establishments are inspected at a frequency determined by their risk classification. Such director of health shall evaluate the food establishment's risk classification on an annual basis to determine accuracy. More frequent inspections may be conducted to ensure compliance with the food code. Each food establishment classification shall be inspected pursuant to the following schedule:

(1) Class 1 food establishments shall be inspected at intervals not to exceed three hundred sixty days.

(2) Class 2 food establishments shall be inspected at intervals not to exceed one hundred eighty days.

(3) Class 3 food establishments shall be inspected at intervals not to exceed one hundred twenty days.

(4) Class 4 food establishments shall be inspected at intervals not to exceed ninety days.

(5) Temporary food service establishments shall be inspected prior to the issuance of a permit to operate and as often as necessary to ensure compliance with the food code.

(P.A. 17-93, S. 5; P.A. 18-168, S. 47; P.A. 21-121, S. 62; P.A. 23-31, S. 26.)

History: P.A. 18-168 amended Subsec. (a) by replacing “July 1, 2018” with “January 1, 2019”, effective June 13, 2018; P.A. 21-121 amended Subsec. (a) by replacing “January 1, 2019” with “January 1, 2023”, effective July 6, 2021; P.A. 23-31 amended Subsec. (a) by deleting “On and after January 1, 2023” and making a conforming change, deleting Subdiv. (1)(A), redesignating Subdiv. (1)(B) to (1)(D) as Subdiv. (1) (A) to (1)(C), adding “prescribed by the commissioner, and” to Subdiv. (1)(B), deleting Subdiv. (1)(E), deleting Subdiv. (2), redesignating existing Subdiv. (3) as Subdiv. (2) and making conforming changes,

added new Subsec. (b) re employment restrictions, added Subsec. (c) re certification re employment restrictions, and redesignated existing Subsec. (b) as Subsec. (d), effective January 1, 2024.

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Sec. 19a-36k. Food-borne illness or outbreak. Investigation. If a director of health has reasonable cause to suspect the possibility of a food-borne illness or food-borne outbreak, such director shall complete an investigation and take action to control the illness or outbreak. Such action may include, but need not be limited to, securing employee morbidity histories, requiring medical and laboratory examinations of an employee, modification of a menu and any other restriction or action deemed necessary by such director of health to control the illness or outbreak. A person who violates any provision of sections [19a-36h](#) to [19a-36m](#), inclusive, section [22-6r](#), or section [22-6s](#), or who provides false information during an investigation, refuses to cooperate with an investigation or otherwise impedes an investigation that is conducted under this section or section [19a-36i](#) or [19a-36j](#) shall be guilty of a class C misdemeanor.

(P.A. 17-93, S. 6; P.A. 18-48, S. 5.)

History: P.A. 18-48 made a technical change, effective May 29, 2018.

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Sec. 19a-36l. Inspection violations. Appeal process. The owner or operator of a food establishment aggrieved by an order to correct any inspection violations identified by the food inspector or to hold, destroy or dispose of unsafe food may appeal such order to the director of health not later than forty-eight hours after issuance of such order. The director of health shall review the request for an appeal and, upon conclusion of the review, may vacate, modify or affirm such order. If affirmed by the director of health, the corrective actions specified by the food inspector shall be so ordered by the director of health. An owner or operator of a food establishment who is aggrieved by the affirmation or modification of an order by the director of health, including, but not limited to, an order to suspend the permit or license to operate the food establishment, may appeal to the department pursuant to section [19a-229](#). During such appeal, the order shall remain in effect unless the commissioner orders otherwise.

(P.A. 17-93, S. 7; P.A. 19-118, S. 4.)

History: P.A. 19-118 replaced “food service establishment” with “food establishment”, effective July 1, 2019.

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Sec. 19a-36m. Authority of directors of health and Commissioner of Agriculture. Application of provisions of food code re certified food managers. Exceptions. (a) Nothing in this section or sections [19a-36h](#) to [19a-36l](#), inclusive, shall limit the authority of directors of health under chapter 368e or 368f.

(b) For purposes of this section and sections [19a-36h](#) to [19a-36l](#), inclusive, the provisions of the general statutes and regulations of Connecticut state agencies pertaining to certified farmers' markets shall not limit the authority of the Commissioner of Agriculture and the director of health to require a farmer to comply with the requirements of sections [22-6r](#) and [22-6s](#).

(c) The provisions of the food code that concern the employment of a certified food protection manager and any reporting requirements relative to such certified food protection manager shall not apply to (1) an owner or operator of a soup kitchen that relies exclusively on services provided by volunteers, (2) any

volunteer who serves meals from a nonprofit organization, including a temporary food service establishment and a special event sponsored by a nonprofit civic organization, including, but not limited to, school sporting events, little league food booths, church suppers and fairs, or (3) any person who serves meals to individuals at a registered congregate meal site funded under Title III of the Older Americans Act of 1965, as amended from time to time, that were prepared under the supervision of a certified food protection manager.

(d) The provisions of the food code shall not (1) apply to a residential care home with thirty beds or less that is licensed pursuant to chapter 368v, provided the administrator of the residential care home or the administrator's designee has satisfactorily passed a test as part of a food protection manager certification program that is evaluated and approved by an accrediting agency recognized by the Conference for Food Protection as conforming to its standard for accreditation of food protection manager certification programs, unless such residential care home enters into a service contract with a food establishment or lends, rents or leases any area of its facility to any person or entity for the purpose of preparing or selling food, at which time the provisions of the food code shall apply to such residential care home, and (2) shall not prohibit the sale or distribution of food at (A) a bed and breakfast establishment that prepares and offers food to guests, provided the operation is owner-occupied and the total building occupant load is not more than sixteen persons, including the owner and occupants, has no provisions for cooking or warming food in the guest rooms, breakfast is the only meal offered and the consumer of such operation is informed by statements contained in published advertisements, mailed brochures and placards posted in the registration area that the food is prepared in a kitchen that is not regulated and inspected by the local health director, and (B) a noncommercial function, including, but not limited to, an educational, religious, political or charitable organization's bake sale or potluck supper, provided the seller or person distributing the food maintains the food at the temperature, pH level and water activity level conditions that will inhibit the growth of infectious or toxigenic microorganisms. For the purposes of this subsection, "noncommercial function" means a function where food is sold or distributed by a person not regularly engaged in the business of selling such food for profit.

(P.A. 17-93, S. 8; P.A. 18-168, S. 21; P.A. 22-58, S. 33.)

History: P.A. 18-168 amended Subsec. (c) by replacing "certified food manager" with "certified food protection manager", and added Subsec. (d) re an exception for residential care homes with 30 beds or less; P.A. 22-58 amended Subsec. (c) by redesignating Subdivs. (1)(A) to (1)(C) as Subdivs. (1) to (3), redesignating existing Subdiv. (2) as Subsec. (d)(2) and making conforming changes, and amended Subsec. (d) by designating existing provisions as Subdiv. (1), effective May 23, 2022.

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Sec. 19a-36n. Commissioner's authority to make public announcement re identity of source of food-borne illness or outbreak. Notwithstanding any provision of the general statutes, the Commissioner of Public Health may announce to the public, at the commissioner's sole discretion, the identity of the food establishment that was the source of any food-borne illness or food-borne outbreak that has been verified by the department for the purpose of reducing morbidity and mortality from any cause or condition of such illness or outbreak. The commissioner shall make every effort to limit the disclosure of personally identifiable health data to the minimal amount necessary to accomplish such purpose.

(P.A. 17-93, S. 9.)

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Sec. 19a-36o. Variance from requirements of Public Health Code for sous vide processing and acidification of sushi rice. Notwithstanding any provision of the general statutes, from June 30, 2017, until December

31, 2022, a food service establishment may request a variance from the Commissioner of Public Health from the requirements of the regulations of Connecticut state agencies, established under section [19a-36](#), to utilize the process of sous vide and acidification of sushi rice, as defined in section 3-502.11 of the United States Food and Drug Administration's Food Code, as amended from time to time. The Commissioner of Public Health shall review the request for a variance and provide the food establishment with notification regarding the status of its request not later than thirty days after the commissioner receives such request. The commissioner may grant such variance if he or she determines that such variance would not result in a health hazard or nuisance.

(P.A. 17-93, S. 10; P.A. 18-168, S. 48; P.A. 21-121, S. 63.)

History: P.A. 17-93 effective June 30, 2017; P.A. 18-168 replaced “June 30, 2018” with “December 31, 2018”, effective June 13, 2018; P.A. 21-121 replaced “December 31, 2018” with “December 31, 2022” and “Public Health Code” with “regulations of Connecticut state agencies”, effective July 6, 2021.

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Sec. 19a-36p. Posting on menus and menu boards of request for customers to notify server of any food allergies. Not later than January 1, 2025, each class 2, class 3 and class 4 food establishment, as defined in section [19a-36g](#), shall post in a clear and conspicuous manner on its menus and menu boards a request for customers to notify their server, prior to placing an order, of any food allergies.

(P.A. 23-115, S. 1.)

History: P.A. 23-115 effective July 1, 2023.

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Sec. 19a-36q. Informational poster regarding food allergies for food establishments. Displaying of poster. (a) Not later than December 1, 2023, the Department of Public Health shall develop or approve an informational poster regarding food allergies for display in class 2, class 3 and class 4 food establishments, as defined in section [19a-36g](#). The poster shall contain information concerning (1) the most common allergy-causing foods, (2) the actions a server should take when a customer notifies the server that the customer has a food allergy, (3) the ways in which kitchen staff and servers can prevent cross contact of foods, and (4) the need to contact the 911 emergency telecommunications number if a customer has an allergic reaction while on the premises of such food establishment.

(b) Not later than March 1, 2024, (1) each class 2, class 3 and class 4 food establishment shall display the poster developed or approved pursuant to subsection (a) of this section in a clear and conspicuous manner in its kitchen or designated staff area, and (2) the certified food protection manager, as defined in section [19a-36g](#), of each class 2, class 3 and class 4 food establishment shall ensure that each employee of the food establishment has viewed the poster and require each employee to confirm, in writing, that the employee has familiarized himself or herself with the information displayed in the poster. Failure to display the poster shall be grounds for an inspection violation under section [19a-36l](#).

(P.A. 23-115, S. 2.)

History: P.A. 23-115 effective June 27, 2023.

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Sec. 19a-36r. Local health department food protection program audits. The Commissioner of Public Health may conduct audits of local health department food protection programs. Such audits may include, but need not be limited to, interviews with local health department staff members and joint inspections with local health department staff members of local food establishments. Upon the conclusion of any such audit, the Commissioner of Public Health shall provide the local director of health with a report detailing such audit's findings and any recommended or necessary corrective actions to be taken by such director.

(P.A. 23-31, S. 27.)

History: P.A. 23-31 effective June 7, 2023.

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Sec. 19a-37. (Formerly Sec. 19-13a). Regulation of water supply wells and springs. Definitions. Information and requirements re testing of private wells or semipublic wells. Transportation of water in bulk by bulk water hauler. (a) As used in this section:

- (1) “Laboratory or firm” means an environmental laboratory registered by the Department of Public Health pursuant to section [19a-29a](#);
 - (2) “Domestic purposes” means drinking, bathing, washing of clothes and dishes, cooking and other common household chores;
 - (3) “First draw sample” means a one-liter sample of tap water that has been standing in plumbing pipes for not less than six hours that is collected without flushing the tap;
 - (4) “Private well” means a water supply well that meets all of the following criteria: (A) Is not a public well; (B) supplies a residential population of less than twenty-five persons per day; and (C) is owned or controlled through an easement or by the same entity that owns or controls the building or parcel that is served by the water supply well;
 - (5) “Public well” means a water supply well that supplies a public water system;
 - (6) “Semipublic well” means a water supply well that (A) does not meet the definition of a private well or public well, and (B) provides water for drinking and other domestic purposes; and
 - (7) “Water supply well” means an artificial excavation constructed by any method for the purpose of obtaining or providing water for drinking or other domestic, industrial, commercial, agricultural, recreational or irrigation use, or other outdoor water use.
- (b) (1) The Commissioner of Public Health may adopt regulations, in accordance with the provisions of chapter 54, for the preservation of the public health pertaining to (A) protection and location of new water supply wells or springs for residential or nonresidential construction or for public or semipublic use, and (B) inspection for compliance with the provisions of municipal regulations adopted pursuant to section [22a-354p](#).
- (2) The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, for the testing of water quality in private wells and semipublic wells.
 - (3) The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, to clarify the criteria under which the commissioner may issue a well permit exception and to describe the terms and conditions that shall be imposed when a well is allowed at a premises that is connected to a public water supply system or whose boundary is located within two hundred feet of an approved community water supply system, measured along a street, alley or easement. Such regulations

shall (A) provide for notification of the permit to the public water supplier, (B) address the (i) quality of the water supplied from the well, (ii) means and extent to which the well shall not be interconnected with the public water supply, (iii) need for a physical separation and the installation of a reduced pressure device for backflow prevention, and (iv) inspection and testing requirements of any such reduced pressure device, and (C) identify the extent and frequency of water quality testing required for the well supply.

(c) (1) Any laboratory or firm which conducts a water quality test on a private well serving a residential property or semipublic well in the state shall, not later than thirty days after the completion of such test, report the results of such test to the local health authority of the municipality where the property is located and the Department of Public Health in a format specified by the department. Results submitted to the Department of Public Health or the local health authority pursuant to this subsection, information obtained from any Department of Public Health or local health authority investigation regarding those results and any Department of Public Health or local health authority study of morbidity and mortality regarding the results shall be confidential pursuant to section [19a-25](#), except the local health authority and the department may, if approved by the commissioner, disclose the results or information obtained from an investigation of the results to (A) the owner of the property on which the well is located, (B) a prospective buyer of such property who has signed a contract to purchase such property, (C) other persons or entities, when such disclosure is necessary to carry out a statutory or regulatory responsibility of the local health authority or department, or (D) an agent of a state agency.

(2) On and after October 1, 2022, the owner of each newly constructed private well or semipublic well shall test the water quality of such well. Such test shall be performed by a laboratory and include, but need not be limited to, testing for coliform, nitrate, nitrite, sodium, chloride, iron, manganese, hardness, turbidity, pH, sulfate, apparent color, odor, arsenic and uranium. If such a well is constructed for an existing structure, a first draw sample collected from the existing plumbing system shall also be tested for lead. The owner shall submit test results to the local health authority where the well is located in a form and manner prescribed by the Commissioner of Public Health. Such local health authority shall determine whether the test results comply with the maximum contaminant levels, as prescribed by sections 19-13-B101 and 19-13-B102 of the regulations of Connecticut state agencies. A newly constructed private well or semipublic well shall not be used for domestic purposes until the local health authority determines that the test results comply with such maximum contaminant levels.

(d) Prior to the sale, exchange, purchase, transfer or rental of real property on which a private or semipublic well is located, the owner shall provide the buyer or tenant notice that educational material concerning private well testing is available on the Department of Public Health web site. If the prospective buyer or tenant has hired a real estate licensee to facilitate the property transaction, such real estate licensee, or, if the prospective buyer or tenant has not hired a real estate licensee, the owner, landlord or closing attorney shall provide to the buyer or tenant an electronic or hard copy of educational material prepared by the Department of Public Health that recommends testing for the contaminants listed in subsection (c) of this section and any other recommendation concerning well testing that the Department of Public Health deems necessary. Failure to provide such notice or educational material shall not invalidate any sale, exchange, purchase, transfer or rental of real property. If the seller or landlord provides such notice or educational material in writing, the seller or landlord and any real estate licensee shall be deemed to have fully satisfied any duty to notify the buyer or tenant.

(e) A certificate of occupancy for a dwelling unit on a residential property shall not be withheld or revoked on the basis of a water quality test performed on a private well pursuant to this section, unless such test results indicate that any maximum contaminant level applicable to public water supply systems for any contaminant listed in the regulations of Connecticut state agencies has been exceeded. No municipality, administrative agency or local health authority shall establish regulations or ordinances that withhold, cause to be withheld or revoke such a certificate of occupancy on the basis of a water quality test performed on a well pursuant to this section, except as provided in this section.

(f) (1) The local director of health may require a private well or semipublic well to be tested for arsenic, radium, uranium, radon or gross alpha emitters, when there are reasonable grounds to suspect that such

contaminants are present in the groundwater. For purposes of this subsection, “reasonable grounds” means (A) the existence of a geological area known to have naturally occurring arsenic, radium, uranium, radon or gross alpha emitter deposits in the bedrock; or (B) the well is located in an area in which it is known that arsenic, radium, uranium, radon or gross alpha emitters are present in the groundwater.

(2) The local director of health may require a private well or semipublic well to be tested for pesticides, herbicides or organic chemicals when there are reasonable grounds to suspect that any such contaminants might be present in the groundwater. For purposes of this subsection, “reasonable grounds” means (A) the presence of nitrate-nitrogen in the groundwater at a concentration greater than ten milligrams per liter, or (B) that the private well or semipublic well is located on land, or in proximity to land, associated with the past or present production, storage, use or disposal of organic chemicals as identified in any public record.

(g) Except as provided in subsection (h) of this section, the collection of samples for determining the water quality of private wells and semipublic wells may be made only by (1) employees of a laboratory or firm certified or approved by the Department of Public Health to test drinking water, if such employees have been trained in sample collection techniques, (2) certified water operators, (3) local health departments and state employees trained in sample collection techniques, or (4) individuals with training and experience that the Department of Public Health deems sufficient.

(h) Any owner of a residential construction, including, but not limited to, a homeowner, on which a private well is located or any general contractor of a new residential construction on which a private well is located may collect samples of well water for submission to a laboratory or firm for the purposes of testing water quality pursuant to this section, provided (1) such laboratory or firm has provided instructions to said owner or general contractor on how to collect such samples, and (2) such owner or general contractor is identified to the subsequent owner on a form to be prescribed by the Department of Public Health. No regulation may prohibit or impede such collection or analysis.

(i) Any water transported in bulk by any means to a premises currently supplied by a private well or semipublic well where the water is to be used for purposes of drinking or domestic use shall be provided by a bulk water hauler licensed pursuant to section [20-278h](#). No bulk water hauler shall deliver water without first notifying the owner of the premises of such delivery. Bulk water hauling to a premises currently supplied by a private well or semipublic well shall be permitted only as a temporary measure to alleviate a water supply shortage.

(1959, P.A. 30; P.A. 77-614, S. 475, 610; P.A. 89-305, S. 26, 32; P.A. 92-251; P.A. 93-381, S. 9, 39; P.A. 94-85, S. 3; P.A. 95-257, S. 12, 21, 58; P.A. 97-296, S. 1, 4; P.A. 02-102, S. 4; P.A. 07-244, S. 4; P.A. 08-184, S. 24; P.A. 11-242, S. 72; P.A. 12-197, S. 7; P.A. 16-66, S. 20; P.A. 17-146, S. 15; P.A. 19-118, S. 22; P.A. 21-121, S. 6; P.A. 22-58, S. 60; P.A. 24-68, S. 16.)

History: P.A. 77-614 replaced public health council with commissioner of health services, effective January 1, 1979; Sec. 19-13a transferred to Sec. 19a-37 in 1983; P.A. 89-305 added provision concerning inspection for compliance with municipal aquifer protection regulations; P.A. 92-251 added Subsec. (b) re testing of private residential wells; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 94-85 amended Subsec. (b) to provide that a laboratory or firm which conducts a water quality test of a private well shall report the results of such test to the local health authority if the test was conducted within six months, rather than three months, of a sale of the property served by such well and specified that results be reported within 30 days after test made; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 97-296 amended Subsec. (b) to prohibit regulations from requiring the testing of well water as a consequence or a condition of the sale, exchange, transfer, purchase or rental of real property, and added new Subsecs. (c) to (g) re regulations, effective July 8, 1997; P.A. 02-102 added new Subsec. (c) requiring the adoption of regulations to clarify the criteria under which a well permit exception may be granted and to describe the terms and conditions to be imposed when a well is allowed at a premises that is connected to a public water supply, and relettered existing Subsecs. (c) to (g) as Subsecs. (d) to (h); P.A. 07-244 amended Subsec. (c) by designating

as Subdiv. (1) existing provision re wells at premises connected to a public water supply system, adding Subdiv. (2) re wells located within 200 feet of approved community water supply system and redesignating existing Subdivs. (1), (2) and (3) as Subparas. (A), (B) and (C); P.A. 08-184 made a technical change in Subsec. (c); P.A. 11-242 amended Subsec. (b) by designating existing requirement re water quality test report to public health authority as Subdiv. (1), by adding Subdiv. (2) re water quality test report to Department of Public Health and by defining “laboratory or firm”, added new Subsec. (c) re owner to provide buyer or tenant with notice re availability of educational material concerning private well testing, redesignated existing Subsecs. (c) and (d) as Subsecs. (d) and (e), deleted former Subsec. (e) re regulations not requiring testing of private residential wells for herbicides or insecticides, added new Subsec. (f) re local director of health's authority to require private residential well to be tested for radionuclides, added new Subsec. (g) re persons authorized to collect water samples from private residential wells, redesignated former Subsec. (f) as Subsec. (h) and amended same to designate existing provision re laboratory or firm to provide instruction on collection of well water samples as Subdiv. (1) and add Subdiv. (2) re notice to subsequent owners that general contractor or former owner was responsible for collecting well water samples, deleted former Subsec. (g) re regulations not requiring testing of private residential wells for organic chemicals, deleted former Subsec. (h) re regulation waiver provision applicable to wells not tested between December 30, 1996, and July 8, 1997, added new Subsec. (i) re local director of health's authority to require private residential well to be tested for pesticides, herbicides or organic chemicals, and made technical changes; P.A. 12-197 amended Subsec. (f) by replacing provisions re testing for radionuclides with provisions re testing for arsenic, radium, uranium, radon or gross alpha emitters; P.A. 16-66 amended Subsecs. (b), (f), (g) and (i) by adding references to wells for semipublic use; P.A. 17-146 added new Subsec. (a) re definitions, redesignated existing Subsec. (a) as Subsec. (b), redesignated existing Subsec. (b) as Subsec. (c) and amended same to replace provision re report shall not be required if party for whom laboratory or firm conducted test informs laboratory or firm that test was not conducted within 6 months of sale of property with provision re report shall only be required if party for whom laboratory or firm conducted test informs laboratory or firm identified on chain of custody documentation that test was conducted in connection with sale of property, and to delete provision defining laboratory or firm, redesignated existing Subsecs. (c) to (i) as Subsecs. (d) to (j), added Subsec. (k) re water transported in bulk, and made conforming changes; P.A. 19-118 amended Subsec. (a) by making technical change in Subdiv. (2), replacing “Well for semipublic use” with “Semipublic well” in Subdiv. (4) and redefining “Water supply well” in Subdiv. (5), amended Subsec. (b) by adding reference to nonresidential construction and amended Subsecs. (c), (g), (h), (j) and (k) by replacing references to well for semipublic use with references to semipublic well, effective July 1, 2019; P.A. 21-121 amended Subsec. (a)(2) by redefining “private well”, amended Subsecs. (b) and (f) by replacing “Public Health Code” with “regulations of Connecticut state agencies”, amended Subsecs. (c) and (f) to (j) by deleting “residential” and amended Subsec. (d) by replacing “residential” with “private or semipublic”; P.A. 22-58 substantially revised section including by adding Subsec. (b)(2) re adoption of regulations for the testing of water quality in private wells and semipublic wells, adding Subsec. (b)(3) re adoption of regulations for well permit exceptions, deleting provision re exception to reporting requirement and adding provision re test result confidentiality in Subsec. (c), adding Subsec. (c)(2) re testing of newly constructed private and semipublic wells, adding provisions re provision of educational materials to prospective buyers and tenants in Subsec. (d), deleting former Subsec. (e) re regulations for well-permit exceptions, redesignating existing Subsecs. (f) and (g) as Subsecs. (e) and (f), adding Subsec. (f)(2) re authority of local directors of health to require well testing, redesignated existing Subsecs. (h) and (i) as Subsecs. (g) and (h), deleting former Subsec. (j), redesignating existing Subsec. (k) as Subsec. (i) and making technical and conforming changes; P.A. 24-68 amended Subsec. (a) by adding new Subdivs. (2) and (3) defining “domestic purposes” and “first draw sample” and redesignating existing Subdivs. (2) to (5) as Subdivs. (4) to (7), amended Subsec. (c)(1) by adding “in the state”, replacing “the public health authority of the municipality” with “the local health authority of the municipality”, deleting Subpara. designators (A) and (B) and adding provision re exceptions to confidentiality requirement as specified in new Subparas. (A) and (B) and added (C) and (D), amended Subsec. (c)(2) by deleting requirement all tests include testing for lead, adding provision requiring testing for lead if well is constructed for existing structure, replacing Department of Public Health as recipient of test results with local health authority where well is located and adding provisions requiring local health authority to determine whether test results comply with maximum

contaminant levels and prohibiting newly constructed wells from being used for domestic purposes prior to determination by local health authority that test results comply with such levels, amended Subsec. (e) by replacing provision prohibiting administrative agencies, health districts or municipal health officers from withholding certificates of occupancy with provision prohibiting municipalities, administrative agencies or local health authorities from establishing regulations or ordinances to revoke such certificates on basis of water quality tests and made technical and conforming changes, effective May 28, 2024.

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Sec. 19a-37a. Regulations establishing standards to prevent contamination of public water supplies. Civil penalties. (a) The Commissioner of Public Health shall adopt regulations in accordance with the provisions of chapter 54 establishing standards to prevent contamination of public water supplies which may result from the installation of automatic fire extinguishing systems, irrigation systems or other physical connections between the distribution system of a public water system and any other water system in any building served by a public water system as defined in subsection (a) of section [25-33d](#). Regulations concerning automatic fire extinguishing systems shall: (1) Delete the requirement for a reduced pressure principle backflow preventer (RPD) on fire sprinkler systems with siamese connections unless chemicals are added to such systems; (2) require owners to install a double check valve assembly (DCVA) on fire sprinkler systems with siamese connections unless chemicals are added to such systems; (3) allow owners to install an RPD instead of a DCVA on fire sprinkler systems with siamese connections; and (4) provide that any person engaged in the installation of an automatic fire extinguishing system shall notify the water company servicing the building of such installation, and shall be subject to all applicable rules and regulations of such water company.

(b) The commissioner shall adopt regulations in accordance with the provisions of chapter 54 concerning automatic fire extinguishing systems that provide for a civil penalty of not more than two thousand dollars if a required device is not installed on existing systems by July 1, 1999, or if the required device is not installed on new systems after June 23, 1999.

(P.A. 87-193; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 99-188, S. 5, 6; P.A. 08-137, S. 4.)

History: P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 99-188 designated existing provisions as Subsec. (a), adding Subdivs. (1) to (3), inclusive, requiring that the regulations provide for reduced pressure principle backflow preventers and double check valve assemblies and added new Subsec. (b) re civil penalties, effective June 23, 1999; P.A. 08-137 amended Subsec. (a) by adding “irrigation systems or other physical connections between the distribution system of a public water system and any other water system” and making corresponding technical changes and amended Subsec. (b) by specifying that subsection pertains to regulations “concerning automatic fire extinguishing systems”.

See Sec. 19a-37c for effective date of regulations adopted pursuant to this section.

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Sec. 19a-37b. Regulations establishing radon measurement requirements and procedures for evaluating radon in indoor air and reducing radon in public schools. The Department of Public Health may adopt regulations pursuant to chapter 54 to establish radon measurement requirements and procedures for evaluating radon in indoor air and reducing elevated radon gas levels when detected in public schools.

(P.A. 90-114, S. 1, 3; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 09-220, S. 5; P.A. 19-118, S. 14.)

History: P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 09-220 deleted requirement that regulations be adopted not later than January 1, 1991, and replaced “acceptable levels of radon in ambient air and drinking water in schools” with “radon measurement requirements and procedures for evaluating radon in indoor air and reducing elevated radon gas levels when detected in public schools”; P.A. 19-118 replaced “shall” with “may”, effective July 1, 2019.

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Sec. 19a-37c. Effective date of regulations re installation of backflow preventer or air gap on a line to existing fire sprinkler system. The provisions of Section 19-13-B38a(c)(2)(I) of the regulations of Connecticut state agencies, adopted pursuant to section [19a-37a](#), concerning requirements for installation of a reduced pressure principle backflow preventer or an air gap on a line to an existing fire sprinkler system, shall be effective July 1, 1999.

(P.A. 98-188, S. 3, 5.)

History: P.A. 98-188, S. 3 effective June 4, 1998.

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Sec. 19a-37d. Changes to public water supply systems. Required notifications to water company and local building inspector. Authority of local director of public health to implement mitigation measures. (a) Any person engaged in the installation of an irrigation system or other physical connection between the distribution system of a public water supply system and any other water system shall notify the water company servicing the property or building of such installation and shall be subject to all applicable rules and regulations of such water company. For purposes of this section, “water company” has the same meaning as provided in section [25-32a](#).

(b) When a permit application is filed with the local building inspector of any municipality concerning any project that includes a change of use or installation of fixtures or facilities in a building that may affect the performance of, or require the installation of, a reduced pressure principle backflow preventer, a double check valve assembly or a pressure vacuum breaker, the local building inspector shall provide written notice of the application to the water company serving the building not later than seven days after the date the application is filed. Upon receipt of such written notice, the water company shall cause to be performed an evaluation of cross-connection protection by a person who has met the requirements prescribed in the regulations of Connecticut state agencies and such water company shall notify the local building inspector regarding its determination. The local building inspector shall not issue a permit or certificate of occupancy until any cross-connection issue has been corrected.

(c) Upon a determination by a local director of health that an automatic fire extinguishing system, irrigation system, change of use, installation of fixtures or facilities in a building or other physical connection between the distribution system of a public water supply system and any other water system creates an unreasonable risk of injury to the health or safety of persons using the water, to the general public, or to any public water supply, the local director of public health may issue an order requiring the immediate implementation of mitigation measures, that include, but are not limited to, the disconnection of the system. In the event that a cross connection with the public water system is found, the owner of such system may terminate services to the premises.

(P.A. 08-137, S. 5.)

Sec. 19a-37e. Small community water system fiscal asset management plan. Assessment review of hydropneumatic pressure tanks. Exception. Penalty. Regulations. (a) As used in this section:

- (1) “Small community water system” means a water company that regularly serves at least twenty-five, but not more than one thousand, year-round residents;**
 - (2) “Unaccounted for water loss” means water that the small community water system supplies to its distribution system, but that never reaches its consumers;**
 - (3) “Useful life” means a manufacturer's recommended life or the estimated lifespan of a water company's capital asset, taking into consideration the service history and the condition of such capital asset at the time a fiscal and asset management plan is prepared; and**
 - (4) “Water company” has the same meaning as provided in section [25-32a](#).**
- (b) Each small community water system shall prepare a fiscal and asset management plan for all of the capital assets that comprise such system. The fiscal and asset management plan shall include, but need not be limited to, (1) a list of all capital assets of the small community water system, (2) the useful life of such capital assets, which shall be based on the current condition of such capital assets, (3) the maintenance and service history of such capital assets, (4) the manufacturer's recommendation regarding such capital assets, and (5) the small community water system's plan for the reconditioning, refurbishment or replacement of such capital assets. Such fiscal and asset management plan shall also provide information regarding whether the small community water system has any unaccounted for water loss, the amount of such unaccounted for water loss, what is causing such unaccounted for water loss and the measures the small community water system is taking to reduce such unaccounted for water loss. Each small community water system shall make the assessment of its hydropneumatic pressure tanks its initial priority in its preparation of the fiscal and asset management plan.**
- (c) Each small community water system shall complete the fiscal and asset management plan for all of its capital assets not later than January 1, 2021. Following the completion of the initial fiscal and asset management plan, each small community water system shall update such fiscal and asset management plan annually and make such fiscal and asset management plan available to the department upon request.**
- (d) Each small community water system shall complete, on a form developed by the Department of Public Health, the fiscal and asset management plan assessment review of its hydropneumatic pressure tanks not later than May 2, 2019.**
- (e) This section shall not apply to a small community water system that is (1) regulated by the Public Utilities Regulatory Authority, (2) subject to the requirements set forth in section [25-32d](#), or (3) a state agency.**
- (f) The provisions of this section shall be deemed to relate to the purity and adequacy of water supplies for the purposes of the imposition of a penalty under section [25-32e](#).**
- (g) The Commissioner of Public Health may adopt regulations, in accordance with the provisions of chapter 54, to carry out the provisions of this section.**

(P.A. 18-168, S. 61.)

Sec. 19a-37f. Safe drinking water primacy assessment. Payment and collection from customers. Termination of requirement to pay. Fees. Report. Regulations. (a) As used in this section:

- (1) “Commissioner” means the Commissioner of Public Health, or the commissioner's designee;**
 - (2) “Community water system” means a public water system that regularly serves at least twenty-five residents;**
 - (3) “Consumer” has the same meaning as provided in section [25-32a](#);**
 - (4) “Customer” means any (A) person, (B) firm, (C) corporation, (D) company, (E) association, (F) governmental unit, except a state agency, (G) lessee that, by the terms of a written lease or agreement, is responsible for the water bill, or (H) owner of property, that receives water service furnished by a water company;**
 - (5) “Department” means the Department of Public Health;**
 - (6) “Noncommunity water system” means a public water system that serves at least twenty-five persons at least sixty days of the year and is not a community water system;**
 - (7) “Nontransient noncommunity water system” means a noncommunity water system that regularly serves at least twenty-five of the same persons over six months per year;**
 - (8) “Public water system” means a water company that supplies drinking water to fifteen or more consumers or twenty-five or more persons daily at least sixty days of the year;**
 - (9) “Sanitary survey” means the review of a public water system by the department to evaluate the adequacy of the public water system, its sources of supply and operations and the distribution of safe drinking water;**
 - (10) “Service connection” means the service pipe from the water main to the curb stop or adjacent to the street line or property line, but does not include a service pipe used only for fire service or irrigation purposes; and**
 - (11) “Water company” has the same meaning as provided in section [25-32a](#).**
- (b) On or before August 1, 2019, and August 1, 2020, the department shall issue a statement, in such manner as the department determines, to each water company that owns a community water system or systems showing the number of service connections and the source of such number each community water system or systems has listed in the department's records as of the date of issuance of the statement. For purposes of this subsection, the department shall combine the number of service connections of all water systems owned and operated by the same water company for a total count of service connections. If any water company disagrees with the number of service connections listed in such statement, the water company shall, not later than thirty days after the date of issuance of such statement, report to the department, in a form and manner prescribed by the department, the accurate number of services connections the water company's community water system or systems serve.**
- (c) On or before October 1, 2019, and October 1, 2020, the department, in consultation with the Office of Policy and Management, shall post on the department's Internet web site (1) the staff and costs to support the department's ability to maintain primacy under the federal Safe Drinking Water Act, 42 USC 300f, et seq., as amended from time to time, which costs, taking into consideration funding received from state and federal sources, shall constitute the safe drinking water primacy assessment for the current fiscal year, and (2) the assessment amounts due, based on the posted costs and in accordance with subsection (d) of this section.**

(d) (1) For the fiscal years ending June 30, 2019, June 30, 2020, and June 30, 2021, each water company that owns a community or nontransient noncommunity water system or systems shall pay annually to the department a safe drinking water primacy assessment amount in accordance with the following: (A) Each community water system having less than fifty service connections and nontransient noncommunity water system shall be assessed one hundred twenty-five dollars; (B) each community water system having at least fifty but less than one hundred service connections shall be assessed one hundred fifty dollars; and (C) each community water system having at least one hundred service connections shall be assessed an amount established by the commissioner, not to exceed three dollars per service connection. For purposes of this subdivision, a community water system's service connections shall be determined in accordance with subsection (b) of this section.

(2) On or before January 1, 2020, and January 1, 2021, the department shall issue an invoice, in such manner as the department determines, to each water company that owns a community or nontransient noncommunity water system or systems for the amount due pursuant to subdivision (1) of this subsection. Each such water company shall pay the amount invoiced, in the same year the department issued in the invoice, in accordance with the following schedule:

(A) A nontransient noncommunity water system shall pay one hundred per cent of the amount invoiced on or before March first;

(B) A community water system having less than one hundred service connections shall pay one hundred per cent of the amount invoiced on or before May first; and

(C) A community water system having one hundred or more service connections shall pay fifty per cent of the invoiced amount by March first and the remaining fifty per cent of the amount invoiced by May first.

(e) If a water company is acquired by another water company for any reason, the acquiring water company shall pay the amount due to the department for the acquired water company's assessment under subsection (d) of this section.

(f) (1) A water company that owns a community water system may collect the assessment amount due for the community water system from a customer of such community water system. The amount collected by the water company from an individual customer may be a pro rata share of such assessment amount and may be adjusted by the water company to reflect the bad debt component and surplus or deficit related to primacy assessment collections of the water company for the prior billing period. Such amount may appear as a separate item on the customer's bills.

(2) The assessment amount due for a community water system under subdivision (1) of this subsection may be adopted in rates through the existing rate approval process for the water company or may appear as a separate item identified as an assessment on each customer's bill without requiring a revision to or approval of the schedule of authorized rates and charges for the water company that is otherwise required pursuant to [section 7-239](#) or [16-19](#) or any special act or enabling legislation establishing a water company. Such charges shall be subject to the past due and collection procedures, including interest charges, of the water company as are applicable to any other authorized customer charge or fee.

(g) The requirement for a water company to pay the assessment shall terminate immediately if the department no longer has primacy under the federal Safe Drinking Water Act, 42 USC 300f, et seq., as amended from time to time, whether removed by the federal Environmental Protection Agency or through any other action by a state or federal authority. If the assessment is terminated and not reinstated on or before one hundred eighty days after such termination, the water company shall credit its customers any amounts collected from such customers for such assessment amount that the water company is no longer required to pay to the department.

(h) If any assessment or part thereof is not paid on or before thirty days after the date when such assessment is due, the commissioner may impose a fee equal to one and one-half per cent on the balance

due of such assessment for each month of nonpayment beyond such initial thirty-day period unless the water company that has not paid such assessment or part thereof is a town, city or borough, in which case the water company shall be subject to the provisions of section [12-38](#).

(i) On or before November 1, 2019, and November 1, 2020, the department shall post on its Internet web site a report that includes: (1) Resources, activities and costs that support the department's ability to maintain primacy under the federal Safe Drinking Water Act, 42 USC 300f, et seq., as amended from time to time, in the previous fiscal year; (2) the number of full-time equivalent positions that performed the required functions to maintain primacy in the previous fiscal year; and (3) quality improvement strategies the department has deployed to streamline operations to make efficient and effective use of staff and resources. The commissioner shall provide for a comment period of thirty days following the posting of such report. At the conclusion of such public comment period, but not later than January 1, 2020, and not later than January 1, 2021, the commissioner shall submit such report and summary of comments received to the Governor and the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section [11-4a](#).

(j) The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to carry out the provisions of this section.

(k) State agencies shall be exempt from the requirements of subsections (d) to (h), inclusive, of this section.

(P.A. 19-117, S. 75.)

History: P.A. 19-117 effective June 26, 2019.

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Sec. 19a-37g. Water company and small community water system emergency plans re alternative sources of potable water during emergency. (a) As used in this section:

(1) “Bottled water” has the same meaning as defined in section [21a-150](#);

(2) “Commissioner” means the Commissioner of Public Health, or his or her designee;

(3) “Department” means the Department of Public Health;

(4) “Fill station” means a location at which customers of a water company may obtain potable water;

(5) “Small community water system” has the same meaning as provided in section [19a-37e](#); and

(6) “Water company” has the same meaning as provided in section [25-32a](#).

(b) A water company shall update its emergency contingency plan prepared pursuant to section [25-32d](#) and section 25-32d-3 of the regulations of Connecticut state agencies, to include information regarding the provision of alternative sources of potable water for human consumption that can be utilized as a temporary measure when there is a water supply emergency. Such plan shall identify alternative sources of potable water for possible use at various stages of an emergency, including, but not limited to, bulk water provided by a bulk water hauler licensed pursuant to section [20-278h](#), bottled water, a fill station, interconnection or agreement with a nearby public water system for supplemental water supplies in the event of an emergency, other approved public water supply source or mechanism for providing water identified in the emergency contingency plan, or as otherwise approved by the commissioner. The commissioner, in consultation with water companies, shall prepare materials and provide guidance to such water companies to implement the provisions of this subsection. Nothing in this section shall prevent a water company from providing an alternative source of potable water for an event lasting less than twelve

hours that may adversely impact the quality or quantity of potable water supplies. As used in this subsection, “water supply emergency” means any event lasting more than twelve consecutive hours that results in the water supplied from the water company to residents that is not in compliance with the regulations of Connecticut state agencies concerning the purity and adequacy of drinking water.

(c) A small community water system shall update its emergency response plan required pursuant to section 19-13-B102 of the regulations of Connecticut state agencies to include information regarding the provision of alternative sources of potable water for human consumption that can be utilized as a temporary measure when there is a water supply emergency. Such plan shall identify alternative sources of potable water for possible use at various stages of an emergency, including, but not limited to, bulk water provided by a bulk water hauler licensed pursuant to section [20-278h](#), bottled water, a fill station, interconnection or agreement with a nearby public water system for supplemental water supplies in the event of an emergency, or other approved public water supply source or mechanism for providing water identified in the emergency contingency plan. The commissioner, in consultation with small community water systems, shall prepare materials and provide guidance to such water systems to implement the provisions of this section. Nothing in this section shall prevent a small community water system from providing an alternative source of potable water for an event lasting less than twelve hours that may adversely impact the quality or quantity of potable water supplies. As used in this subsection, “water supply emergency” means any event lasting more than twelve consecutive hours that results in the water supplied from the small community water system to residents that is not in compliance with the regulations of Connecticut state agencies concerning the purity and adequacy of drinking water.

(P.A. 21-121, S. 82.)

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Sec. 19a-37h. Water companies to provide multilingual tier 1 notices. A water company shall provide tier 1 notices to its consumers in the languages predominantly spoken by the consumers in the water company's service area. A water company shall update its emergency response plan prepared pursuant to section [25-32d](#) or pursuant to section 19-13-B102 of the regulations of Connecticut state agencies to include information regarding the provision of such multilingual communications. As used in this section, “water company” has the same meaning as provided in section [25-32a](#) and “tier 1 notices” has the same meaning as provided in section 19-13-B102 of the regulations of Connecticut state agencies.

(P.A. 21-121, S. 83.)

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Sec. 19a-37i. Community water system reporting re operational status during civil preparedness or public health emergency. In the event that the Governor declares a state of civil preparedness emergency pursuant to section [28-9](#), or a public health emergency, pursuant to section [19a-131a](#), each community water system shall report the community water system's operational status to WebEOC as soon as practicable, but not later than eight hours after the time reporting on WebEOC is made available regarding such declaration, and at any time thereafter that the status of such system significantly changes. As used in this section, “community water system” means a public water system that serves at least twenty-five residents, and “WebEOC” means a web-based emergency management information system used by the state to document routine and emergency events or incidents and provide a real-time common operating picture and resource request management tool for emergency managers at the local and state levels during exercises, drills, local or regional emergencies or state-wide emergencies.

(P.A. 21-121, S. 84; P.A. 22-92, S. 21.)

History: P.A. 22-92 replaced reference to Sec. 19a-131 with reference to Sec. 19a-131a, effective May 24, 2022.

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Sec. 19a-37j. Small community water system capacity implementation plan. Annual updates. Summary. Regulations. (a) As used in this section:

- (1) “Consumer” has the same meaning as provided in section [25-32a](#);**
 - (2) “Owner” means the person or entity that owns or controls the small community water system; and**
 - (3) “Small community water system” has the same meaning as provided in section [19a-37e](#).**
- (b) Not later than January 1, 2025, each owner of a small community water system shall complete a small community water system capacity implementation plan on a form prescribed by the Department of Public Health demonstrating that such owner has the managerial, technical and financial capacity to continue to own and operate such system and shall implement such plan. Following the completion of the initial small community water system capacity implementation plan, each small community water system shall update such small community water system capacity implementation plan annually and make such small community water system capacity implementation plan available to the department upon request. Such plan shall include:**
- (1) A description of the small community water system, including the number of consumers and persons served and sources of drinking water;**
 - (2) Ownership and management information, including the type of ownership structure and the current names, addresses and telephone numbers of the owners, certified operators and emergency contact persons for the small community water system;**
 - (3) Service area maps;**
 - (4) Facilities maps, including the location of and specific information regarding sources, storage facilities, treatment facilities, pressure zones, booster pumps, hydrants, distribution lines, valves and sampling points;**
 - (5) A description of such system's cross-connection control program;**
 - (6) A description of such system's source water protection program;**
 - (7) A copy of such system's emergency response plan required pursuant to section 19-13-B102 of the regulations of Connecticut state agencies;**
 - (8) A capital improvement program, including the schedule that identifies all capital improvements scheduled for a five-year planning period and capital improvements or major projects scheduled for a twenty-year planning period;**
 - (9) Water production and consumption information;**
 - (10) Information regarding public water systems that are nearby, including the distance from the small community water system and type of public water system, if any. Such information shall be based on the coordinated water system plan approved by the Commissioner of Public Health pursuant to section [25-33h](#) for the water utility coordinating committee in which such small community water system is located; and**

(11) Financial capacity information, including:

(A) An evaluation of the small community water system's fiscal and assessment management plan prepared pursuant to section [19a-37e](#);

(B) A summary of the income and expenses for the five years preceding the date of submission of the plan;

(C) A five-year balanced operation budget;

(D) Water rate structure and fees charged, including information regarding how such rates and fees are updated and whether such rates and fees are sufficient to maintain cash flow stability and to fund the capital improvement program, as well as any emergency improvements; and

(E) An evaluation that has considered the affordability of water rates.

(c) On or before July 1, 2025, and annually thereafter, the small community water system shall provide a summary of its small community water system capacity plan in the small community water system's consumer confidence report required by section 19-13-B102 of the regulations of Connecticut state agencies.

(d) The provisions of this section shall not apply to a small community water system that is (1) regulated by the Public Utilities Regulatory Authority, (2) subject to the requirements set forth in section [25-32d](#), or (3) a state agency.

(e) The provisions of this section shall be deemed to relate to the purity and adequacy of water supplies for the purposes of the imposition of a penalty under section [25-32e](#).

(f) The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to carry out the provisions of this section.

(P.A. 21-121, S. 85.)

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Sec. 19a-37k. Residential or commercial property water supply testing. Notification to tenants and lessees of contamination. The owner of any residential or commercial property shall notify each tenant of any leased or rented unit located on such property and the lessee of such property whenever any testing of the water supply for such property indicates that the water exceeds a maximum contaminant level applicable to water supply systems for any contaminant listed in the regulations of Connecticut state agencies or for any contaminant listed on the state drinking water action level list established pursuant to section [22a-471](#). As soon as practicable, but not later than forty-eight hours after receiving notification of the results of such testing, the owner shall forward a copy of such notification to each such tenant and lessee. The local director of health shall take all reasonable steps to verify that such owner forwarded the notice required pursuant to this section.

(P.A. 21-121, S. 7.)

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Sec. 19a-38. (Formerly Sec. 19-13b). Water company to add fluoride to water supply. A water company, as defined in section [25-32a](#), shall add a measured amount of fluoride to the water supply of any water system that it owns and operates and that serves twenty thousand or more persons so as to maintain an average monthly fluoride content that is not more or less than 0.15 of a milligram per liter different than

the United States Department of Health and Human Services' most recent recommendation for optimal fluoride levels in drinking water to prevent tooth decay.

(February, 1965, P.A. 156; P.A. 16-4, S. 1.)

History: Sec. 19-13b transferred to Sec. 19a-38 in 1983; P.A. 16-4 substantially amended provisions, including adding provisions requiring water company to add fluoride to water supply to maintain average monthly fluoride content of not more than .15 milligram per liter different than U.S. Department of Health and Human Services' most recent recommended fluoride levels.

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Sec. 19a-39. (Formerly Sec. 19-13c). Protection of wells. The owner of any well which is being constructed or which has been completed shall securely protect or fence the same, and the owner of any well which is no longer used or which has been abandoned shall effectively cover and seal the same so as to prevent danger to any human being or domestic dog, cat or pet or any cattle, horses, asses, mules, sheep, swine or goats. Any person violating any provision of this section shall be fined not less than fifty dollars and not more than one hundred dollars for a first offense, and for each subsequent offense shall be fined not less than one hundred dollars and not more than two hundred dollars. The provisions of this section shall not be construed to repeal any local ordinance, the provisions of which require at least the degree of protection herein required. The local health officer of each municipality is empowered to promulgate and enforce regulations consistent with this section and to carry out its intent.

(1969, P.A. 75.)

History: Sec. 19-13c transferred to Sec. 19a-39 in 1983.

See chapter 482 re regulation of well drilling.

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Sec. 19a-40. (Formerly Sec. 19-14). Supervision of vital statistics. The Department of Public Health shall have general supervision of the state system of registration of births, marriages, deaths and fetal deaths, and shall develop the necessary uniform methods and forms for obtaining and preserving such records in order to insure the faithful registration of such records in the several towns and in the department. The department shall recommend such forms, procedures and legislation as are necessary to secure complete and accurate registration of vital statistics throughout the state. The Commissioner of Public Health shall be the superintendent of registration of vital statistics.

(1949 Rev., S. 3812; 1959, P.A. 148, S. 8; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 01-163, S. 30.)

History: 1959 act deleted provision re insuring faithful registration in central bureau of vital statistics, substituting reference to department; P.A. 77-614 replaced commissioner and department of health with commissioner and department of health services, effective January 1, 1979; Sec. 19-14 transferred to Sec. 19a-40 in 1983; P.A. 93-381 replaced department and commissioner of health services with department and commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 01-163 added provisions re fetal deaths, development of uniform methods and forms and recommendation of procedures and made technical changes.

See Sec. 7-36 for applicable definitions.

Annotation to former section 19-14:

Admissibility of medical examiner's report to show cause of death. 102 C. 486.

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Sec. 19a-40a. Criminal history records checks required for applicants for employment in the vital records unit. The Commissioners of Public Health and Administrative Services shall require each applicant for employment in, and each employee applying for transfer to, the vital records unit of the Department of Public Health to (1) state whether such applicant or employee has ever been convicted of a crime or whether criminal charges are pending against such applicant or employee at the time of application for employment or transfer; and (2) submit to state and national criminal history records checks. The criminal history records checks required pursuant to this section shall be conducted in accordance with section [29-17a](#).

(P.A. 07-79, S. 1; P.A. 23-204, S. 100.)

History: P.A. 23-204 added reference to Commissioner of Administrative Services, effective June 12, 2023.

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Sec. 19a-41. (Formerly Sec. 19-15). Compilation of vital records and statistics. Regulations. The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, specifying the methods of reporting, recording, issuing, maintaining, indexing, correcting and amending vital records and statistics collected under the provisions of sections [19a-42](#) to [19a-45](#), inclusive, chapter 93 or chapter 815e. The commissioner shall develop such forms, formats and uniform procedures as the commissioner deems necessary to carry out the provisions of sections [19a-42](#) to [19a-45](#), inclusive, chapter 93 and chapter 815e.

(1949 Rev., S. 3818; 1959, P.A. 148, S. 9; P.A. 77-614, S. 323, 610; P.A. 79-434, S. 16; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; June 18 Sp. Sess. P.A. 97-8, S. 45, 88; P.A. 01-163, S. 31.)

History: 1959 act deleted reference to bureau of vital statistics of department carrying out provisions of sections, substituting reference to department; P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; P.A. 79-434 replaced “department” with “commissioner” and reworded powers re regulations and recording, preserving and indexing of vital statistics; Sec. 19-15 transferred to Sec. 19a-41 in 1983; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; June 18 Sp. Sess. P.A. 97-8 deleted references to Sec. 46b-68, effective July 1, 1997; P.A. 01-163 deleted provision re specifying methods of preserving vital records and statistics, added provisions re specifying methods of reporting, issuing, maintaining and correcting vital records and statistics, added provisions re development of forms, formats and uniform procedures, deleted provisions re penalty under Sec. 7-41 and made a technical change.

See Sec. 7-36 for applicable definitions.

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Sec. 19a-41a. Mashantucket Pequot Tribal Nation and Mohegan Tribe of Indians of Connecticut access to state's birth and death registries. (a) Upon the request of the Mashantucket Pequot Tribal Nation or the

Mohegan Tribe of Indians of Connecticut, the Department of Public Health shall grant said requesting tribe access to the state's birth and death registries in the department's electronic vital records system. Such access shall allow said tribe to register in the state's electronic birth and death registries all births and deaths that occur on land held in trust by the United States for said tribe in lieu of a town or municipality registering such births and deaths. Any birth or death certificate issued by said tribe for registration in the state's electronic birth and death registries shall be recognized as valid in the state, provided such certificate meets the requirements for registering, indexing, maintaining, issuing, correcting and amending such certificate set forth in sections [7-36](#) to [7-78](#), inclusive, [19a-40](#) to [19a-45](#), inclusive, [19a-322](#), [19a-323](#), and [46b-450](#) to [46b-480](#), inclusive, and in the regulations of Connecticut state agencies adopted pursuant to said sections. Any entity or official responsible for filing a birth or death certificate pursuant to the general statutes with a town or municipality shall cooperate and fulfill its filing obligations with a requesting tribe in the same manner that it would cooperate and fulfill its filing obligations with a town or municipality. Such entities and officials shall be subject to the same terms of enforcement for failure to cooperate or fulfill their filing obligations with a requesting tribe as they would for failure to cooperate or fulfill their filing obligations with a town or municipality.

(b) If the department determines that a tribe granted access to such birth and death registries has failed to comply with any of the requirements of any provision of subsection (a) of this section or has submitted filings to the system that do not conform with such requirements, the department may give notice by certified mail, return receipt requested, to said tribe of the facts or conduct that contributed to such determination and the specific provisions of the general statutes or regulations of Connecticut state agencies that are alleged to have been violated. The department shall provide said tribe an opportunity to demonstrate compliance with such provisions and submit a plan of correction to achieve compliance with such provisions. If said tribe does not demonstrate compliance or fully implement a department approved plan of correction on or before thirty days after receiving notice from the department under this subsection, the department may terminate the tribe's access to the state's electronic birth and death registries in the department's electronic vital records system or remove any nonconforming filings from such registries.

(c) Nothing in this section shall be construed to (1) grant the department jurisdiction over a requesting tribe or its tribal office responsible for the issuance and maintenance of birth or death certificates, or (2) limit the department's authority to (A) grant or restrict a requesting tribe's access to the state's electronic birth and death registries consistent with the provisions of this section, or (B) remove any nonconforming filings from such registries.

(P.A. 24-68, S. 39.)

History: P.A. 24-68 effective May 28, 2024.

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Sec. 19a-42. (Formerly Sec. 19-15a). Amendment of vital records. (a) To protect the integrity and accuracy of vital records, a certificate registered under chapter 93 may be amended only in accordance with sections [19a-41](#) to [19a-45](#), inclusive, chapter 93, regulations adopted by the Commissioner of Public Health pursuant to chapter 54 and uniform procedures prescribed by the commissioner. Only the commissioner may amend birth certificates to reflect changes concerning parentage or the legal name of a parent or birth or marriage certificates to reflect changes concerning gender. Amendments related to parentage, gender change or the legally changed name of a parent shall result in the creation of a replacement certificate that supersedes the original, and shall in no way reveal the original language changed by the amendment. Any amendment to a vital record made by the registrar of vital statistics of the town in which the vital event occurred or by the commissioner shall be in accordance with such regulations and uniform procedures.

(b) The commissioner and the registrar of vital statistics shall maintain sufficient documentation, as prescribed by the commissioner, to support amendments and shall ensure the confidentiality of such documentation as required by law. The date of amendment and a summary description of the evidence submitted in support of the amendment shall be endorsed on or made part of the record and the original certificate shall be marked “Amended”, except for amendments concerning parentage, gender change or the legally changed name of a parent. When the registrar of the town in which the vital event occurred amends a certificate, such registrar shall, within ten days of making such amendment, forward an amended certificate to the commissioner and to any registrar having a copy of the certificate. When the commissioner amends a birth certificate, including changes concerning parentage, gender change or the legally changed name of a parent, the commissioner shall forward an amended certificate to the registrars of vital statistics affected and their records shall be amended accordingly.

(c) An amended certificate shall supersede the original certificate that has been changed and shall be marked “Amended”, except for amendments concerning parentage, gender change or the legally changed name of a parent. The original certificate in the case of amendments concerning parentage, gender change or the legally changed name of a parent shall be physically or electronically sealed and kept in a confidential file by the department and the registrar of any town in which the birth was recorded, and may be unsealed for issuance only as provided in section [7-53](#) with regard to an original birth certificate or upon a written order of a court of competent jurisdiction. The amended certificate shall become the official record.

(d) (1) Upon receipt of (A) an acknowledgment of parentage executed in accordance with the provisions of sections [46b-476](#) to [46b-487](#), inclusive, by both parents of a child, or (B) a certified copy of an order of a court of competent jurisdiction establishing the parentage of a child, the commissioner shall include on or amend, as appropriate, such child's birth certificate to show such parentage if parentage is not already shown on such birth certificate and to change the name of the child under eighteen years of age if so indicated on the acknowledgment of parentage form or within the certified court order as part of the parentage action. If a person who is the subject of a voluntary acknowledgment of parentage, as described in this subdivision, is eighteen years of age or older, the commissioner shall obtain a notarized affidavit from such person affirming that such person agrees to the commissioner's amendment of such person's birth certificate as such amendment relates to the acknowledgment of parentage. The commissioner shall amend the birth certificate for an adult child to change the child's name only pursuant to a court order.

(2) If the birth certificate lists the information of a parent other than the parent who gave birth, the commissioner shall not remove or replace the parent's information unless presented with a certified court order that meets the requirements specified in section [7-50](#), or upon the proper filing of a rescission, in accordance with the provisions of section [46b-570](#). The commissioner shall thereafter amend such child's birth certificate to remove or change the name of the parent other than the person who gave birth and, if relevant, to change the name of the child, as requested at the time of the filing of a rescission, in accordance with the provisions of section [46b-570](#). Birth certificates amended under this subsection shall not be marked “Amended”.

(e) When the parent or parents of a child request the amendment of the child's birth certificate to reflect a new name of the parent who gave birth because the name on the original certificate is fictitious, such parent or parents shall obtain an order of a court of competent jurisdiction declaring the person who gave birth to be the child's parent. Upon receipt of a certified copy of such order, the department shall amend the child's birth certificate to reflect the parent's true name.

(f) Upon receipt of a certified copy of an order of a court of competent jurisdiction changing the name of a person born in this state and upon request of such person or such person's parents, guardian, or legal representative, the commissioner or the registrar of vital statistics of the town in which the vital event occurred shall amend the birth certificate to show the new name by a method prescribed by the department.

(g) When an applicant submits the documentation required by the regulations to amend a vital record, the commissioner shall hold a hearing, in accordance with chapter 54, if the commissioner has reasonable cause to doubt the validity or adequacy of such documentation.

(h) When an amendment under this section involves the changing of existing language on a death certificate due to an error pertaining to the cause of death, the death certificate shall be amended in such a manner that the original language is still visible. A copy of the death certificate shall be made. The original death certificate shall be sealed and kept in a confidential file at the department and only the commissioner may order it unsealed. The copy shall be amended in such a manner that the language to be changed is no longer visible. The copy shall be a public document.

(i) The commissioner shall issue a new birth certificate to reflect a gender change upon receipt of the following documents submitted in the form and manner prescribed by the commissioner: (1) A written request from the applicant, signed under penalty of law, for a replacement birth certificate to reflect that the applicant's gender differs from the sex designated on the original birth certificate; (2) a notarized affidavit by a physician licensed pursuant to chapter 370 or holding a current license in good standing in another state, a physician assistant licensed pursuant to chapter 370 or holding a current license in good standing in another state, an advanced practice registered nurse licensed pursuant to chapter 378 or holding a current license in good standing in another state, or a psychologist licensed pursuant to chapter 383 or holding a current license in good standing in another state, stating that the applicant has undergone surgical, hormonal or other treatment clinically appropriate for the applicant for the purpose of gender transition; and (3) if an applicant is also requesting a change of name listed on the original birth certificate, proof of a legal name change. The new birth certificate shall reflect the new gender identity by way of a change in the sex designation on the original birth certificate and, if applicable, the legal name change.

(j) The commissioner shall issue a new birth certificate to reflect the legally changed name of a parent of a minor child who is the subject of such birth certificate upon receipt of the following documents, submitted in a form and manner prescribed by the commissioner: (1) A written request from the parent, signed under penalty of law, for a replacement birth certificate to reflect that the parent's legal name differs from the name designated on the original birth certificate, and (2) a certified copy of an order of a court of competent jurisdiction changing such parent's name. The commissioner shall issue a new birth certificate to an adult child who is the subject of such birth certificate and wishes to change the name of a parent who has legally changed such parent's name upon presentation by such adult child to the commissioner of a certified copy of an order of a court of competent jurisdiction changing such parent's name.

(k) The commissioner shall issue a new marriage certificate to reflect a gender change upon receipt of the following documents, submitted in a form and manner prescribed by the commissioner: (1) A written request from the applicant, signed under penalty of law, for a replacement marriage certificate to reflect that the applicant's gender differs from the sex designated on the original marriage certificate, along with an affirmation that the marriage is still legally intact; (2) a notarized statement from the spouse named on the marriage certificate to be amended, consenting to the amendment; (3) (A) a United States passport or amended birth certificate or court order reflecting the applicant's gender as of the date of the request, or (B) a notarized affidavit by a physician licensed pursuant to chapter 370 or holding a current license in good standing in another state, physician assistant licensed pursuant to chapter 370 or holding a current license in good standing in another state, an advanced practice registered nurse licensed pursuant to chapter 378 or holding a current license in good standing in another state or a psychologist licensed pursuant to chapter 383 or holding a current license in good standing in another state stating that the applicant has undergone surgical, hormonal or other treatment clinically appropriate for the applicant for the purpose of gender transition; and (4) if an applicant is also requesting a change of name listed on the original marriage certificate, proof of a legal name change. The new marriage certificate shall reflect the new gender identity by way of a change in the sex designation on the original marriage certificate and, if applicable, the legal name change.

(P.A. 79-434, S. 11; P.A. 90-168; P.A. 91-252, S. 4; P.A. 93-97, S. 1, 2; 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; June 18 Sp. Sess. P.A. 97-7, S. 12, 38; June 18 Sp. Sess. P.A. 97-8, S. 44; June 18 Sp. Sess. P.A. 97-10, S. 3; P.A. 01-163, S. 32; P.A. 03-19, S. 48; P.A. 04-255, S. 14, 15; 04-257, S. 35; June Sp. Sess. P.A. 09-3, S. 166; P.A. 11-219, S. 3; P.A. 14-133, S. 8; 14-231, S. 2; P.A. 15-132, S. 1; P.A. 21-15, S. 96; 21-121, S. 77; P.A. 23-204, S. 303.)

History: Sec. 19-15a transferred to Sec. 19a-42 in 1983; P.A. 90-168 added Subsec. (f) on the amendment of death certificates; P.A. 91-252 amended Subsec. (b) by deleting phrase “except as otherwise provided in this section”, adding “on the original” and by adding provisions specifying that original birth, death or marriage certificate shall be sealed and kept in confidential file at department of health services and may be unsealed only upon order of commissioner, that a copy of original shall be made and shall be amended so that changed language is no longer visible and that the copy shall be a public record; P.A. 93-97 amended Subsec. (c) to add a \$25 fee for amendment of a birth certificate to show paternity, effective July 1, 1993; P.A. 93-381 replaced department and commissioner of health services with department and commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; June 18 Sp. Sess. P.A. 97-7 amended Subsec. (c) by deleting requirement of written request of both parents and adding provision that birth certificate shall include or be amended to include paternity upon receipt of voluntary acknowledgment of paternity or certified court order establishing paternity, removal only upon filing of rescission of paternity or upon court order and by providing for fee of \$25 for each amendment to birth certificate, effective July 1, 1997; June 18 Sp. Sess. P.A. 97-8 added new Subsec. (e) re specific authority for department to amend birth certificate to reflect gender of a person born with hermaphroditism and redesignated former Subsecs. (e) and (f) accordingly; June 18 Sp. Sess. P.A. 97-10 deleted changes enacted by June 18 Sp. Sess. P.A. 97-8, except for the addition of a comma following reference to “vital records” in Subsec. (a); P.A. 01-163 amended Subsec. (a) by adding provisions re uniform procedures prescribed by the commissioner, deleting provision re report of amendment to affected registrars and adding provisions re amendments concerning parentage or gender change and amendments made by registrar, deleted former Subsec. (b), added new Subsecs. (b) and (c), redesignated former Subsec. (c) as Subsec. (d) and amended by deleting “voluntary”, changing “surname” to “name”, adding provision re father's information and making technical changes in Subdiv. (1), revising provision re filing of rescission, deleting provision re court order and adding provision re changing the name of child and reference to Sec. 7-50 in Subdiv. (2) and making a technical change in Subdiv. (3), added new Subsec. (e), redesignated former Subsec. (d) as Subsec. (f) and amended by adding provisions re registrar of the town in which the vital event occurred and method prescribed by the department and making technical changes, and redesignated former Subsecs. (e) and (f) as Subsecs. (g) and (h) and amended by making technical changes; P.A. 03-19 made technical changes in Subsec. (e), effective May 12, 2003; P.A. 04-255 amended Subsec. (a) by requiring commissioner to make amendments in accordance with regulations and uniform procedures and amended Subsec. (d) by replacing provisions in Subdiv. (1) re changing name of child, removal or replacement of father's information and making of certificate, with provision re changing name of child if indicated on form or within order, and by adding provisions in Subdiv. (2) requiring that no father's information be removed without a court order or filing of a rescission and that certificates amended under section not be marked “amended”; P.A. 04-257 made a technical change in Subsec. (c), effective June 14, 2004; June Sp. Sess. P.A. 09-3 amended Subsec. (d)(3) to increase fee from \$25 to \$50; P.A. 11-219 deleted former Subsec. (d)(3) re fee for amendment to birth certificate; P.A. 14-133 amended Subsec. (c) by deleting reference to viewing original certificate, adding reference to Sec. 7-53 and replacing “public record” with “official record”, effective July 1, 2015; P.A. 14-231 amended Subsec. (d)(1) by adding “under eighteen years of age” and adding provisions re commissioner to obtain notarized affidavit and amend birth certificate for person 18 years of age or older; P.A. 15-132 added Subsec. (i) re issuance of new birth certificate to reflect a gender change; P.A. 21-15 amended Subsec. (d)(1) by replacing “paternity” with “parentage”, replacing “subsection (a) of section 46b-172” with “sections 46b-476 to 46b-487, inclusive,” deleting “born out of wedlock” and by making technical changes, amended Subsec. (d)(2) by replacing “another father is listed on the birth certificate” with “the birth certificate lists the information of a parent other than the person who gave birth”, replacing “father's information” with “parent's information”, replacing “change the father's name” with

“change the name of the parent other than the person who gave birth” and by adding “if relevant” re commissioner changing the name of child on birth certificate, and amended Subsec. (e) by replacing “mother’s name” with “name of the parent who gave birth”, “putative mother” with “person who gave birth” and replacing “mother” with “parent”, effective January 1, 2022; P.A. 21-121 amended Subsec. (a) by adding “birth or marriage certificates to reflect changes concerning”, amended Subsec. (c) by adding “with regard to an original birth certificate”, amended Subsec. (i) by adding reference to physician assistant and added Subsec. (j) re issuance of new marriage certificate to reflect gender change; P.A. 23-204 amended Subsecs. (a) to (c) by adding changes concerning the legally changed name of a parent and conforming technical changes, inserted new Subsec. (j) re issuance of new birth certificates and redesignated existing Subsec. (j) as Subsec. (k), effective July 1, 2023.

See Sec. 7-36 for applicable definitions.

Commissioner may amend parental information contained on birth certificates only when there is an error or omission in such information. 253 C. 570. A birth certificate is a vital record that must accurately reflect the legal relationships between parents and children, it does not create those relationships. 299 C. 681.

Subsec. (d):

Subdiv. (1) clearly and unambiguously provides that commissioner may only include on or amend a child's birth certificate to show paternity if paternity is not already shown on the birth certificate. 304 C. 317.

Denial of plaintiff's application to amend his son's birth certificate after birth mother changed name to one different than that on acknowledgment of paternity form was proper because paternity was correctly listed on the certificate and there was no new information that needed to be added and section only permits a change of name on the basis of an acknowledgment of paternity form if paternity was not so indicated on the certificate. 122 CA 373.

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Sec. 19a-42a. Record of acknowledgment, rescission or adjudication of parentage to be maintained in parentage registry. Disclosure of information to IV-D agency. Access to copies of acknowledgments of parentage. (a) All (1) voluntary acknowledgments of parentage and rescissions of such acknowledgments executed in accordance with sections [46b-476](#) to [46b-489](#), inclusive, and (2) adjudications of parentage issued by a court or family support magistrate under section [46b-471](#), section [46b-569](#), section [46b-571](#), or any other provision of the general statutes shall be filed in the parentage registry maintained by the Department of Public Health. All information in such registry shall be made available to the IV-D agency, as defined in subdivision (12) of subsection (b) of section [46b-231](#), for comparison with information in the state case registry established under subsection (l) of section [17b-179](#). The IV-D agency may disclose information in the parentage registry to an agency under cooperative agreement with the IV-D agency for child support enforcement purposes.

(b) Except for the IV-D agency, as provided in subsection (a) of this section, the department shall restrict access to and issuance of certified copies of acknowledgments of parentage to the following parties: (1) Parents named on the acknowledgment of parentage; (2) the person whose birth is acknowledged, if such person is eighteen years of age or older; (3) a guardian of the person whose birth is acknowledged; (4) an authorized representative of the Department of Social Services; (5) an attorney representing such person or a parent named on the acknowledgment; or (6) agents of a state or federal agency, as approved by the department.

(June 18 Sp. Sess. P.A. 97-7, S. 6, 38; P.A. 04-255, S. 16; P.A. 11-219, S. 4; P.A. 18-168, S. 57; P.A. 21-15, S. 97.)

History: June 18 Sp. Sess. P.A. 97-7 effective July 1, 1997; P.A. 04-255 designated existing provisions as Subsec. (a) and added Subsec. (b) re access to and issuance of copies of acknowledgments of paternity; P.A. 11-219 amended Subsec. (a) to provide that IV-D agency may disclose information in registry to agency under cooperative agreement; P.A. 18-168 amended Subsec. (b) by making a technical change in Subdiv. (2), adding a new Subdiv. (3) re guardian of person whose birth is acknowledged and redesignating existing Subdivs. (3) to (5) as Subdivs. (4) to (6), effective July 1, 2018; P.A. 21-15 amended Subsecs. (a) and (b) by changing “paternity” to “parentage”, amended Subsec. (a)(1) by changing “subsection (a) of section 46b-172” to “sections 46b-476 to 46b-489, inclusive,” and amended Subsec. (a)(2) by adding reference to Sec. 46b-471, effective January 1, 2022.

See Sec. 7-36 for applicable definitions.

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Sec. 19a-42b. Amendment of out-of-state or foreign birth certificate to reflect gender change. Probate court jurisdiction. Application process. (a) In the case of a person who is a resident of this state and was born in another state or in a foreign jurisdiction, the probate courts in this state shall have jurisdiction to issue a decree of a change of sex. Such person may apply to the probate court for the district in which such person resides for a decree that such person's gender is different from the sex designated on such person's original birth certificate and that such birth certificate be amended to reflect the change in gender. The application to the probate court shall be accompanied by the following documents: (1) A written statement from the applicant, signed under penalty of law, that the applicant's gender differs from the sex designated on the original birth certificate; and (2) a notarized affidavit by a physician licensed pursuant to chapter 370 or holding a current license in good standing in another state, an advanced practice registered nurse licensed pursuant to chapter 378 or holding a current license in good standing in another state, or a psychologist licensed pursuant to chapter 383 or holding a current license in good standing in another state, stating that the applicant has undergone surgical, hormonal or other treatment clinically appropriate for the applicant for the purpose of gender transition. Upon issuance, such probate court decree shall be transmitted to the registration authority of such person's place of birth.

(b) Nothing in this section shall be construed to limit the authority of the Commissioner of Public Health to amend birth certificates in accordance with section [19a-42](#).

(P.A. 03-247, S. 1; P.A. 15-132, S. 2.)

History: P.A. 15-132 amended Subsec. (a) by deleting provision re court decree required by other state or foreign jurisdiction, adding “of a change in sex”, deleting provision re completion of treatment, adding provision re gender different from sex designated on original birth certificate, replacing provision re affidavits with provisions re required documents, and making technical changes.

See Sec. 7-36 for applicable definitions.

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Sec. 19a-42c. Revision of marriage license applications and marriage certificates to replace references to bride and groom and eliminate reference to race or ethnicity. On or before January 1, 2022, the Commissioner of Public Health shall revise the application for a marriage license made under section [46b-25](#) and any marriage certificate issued on or after January 1, 2022, under section [7-51a](#) to eliminate (1) the references to “bride” and “groom” and replace such references with “spouse one” and “spouse two”, and (2) any reference to the race or ethnicity of a spouse and any race or ethnicity designation of a spouse.

(P.A. 21-26, S. 7.)

History: P.A. 21-26 effective July 1, 2021.

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Sec. 19a-43. (Formerly Sec. 19-15b). Reproduction of vital records. To preserve vital records, the Commissioner of Public Health is authorized to prepare typewritten, photographic, electronic, or other reproductions of certificates or reports in the Department of Public Health. Such reproductions when certified by the commissioner shall be accepted as the original records. The documents from which permanent reproductions have been made and verified may be disposed of as provided by regulation.

(P.A. 79-434, S. 12; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; June 18 Sp. Sess. P.A. 97-8, S. 74, 88.)

History: Sec. 19-15b transferred to Sec. 19a-43 in 1983; P.A. 93-381 replaced department and commissioner of health services with department and commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; June Sp. Sess. P.A. 97-8 deleted reference to reports received under Sec. 46b-68, effective July 1, 1997.

See Sec. 7-36 for applicable definitions.

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Sec. 19a-44. (Formerly Sec. 19-15c). Matching of birth and death certificates. To protect the integrity of vital records and to prevent the fraudulent use of birth certificates of deceased persons, the Commissioner of Public Health and the local registrars of vital records are hereby authorized to match birth and death certificates and to post the facts of death to the appropriate birth certificate. Copies issued from birth certificates marked deceased shall be similarly marked.

(P.A. 79-434, S. 13; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 04-255, S. 17.)

History: Sec. 19-15c transferred to Sec. 19a-44 in 1983; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 04-255 authorized local registrars of vital records to match birth and death certificates.

See Sec. 7-36 for applicable definitions.

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Sec. 19a-45. (Formerly Sec. 19-15d). Transmittal of vital records to other states and the United States Department of Health and Human Services. (a) The Department of Public Health may, by agreement, transmit copies of vital records required by sections [7-42](#), [7-45](#), [7-46](#), [7-47b](#), [7-48](#), [7-50](#), [7-57](#), [7-60](#), [7-62b](#), [7-62c](#), [7-64](#), [7-65](#) and [19a-41](#) to [19a-45](#), inclusive, to offices of vital statistics outside this state when such records relate to residents of those jurisdictions or persons born in those jurisdictions. The agreement shall require that the copies be used for statistical and administrative purposes only and the agreement shall further provide for the retention and disposition of such copies. Copies received by the department from offices of vital statistics in other states shall be handled in the same manner as prescribed in this section.

(b) The Department of Public Health shall, by agreement, transmit to the United States Department of Health and Human Services information concerning individuals for whom a death certificate has been

issued pursuant to section [7-62b](#). Such agreement may not include any restrictions on the use of the information, except that the agreement may provide that the information may only be used by a federal agency for purposes of ensuring that federal benefits or other payments are not erroneously paid to deceased individuals.

(P.A. 79-434, S. 15; P.A. 93-381, S. 9, 39; P.A. 94-18, S. 1, 2; P.A. 95-257, S. 12, 21, 58; P.A. 01-163, S. 33; P.A. 09-232, S. 22.)

History: Sec. 19-15d transferred to Sec. 19a-45 in 1983; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 94-18 added Subsec. (b) requiring department to transmit death certificate information to United States Department of Health and Human Services, effective May 2, 1994; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 01-163 made technical changes in Subsec. (a); P.A. 09-232 deleted reference to Sec. 7-68.

See Sec. 7-36 for applicable definitions.

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Sec. 19a-45a. Memorandum of understanding between the Commissioners of Public Health and Social Services for improving public health services. The Commissioners of Social Services and Public Health shall enter into a memorandum of understanding for the purpose of improving public health service delivery and public health outcomes for low income populations through the sharing of available HUSKY Health program and Title V data, provided the sharing of such data: (1) Is directly related to the administration of the Medicaid state plan or any other applicable state plan administered by the Department of Social Services or the Department of Public Health; (2) is in accordance with federal and state law and regulations concerning the privacy, security, confidentiality and safeguarding of individually identifiable information contained in such data; (3) includes a detailed description of the intended public health service delivery and public health outcome goals that are achieved by the sharing of such data; and (4) the costs of compiling and transmitting any such data can be accomplished within the available resources of the Departments of Social Services and Public Health.

(P.A. 02-65, S. 1; P.A. 15-69, S. 36.)

History: P.A. 15-69 changed “Medicaid, HUSKY Plus, HUSKY Plan Part B,” to “HUSKY Health program”, effective June 19, 2015.

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Sec. 19a-45b. Medical home pilot program. On or after January 1, 2007, and within any available federal or private funds, the Commissioner of Public Health, in consultation with the Commissioner of Social Services, may establish a medical home pilot program in one region of the state to be determined by the Commissioner of Public Health in order to enhance health outcomes for children, including children with special health care needs, by ensuring that each child has a primary care physician who will provide continuous comprehensive health care for such child. The Commissioner of Public Health may solicit and accept private funds to implement such pilot program.

(P.A. 06-188, S. 47; P.A. 10-179, S. 70; P.A. 11-25, S. 15.)

History: P.A. 06-188 effective May 26, 2006; P.A. 10-179 replaced provision requiring Commissioner of Public Health to consult with Medicaid managed care organizations with provision requiring said commissioner to consult with Commissioner of Social Services, effective July 1, 2010; P.A. 11-25 made technical changes.

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Sec. 19a-45c. Evaluation and report required re medical home pilot program. Not later than one year following the establishment of the medical home pilot program under section [19a-45b](#), the Commissioner of Public Health, shall evaluate such pilot program to ascertain specific improved health outcomes and any cost efficiencies achieved. Not later than thirty days following such evaluation, the Commissioner of Public Health shall submit a report, in accordance with section [11-4a](#), to the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations and the budgets of state agencies on the evaluation of such pilot program.

(P.A. 06-188, S. 48.)

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Sec. 19a-45d. Development of plan to streamline cross-enrollment of children receiving services under HUSKY A in other supplemental nutrition programs. Fact sheet containing eligibility requirements. Report. (a) Not later than January 1, 2025, the Department of Public Health, in collaboration with the Departments of Social Services and Agriculture, shall develop a plan to streamline cross-enrollment of any child who is receiving services under HUSKY A, as defined in section [17b-290](#), in (1) the federal Special Supplemental Food Program for Women, Infants and Children administered by the Department of Public Health pursuant to section [19a-59c](#), (2) the supplemental nutrition assistance program administered by the Department of Social Services pursuant to the federal Food and Nutrition Act of 2008 and section [17b-2](#), and (3) the Connecticut Farmers' Market/Women, Infants and Children Nutrition Program administered by the Department of Agriculture pursuant to section [22-6h](#). Such plan shall include, but need not be limited to, using licensed health care professionals employed by the Department of Public Health to make an initial assessment regarding whether a child meets the criteria for enrollment in the federal Special Supplemental Food Program for Women, Infants and Children.

(b) Not later than January 1, 2025, the Departments of Public Health, Social Services and Agriculture shall (1) jointly create, in clear and readily understandable language and graphics, a simple fact sheet containing the eligibility requirements for, instructions for applying to and types of benefits provided by HUSKY A and the programs described in subdivisions (1) to (3), inclusive, of subsection (a) of this section, and (2) translate the fact sheet into the five most commonly spoken languages in the state, as determined by the Commissioners of Public Health, Social Services and Agriculture. Such fact sheet shall include a telephone number for the administrative or outreach office of the HUSKY A program that members of the public may contact with questions regarding the program.

(c) Not later than January 1, 2025, the Commissioners of Public Health, Social Services and Agriculture shall jointly report, in accordance with the provisions of section [11-4a](#), to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services and the environment regarding (1) the plan developed pursuant to subsection (a) of this section and the anticipated implementation date of such plan, and (2) a copy of the fact sheet created pursuant to subsection (b) of this section.

(d) Not later than January 1, 2025, the Commissioners of Public Health, Social Services and Agriculture shall make (1) the applications for HUSKY A and the programs described in subsection (a) of this section, and (2) the fact sheet created pursuant to subsection (b) of this section, or the information contained in the fact sheet, available and easily accessible to potential applicants both electronically and telephonically, including, but not limited to, through conspicuously posting such applications and fact sheet, and the translations for the fact sheet made pursuant to subsection (b) of this section, on the Internet web sites of the Departments of Public Health, Social Services and Agriculture.

(e) Not later than January 1, 2025, the Commissioner of Public Health shall distribute the fact sheet created pursuant to subsection (b) of this section to each provider of pediatric health care and obstetrics and gynecology services in the state at the time such provider (1) is initially licensed by the Department of Public Health, and (2) renews such provider's license with the department, for provision to the provider's patients.

(P.A. 24-82, S. 1.)

History: P.A. 24-82 effective May 30, 2024.

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Sec. 19a-46. (Formerly Sec. 19-17). Expert examinations and inspections. Said department may, from time to time, engage suitable persons to render sanitary service and to make or supervise practical and scientific investigations and examinations requiring expert skill and to prepare plans and reports relative thereto. All officers, persons, corporations or agents, having the control, charge or custody of any public structure, work, ground or erection, or of any plan, description, outlines, drawings or charts thereof, or relating thereto, made, kept or controlled under any public authority, shall permit and facilitate the examination and inspection and the making of copies of the same by any person authorized by said department; and the members of said department and such persons as are authorized by said department may, without fee or hindrance, enter, examine and survey all such grounds, erections, vehicles, structures, apartments, buildings and places.

(1949 Rev., S. 3810.)

History: Sec. 19-17 transferred to Sec. 19a-46 in 1983.

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Sec. 19a-47. (Formerly Sec. 19-18). Information to local authorities. Reports to department. Notification of spills. (a) The Department of Public Health shall cause all proper sanitary information in its possession to be forwarded promptly to the local health authorities of any town, city, borough or county in the state which requests the same, adding thereto such useful suggestions as the experience of said department may supply. The local health authorities shall supply like information to said department, together with a copy of their reports and other publications. Said department may require reports and information at such times and of such facts, and generally of such nature and extent, relating to the safety of life and promotion of health, as its rules provide, from all public dispensaries, hospitals, asylums, infirmaries, prisons and schools, from the officers thereof and from all other public institutions, their officers and managers, and from the proprietors, managers, lessees and occupants of all places of public resort in the state; but such reports and information shall only be required relating to matters concerning which said department may in its opinion need information for the discharge of its duties. Said department shall, when requested by public authorities, advise officers of the state or local government in regard to sanitary drainage, and the location, drainage, ventilation and sanitary provisions of any public institution, building or place. Said department shall give all information that may be reasonably requested, concerning any threatened danger to the public health, to local directors of health and to all other sanitary authorities in the state, who shall give like information to said department; and said department and such directors and sanitary authorities shall cooperate to prevent the spread of disease, and for the protection of life and the promotion of health.

(b) The Department of Public Health shall cause all information concerning a discharge, spillage, uncontrolled loss, seepage or filtration of oil or petroleum or chemical liquids or solid, liquid or gaseous products or hazardous wastes upon any land or into any of the waters of the state or into any offshore or

coastal waters which may result in a threatened danger to the public health to be transmitted to the Commissioner of Energy and Environmental Protection, and the chief executive officer and the local director of health of the municipality in which such discharge, spillage, uncontrolled loss, seepage or filtration occurs. Such information shall be provided in a timely manner.

(1949 Rev., S. 3809; P.A. 77-614, S. 323, 610; P.A. 90-276, S. 2; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 11-80, S. 1.)

History: P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; Sec. 19-18 transferred to Sec. 19a-47 in 1983; P.A. 90-276 added Subsec. (b) re notification of certain spills; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; pursuant to P.A. 11-80, "Commissioner of Environmental Protection" was changed editorially by the Revisors to "Commissioner of Energy and Environmental Protection" in Subsec. (b), effective July 1, 2011.

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Sec. 19a-48. (Formerly Sec. 19-19). Care for children with cerebral palsy. The Department of Public Health shall furnish services for children who have cerebral palsy or who are suffering from conditions which lead to cerebral palsy, such services to include the locating of such children, the providing of medical, surgical, corrective and allied services and care, and the providing of facilities for hospitalization and aftercare. Said department shall also provide for the training of personnel for research in causes, prevention and treatment of cerebral palsy in children.

(November, 1949, S. 2040d; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; Sec. 19-19 transferred to Sec. 19a-48 in 1983; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

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Sec. 19a-49. (Formerly Sec. 19-19a). Services for persons with cystic fibrosis. The Department of Public Health shall establish and administer a program of services for children and adults suffering from cystic fibrosis, and for such purpose shall have the same powers as are conferred on it by section [19a-50](#).

(1961, P.A. 552, S. 1; 1967, P.A. 865; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 15-109, S. 3.)

History: 1967 act added services for adults; P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; Sec. 19-19a transferred to Sec. 19a-49 in 1983; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 15-109 deleted reference to crippled children.

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Sec. 19a-50. (Formerly Sec. 19-20). Children with physical disabilities or cardiac defects. Payment of “clean claims”. (a) The Department of Public Health is designated as the state agency to (1) administer a program of services for children with physical disabilities or who are suffering from conditions which lead to such disabilities or suffering from cardiac defect or damage, and (2) receive and administer federal funds which may become available for such services. The Commissioner of Public Health is authorized to extend and improve, as far as practicable, such services for locating such children and for providing medical, surgical, corrective and other services and care, and facilities for diagnosis, clinical services, hospitalization and aftercare for such children. The Commissioner of Public Health shall have final administrative responsibility for all activities on behalf of such children as are provided for by this section and shall have charge of the disbursement of all funds to be used for such purposes, whether by state or federal grant or appropriation, and said commissioner is authorized, in addition to the powers conferred herein, to cooperate with the federal government or any authority thereunder respecting the exercise of powers herein granted.

(b) Ninety per cent of clean claims for payments to persons furnishing services hereunder shall be made no later than thirty days from receipt of the request for payment and ninety-nine per cent shall be made within ninety days of such receipt. For the purposes of this section “clean claim” means a claim which can be processed without obtaining additional substantiation from the person furnishing such services or other persons entitled to receive payment. A claim submitted by any such person who is under investigation for fraud or abuse shall not be considered a clean claim.

(1949 Rev., S. 3824; 1963, P.A. 64; 572, S. 1; P.A. 77-614, S. 323, 610; P.A. 80-348; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 15-109, S. 4.)

History: 1963 acts added provision for children suffering from cardiac defect or damage, deleted stipulation that commissioner's authority to extend and improve services be especially in rural areas and in areas suffering economic distress and added clinical services to those provided; P.A. 77-614 replaced commissioner and department of health with commissioner and department of health services, effective January 1, 1979; P.A. 80-348 added Subsec. (b) re clean claims; Sec. 19-20 transferred to Sec. 19a-50 in 1983; P.A. 93-381 replaced department and commissioner of health services with department and commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 15-109 amended Subsec. (a) by adding Subdiv. (1) and (2) designators, replacing references to crippled or crippling with references to physical disabilities or disabilities and making technical changes.

Annotation to former section 19-20:

Cited. 170 C. 675.

Annotation to present section:

Cited. 33 CA 673.

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Sec. 19a-51. (Formerly Sec. 19-20a). Pediatric Cardiac Patient Care Fund. There shall be a Pediatric Cardiac Patient Care Fund to be administered by the Department of Public Health and to be used exclusively for medical, surgical, preoperative and postoperative care and hospitalization of children, residents of this state, who are or may be patients of approved cardiac centers in this state.

(1963, P.A. 572, S. 2; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; Sec. 19-20a transferred to Sec. 19a-51 in 1983; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

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Sec. 19a-52. (Formerly Sec. 19-20b). Purchase of equipment for children with physical disabilities or cardiac defects. Notwithstanding any other provision of the general statutes, the Department of Public Health or the department's contractor, in carrying out its powers and duties under section [19a-50](#), may, within available appropriations, purchase medically necessary and appropriate durable medical equipment and other department approved goods and services. Such goods and services shall be identical to goods and services that are covered under the Connecticut Medicaid and HUSKY Programs administered by the Department of Social Services and the payment for such goods and services shall not exceed the Connecticut Medicaid payment rate for the same goods and services.

(P.A. 78-7, S. 1, 2; P.A. 93-381, S. 9, 39; P.A. 94-197, S. 1; P.A. 95-257, S. 12, 21, 58; P.A. 17-146, S. 12; 17-202, S. 73.)

History: Sec. 19-20b transferred to Sec. 19a-52 in 1983; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 94-197 increased maximum for purchase without a purchase order from \$3,500 to \$6,500 per unit; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 17-146 added “and the department's contractors” re carrying out powers and duties, and replaced provisions re purchases and bids with provisions re purchase of medically necessary and appropriate durable medical equipment and other goods and services and payment for goods and services; P.A. 17-202 added “or the department's contractor” re carrying out powers and duties, and replaced provisions re purchases and bids with provisions re purchase of medically necessary and appropriate durable medical equipment and other goods and services and payment for goods and services.

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Sec. 19a-53. (Formerly Sec. 19-21). Birth defects surveillance program. Definitions. Birth defects screenings. Notification. Analyses. Confidentiality. Records. Approval of research. Publication of statistical compilations. (a) As used in this section:

- (1) “Commissioner” means the Commissioner of Public Health, or the commissioner's designee;
 - (2) “Department” means the Department of Public Health;
 - (3) “Licensed health care professional” means a physician licensed pursuant to chapter 370, a physician assistant licensed pursuant to chapter 370, an advanced practice registered nurse or a registered nurse licensed pursuant to chapter 378 or a nurse midwife licensed pursuant to chapter 377; and
 - (4) “Newborn screening system” means the department's tracking system for the screening of newborns pursuant to section [19a-55](#).
- (b) The department may, within available appropriations, establish a birth defects surveillance program. Such program shall monitor the frequency, distribution and types of birth defects occurring in the state.

(c) Each child that is born in the state shall have a birth defects screening completed by a licensed health care professional prior to discharge from the hospital. The administrative officer or other person in charge of each hospital shall enter the results of each birth defects screening into the birth defects registry located in the department's newborn screening system in a form and manner prescribed by the commissioner.

(d) Any licensed health care professional who provides care or treatment to a child that is under the age of one and was born in the state and who observes or acquires knowledge that the child has a birth defect shall, not later than forty-eight hours after observing or acquiring knowledge of such defect, notify the department of such defect in a form and manner prescribed by the commissioner. Such notification shall contain information, including, but not limited to, the nature of the birth defect and such other information as may reasonably be required by the department. The department shall post the notification form on the department's Internet web site and keep each notification made under this section on file for at least six years from the date of its receipt.

(e) The commissioner shall have access to identifying information in the hospital discharge records of newborn infants born in the state upon request. Such identifying information shall be used solely for purposes of the birth defects surveillance program. A hospital, as defined in section [19a-490](#), shall make available to the department upon request the medical records of a patient diagnosed with a birth defect or other adverse reproductive outcomes for purposes of research and verification of data.

(f) The commissioner shall use the information collected under this section and information available from other sources to conduct routine analyses to determine whether there were any preventable causes of the birth defects about which the department was notified under this section.

(g) All information, including, but not limited to, personally identifiable information collected from a health care professional or hospital under this section shall be confidential. Such personally identifiable information shall be used solely for purposes of the birth defects surveillance program. Access to such information shall be limited to the department and persons with a valid scientific interest and qualification as determined by the commissioner, provided the department and such persons are engaged in demographic, epidemiologic or other similar studies related to health and agree, in writing, to maintain the confidentiality of such information as prescribed in this section and section [19a-25](#).

(h) The commissioner shall maintain an accurate record of all persons who are given access to the information in the newborn screening system. The record shall include (1) the name, title and organizational affiliation of persons given access to the system, (2) dates of access, and (3) the specific purpose for which the information is used. The record shall be open to public inspection during the department's normal operating hours.

(i) All research proposed to be conducted using personally identifiable information in the newborn screening system or requiring contact with affected individuals shall be reviewed and approved in advance by the commissioner.

(j) The commissioner may publish statistical compilations relating to birth defects or other adverse reproductive outcomes that do not in any way identify individual cases or individual sources of information.

(1949 Rev., S. 3825; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 99-102, S. 16; P.A. 17-146, S. 13.)

History: P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; Sec. 19-21 transferred to Sec. 19a-53 in 1983; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 99-102 deleted obsolete reference to osteopathy and made technical changes; P.A. 17-146 deleted provision re mailing report to department within forty-

eight hours of acquiring knowledge child has physical defect, added Subsec. (a) re definitions, added Subsec. (b) re establishment of birth defects surveillance program, added Subsec. (c) re birth defects screenings, added Subsec. (d) re notification to department of child having birth defect by licensed health care professionals, added Subsec. (e) re access to identifying information by the commissioner, added Subsec. (f) re routine analyses of information, added Subsec. (g) re confidentiality of information, added Subsec. (h) re maintenance of record of persons given access to newborn screening system, added Subsec. (i) re review and approval of research, and added Subsec. (j) re publication of statistical compilations.

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Sec. 19a-54. (Formerly Sec. 19-21a). Registration of children with special health care needs. Each institution supported in whole or in part by the state shall report to the Department of Public Health, on a form prescribed by said department, the name and address of each child under twenty-one years of age with special health care needs for whom an application is made for admission, whether such child is admitted or rejected.

(1949 Rev., S. 2637; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 17-202, S. 68.)

History: Sec. 17-47 transferred to Sec. 19-21a in 1968; P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; Sec. 19-21a transferred to Sec. 19a-54 in 1983; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 17-202 replaced “who is physically handicapped” with “with special health care needs” and made a technical change.

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Sec. 19a-54a. Registry of data on infants exposed to AIDS medication. Section [19a-54a](#) is repealed, effective October 1, 2016.

(June Sp. Sess. P.A. 99-2, S. 32, 72; P.A. 16-87, S. 5.)

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Sec. 19a-55. (Formerly Sec. 19-21b). Newborn screening program. Tests required. Report to Department of Public Health. Exemptions. Regulations. (a) There is established a newborn screening program. The Commissioner of Public Health shall (1) administer the newborn screening program, (2) direct persons identified through the screening program to appropriate specialty centers for treatments, consistent with any applicable confidentiality requirements, and (3) set the fees to be charged to institutions to cover all expenses of the comprehensive screening program including testing, tracking and treatment, subject to the approval of the Secretary of the Office of Policy and Management. The fees to be charged pursuant to subdivision (3) of this subsection shall be set at a minimum of ninety-eight dollars.

(b) The administrative officer or other person in charge of each institution caring for newborn infants, a nurse-midwife licensed pursuant to chapter 377 or a midwife shall cause to have administered to every such newborn infant in his or her care a blood spot specimen and an HIV-related test, as defined in section [19a-581](#), except that the person responsible for testing may omit such test if the mother has had an HIV-related test pursuant to section [19a-90](#) or [19a-593](#). The blood spot specimen shall be collected not earlier than twenty-four hours after the birth of the newborn infant and not later than forty-eight hours after the

birth of such infant, unless the institution caring for newborn infants, nurse-midwife licensed pursuant to chapter 377 or midwife determines that a situation exists to warrant an early collection of the specimen or if collection of the specimen is medically contraindicated. Situations that warrant early collection of the specimen shall include, but not be limited to, the imminent transfusion of blood products, dialysis, early discharge of the newborn infant from the institution, transfer of the newborn infant to another institution or imminent death. If the newborn infant dies before a blood spot specimen can be obtained, the specimen shall be collected as soon as practicable after death. The institution licensed to care for newborn infants, nurse-midwife or midwife shall notify the Department of Public Health when a specimen is not collected within forty-eight hours after the birth of such infant due to: (1) The infant's medical fragility, (2) refusal by the parents when newborn infant screening is in conflict with their religious tenets and practice, (3) the newborn infant receiving comfort measures only, or (4) any other reason. Such notification shall be documented in the department's newborn screening system pursuant to section [19a-53](#) by the institution caring for newborn infants, nurse-midwife or midwife or sent in writing to the department not later than seventy-two hours after the birth of the newborn infant. The institution caring for newborn infants, nurse-midwife or midwife shall send the blood spot specimen to the state public health laboratory not later than twenty-four hours after the time of collection. The department may request an additional blood spot specimen if: (A) There was an early collection of the specimen, (B) the specimen was collected following a transfusion of blood products, (C) the specimen is unsatisfactory for testing, or (D) the department determines that there is an abnormal result. The state public health laboratory shall make and maintain a record of the date and time of its receipt of each blood spot specimen and make such record available for inspection by the institution caring for newborn infants, nurse-midwife or midwife that sent the blood spot specimen not later than forty-eight hours after such institution, nurse-midwife or midwife submits a request to inspect such record.

(c) The Commissioner of Public Health shall publish a list of all the abnormal conditions for which the department screens newborns under the newborn screening program, which shall include, but need not be limited to, testing for (1) amino acid disorders, including phenylketonuria, organic acid disorders, fatty acid oxidation disorders, including, but not limited to, long-chain 3-hydroxyacyl CoA dehydrogenase (L-CHAD) and medium-chain acyl-CoA dehydrogenase (MCAD), hypothyroidism, galactosemia, sickle cell disease, maple syrup urine disease, homocystinuria, biotinidase deficiency, congenital adrenal hyperplasia, severe combined immunodeficiency disease, adrenoleukodystrophy, spinal muscular atrophy and any other disorder included on the recommended uniform screening panel pursuant to 42 USC 300b-10, as amended from time to time, and as prescribed by the Commissioner of Public Health, and (2) on and after July 1, 2025, cytomegalovirus.

(d) In addition to the testing requirements prescribed in subsection (b) of this section, the administrative officer or other person in charge of each institution caring for newborn infants shall cause to have administered to every such infant in its care a screening test for (1) cystic fibrosis, and (2) critical congenital heart disease. Such screening tests shall be administered as soon after birth as is medically appropriate.

(e) The clinical laboratory that completes the testing for cystic fibrosis shall report the number of newborn infants screened and the results of such testing, not less than annually, to the Department of Public Health into the newborn screening system pursuant to section [19a-53](#). The administrative officer or other person in charge of each institution caring for newborn infants who performs the testing for critical congenital heart disease shall enter the results of such test into the newborn screening system pursuant to section [19a-53](#).

(f) The provisions of this section shall not apply to any infant whose parents object to the test or treatment as being in conflict with their religious tenets and practice. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of this section.

(February, 1965, P.A. 108, S. 1, 2; P.A. 77-614, S. 323, 610; P.A. 78-193, S. 1, 2, 4; P.A. 92-227, S. 1, 2; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; June 18 Sp. Sess. P.A. 97-8, S. 26; June Sp. Sess. P.A. 99-2, S. 30; P.A. 02-113, S. 1; June 30 Sp. Sess. P.A. 03-3, S. 5; P.A. 05-272, S. 43; P.A. 06-196, S. 210; P.A. 09-20, S. 1;

June Sp. Sess. P.A. 09-3, S. 167; P.A. 11-48, S. 38; P.A. 12-13, S. 1; P.A. 13-242, S. 1; P.A. 15-10, S. 1; 15-242, S. 49; June Sp. Sess. P.A. 15-5, S. 346, 506; P.A. 16-66, S. 22; P.A. 17-146, S. 14; P.A. 19-117, S. 148; 19-176, S. 1; P.A. 21-121, S. 75; P.A. 23-204, S. 191.)

History: P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; P.A. 78-193 included tests for hypothyroidism and galactosemia and transferred regulation power from department to commissioner; Sec. 19-21b transferred to Sec. 19a-55 in 1983; P.A. 92-227 amended Subsec. (a) to add sickle cell disease, maple syrup urine disease, homocystinuria and biotinidase deficiency to list of diseases for infant testing and to detail responsibilities of the commissioner in administering the program; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; June 18 Sp. Sess. P.A. 97-8 added congenital adrenal hyperplasia to the list of diseases tested for; June Sp. Sess. P.A. 99-2 amended Subsec. (a) by replacing “infants twenty-eight days or less of age” with “newborn infants”, adding HIV-related test, adding provision that tests be administered as soon after birth as is medically appropriate and that test may be omitted if done under other statutes, and adding “consistent with any applicable confidentiality requirements” in Subdiv. (2); P.A. 02-113 amended Subsec. (a) to add requirement for testing of “other metabolic diseases”, to add a minimum fee requirement of \$28, and to add requirement that on or before January 1, 2003, the regulations shall include testing for amino acid disorders, organic acid disorders and fatty acid oxidation disorders; June 30 Sp. Sess. P.A. 03-3 amended Subsec. (a) by changing date for regulations requiring testing for certain disorders from January 1, 2003, to January 1, 2004, effective August 20, 2003; P.A. 05-272 amended Subsec. (a) by removing requirement that newborn screening regulations specify abnormal conditions to be tested for and manner of recording and reporting results and, instead, requiring Commissioner of Public Health to publish list of all abnormal conditions for which department screens newborns under newborn screening program, effective July 13, 2005; P.A. 06-196 made a technical change in Subsec. (a), effective June 7, 2006; P.A. 09-20 added new Subsec. (b) requiring that newborn infants be administered screening test for cystic fibrosis and redesignated existing Subsec. (b) as Subsec. (c); June Sp. Sess. P.A. 09-3 amended Subsec. (a) to increase fee from \$28 to \$56; P.A. 11-48 repositioned provision re adoption of regulations from Subsec. (a) to Subsec. (c) and amended Subsec. (b) by requiring screening test for severe combined immunodeficiency disease and by making a technical change; P.A. 12-13 amended Subsec. (b) by designating existing provisions re screening tests for cystic fibrosis and severe combined immunodeficiency disease as Subdivs. (1) and (2) and adding Subdiv. (3) re screening test for critical congenital heart disease; P.A. 13-242 added new Subsec. (c) re test for adrenoleukodystrophy and redesignated existing Subsec. (c) as Subsec. (d); P.A. 15-10 amended Subsec. (b) by designating existing provisions re screening tests to be administered as Subdiv. (1), redesignating existing Subdivs. (1) to (3) as Subparas. (A) to (C) and adding new Subdiv. (2) re screening test for infant who fails a hearing screening, added new Subsec. (d) re reporting cases of cytomegalovirus and redesignated existing Subsec. (d) as Subsec. (e), effective July 1, 2015; P.A. 15-242 amended Subsec. (d) by making a technical change, effective June 30, 2015; June Sp. Sess. P.A. 15-5 amended Subsec. (a) to replace “fifty-six” with “ninety-eight” re minimum fees, effective July 1, 2015, and deleted former Subsec. (c) re development and validation of reliable methodology for screening for adrenoleukodystrophy and added new Subsec. (c) re agreement with New York State Department of Health to screen for adrenoleukodystrophy, effective October 1, 2015; P.A. 16-66 amended Subsec. (a) to add reference to severe combined immunodeficiency disease and adrenoleukodystrophy, amended Subsec. (b)(1) to delete former Subpara. (B) re severe combined immunodeficiency disease and redesignate existing Subpara. (C) re critical congenital heart disease as Subpara. (B), deleted former Subsec. (c) re screening test for adrenoleukodystrophy and redesignated existing Subsecs. (d) and (e) as Subsecs. (c) and (d); P.A. 17-146 amended Subsec. (b) by adding provision re entering results of testing for critical congenital heart disease into newborn screening system; P.A. 19-117 amended Subsec. (a) by adding provision re screening for any other disorder included on recommended uniform screening panel subject to approval by the Secretary of the Office of Policy and Management and made technical changes; P.A. 19-176 amended Subsec. (b)(1) by adding Subpara. (C) re spinal muscular atrophy and making technical changes; P.A. 21-121 substantially revised section including by adding provision re approval of fees by Secretary of the Office of Policy and Management in Subsec. (a)(3), moving existing provisions re specific

screenings from Subsec. (a) to new Subsec. (b) and amended same by adding provisions re screenings performed using bloodspot specimens and re timeframes for specimen collection and notification, designating existing provisions in Subsec. (a) re commissioner to publish list of abnormal conditions as new Subsec. (c) and amending same to add additional amino acid disorders, redesignating existing Subsec. (b) as new Subsec. (d) and amending same to delete Subdiv. (1)(C) re spinal muscular atrophy and provisions re funding for cytomegalovirus screening test and reporting re congenital heart disease in Subdiv. (2), adding Subsec. (e)(1) re reporting requirements, redesignating existing Subsec. (c) as Subsec. (e)(2) and amending same to add provisions re newborn screening system and patient's insurance status or source of payment, redesignating existing Subsec. (d) as Subsec. (f) and making technical and conforming changes, effective July 6, 2021; P.A. 23-204 amended Subsec. (c) by designating existing provisions as Subdiv. (1) and adding Subdiv. (2) re cytomegalovirus, Subsec. (d) by deleting former Subdiv. (2) re cytomegalovirus and making technical changes, and Subsec. (e) by deleting former Subdiv. (2) re cytomegalovirus and Subdiv. (1) designator, effective June 12, 2023.

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Sec. 19a-55a. Newborn screening account. Section [19a-55a](#) is repealed, effective July 1, 2018.

(June 30 Sp. Sess. P.A. 03-3, S. 4; P.A. 06-188, S. 20; June Sp. Sess. P.A. 17-2, S. 678, 728.)

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Sec. 19a-55b. Information on newborn infant safe sleep practices. Each hospital, as defined in section [19a-490](#), through its maternity program, shall provide the parent or parents or the legal guardian of a newborn infant with written informational materials containing the American Academy of Pediatrics' recommendations concerning safe sleep practices at the time of such infant's discharge from the hospital.

(P.A. 15-39, S. 1.)

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Sec. 19a-56. (Formerly Sec. 19-21c). Program for prevention of erythroblastosis. Section [19a-56](#) is repealed.

(1969, P.A. 734, S. 1; P.A. 77-614, S. 323, 610; P.A. 90-13, S. 12.)

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Secs. 19a-56a and 19a-56b. (Formerly Secs. 10a-132b and 10a-132d). Birth defects surveillance program; collection of birth defects data; advisory committee. Confidentiality of birth defects information; access. Sections [19a-56a](#) and [19a-56b](#) are repealed, effective October 1, 2016.

(P.A. 88-286, S. 1, 4; P.A. 89-340, S. 1, 2, 4; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 98-250, S. 6, 7, 39; P.A. 16-66, S. 53.)

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Sec. 19a-57. (Formerly Sec. 19-21d). Loans for purchase of hemodialysis treatment machines. Section [19a-57](#) is repealed, effective October 1, 2016.

(P.A. 73-447, S. 1, 2; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 16-66, S. 53.)

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Sec. 19a-58. (Formerly Sec. 19-21e). Pamphlet concerning hearing impairments in infants. Section [19a-58](#) is repealed, effective October 1, 2002.

(P.A. 79-287; P.A. 80-483, S. 78, 186; P.A. 81-205, S. 1, 3; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 00-27, S. 9, 24; S.A. 02-12, S. 1.)

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Sec. 19a-59. Program to identify infants who are hard of hearing. (a) Each institution, as defined in section [19a-490](#), that provides childbirth service shall, not later than July 1, 2000, include a universal newborn hearing screening program as part of its standard of care and shall establish a mechanism for compliance review. The provisions of this subsection shall not apply to any infant whose parents object to hearing screening as being in conflict with their religious tenets and practice.

(b) The Department of Public Health shall establish a plan to implement and operate a program of early identification of infants who are hard of hearing. The purpose of such plan shall be to: (1) Identify infants at high risk of having hearing impairments; (2) notify parents of such infants of the risk; (3) inform parents of resources available to them for further testing and treatment, including rehabilitation services for such infants; and (4) inform parents of financial assistance available through the Department of Public Health, including, but not limited to, parental eligibility criteria, which may result in reduced cost or no cost to parents for testing, evaluation or treatment, including rehabilitation of such infants. The department shall develop such plan in consultation with persons including, but not limited to, pediatricians, otolaryngologists, audiologists, educators and parents of children who are deaf or hard of hearing.

(c) The Commissioner of Public Health shall adopt regulations, in accordance with chapter 54, to implement the provisions of subsection (a) of this section.

(P.A. 81-205, S. 2, 3; P.A. 82-472, S. 61, 183; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; June 18 Sp. Sess. P.A. 97-8, S. 9, 88; June Sp. Sess. P.A. 99-2, S. 36, 72; P.A. 00-27, S. 10, 24; P.A. 17-202, S. 69, 74.)

History: P.A. 82-472 made technical changes; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; June 18 Sp. Sess. P.A. 97-8 added new Subsecs. (a) and (c) re newborn hearing screening, designating existing Subsecs. (a) and (b) as Subsec. (b); June Sp. Sess. P.A. 99-2 amended Subsec. (a) by replacing “1999” with “2000”, effective July 1, 1999; P.A. 00-27 made a technical change in Subsec. (b), effective May 1, 2000; P.A. 17-202 amended Subsec. (b) to replace “infant hearing impairment” with “infants who are hard of hearing”, and replace reference to deaf and hearing impaired children with reference to children who are deaf and hard of hearing.

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Sec. 19a-59a. Low protein modified food products and amino acid modified preparations for inherited metabolic disease. Prescription required. Purchase by department. (a) For purposes of this section:

(1) “Inherited metabolic disease” means a disease for which newborn screening is required under section [19a-55](#).

(2) “Low protein modified food product” means a product formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a physician.

(3) “Amino acid modified preparation” means a product intended for the dietary treatment of an inherited metabolic disease under the direction of a physician.

(b) Amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic disease shall be dispensed only upon the prescription of an individual authorized to prescribe drugs within this state.

(c) Notwithstanding any other provision of the general statutes, the Department of Public Health, in carrying out its powers and duties under this section, may, within available appropriations, purchase prescribed special infant formula, amino acid modified preparations and low protein modified food products directly and without the issuance of a purchase order.

(P.A. 82-355, S. 7, 8; P.A. 88-286, S. 3, 4; P.A. 94-174, S. 9, 12; 94-197, S. 2–4; P.A. 95-257, S. 12, 21, 58; P.A. 97-167, S. 3.)

History: P.A. 88-286 replaced “phenyl-free and Lofenolac formulas” with “amino acid preparations for the treatment of inborn errors of metabolism, for use by infants, children or pregnant women”; P.A. 94-174 and 94-197 applied section to protein modified foods and defined the term, effective June 6, 1994; P.A. 94-197 further amended Subsec. (a) to replace physician with any individual authorized to prescribe and added new Subsec. (b) authorizing department's purchase of special infant formula and medical foods without a purchase order; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 97-167 added new Subsec. (a) expanding definitions and redesignated and modified former Subsecs. (a) and (b) accordingly.

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Sec. 19a-59b. Maternal and child health protection program. (a) The Commissioner of Public Health shall establish a maternal and child health protection program. He shall contract, for purposes of the program, annually, within available appropriations, with local providers of health services to provide outpatient maternal health services and labor and delivery services to needy pregnant women and child health services to children under six years of age. Eligibility shall be limited to families who have an income equal to or less than one hundred eighty-five per cent of the poverty level, according to the federal Office of Management and Budget poverty guidelines for nonfarm families, lack private, third party health insurance to cover such services. Such local providers shall determine eligibility for services under the program. The contracts shall include criteria for making such determination in accordance with this section. Outpatient services provided under the program shall include at least the outpatient services provided to Medicaid recipients. The commissioner shall conduct an outreach program designed to educate the public with regard to the program and to encourage providers to participate in the program. The commissioner, in consultation with the Commissioner of Social Services, shall seek any federal matching funds available for the program.

(b) The Commissioner of Public Health shall allocate a percentage of program funds, for contracts with community health centers in Bridgeport, Hartford, Middletown, New Haven, New London, Stamford, Waterbury and Willimantic. The commissioner may use program funds to establish or fund innovative programs designed to improve the delivery of health services to eligible women and children. The

commissioner shall continue to perform evaluation using outcome measures developed in consultation with the Office of Policy and Management.

(June Sp. Sess. P.A. 83-17, S. 1, 3; P.A. 86-392, S. 1, 3; P.A. 88-238, S. 1, 2; P.A. 90-13, S. 2; 90-134, S. 9, 28; P.A. 93-262, S. 1, 87; 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 96-160; June 18 Sp. Sess. P.A. 97-2, S. 91, 165.)

History: P.A. 86-392 added Subsec. (c) re allocation of funds to community health centers; P.A. 88-238 amended Subsec. (a) by adding labor and delivery services, adding language pertaining to children, up to an age, not to exceed age 5, specifying that outpatient services include at least the outpatient services provided to medical assistance recipients and adding language on regulations, the outreach program and federal matching funds, deleted former Subsec. (b) describing services under the program and relettered Subsec. (c), amending it to remove language specifying how the funds allocated to community health centers should be used and adding language on program evaluation and the use of funds for innovative programs; P.A. 90-13 removed the requirement for the commissioner of health services to adopt regulations, deleted language prohibiting participation in the program by medical assistance recipients and specified that the age limit be determined by the commissioner; P.A. 90-134 changed the age limitation from an age determined by the commissioner not to exceed age 5 to 6 years of age; P.A. 93-262 authorized substitution of commissioner and department of social services for commissioner and department of income maintenance, effective July 1, 1993; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 96-160 amended Subsec. (b) deleting 2% reserve fund requirement and adding requirement that the commissioner continue to perform evaluation; June 18 Sp. Sess. P.A. 97-2 amended Subsec. (a) to make a technical and conforming change, effective July 1, 1997.

See Sec. 19a-490a for definition of “community health center”.

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Sec. 19a-59c. Administration of federal Special Supplemental Food Program for Women, Infants and Children in the state. The Department of Public Health is authorized to administer the federal Special Supplemental Food Program for Women, Infants and Children in the state, in accordance with federal law and regulations. The Commissioner of Public Health may adopt regulations, in accordance with the provisions of chapter 54, necessary to administer the program.

(P.A. 88-172, S. 5; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 07-252, S. 84; May Sp. Sess. P.A. 16-3, S. 158; P.A. 17-146, S. 21.)

History: P.A. 93-381 replaced department and commissioner of health services with department and commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 07-252 designated existing provisions as Subsec. (a) and added Subsec. (b) establishing a Women, Infants and Children Advisory Council; May Sp. Sess. P.A. 16-3 amended Subsec. (b) by replacing “Commission on Children” with “Commission on Women, Children and Seniors”, effective July 1, 2016; P.A. 17-146 deleted Subsec. (b) re advisory council and deleted Subsec. (a) designator.

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Sec. 19a-59d. Penalties for violations of regulations for the Special Supplemental Food Program for Women, Infants and Children. The Commissioner of Public Health may, in accordance with regulations

adopted pursuant to section [19a-59c](#), impose a civil penalty of not more than two thousand five hundred dollars, or disqualify from participation in the Special Supplemental Food Program for Women, Infants and Children, or both, any vendor who engages in conduct in violation of said regulations.

(P.A. 93-110, S. 1, 5; 93-381, S. 9, 39; 93-435, S. 59, 95; P.A. 95-257, S. 12, 21, 58.)

History: P.A. 93-110 effective October 1, 1993 (Revisor's note: Pursuant to P.A. 93-381 and P.A. 93-435 commissioner of health services was changed editorially by the Revisors to commissioner of public health and addiction services); P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

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Sec. 19a-59e. Media campaign for the reduction of adolescent pregnancies. Section [19a-59e](#) is repealed, effective October 1, 2018.

(P.A. 95-227, S. 1, 2; 95-257, S. 12, 21, 58; June 18 Sp. Sess. P.A. 97-8, S. 56, 88; P.A. 18-168, S. 85.)

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Sec. 19a-59f. Federal Special Supplemental Food Program for Women, Infants and Children. Requirements re participating vendors. Federal audits. Revision of state plan. (a) The Department of Public Health shall permit a vendor, who the department previously authorized to participate in the federal Special Supplemental Food Program for Women, Infants and Children, but who was disqualified from program participation during the period commencing on January 1, 2007, through June 12, 2008, due to the failure of such vendor to: (1) File a complete application for continued participation in the program, or (2) comply with the department's prescribed minimum inventory requirements, to reapply for reinstatement as an authorized vendor in the program. The Department of Public Health shall, not later than thirty days from June 12, 2008, provide written notification to vendors who are permitted to reapply for program participation pursuant to this section. A vendor receiving such notification from the department shall have not more than thirty days after the date of notification to reapply for continued participation in the program. A vendor who reapplies for program participation pursuant to the provisions of this section shall be notified in writing of the department's decision on the application for reinstatement not later than sixty days following the date of submission of the completed application.

(b) Any applicant who initially seeks to participate as a vendor in the program and any authorized vendor currently participating in the program who reapplies for continued participation in the program and thereafter receives written notification from the department of a deficiency in such application shall be afforded fifteen days from the date of such notification by the department to cure such deficiency and file a completed application. The provisions of this subsection shall not apply to vendors who reapply for program participation pursuant to subsection (a) of this section.

(c) The department shall not deny an application from a vendor who initially seeks to participate in the program or an authorized vendor, who is reapplying for continued participation in the program, on the basis of minimum distance requirements between vendors in the geographic area for which the application or reapplication is made.

(d) On and after June 12, 2008, if the Food and Nutrition Service of the United States Department of Agriculture conducts a comprehensive programmatic audit of the department's administration of the federal Special Supplemental Food Program for Women, Infants and Children and thereafter provides written notification to the department that the department's administration of the program is not in compliance with federal law and that the state may be subjected to financial penalties due to such noncompliance, the department shall take such action as the department deems necessary to ensure

compliance with federal law, including suspension of the requirements prescribed in subsections (a), (b) and (c) of this section.

(e) Not later than January 1, 2009, the Department of Public Health shall submit to the Food and Nutrition Service of the United States Department of Agriculture a revised state plan concerning administration of the program that addresses all requirements prescribed in federal law and incorporates the vendor selection, notification and disqualification provisions set forth in this section.

(f) Implementation of the provisions of this section shall be within available appropriations.

(P.A. 08-184, S. 60.)

History: P.A. 08-184 effective June 12, 2008.

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Sec. 19a-59g. Programs and services for pregnant women to reduce incidence of low birth weight among infants. The Department of Public Health, within available appropriations and in consultation with the Departments of Social Services and Education, shall seek to reduce the incidence of low birth weight among infants and reduce the cost to the state from unnecessary hospitalizations of such infants by (1) maximizing coenrollment in the federal Special Supplemental Food Program for Women, Infants and Children and Medicaid for all eligible women; (2) encouraging tobacco cessation programs targeted to pregnant women; and (3) promoting the use of the centering pregnancy model of prenatal care. The department may recover the costs of implementing the provisions of this section through funds available from the Tobacco and Health Trust Fund established under section [4-28f](#) and the federal Temporary Assistance for Needy Families Emergency Fund.

(P.A. 10-133, S. 9.)

History: P.A. 10-133 effective June 8, 2010.

See Sec. 4-165c re immunity of the state and its officials, employees and agents.

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Sec. 19a-59h. Maternal mortality review program. Confidentiality of information. (a) As used in this section and section [19a-59i](#), “maternal death” means the death of a woman while pregnant or not later than one year after the date on which the woman ceases to be pregnant, regardless of whether the woman’s death is related to her pregnancy, and “department” means the Department of Public Health.

(b) There is established, within the department, a maternal mortality review program. The program shall be responsible for identifying maternal death cases in Connecticut and reviewing medical records and other relevant data related to each maternal death case, including, but not limited to, information collected from death and birth records, files from the Office of the Chief Medical Examiner, and physician office and hospital records.

(c) Licensed health care providers, health care facilities and pharmacies shall provide the maternal mortality review program, established under this section with reasonable access to all relevant medical records associated with a maternal death case under review by the program.

(d) A hospital shall provide the department with access, including remote access, to the entirety of a patient’s medical record, as the department deems necessary, to review case information related to a maternal death case under review by the program. Such remote access shall be provided on or before

October 1, 2022, if technically feasible. All personal information obtained from the medical record shall not be divulged to anyone and shall be held strictly confidential pursuant to section [19a-25](#) by the department.

(e) All information obtained by the department for the maternal mortality review program shall be confidential pursuant to section [19a-25](#).

(f) Notwithstanding subsection (e) of this section, the department may provide the maternal mortality review committee, established pursuant to section [19a-59i](#), with information as is necessary, in the department's discretion, for the committee to make recommendations regarding the prevention of maternal death.

(P.A. 18-150, S. 2; P.A. 21-121, S. 81.)

History: P.A. 21-121 added new Subsec. (d) re remote access to medical records, redesignated existing Subsecs. (d) and (e) as Subsecs. (e) and (f) and made a conforming change in Subsec. (f).

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Sec. 19a-59i. Maternal mortality review committee. Development of educational materials by the Department of Public Health. (a) There is established a maternal mortality review committee within the department to conduct a comprehensive, multidisciplinary review of maternal deaths for purposes of identifying factors associated with maternal death and making recommendations to reduce maternal deaths.

(b) The cochairpersons of the maternal mortality review committee shall be the Commissioner of Public Health, or the commissioner's designee, and a representative designated by the Connecticut State Medical Society. The cochairpersons shall convene a meeting of the maternal mortality review committee upon the request of the Commissioner of Public Health.

(c) The maternal mortality review committee may include, but need not be limited to, any of the following members, as needed, depending on the maternal death case being reviewed:

(1) A physician licensed pursuant to chapter 370 who specializes in obstetrics and gynecology, appointed by the Connecticut State Medical Society;

(2) A physician licensed pursuant to chapter 370 who is a pediatrician, appointed by the Connecticut State Medical Society;

(3) A community health worker, appointed by the Commission on Women, Children, Seniors, Equity and Opportunity;

(4) A nurse-midwife licensed pursuant to chapter 377, appointed by the Connecticut Nurses Association;

(5) A clinical social worker licensed pursuant to chapter 383b, appointed by the Connecticut Chapter of the National Association of Social Workers;

(6) A psychiatrist licensed pursuant to chapter 370, appointed by the Connecticut Psychiatric Society;

(7) A psychologist licensed pursuant to chapter [20-136](#), appointed by the Connecticut Psychological Association;

(8) The Chief Medical Examiner, or the Chief Medical Examiner's designee;

(9) A member of the Connecticut Hospital Association;

- (10) A representative of a community or regional program or facility providing services for persons with psychiatric disabilities or persons with substance use disorders, appointed by the Commissioner of Public Health;
- (11) A representative of The University of Connecticut-sponsored health disparities institute; or
- (12) Any additional member the cochairpersons determine would be beneficial to serve as a member of the committee.
- (d) Whenever a meeting of the maternal mortality review committee takes place, the committee shall consult with relevant experts to evaluate the information and findings obtained from the department pursuant to section [19a-59h](#) and make recommendations regarding the prevention of maternal deaths. Not later than ninety days after such meeting, the committee shall report, to the Commissioner of Public Health, any recommendations and findings of the committee in a manner that complies with section [19a-25](#).
- (e) Not later than January 1, 2022, and annually thereafter, the maternal mortality review committee shall submit a report of disaggregated data, in accordance with the provisions of section [19a-25](#), regarding the information and findings obtained through the committee's investigation process to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section [11-4a](#). Such report may include recommendations to reduce or eliminate racial inequities and other public health concerns regarding maternal mortality and severe maternal morbidity in the state.
- (f) All information provided by the department to the maternal mortality review committee shall be subject to the provisions of section [19a-25](#).
- (g) The Department of Public Health shall develop educational materials regarding:
- (1) The health and safety of expectant and postpartum mothers and persons with mental health disorders, including, but not limited to, perinatal mood and anxiety disorders, for distribution by the department to each birthing hospital in the state. As used in this subdivision, "birthing hospital" means a health care facility, as defined in section [19a-630](#), operated and maintained in whole or in part for the purpose of caring for patients during the delivery of a child and for a postpartum mother or person and such mother's or person's newborn following birth;
- (2) Evidence-based screening tools for screening patients for intimate partner violence, peripartum mood disorders and substance use disorder for distribution by the department to obstetricians and other health care providers who practice obstetrics;
- (3) Indicators of intimate partner violence for distribution by the department to (A) hospitals for use by health care providers in the emergency department and hospital social workers, and (B) obstetricians and other health care providers who practice obstetrics; and
- (4) Not later than January 1, 2025, intimate partner violence toward expectant and postpartum mothers and persons for distribution by the department (A) in print to each birthing hospital and birth center in the state, and (B) electronically to obstetricians and other health care providers who practice obstetrics for provision to expectant and postpartum patients. The department shall consult with organizations that advocate on behalf of victims of domestic violence in the development of educational materials pursuant to this subdivision.

(P.A. 18-150, S. 3; P.A. 19-56, S. 5; 19-117, S. 140; P.A. 21-35, S. 12; P.A. 22-58, S. 75; P.A. 24-81, S. 45; 24-151, S. 141.)

History: P.A. 19-56 made a technical change in Subsec. (c), effective June 28, 2019; P.A. 19-117 amended Subsec. (c)(3) to replace “Commission on Equity and Opportunity” with “Commission on Women, Children, Seniors, Equity and Opportunity”, effective July 1, 2019; P.A. 21-35 added new Subsec. (e) re report of disaggregated data and redesignated existing Subsec. (e) as Subsec. (f), effective June 14, 2021; P.A. 22-58 added Subsec. (g) re development of educational materials, effective May 23, 2022; P.A. 24-81 amended Subsec. (g) to replace “Not later than January 1, 2023, the maternal mortality review committee” with “The Department of Public Health”, add Subdiv. (4) re educational materials re intimate partner violence toward pregnant and postpartum persons, and make technical and conforming changes throughout, effective May 30, 2024; P.A. 24-151 amended Subsec. (g) to replace “pregnant” with “expectant” and add references to mothers, effective July 1, 2024.

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Sec. 19a-59j. Infant mortality review program. Confidentiality of information. (a) As used in this section and section [19a-59k](#), “infant death” means the death of a child that occurs between birth and one year of age.

(b) There is established, within the Department of Public Health, an infant mortality review program. The purpose of the program shall be to review medical records and other relevant data related to infant deaths, including, but not limited to, information collected from death and birth records, and medical records from health care providers and health care facilities for the purposes of making recommendations to reduce health care disparities and identify gaps in or problems with the delivery of care or services to reduce infant deaths.

(c) All health care providers, health care facilities and pharmacies shall provide the Commissioner of Public Health, or the commissioner's designee, with access to all medical and other records associated with an infant death case under review by the program, including, but not limited to, prenatal care records, upon the request of the commissioner.

(d) A person who completes a death certificate pursuant to section [7-62b](#) or [19a-409](#) for an infant death shall report such death to the department in a form and manner prescribed by the commissioner.

(e) Notwithstanding any provision of the general statutes, the commissioner shall notify the child fatality review panel, established pursuant to section [46a-13l](#), of an infant death if, pursuant to a review performed by the infant mortality review program, the commissioner determines that such infant death occurred in out-of-home care or was due to unexpected or unexplained causes.

(f) All information obtained by the commissioner, or the commissioner's designee, for the infant mortality review program shall be confidential pursuant to section [19a-25](#).

(g) Notwithstanding any provision of the general statutes, the commissioner, or the commissioner's designee, may provide the infant mortality review committee, established pursuant to section [19a-59k](#), with information as is necessary, in the commissioner's discretion, for the committee to make recommendations regarding the prevention of infant deaths.

(h) The provisions of this section and section [19a-59k](#) shall not be construed to limit or alter the authority of the Office of the Child Advocate or the child fatality review panel, established pursuant to section [46a-13l](#), to investigate or make recommendations regarding a child's death pursuant to the provisions of said section.

(P.A. 23-147, S. 10; P.A. 24-68, S. 55.)

History: P.A. 24-68 amended Subsec. (g) by making a technical change.

Sec. 19a-59k. Infant mortality review committee. (a) There is established an infant mortality review committee within the department to conduct a comprehensive, multidisciplinary review of infant deaths for purposes of reducing health care disparities, identifying factors associated with infant deaths and making recommendations to reduce infant deaths.

(b) The cochairpersons of the infant mortality review committee shall be the Commissioner of Public Health, or the commissioner's designee, and a representative designated by the Connecticut chapter of the American Academy of Pediatrics. The cochairpersons shall convene a meeting of the infant mortality review committee upon the request of the Commissioner of Public Health.

(c) The infant mortality review committee may include, but need not be limited to, any of the following members, as needed, depending on the infant death case being reviewed:

(1) A physician licensed pursuant to chapter 370, who specializes in obstetrics and gynecology, designated by the Connecticut Chapter of the American College of Obstetrics and Gynecology;

(2) A community health worker, designated by the Commission on Women, Children, Seniors, Equity and Opportunity;

(3) A pediatric nurse licensed pursuant to chapter 378, designated by the Connecticut Nurses Association;

(4) A clinical social worker licensed pursuant to chapter 383b, designated by the Connecticut Chapter of the National Association of Social Workers;

(5) The Chief Medical Examiner, or the Chief Medical Examiner's designee;

(6) A member of the Connecticut Hospital Association representing a pediatric facility;

(7) A representative of The University of Connecticut-sponsored Health Disparities Institute;

(8) A physician licensed pursuant to chapter 370, who practices neonatology, designated by the Connecticut Medical Society;

(9) A physician assistant licensed pursuant to chapter 370 or advanced practice registered nurse licensed pursuant to chapter 378, designated by an association representing physician assistants or advanced practice registered nurses in the state;

(10) The Child Advocate, or the Child Advocate's designee;

(11) The Commissioner of Social Services, or the commissioner's designee;

(12) The Commissioner of Children and Families, or the commissioner's designee;

(13) The Commissioner of Early Childhood, or the commissioner's designee;

(14) The Commissioner of Mental Health and Addiction Services, or the commissioner's designee; and

(15) Any additional member the cochairpersons determine would be beneficial to serve as a member of the committee.

(d) For any infant mortality review, the committee may consult with relevant experts to evaluate the information and findings obtained from the department pursuant to section [19a-59j](#) and make recommendations regarding the prevention of infant deaths.

(e) The infant mortality review committee shall include available infant death reports and recommendations produced by the child fatality review panel, established pursuant to section [46a-13/](#), in its review of infant deaths for the purposes of making recommendations to reduce health care disparities and identify gaps in or problems with the delivery of care or services to reduce infant deaths.

(f) Not later than ninety days after completing an infant mortality review, the committee shall, in consultation with the Office of the Child Advocate, report to the Commissioner of Public Health the recommendations and findings of the committee in a manner that complies with section [19a-25](#).

(g) All information provided by the department to the infant mortality review committee or provided to any expert consulted by the committee shall be subject to the provisions of section [19a-25](#).

(P.A. 23-147, S. 11.)

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Sec. 19a-59I. Midwifery working group. Responsibilities. Appointments. Annual report. (a) As used in this section:

(1) “Certified midwife” means any individual who completes a graduate degree in midwifery and passes a national certification examination administered by the American Midwifery Certification Board to receive the professional designation of certified midwife;

(2) “Community birth” means a planned home birth or a birth occurring at a birth center;

(3) “Direct entry midwife” means any individual trained in planned out-of-hospital births other than a nurse-midwife, which may include certified midwives, certified professional midwives, community midwives and traditional midwives; and

(4) “Licensed nurse-midwife” means any individual licensed as a nurse-midwife pursuant to chapter 377.

(b) The Commissioner of Public Health shall establish a midwifery working group. The working group shall study and make recommendations concerning the advancement of choices in care for community birth and the role of direct entry midwives in addressing maternal and infant health disparities. Such study shall include, but need not be limited to:

(1) Improvements in birthing care quality and safety, including improvements addressing racial disparities in maternal and infant health outcomes;

(2) Regulation, licensure or certification of direct entry midwives not otherwise licensed to practice midwifery in the state;

(3) Regulation, licensure or certification of certified midwives not otherwise licensed to practice midwifery in the state; and

(4) Advancements of interprofessional coordination of birthing care, including community birth.

(c) The Commissioner of Public Health shall appoint members of the working group. Such members shall include, but need not be limited to, the commissioner's designee, at least six direct-entry midwives practicing in the state, a certified nurse-midwife with experience working with direct entry midwives, a certified midwife representing an entity that certifies midwives, a doula serving communities of color, a representative of families or a community-based organization with an interest in maternity care, a representative of a community organization furthering health equity, representatives of associated

maternity care professions, a representative of the state hospital association and a representative of the Department of Social Services.

(d) Not later than February 1, 2024, and annually thereafter, the midwifery working group shall report to the Commissioner of Public Health and, in accordance with the provisions of section [11-4a](#), to the joint standing committee of the General Assembly having cognizance of matters relating to public health on its findings and recommendations.

(e) The midwifery working group shall select to renew or disband the group on an annual basis in a manner determined by the commissioner or the commissioner's designee.

(P.A. 23-147, S. 15.)

History: P.A. 23-147 effective July 1, 2023.

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Sec. 19a-59m. Consideration of nutrition education programs re eligibility to receive services from federal program. Not later than January 1, 2025, the Commissioner of Public Health shall consider, to the extent permissible under federal law, each nutrition education program offered as part of the supplemental nutrition assistance program administered by the Department of Social Services pursuant to the federal Food and Nutrition Act of 2008 and section [17b-2](#) as a nutrition education program that qualifies under the federal Special Supplemental Food Program for Women, Infants and Children administered by the Department of Public Health pursuant to section [19a-59c](#) as a nutrition education program the participation in which satisfies the requirement that a recipient of services from said program shall receive nutrition education to maintain eligibility to receive such services.

(P.A. 24-82, S. 4.)

History: P.A. 24-82 effective May 30, 2024.

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Sec. 19a-59n. Annual report re funds for administering federal Special Supplemental Food Program for Women, Infants and Children. List of expenditures. Not later than January 1, 2025, and annually thereafter, the Commissioner of Public Health shall report, in accordance with the provisions of section [11-4a](#), to the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services regarding (1) the Department of Public Health's plan for expending the funds received for administering the federal Special Supplemental Food Program for Women, Infants and Children pursuant to section [19a-59c](#) for the next calendar year, and (2) a detailed list of expenditures of such funds for administering said program during the immediately preceding calendar year.

(P.A. 24-82, S. 6.)

History: P.A. 24-82 effective May 30, 2024.

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Sec. 19a-60. (Formerly Sec. 19-22). Dental services for children. The Department of Public Health may, on request, furnish dental services for children in areas of the state where adequate dental service is unavailable. Such dental service shall be furnished free of charge to all children where the cost of necessary service would be a financial hardship to their parents. Such dental service may be furnished to

children of parents who are financially able to pay part or all of the cost of dental services received by their children. Said department is authorized to charge for dental service in such cases, but in no case more than the actual cost of such service and materials.

(1949 Rev., S. 3827; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; Sec. 19-22 transferred to Sec. 19a-60 in 1983; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

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Sec. 19a-60a. Dental services for children of low-income families. The Commissioner of Public Health, the Commissioner of Social Services and the chief executive officer of The University of Connecticut Health Center, shall establish a pilot program for the delivery of dental services to children of low-income families in two regions of the state. Such program shall provide for the design and implementation of a model integrated system of children's dental care in such regions, including dental disease prevention and service intervention components, and shall provide for measurable outcomes.

(June Sp. Sess. P.A. 00-2, S. 2, 53.)

History: June Sp. Sess. P.A. 00-2 effective July 1, 2000.

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Sec. 19a-61. (Formerly Sec. 19-22b). Services for children suffering from diabetes. The Department of Public Health shall establish and administer a program of services for children suffering from diabetes. Diabetic centers for children shall be geographically located so as to conveniently serve the population of the state. Such centers shall provide medical evaluations for the children and counseling and education concerning the disease for the children and their families, or other such services as are necessary to accomplish the purposes of this section. The staff of each center may include, but shall not be limited to, a nurse practitioner, dietitian, physician and social case worker.

(P.A. 78-196, S. 1, 2, 4; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: Sec. 19-22b transferred to Sec. 19a-61 in 1983; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

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Sec. 19a-62. (Formerly Sec. 19-22c). Services for children suffering from cancer. The health center of The University of Connecticut at Farmington shall establish and administer a program of services for children suffering from cancer. Such center shall provide medical evaluations for such children, counseling and education concerning the disease for the children and their families, and such other services as are necessary to accomplish the purposes of this section. The staff of the center may include, but shall not be limited to, a nurse practitioner, a dietitian, a physician and a social case worker.

(P.A. 79-465, S. 1, 2.)

History: Sec. 19-22c transferred to Sec. 19a-62 in 1983.

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Sec. 19a-62a. Asthma monitoring system. Posting of activities of system on department's Internet web site.
(a) The Commissioner of Public Health shall maintain a system of monitoring asthma screening information reported to the Department of Public Health pursuant to subsection (f) of section [10-206](#).

(b) Not later than October 1, 2021, and triennially thereafter, the Department of Public Health shall post on its Internet web site the activities of the asthma screening monitoring system maintained under subsection (a) of this section, including a report of the information obtained by the department pursuant to subsection (f) of section [10-206](#).

(P.A. 00-216, S. 8, 28; June Sp. Sess. P.A. 01-4, S. 42; P.A. 06-164, S. 4; P.A. 18-168, S. 7.)

History: P.A. 00-216 effective July 1, 2000; June Sp. Sess. P.A. 01-4 designated existing Subsec. (a) as Subsec. (a)(1) and existing Subsec. (b) as Subsec. (a)(2), making a technical change therein, added new Subsec. (b) re asthma monitoring system, added Subsec. (c) re state-wide asthma plan and model case definition and added Subsec. (d) re annual report; P.A. 06-164 amended Subsec. (a)(1) to substitute “Nurturing Families Network” for “Healthy Families”, effective July 1, 2006; P.A. 18-168 deleted Subsec. (a) re pediatric asthma pilot program, redesignated Subsec. (b) re system of monitoring asthma as Subsec. (a) and amended same to delete provisions re information to be included in system and add provision re monitoring screening information reported to department pursuant to Sec. 10-206, deleted Subsec. (c) re state-wide asthma plan and deleted Subsec. (d) re report on status and results of monitoring system, and added new Subsec. (b) re department to post on Internet web site activities of monitoring system.

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Secs. 19a-63 to 19a-67. (Formerly Secs. 19-23a to 19-23e). Diagnostic x-ray systems; regulatory authority; definition. Prevention of excess x-ray exposure; regulations. Compliance with regulations. Advisory board. Exemption from regulation. Sections [19a-63](#) to [19a-67](#), inclusive, are repealed.

(P.A. 78-239, S. 1, 3–6, 8; 78-303, S. 85, 136; P.A. 93-249, S. 7.)

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Sec. 19a-68. (Formerly Sec. 19-26). Detention of persons affected with communicable disease or radioactive material. Section [19a-68](#) is repealed.

(1949 Rev., S. 3805; 1955, S. 2036d; P.A. 77-614, S. 323, 610; P.A. 84-336, S. 5.)

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Sec. 19a-69. (Formerly Sec. 19-27). Distribution of biologic products. In order to protect the public health of the citizens of the state and to assist in the enforcement of, and compliance with, day care center and school immunization regulations, the Department of Public Health may procure and distribute vaccine or other biologic products to town, city and borough directors of health and to health care providers for administration as determined by the department.

(1949 Rev., S. 3832; 1955, S. 2046d; 1957, P.A. 151, S. 1; P.A. 87-111; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: Sec. 19-27 transferred to Sec. 19a-69 in 1983; P.A. 87-111 clarified the department's authority to distribute biologic products as determined necessary; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

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Sec. 19a-70. (Formerly Sec. 19-28). Priority of distribution in emergency. If the Department of Public Health finds that there is an epidemic of any disease within the state and that antitoxin or other biologic product is in short supply, the commissioner shall notify the Governor, who may proclaim that an emergency exists. On such declaration, the Governor shall appoint an advisory committee, consisting of the Commissioner of Public Health and such five other persons as the Governor deems advisable. The committee shall recommend to the Department of Public Health the priority of the supply, distribution and use of such biologic products in the interest of the health, welfare and safety of the people of the state. The Department of Public Health, after receiving the recommendations of the committee, is authorized to make regulations determining the priority of supply, distribution and use of such biologic product. Violation of any such regulation on the part of any physician or pharmacist shall be cause for the revocation, suspension or annulment of a license or certificate of registration or other disciplinary action in accordance with sections [20-13a](#) to [20-13e](#), inclusive, or section [20-45](#), [20-576](#) or [20-579](#).

(1955, S. 2047d; 1957, P.A. 151, S. 2; P.A. 76-276, S. 17, 22; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; 95-264, S. 47; P.A. 08-184, S. 6.)

History: P.A. 76-276 added reference to Secs. 20-13a to 20-13i; P.A. 77-614 replaced department and commissioner of health with department and commissioner of health services, effective January 1, 1979; Sec. 19-28 transferred to Sec. 19a-70 in 1983; P.A. 93-381 replaced department and commissioner of health services with department and commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 95-264 provided that discipline for violations of regulations shall be in accordance with Secs. 20-45, 20-576 and 20-579; P.A. 08-184 replaced “20-13i” with “20-13e”.

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Sec. 19a-71. (Formerly Sec. 19-29). Observation and treatment of certain typhoid germ carriers. Section [19a-71](#) is repealed, effective October 1, 2002.

(1949 Rev., S. 3834; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; S.A. 02-12, S. 1.)

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Sec. 19a-72. (Formerly Sec. 19-29a). Connecticut Tumor Registry. Definitions. Duties of Department of Public Health. Reporting requirements. Penalties. Regulations. (a) As used in this section:

(1) “Clinical laboratory” has the same meaning as provided in section [19a-490](#);

(2) “Hospital” has the same meaning as provided in section [19a-490](#);

(3) “Health care provider” means any person or organization that furnishes health care services and is licensed or certified to furnish such services pursuant to chapters 370, 372, 373, 375, 378 and 379 or is licensed or certified pursuant to chapter 384d;

(4) “Occupation” means the usual kind of work performed by an individual;

(5) “Industry” means the type of business to which an occupation relates; and

(6) “Reportable tumor” means tumors and conditions included in the Connecticut Tumor Registry reportable list maintained by the Department of Public Health, as amended from time to time, as deemed necessary by the department.

(b) The Department of Public Health shall maintain and operate the Connecticut Tumor Registry. Said registry shall include a report of every occurrence of a reportable tumor that is diagnosed or treated in the state. Such reports shall be made to the department by any hospital, clinical laboratory or health care provider in the state. Such reports shall include, but not be limited to, pathology reports and information obtained from records of any person licensed as a health care provider and may include a collection of actual tissue samples and such information as the department may prescribe. Information contained in the report shall include, when available: (1) Demographic data; (2) occupation and industry of the patient; (3) diagnostic, treatment and pathology reports; (4) operative reports, hematology, medical oncology and radiation therapy consults, or abstracts of such reports or consults in a format prescribed by the department; and (5) other medical information as the department may prescribe. Such information shall be reported to the department not later than six months after diagnosis or the first encounter for treatment of a reportable tumor, in the form and manner prescribed by the department and updates of such information shall be reported to the department, annually, for the duration of the patient's lifetime. Such reports shall include every occurrence of a reportable tumor that is diagnosed or treated during a calendar year.

(c) (1) A health care provider shall provide the Department of Public Health, at the request of the department, access to the clinical records of any patient, as the department deems necessary, to perform case finding or other quality improvement audits to ensure completeness of reporting and data accuracy consistent with the purposes of this section.

(2) A hospital shall provide the Department of Public Health with access, including remote access, to the entirety of a patient's medical record, as the department deems necessary, to perform case finding or other quality improvement audits to ensure completeness of reporting and data accuracy consistent with the purposes of this section. Such remote access shall be provided on or before October 1, 2022, if technically feasible. The department shall not divulge any personal information obtained from the medical record to anyone and shall hold any such personal information strictly confidential pursuant to section [19a-25](#).

(d) The Department of Public Health may enter into a contract for the receipt, storage, holding or maintenance of the data, files or tissue samples under its control and management.

(e) The Department of Public Health may enter into reciprocal reporting agreements with the appropriate agencies of other states to exchange tumor reports.

(f) (1) Failure by a hospital, clinical laboratory or health care provider to comply with the reporting requirements prescribed in this section may result in the department electing to perform the registry services for such hospital, clinical laboratory or provider. In such case, the hospital, clinical laboratory or provider shall reimburse the department for actual expenses incurred in performing such services.

(2) Any hospital, clinical laboratory or health care provider that fails to comply with the provisions of this section shall be liable for a civil penalty not to exceed five hundred dollars for each failure to disclose a

reportable tumor, as determined by the commissioner.

(3) A hospital, clinical laboratory or health care provider that fails to report cases of cancer as required in regulations adopted in accordance with the provisions of subsection (h) of this section, shall be assessed a civil penalty not to exceed two hundred fifty dollars per business day, for each day thereafter that the report is not submitted and ordered to comply with the terms of this subsection by the Commissioner of Public Health.

(4) The reimbursements, expenses and civil penalties set forth in this section shall be assessed only after the Department of Public Health has provided a hospital, clinical laboratory or health care provider with written notice of deficiency and such hospital, clinical laboratory or health care provider has been afforded not less than fourteen business days after the date of receiving such notice to provide a written response to the department. Such written response shall include any information requested by the department.

(g) The Commissioner of Public Health may request that the Attorney General initiate an action to collect any civil penalties assessed pursuant to this section and obtain such orders as necessary to enforce any provision of this section.

(h) The Commissioner of Public Health may adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of this section.

(P.A. 80-143, S. 1, 3; P.A. 81-472, S. 43, 159; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 09-232, S. 7; P.A. 10-18, S. 5; P.A. 12-197, S. 3; P.A. 13-208, S. 23; P.A. 14-231, S. 29; P.A. 18-168, S. 1; P.A. 21-121, S. 79; P.A. 22-58, S. 25.)

History: P.A. 81-472 made technical changes; Sec. 19-29a transferred to Sec. 19a-72 in 1983; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 09-232 replaced existing provisions with Subsecs. (a) to (g) re definitions, duties of department, reporting requirements and penalties for noncompliance with such requirements; P.A. 10-18 made a technical change in Subsec. (f)(2); P.A. 12-197 amended Subsec. (b) by adding provision re pathology reports to be included in registry and making a technical change; P.A. 13-208 amended Subsec. (b) by replacing provision re data, demographic, diagnostic and treatment information with provisions re information to be contained in report, adding provision re deadline for information to be reported and deleting provision re annual report, effective June 21, 2013; P.A. 14-231 amended Subsec. (a) by replacing references to Chs. 375a to 384a, 388, 398 and 399 with references to Chs. 378 and 379 in Subdiv. (3), adding new Subdiv. (4) defining “occupation”, adding Subdiv. (5) defining “industry” and redesignating existing Subdiv. (4) as Subdiv. (6), amended Subsec. (b) by adding new Subdiv. (2) re occupation and industry, redesignating existing Subdivs. (2) to (4) as Subdivs. (3) to (5), adding provision re updates of information and deleting provision re list of data items, amended Subsec. (d) by adding “receipt”, replacing “and” with “or” and adding “data, files or”, amended Subsec. (f) by replacing provision re Sec. 19a-73 with provision re Subsec. (h) in Subdiv. (3) and substantially revising Subdiv. (4) re notice, added Subsec. (h) re regulations and made technical changes; P.A. 18-168 amended Subsec. (a)(3) by replacing “chapter 368d” with “chapter 384d”; P.A. 21-121 amended Subsec. (c) by designating existing provision as Subdiv. (1) and amending same to make technical changes and adding Subdiv. (2) re remote access to medical records; P.A. 22-58 amended Subsec. (a)(1) by redefining “clinical laboratory” and amended Subsec. (a)(2) by redefining “hospital”.

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Sec. 19a-72a. State-wide stroke registry. (a) The Department of Public Health shall maintain and operate a state-wide stroke registry.

(b) On and after July 1, 2023, each comprehensive stroke center, thrombectomy-capable stroke center, primary stroke center or acute stroke-ready hospital shall, on a quarterly basis, submit to the Department of Public Health data concerning stroke care that are necessary for including in the state-wide stroke registry, as determined by the Commissioner of Public Health, and that, at a minimum, align with the stroke consensus metrics developed and approved by a nationally-recognized stroke certification body. The department shall apply privacy and security standards for such registry's data that are consistent with the department's policies for use of patient data.

(c) Each comprehensive stroke center, thrombectomy-capable stroke center, primary stroke center and acute stroke-ready hospital shall provide access to its records to the Department of Public Health, as the department deems necessary, to perform case finding or other quality improvement audits to ensure completeness of reporting and data accuracy consistent with the purposes of this section.

(d) The Department of Public Health may enter into a contract for the receipt, storage, holding or maintenance of the data or files under its control and management.

(e) The Department of Public Health may enter into reciprocal reporting agreements with the appropriate agencies of other states to exchange stroke care data.

(f) There is established a stroke registry data oversight committee to monitor the operations of the state-wide stroke registry, provide advice regarding the oversight of such registry, develop a plan to improve quality of stroke care and address disparities in the provision of such care, and develop short and long-term goals for improvement of stroke care in comprehensive stroke centers, thrombectomy-capable stroke centers, primary stroke centers and acute stroke-ready hospitals. Said committee shall be within the Legislative Branch and the administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall serve as administrative staff to said committee. Said committee shall consist of the following members, who shall be appointed not later than July 1, 2023: (1) One appointed by the speaker of the House of Representatives; (2) one appointed by the president pro tempore of the Senate; (3) one appointed by the majority leader of the House of Representatives; (4) one appointed by the majority leader of the Senate; (5) one appointed by the minority leader of the House of Representatives; and (6) one appointed by the minority leader of the Senate. An appointing authority may consult with the State of Connecticut Stroke Advisory Council in selecting a member to appoint to the oversight committee. Each member shall serve a term of two years. The speaker of the House of Representatives and the president pro tempore of the Senate shall each appoint, from among the members of the oversight committee, a co-chairperson, who shall jointly schedule the first meeting of the oversight committee on or before August 1, 2023. The Department of Public Health shall assist said committee in its work and provide any information or data that the committee deems necessary to fulfil its duties, unless the disclosure of such information or data is prohibited by state or federal law. Not later than January 1, 2024, and annually thereafter, the co-chairpersons of the committee shall jointly report, in accordance with the provisions of section [11-4a](#), to the joint standing committee of the General Assembly having cognizance of matters relating to public health, regarding the work of the committee. Not later than January 1, 2024, and at least annually thereafter, such co-chairpersons shall report to the Commissioner of Public Health and the State of Connecticut Stroke Advisory Council, regarding the work of the committee.

(g) The Commissioner of Public Health may adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of this section.

(P.A. 22-118, S. 147.)

History: P.A. 22-118 effective May 7, 2022.

Sec. 19a-72b. State-wide registry on Parkinson's disease and Parkinsonism. Oversight committee. Regulations. (a) As used in this section:

(1) "Health care provider" means any person or organization that furnishes health care services to persons with Parkinson's disease or Parkinsonism and is licensed or certified to furnish such services pursuant to chapters 370 and 378; and

(2) "Hospital" has the same meaning as provided in section [19a-490](#).

(b) Not later than April 1, 2026, the Department of Public Health, in collaboration with a public institution of higher education in the state, shall maintain and operate, within available appropriations, a state-wide registry of data on Parkinson's disease and Parkinsonism.

(c) Each hospital and each health care provider shall make available to the registry such data concerning each patient with Parkinson's disease or Parkinsonism admitted to such hospital or treated by such health care provider for such patient's Parkinson's disease or Parkinsonism as the Commissioner of Public Health shall require by regulations adopted in accordance with chapter 54. Each hospital and health care provider shall provide each such patient with notice of, and the opportunity to opt out of, such disclosure.

(d) The data contained in such registry may be used by the department and authorized researchers as specified in such regulations, provided personally identifiable information in such registry concerning any such patient with Parkinson's disease or Parkinsonism shall be held confidential pursuant to section [19a-25](#). The data contained in the registry shall not be subject to disclosure under the Freedom of Information Act, as defined in section [1-200](#). The commissioner may enter into a contract with a nonprofit association in this state concerned with the prevention and treatment of Parkinson's disease and Parkinsonism to provide for the implementation and administration of the registry established pursuant to this section.

(e) Each hospital shall provide access to its records to the Department of Public Health, as the department deems necessary, to perform case finding or other quality improvement audits to ensure completeness of reporting and data accuracy consistent with the purposes of this section.

(f) The Department of Public Health may enter into a contract for the receipt, storage, holding or maintenance of the data or files under its control and management for the purpose of implementing the provisions of this section.

(g) The Department of Public Health may enter into reciprocal reporting agreements with the appropriate agencies of other states to exchange Parkinson's disease and Parkinsonism care data.

(h) The Department of Public Health shall establish a Parkinson's disease and Parkinsonism data oversight committee to (1) monitor the operations of the state-wide registry established pursuant to subsection (b) of this section, (2) provide advice regarding the oversight of such registry, (3) develop a plan to improve quality of Parkinson's disease and Parkinsonism care and address disparities in the provision of such care, and (4) develop short and long-term goals for improvement of such care.

(i) Said committee shall include, but need not be limited to, the following members, who shall be appointed by the Commissioner of Public Health not later than April 1, 2026: (1) A neurologist; (2) a movement disorder specialist; (3) a primary care provider; (4) a neuropsychiatrist who treats Parkinson's disease; (5) a patient living with Parkinson's disease; (6) a public health professional; (7) a population health researcher with experience in state-wide registries of health condition data; (8) a patient advocate; (9) a family caregiver of a person with Parkinson's disease; (10) a representative of a nonprofit organization related to Parkinson's disease; (11) a physical therapist with experience working with persons with Parkinson's disease; (12) an occupational therapist with experience working with persons with Parkinson's disease; (13) a speech therapist with experience working with persons with Parkinson's disease; (14) a social worker with experience providing services to persons with Parkinson's disease; (15) a geriatric specialist; and (16) a palliative care specialist. Each member shall serve a term of two years. The

commissioner shall appoint, from among the members of the oversight committee, a chairperson who shall schedule the first meeting of the oversight committee on or before April 1, 2026. The Department of Public Health shall assist said committee in its work and provide any information or data that the committee deems necessary to fulfil its duties, unless the disclosure of such information or data is prohibited by state or federal law. Not later than January 1, 2027, and annually thereafter, the chairperson of the committee shall report, in accordance with the provisions of section [11-4a](#), to the joint standing committee of the General Assembly having cognizance of matters relating to public health, regarding the work of the committee. Not later than January 1, 2027, and at least annually thereafter, such chairperson shall report to the Commissioner of Public Health regarding the work of the committee.

(j) The Commissioner of Public Health may adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of this section. The commissioner may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulations, provided notice of intent to adopt regulations is published on the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

(P.A. 24-19, S. 26.)

History: P.A. 24-19 effective May 21, 2024.

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Sec. 19a-73. (Formerly Sec. 19-29b). Occupational history of cancer patients in hospital medical records. Regulations. Section [19a-73](#) is repealed, effective October 1, 2014.

(P.A. 80-143, S. 2, 3; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 01-195, S. 138, 181; P.A. 14-231, S. 72.)

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Sec. 19a-73a. Establishment of comprehensive cancer plan for state. The Department of Public Health shall, within available appropriations, establish a comprehensive cancer plan for the state of Connecticut. Such plan shall provide for (1) creation of a state-wide smoking cessation program targeting Medicaid recipients, (2) development and implementation of a program to encourage colorectal screenings for state residents, (3) development and implementation of a state-wide clinical trials network, (4) identification of services for, and provision of assistance to, cancer survivors, and (5) identification of, and the provision of services to, organizations that offer educational programs on hospice or palliative care.

(P.A. 06-195, S. 52.)

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Sec. 19a-73b. Funding sources for comprehensive cancer program. The Department of Public Health may apply for and receive money from public and private sources and from the federal government for the purpose of funding, in whole or in part, a comprehensive cancer program. Any payment to the state as a settlement of a court action of which the proceeds may be used for health shall be deposited in an account designated for use by the department for comprehensive cancer initiatives.

(P.A. 06-195, S. 6.)

History: P.A. 06-195 effective July 1, 2006.

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Sec. 19a-74. (Formerly Sec. 19-30). Cancer. The Department of Public Health may make investigations concerning cancer, the prevention and treatment thereof and the mortality therefrom and take such action as it deems will assist in bringing about a reduction in the mortality due thereto.

(1949 Rev., S. 3835; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; Sec. 19-30 transferred to Sec. 19a-74 in 1983; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

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Sec. 19a-74a. Regulations re information on nicotine yield ratings for brands of tobacco products. Section [19a-74a](#) is repealed, effective June 11, 2014.

(P.A. 99-250, S. 2; P.A. 14-187, S. 55.)

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Sec. 19a-75. (Formerly Sec. 19-30b). State aid for health career educational programs. Any state-aided hospital or nonprofit institution of higher learning which operates or intends to operate a school of nursing approved by the State Board of Examiners for Nursing or operates or intends to operate other health career educational programs may apply to the Department of Public Health or the Board of Regents for Higher Education, as the case may be, for funds to be used to establish or maintain such school or to support such programs. Said department or board shall, within available appropriations, grant such funds to any such hospital or institution of higher learning, provided the purposes for which such funds are to be used shall be approved by said department or board.

(1967, P.A. 618, S. 2; 1969, P.A. 693, S. 7; P.A. 77-573, S. 24, 30; 77-614, S. 323, 610; P.A. 82-218, S. 37, 46; P.A. 84-241, S. 2, 5; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 11-48, S. 285.)

History: 1969 act included “other health career educational programs” in addition to nursing, which programs would be under commission for higher education re fund applications for program support; P.A. 77-573 replaced commission for higher education with board of higher education; P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; P.A. 82-218 reorganized system of higher education, replacing board of higher education with board of governors, effective March 1, 1983; Sec. 19-30b transferred to Sec. 19a-75 in 1983; P.A. 84-241 added “of higher education” to board of governors' title; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; pursuant to P.A. 11-48, “Board of Governors of Higher Education” was changed editorially by the Revisors to “Board of Regents for Higher Education”, effective July 1, 2011.

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Sec. 19a-75a. Child and adolescent psychiatrist grant program for recruitment, hiring and retention of child and adolescent psychiatrists. Report. (a) On or before January 1, 2023, the Department of Public Health shall establish and administer a child and adolescent psychiatrist grant program. The program shall provide incentive grants to employers of child and adolescent psychiatrists for recruiting and hiring new child and adolescent psychiatrists and retaining child and adolescent psychiatrists who are in their employ. The Commissioner of Public Health shall establish eligibility requirements, priority categories, funding limitations and the application process for the grant program. Such priority categories shall include, but need not be limited to, nonhospital employers. The commissioner, in consultation with the Office of Health Strategy, shall distribute incentive grant funds equitably with regard to the type of employer and location of such employer.

(b) Not later than January 1, 2024, and annually thereafter, the Commissioner of Public Health shall report, in accordance with the provisions of section [11-4a](#), to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding the number and demographics of the employers who applied for and received incentive grants from the child and adolescent psychiatrist grant program established under subsection (a) of this section, the use of incentive grant funds by such recipients and any other information deemed pertinent by the commissioner.

(P.A. 22-47, S. 38.)

History: P.A. 22-47 effective May 23, 2022.

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Sec. 19a-75b. Incentive program to encourage doctoral degree candidates to serve a semester-long clerkship as a psychological assessor or psychotherapist at a facility licensed or operated by the Department of Children and Families or any other state agency deemed appropriate by the Commissioner of Children and Families. (a) As used in this section, “clerkship” means a program in which a candidate for a doctoral degree based on a program of studies whose content was primarily psychological at an educational institution approved in accordance with section [20-189](#), works as a psychological assessor or psychotherapist for between twelve and sixteen hours per week and during which the candidate was supervised by an agency-affiliated psychologist and at least one core faculty member of the doctoral degree program.

(b) On or before January 1, 2023, the Department of Public Health shall establish an incentive program to encourage doctoral degree candidates to serve at least one semester-long clerkship at a facility licensed or operated by the Department of Children and Families, or for any other state agency as deemed appropriate by the Commissioner of Children and Families. Any person who serves at least one semester-long clerkship at such facility may renew such person's license issued under chapter 383 once every two years for the first four years such person is licensed under said chapter.

(P.A. 22-47, S. 45.)

History: P.A. 22-47 effective July 1, 2022.

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Sec. 19a-76. (Formerly Sec. 19-30d). State aid to municipal and district departments of health. Regulations. The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, establishing minimum standards for approval of the public health programs and budgets of health districts and municipal health departments, as required under sections [19a-202](#) and [19a-245](#).

(P.A. 78-251, S. 5–7; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: Sec. 19-30d transferred to Sec. 19a-76 in 1983; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

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Sec. 19a-77. “Child care services” defined. Exclusions. Additional license. (a) As used in this section and sections [19a-77a](#) to [19a-80](#), inclusive, and sections [19a-82](#) to [19a-87a](#), inclusive, “child care services” includes:

- (1) A “child care center” which offers or provides a program of supplementary care to more than twelve related or unrelated children outside their own homes on a regular basis;
 - (2) A “group child care home” which offers or provides a program of supplementary care (A) to not less than seven or more than twelve related or unrelated children on a regular basis, or (B) that meets the definition of a family child care home except that it operates in a facility other than a private family home;
 - (3) A “family child care home” which consists of a private family home providing care (A) for (i) not more than six children, including the provider's own children not in school full time, without the presence or assistance of an assistant or substitute staff member approved by the Commissioner of Early Childhood, pursuant to section [19a-87b](#), present and assisting the provider, or (ii) not more than nine children, including the provider's own children, with the presence and assistance of such approved assistant or substitute staff member, and (B) for not less than three or more than twelve hours during a twenty-four-hour period and where care is given on a regularly recurring basis except that care may be provided in excess of twelve hours but not more than seventy-two consecutive hours to accommodate a need for extended care or intermittent short-term overnight care. During the regular school year, for providers described in subparagraph (A)(i) of this subdivision, a maximum of three additional children who are in school full time, including such provider's own children, shall be permitted, except that if such provider has more than three children who are such provider's own children and in school full time, all of such provider's own children shall be permitted. During the summer months when regular school is not in session, for providers described in subparagraph (A)(i) of this subdivision, a maximum of three additional children who are otherwise enrolled in school full time shall be permitted if there is such an approved assistant or substitute staff member present and assisting such provider, except that (i) if such provider has more than three such additional children who are such provider's own children, all of such provider's own children shall be permitted, and (ii) such approved assistant or substitute staff member shall not be required if all of such additional children are such provider's own children;
 - (4) “Night care” means the care provided for one or more hours between the hours of 10:00 p.m. and 5:00 a.m.; and
 - (5) “Year-round program” means a program open at least fifty weeks per year.
- (b) For licensing requirement purposes, child care services shall not include such services which are:
- (1) (A) Administered by a public school system, or (B) administered by a municipal agency or department;
 - (2) Administered by a private school which is in compliance with section [10-188](#) and is approved by the State Board of Education or is accredited by an accrediting agency recognized by the State Board of Education, provided the provision of such child care services by the private school is only to those children whose ages are covered under such approval or accreditation;

(3) Classes in music, dance, drama and art that are no longer than two hours in length; classes that teach a single skill that are no longer than two hours in length; library programs that are no longer than two hours in length; scouting; programs that offer exclusively sports activities; rehearsals; academic tutoring programs; or programs exclusively for children thirteen years of age or older;

(4) Informal arrangements among neighbors and formal or informal arrangements among relatives in their own homes, provided the relative is limited to any of the following degrees of kinship by blood, marriage or court order to the child being cared for: Grandparent, great-grandparent, sibling, aunt or uncle;

(5) Supplementary child care operations for educational or recreational purposes and the child receives such care infrequently where the parents are on the premises;

(6) Supplementary child care operations in retail establishments where the parents remain in the same store as the child for retail shopping, provided the drop-in supplementary child-care operation does not charge a fee and does not refer to itself as a child care center;

(7) Administered by a nationally chartered boys' and girls' club that are exclusively for school-age children;

(8) Religious educational activities administered by a religious institution exclusively for children whose parents or legal guardians are members of such religious institution;

(9) Administered by Solar Youth, Inc., a New Haven-based nonprofit youth development and environmental education organization;

(10) Programs administered by organizations under contract with the Department of Social Services pursuant to section [17b-851a](#) that promote the reduction of teenage pregnancy through the provision of services to persons who are ten to nineteen years of age, inclusive;

(11) Administered by the Cardinal Shehan Center, a Bridgeport-based nonprofit organization that is exclusively for school-age children;

(12) Administered by Organized Parents Make a Difference, Inc., a Hartford-based nonprofit organization that is exclusively for school-age children;

(13) Administered by Leadership, Education and Athletics in Partnership, Inc., a New Haven-based nonprofit youth development organization;

(14) Programs that exclusively provide care for children of members of the United States Coast Guard or any branch of the military under the United States Department of Defense and that are (A) administered by the federal government or on federal property, or (B) administered by a person certified as a family child care provider by the United States Coast Guard or a branch of the military under the United States Department of Defense; or

(15) Administered by Police Athletic League of Stamford, Inc., a Stamford-based nonprofit youth activities organization.

(c) Any entity or organization that provides services or a program described in subsection (b) of this section shall inform the parents and legal guardians of any children receiving such services or enrolled in such programs that such entity or organization is not licensed by the Office of Early Childhood to provide such services or offer such program.

(d) No registrant or licensee of any child care services as defined in subsection (a) of this section shall be issued an additional registration or license to provide any such services at the same facility.

(e) When a licensee has vacated premises approved by the office for the provision of child care services and the landlord of such licensee establishes to the satisfaction of the office that such licensee has no legal right or interest to such approved premises, the office may make a determination with respect to an application for a new license for the provision of child care services at such premises.

(1967, P.A. 696, S. 1; 1971, P.A. 276, S. 1; P.A. 77-157, S. 1, 11; P.A. 82-35, S. 1, 2; P.A. 83-56; P.A. 85-613, S. 39, 154; P.A. 86-417, S. 10, 15; P.A. 87-131; P.A. 90-298, S. 1; P.A. 93-20, S. 1; 93-175; P.A. 95-360, S. 21, 30, 32; P.A. 97-259, S. 32, 41; P.A. 98-71, S. 1, 3; 98-252, S. 56; P.A. 00-135, S. 2, 21; P.A. 03-252, S. 22; June 30 Sp. Sess. P.A. 03-3, S. 29; P.A. 05-272, S. 40; P.A. 07-129, S. 1; 07-252, S. 87; P.A. 08-184, S. 25; P.A. 09-232, S. 42, 103; P.A. 10-117, S. 75; P.A. 11-193, S. 1; 11-242, S. 14; P.A. 14-38, S. 2; 14-39, S. 48; P.A. 15-227, S. 20, 25; P.A. 16-100, S. 2; P.A. 18-169, S. 1; 18-172, S. 4; P.A. 19-122, S. 1; P.A. 22-81, S. 7; P.A. 23-29, S. 1; 23-204, S. 187; P.A. 24-68, S. 45.)

History: 1971 act excluded from consideration as child day care center, facilities which are an integral part of a public or private school in compliance with Sec. 10-188, previously exclusion was for facilities forming an integral part of “the school system”; P.A. 77-157 redefined “child day care center” to remove reference to excluded facilities and to require enrollment of “more than twelve” children rather than of “five or more”, defined “group day care home” and “family day care home” in new Subsecs. (b) and (c) and grouped all definitions as “child day care services” and added Subsec. (d) re services not considered child day care services; P.A. 82-35 amended Subsec. (a) to include “related” children in the description of a child day care center, amended Subsec. (b) to change the number of children cared for in a group day care home from not less than five to not less than seven, amended Subsec. (c) to allow “six children including the provider's own children not in school full time” to be cared for in a family day care home where previously the limit had been “four children not related to the provider”, and added Subdiv. (4) on drop in supplementary child care operations to Subsec. (d); Sec. 19-43b transferred to Sec. 19a-77 in 1983; P.A. 83-56 added Subsec. (e) prohibiting the issuance of an additional license to provide services at the same facility; P.A. 85-613 made technical changes; P.A. 86-417 added references to registration in Subsecs. (d) and (e); P.A. 87-131 reordered the subsections, combining Subsecs. (a), (b) and (c) as Subsec. (a) and relettering Subsecs. (d) and (e) accordingly and added language in Subsec. (a) on the maximum number of children in school full time allowed during the school year; P.A. 90-298 excluded library programs from registration and licensing requirements in Subsec. (b); P.A. 93-20 amended definition of “family day care home” in Subsec. (a) to allow extended care or intermittent short-term overnight care; P.A. 93-175 amended Subsec. (b) by removing reference to private schools in Subdiv. (1) and inserting as new Subdiv. (2) a provision requiring private schools to be approved or accredited to remain exempt from licensing and registration requirements and renumbered remaining Subdivs. accordingly; P.A. 95-360 substituted Sec. 19a-82 for Sec. 19a-81 in Subsec. (a), effective July 13, 1995, and amended Subsec. (b) by providing the definition of “relative” for purposes of Subdiv. (4); P.A. 97-259 added definitions of “night care” and “year-round” in Subsec. (a), effective July 1, 1997; P.A. 98-71 amended Subsec. (b) by adding Subdiv. (6) re retail establishments and made technical changes by moving definition of “relative” to Subdiv. (4), effective May 19, 1998; P.A. 98-252 amended Subsec. (b) to add creative art studios in Subdiv. (3); P.A. 00-135 amended Subsec. (b)(1) by designating existing provisions as Subpara. (A) and adding Subpara. (B) re services administered by a municipal agency or department and located in a public school building, effective May 26, 2000; P.A. 03-252 amended Subsec. (b) by adding Subdiv. (7) re activities administered by religious institution, effective July 9, 2003; June 30 Sp. Sess. P.A. 03-3 amended Subsec. (b) by deleting reference to “registration” requirement purposes and deleting requirement in Subdiv. (1) that children be “students enrolled in that school”, effective August 20, 2003; P.A. 05-272 amended Subsec. (b) by making technical changes and removing reference to “boys' and girls' clubs” in Subdiv. (3), adding new Subdiv. (7) to exempt drop-in programs administered by a nationally chartered boys' and girls' club from day care licensing requirements and redesignating existing Subdiv. (7) as Subdiv. (8), effective July 13, 2005; P.A. 07-129 amended Subsec. (a)(2) by redefining “group day care home” to include programs of supplementary care that meet definition of a family day care home except that they operate in a facility other than a private family home, amended Subsec. (b)(3) by modifying list of services exempted from child day care licensing requirements and made technical changes; P.A. 07-252 amended Subsec. (b)(3) to delete 4-H from list of exempted activities and to revise exemption re sports activities; P.A. 08-184 made

technical changes in Subsec. (a)(2) and (3); P.A. 09-232 added Subsec. (b)(9) excluding Solar Youth, Inc. from licensing requirements, effective July 1, 2009, and added Subsec. (d) re application for new license at approved premises when former licensee has vacated such premises, effective July 8, 2009; P.A. 10-117 added Subsec. (b)(10) re excluding for licensing requirement purposes programs administered by organizations under contract with Department of Social Services that promote reduction of teenage pregnancy, effective June 8, 2010; P.A. 11-193 added Subsec. (b)(11) excluding Cardinal Shehan Center from licensing requirements, effective July 1, 2011; P.A. 11-242 amended Subsec. (b)(4) by excluding formal arrangements among relatives from child day care licensing requirements and amended Subsec. (b)(6) by deleting reference to repealed Sec. 19a-77a and by substituting “parents remain in the same store as the child” for “parents are on the premises”; P.A. 14-38 amended Subsec. (b)(1) by deleting “and located in a public school building”, effective July 1, 2014; P.A. 14-39 replaced references to Department of Public Health with references to Office of Early Childhood, effective July 1, 2014; P.A. 15-227 amended Subsec. (a) by making definitions applicable to Sec. 19a-87a, replacing “child day care services” with “child care services”, “child day care center” with “child care center”, “group day care home” with “group child care home” and “family day care home” with “family child care home”, and making technical changes, effective July 1, 2015; pursuant to P.A. 15-227, “child day care services” and “child day care center” were changed editorially by the Revisors to “child care services” and “child care center”, respectively, in Subsecs. (b) to (d), effective July 1, 2015; P.A. 16-100 amended Subsec. (b) by replacing “Drop-in supplementary” with “Supplementary” in Subdivs. (5) and (6), replacing “Drop-in programs administered” with “Administered” and adding “that are exclusively for school-age children” in Subdiv. (7) and deleting provisions re programs to inform parents and guardians that such programs are not licensed by Office of Early Childhood in Subdivs. (9) and (11), added new Subsec. (c) re certain programs to inform parents and guardians that such programs are not licensed by Office of Early Childhood, and redesignated existing Subsecs. (c) and (d) as Subsecs. (d) and (e), effective July 1, 2016; P.A. 18-169 added Subsec. (b)(12) re Organized Parents Make a Difference, Inc., effective June 14, 2018; P.A. 18-172 amended Subsec. (a)(3) by redefining “family child care home” to include provision re maximum number of additional children during summer months when school is not in session, and amended Subsec. (b) by adding provision re child care services provided by private school only to children covered under approval or accreditation in Subdiv. (2), and substantially revising provision re degrees of kinship, including adding reference to court order in Subdiv. (4), effective July 1, 2018; P.A. 19-122 added Subsec. (b)(13) re Leadership, Education and Athletics in Partnership, Inc., effective July 12, 2019; P.A. 22-81 amended Subsec. (a)(3) by redefining “family child care home”, effective July 1, 2022; P.A. 23-29 amended Subsec. (b) by adding Subdiv. (14) re programs that exclusively provide care for children of military members, effective June 12, 2023; P.A. 23-204 added Subsec. (b)(14), codified by the Revisors as Subsec. (b)(15), re Police Athletic League of Stamford, Inc., effective June 12, 2023; P.A. 24-68 amended Subsec. (a)(5) by making a technical change, effective May 28, 2024.

Cited. 237 C. 272.

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Sec. 19a-77a. Child day care services in retail stores. Section [19a-77a](#) is repealed, effective October 1, 2011.

(P.A. 98-71, S. 2, 3; P.A. 99-67; P.A. 01-175, S. 14, 32; P.A. 03-243, S. 10; P.A. 04-257, S. 36; P.A. 05-207, S. 8; P.A. 11-242, S. 98.)

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Sec. 19a-78. Transferred to Chapter 319rr, Sec. [17b-748](#).

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Sec. 19a-79. (Formerly Sec. 19-43d). Regulations. Exemptions. Waivers. (a) The Commissioner of Early Childhood shall adopt regulations, in accordance with the provisions of chapter 54, to carry out the purposes of sections [19a-77](#) to [19a-80](#), inclusive, and [19a-82](#) to [19a-87](#), inclusive, and to assure that child care centers and group child care homes meet the health, educational and social needs of children utilizing such child care centers and group child care homes. Such regulations shall (1) specify that before being permitted to attend any child care center or group child care home, each child shall be protected as age-appropriate by adequate immunization against diphtheria, pertussis, tetanus, poliomyelitis, measles, mumps, rubella, haemophilus influenzae type B and any other vaccine required by the schedule of active immunization adopted pursuant to section [19a-7f](#), (2) specify conditions under which child care center directors and teachers and group child care home providers may administer tests to monitor glucose levels in a child with diagnosed diabetes mellitus, and administer medicinal preparations, including controlled drugs specified in the regulations by the commissioner, to a child receiving child care services at such child care center or group child care home pursuant to the written order of a physician licensed to practice medicine or a dentist licensed to practice dental medicine in this or another state, or an advanced practice registered nurse licensed to prescribe in accordance with section [20-94a](#), or a physician assistant licensed to prescribe in accordance with section [20-12d](#), and the written authorization of a parent or guardian of such child, (3) specify that an operator of a child care center or group child care home, licensed before January 1, 1986, or an operator who receives a license after January 1, 1986, for a facility licensed prior to January 1, 1986, shall provide a minimum of thirty square feet per child of total indoor usable space, free of furniture except that needed for the children's purposes, exclusive of toilet rooms, bathrooms, coatrooms, kitchens, halls, isolation room or other rooms used for purposes other than the activities of the children, (4) specify that a child care center or group child care home licensed after January 1, 1986, shall provide thirty-five square feet per child of total indoor usable space, (5) establish appropriate child care center staffing requirements for employees certified in cardiopulmonary resuscitation by the American Red Cross, the American Heart Association, the National Safety Council, American Safety and Health Institute, Medic First Aid International, Inc. or an organization using guidelines for cardiopulmonary resuscitation and emergency cardiovascular care published by the American Heart Association and International Liaison Committee on Resuscitation, (6) specify that a child care center or group child care home (A) shall not deny services to a child on the basis of a child's known or suspected allergy or because a child has a prescription for an automatic prefilled cartridge injector or similar automatic injectable equipment used to treat an allergic reaction, or for injectable equipment used to administer glucagon, (B) shall, not later than three weeks after such child's enrollment in such a center or home, have staff trained in the use of such equipment on-site during all hours when such a child is on-site, (C) shall require such child's parent or guardian to provide the injector or injectable equipment and a copy of the prescription for such medication and injector or injectable equipment upon enrollment of such child, and (D) shall require a parent or guardian enrolling such a child to replace such medication and equipment prior to its expiration date, (7) specify that a child care center or group child care home (A) shall not deny services to a child on the basis of a child's diagnosis of asthma or because a child has a prescription for an inhalant medication to treat asthma, and (B) shall, not later than three weeks after such child's enrollment in such a center or home, have staff trained in the administration of such medication on-site during all hours when such a child is on-site, (8) establish physical plant requirements for licensed child care centers and licensed group child care homes that exclusively serve school-age children, (9) specify that a child care center or group child care home shall immediately notify the parent or guardian of a child enrolled in such center or home if such child exhibits or develops an illness or is injured while in the care of such center or home, (10) specify that a child care center or group child care home shall create a written record of any such illness or injury, which shall, (A) include, but not be limited to, (i) a description of such illness or injury, (ii) the date, time of occurrence and location of such illness or injury, (iii) any responsive action taken by an employee of such center or home, and (iv) whether such child was transported to a hospital emergency room, doctor's office or other medical facility as a result of such illness or injury, (B) be provided to the parent or guardian of such child not later than the next business day, and (C) be maintained by such center or home for a period of not less than two years and be made immediately available upon the request of the Office of Early Childhood, and (11) specify that a child care center or group child care home shall maintain any video recordings created at such center or home for a period of not less than thirty days, and make such recordings immediately available upon the request of the Office

of Early Childhood. When establishing such requirements, the Office of Early Childhood shall give consideration to child care centers and group child care homes that are located in private or public school buildings. With respect to subdivision (8) of this subsection, the commissioner shall implement policies and procedures necessary to implement the physical plant requirements established pursuant to this subdivision while in the process of adopting such policies and procedures in regulation form. Until replaced by policies and procedures implemented pursuant to this subdivision, any physical plant requirement specified in the office's regulations that is generally applicable to child care centers and group child care homes shall continue to be applicable to such centers and homes that exclusively serve school-age children. The commissioner shall post notice of the intent to adopt regulations pursuant to this subdivision on the eRegulations System not later than twenty days after the date of implementation of such policies and procedures. Policies and procedures implemented pursuant to this subdivision shall be valid until the time final regulations are adopted. For purposes of this subsection, "illness" means fever, vomiting, diarrhea, rash, headache, persistent coughing, persistent crying or any other condition deemed an illness by the Commissioner of Early Childhood.

(b) Any child who (1) presents a certificate, in a form prescribed by the Commissioner of Public Health pursuant to section [19a-7q](#), signed by a physician, a physician assistant or an advanced practice registered nurse stating that, in the opinion of such physician, physician assistant or advanced practice registered nurse, the immunizations required pursuant to regulations adopted pursuant to subdivision (1) of subsection (a) of this section are medically contraindicated, (2) in the case of a child who is enrolled in kindergarten through twelfth grade, presented a statement, prior to April 28, 2021, that such immunizations are contrary to the religious beliefs of such child or the parents or guardian of such child, or (3) in the case of a child who is enrolled in a preschool program or other prekindergarten program or below, (A) presented a statement, prior to April 28, 2021, that such immunizations are contrary to the religious beliefs of such child or the parents or guardian of such child, and (B) presents a written declaration, in a form prescribed by the Commissioner of Public Health, from a physician, a physician assistant or an advanced practice registered nurse stating that an immunization against diphtheria, pertussis, tetanus, poliomyelitis, measles, mumps, rubella, haemophilus influenzae type B and any other vaccine required by the schedule of active immunization adopted pursuant to section [19a-7f](#) has been given to such child and that any additional necessary immunizations of such student against diphtheria, pertussis, tetanus, poliomyelitis, measles, mumps, rubella, haemophilus influenzae type B and any other vaccine required by such schedule of active immunization are in process under guidelines specified by the Commissioner of Public Health or as recommended for the child by the physician, physician assistant or advanced practice registered nurse, shall be exempt from the immunization requirements set forth in such regulations. The statement described in subparagraph (A) of subdivision (3) of this subsection shall be acknowledged, in accordance with the provisions of sections [1-32](#), [1-34](#) and [1-35](#), by a judge of a court of record or a family support magistrate, a clerk or deputy clerk of a court having a seal, a town clerk, a notary public, a justice of the peace, or an attorney admitted to the bar of this state.

(c) Any child who is enrolled in a preschool program or other prekindergarten program or below on or before April 28, 2021, who presented, prior to April 28, 2021, the statement described in subparagraph (A) of subdivision (3) of subsection (b) of this section, but did not present the written declaration described in subparagraph (B) of subdivision (3) of subsection (b) of this section, shall comply, on or before September 1, 2022, or not later than fourteen days after applying to enroll in the child care center or group child care home, whichever is later, with the immunization requirements set forth in the regulations adopted pursuant to subdivision (1) of subsection (a) of this section.

(d) The commissioner may adopt regulations, pursuant to chapter 54, to establish civil penalties of not more than one hundred dollars per day for each day of violation and other disciplinary remedies that may be imposed, following a contested-case hearing, upon the holder of a license issued under section [19a-80](#) to operate a child care center or group child care home or upon the holder of a license issued under section [19a-87b](#) to operate a family child care home.

(e) The commissioner shall exempt Montessori schools accredited by the American Montessori Society or the Association Montessori Internationale from any provision in regulations adopted pursuant to

subsection (a) of this section which sets requirements on group size or child to staff ratios or the provision of cots.

(f) Upon the declaration by the Governor of a civil preparedness emergency pursuant to section [28-9](#) or a public health emergency pursuant to section [19a-131a](#), the commissioner may waive the provisions of any regulation adopted pursuant to this section if the commissioner determines that such waiver would not endanger the life, safety or health of any child. The commissioner shall prescribe the duration of such waiver, provided such waiver shall not extend beyond the duration of the declared emergency. The commissioner shall establish the criteria by which a waiver request shall be made and the conditions for which a waiver will be granted or denied. The provisions of section [19a-84](#) shall not apply to a denial of a waiver request under this subsection.

(g) Any child care center or group child care home may provide child care services to homeless children and youths, as defined in 42 USC 11434a, as amended from time to time, for a period not to exceed ninety days without complying with any provision in regulations adopted pursuant to this section relating to immunization and physical examination requirements. Any child care center or group child care home that provides child care services to homeless children and youths at such center or home under this subsection shall maintain a record on file of all homeless children and youths who have attended such center or home for a period of two years after such homeless children or youths are no longer receiving child care services at such center or home.

(h) Any child care center or group child care home may provide child care services to a foster child for a period not to exceed forty-five days without complying with any provision in regulations adopted pursuant to this section relating to immunization and physical examination requirements. Any child care center or group child care home that provides child care services to a foster child at such center or home under this subsection shall maintain a record on file of such foster child for a period of two years after such foster child is no longer receiving child care services at such center or home. For purposes of this subsection, “foster child” means a child who is in the care and custody of the Commissioner of Children and Families and placed in a foster home licensed pursuant to section [17a-114](#), foster home approved by a child-placing agency licensed pursuant to section [17a-149](#), facility licensed pursuant to section [17a-145](#) or with a relative or fictive kin caregiver pursuant to section [17a-114](#).

(1967, P.A. 696, S. 5; P.A. 75-527, S. 4, 5; P.A. 76-38, S. 2, 3; P.A. 77-157, S. 3, 11; P.A. 78-303, S. 60, 136; P.A. 85-59, S. 1, 2; 85-495, S. 2, 7; 85-613, S. 41, 154; P.A. 88-182, S. 2, 3; P.A. 90-97; P.A. 91-327, S. 4, 8; P.A. 93-381, S. 9, 39; P.A. 94-38; 94-213, S. 2; May 25 Sp. Sess. P.A. 94-1, S. 129, 130; P.A. 95-257, S. 12, 21, 58; 95-360, S. 16, 22, 32; P.A. 97-14, S. 1; June Sp. Sess. P.A. 01-4, S. 48, 58; P.A. 02-84, S. 1; P.A. 04-221, S. 24, 32; P.A. 07-252, S. 83; P.A. 10-90, S. 1; P.A. 14-39, S. 49; P.A. 15-174, S. 2; 15-227, S. 7; P.A. 18-172, S. 1; P.A. 19-31, S. 3; 19-105, S. 4; 19-121, S. 2; P.A. 21-6, S. 5; P.A. 22-81, S. 14.)

History: P.A. 75-527 required consultation with office of child day care; P.A. 76-38 changed placement of phrase re consultation with office of child day care; P.A. 77-157 included regulations re group day care homes; P.A. 78-303 replaced public health council with commissioner of health services; Sec. 19-43d transferred to Sec. 19a-79 in 1983; P.A. 85-59 made the existing section Subsec. (a) and added Subsec. (b) re exemptions for certain Montessori schools; P.A. 85-495 removed a reference to the office of child day care as consulting authority re regulatory power; P.A. 85-613 made technical changes; P.A. 88-182 amended Subsec. (a) to delete provisions requiring consultation with the child day care council; P.A. 90-97 added language in Subsec. (a) on the administration of medication; P.A. 91-327 directed the department to establish regulations to require immunization according to the schedule established by the department before attending a child day care center or group day care home; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 94-38 added Subsec. (a)(3) and (4) re minimum square footage requirements; P.A. 94-213 amended Subsec. (a) to add reference to prescriptions by advanced practice registered nurses and physicians assistants; May 25 Sp. Sess. 94-1 amended Subsec. (a) to add the word “total” before indoor usable space; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 95-360 substituted Sec. 19a-82 for Sec. 19a-81 in

Subsec. (a) and inserted new Subsec. (b) re adoption of regulations on civil penalties and disciplinary remedies, relettering the former Subsec., effective July 13, 1995; P.A. 97-14 added provision re diabetes monitoring in Subsec. (a)(2); June Sp. Sess. P.A. 01-4 amended Subsec. (a) by making technical changes and adding Subdiv. (5) re staffing requirements for employees certified in cardiopulmonary resuscitation; P.A. 02-84 added Subsec. (a)(6) providing for regulations prohibiting a child day care center or group day care home from denying services to a child based on the child's known or suspected allergy or because the child has a prescription for certain automatic injectable medication equipment, requiring the training of staff in the use of such equipment, and requiring the child's parent or guardian to provide the equipment and a copy of the prescription and to replace the medication or equipment prior to its expiration date; P.A. 04-221 amended Subsec. (a)(5) by allowing certification by the National Safety Council, American Safety and Health Institute and Medic First Aid International, Inc., effective June 8, 2004, and amended Subsec. (a)(6) by adding provision re use of injectable equipment to administer glucagon in Subpara. (A) and making technical changes in Subpara. (B), and added Subsec. (a)(7) re services for children with asthma; P.A. 07-252 added Subsec. (d) establishing process for certain child day care centers and group day care homes to obtain a variance to physical plant requirements adopted as regulations pursuant to Subsec. (a), effective July 12, 2007; P.A. 10-90 added Subsec. (a)(8) re commissioner's responsibility to adopt regulations that establish physical plant requirements for certain child day care centers and group day care homes and deleted former Subsec. (d) re authorization provided to certain child day care centers and group day care homes to seek a variance from physical plant requirements, effective May 26, 2010; P.A. 14-39 replaced references to Commissioner and Department of Public Health with references to Commissioner and Office of Early Childhood, effective July 1, 2014; P.A. 15-174 amended Subsec. (a)(1) to add provision re objection on religious grounds to be accompanied by acknowledged statement that immunization would be contrary to religious beliefs, effective July 1, 2015; P.A. 15-227 replaced "child day care center" with "child care center", "group day care home" with "group child care home" and "family day care home" with "family child care home" and added Subsec. (d) re waiver of regulations during civil preparedness or public health emergency, effective July 1, 2015; P.A. 18-172 made a technical change in Subsec. (a) and added Subsec. (e) re provision of child care services to homeless children and youths for period not to exceed 90 days without complying with immunization and physical examination requirements, effective July 1, 2018; P.A. 19-31 replaced reference to Connecticut Law Journal with reference to eRegulations System and made technical changes in Subsec. (a), effective June 26, 2019; P.A. 19-105 amended Subsec. (a)(5) by adding reference to organization using guidelines for cardiopulmonary resuscitation and emergency cardiovascular care published by the American Heart Association and International Liaison Committee on Resuscitation, effective July 1, 2019; P.A. 19-121 added Subsec. (f) re provision of child care services to foster child for period not to exceed 45 days without complying with immunization and physical examination requirements, effective July 1, 2019; P.A. 21-6 amended Subsec. (a) by deleting provisions re adoption of regulations re exemptions to immunization requirements in Subdiv. (1), deleting "on and after January 1, 2003," in Subdiv. (6), deleting "on and after January 1, 2005," in Subdiv. (7) and making technical changes, added new Subsec. (b) re exemptions from immunization requirements, added new Subsec. (c) re compliance with immunization requirements for certain children and redesignated existing Subsecs. (b) to (f) as Subsecs. (d) to (h), effective April 28, 2021; P.A. 22-81 amended Subsec. (a) by adding Subdiv. (9) re notification of illness or injury, Subdiv. (10) re written record of illness or injury, Subdiv. (11) re video recordings, making a conforming change, and defining "illness", effective July 1, 2022.

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Sec. 19a-79a. Pesticide applications at child care facilities. (a) As used in this section, "pesticide" means a fungicide used on plants, an insecticide, a herbicide or a rodenticide but does not mean a sanitizer, disinfectant, antimicrobial agent or a pesticide bait; "lawn care pesticide" means a pesticide registered by the United States Environmental Protection Agency and labeled pursuant to the federal Insecticide, Fungicide and Rodenticide Act for use in lawn, garden and ornamental sites or areas; "certified pesticide applicator" means a pesticide applicator with (1) supervisory certification under section [22a-54](#), or (2) operational certification under section [22a-54](#), who operates under the direct supervision of a pesticide

applicator with said supervisory certification; “licensee” means a person licensed under sections [19a-77](#) to [19a-87e](#), inclusive; and “child care facility” means a child care center, group child care home or family child care home that provides “child care services”, as described in section [19a-77](#).

(b) No person other than a certified pesticide applicator shall apply pesticide within any child care facility, except that a person other than a certified pesticide applicator may make an emergency application to eliminate an immediate threat to human health, including, but not limited to, for the elimination of mosquitoes, ticks and stinging insects, provided (1) the licensee or a designee of the licensee determines such emergency application to be necessary, (2) the licensee or a designee of the licensee deems it impractical to obtain the services of a certified pesticide applicator, and (3) such emergency application does not involve a restricted use pesticide, as defined in section [22a-47](#).

(c) No person shall apply a lawn care pesticide on the grounds of any child care facility, except that an emergency application of pesticide may be made to eliminate an immediate threat to human health, including, but not limited to, the elimination of mosquitoes, ticks and stinging insects, provided (1) the licensee or a designee of the licensee determines such emergency application to be necessary, and (2) such emergency application does not involve a restricted use pesticide, as defined in section [22a-47](#). The provisions of this subsection shall not apply to a family child care home, as described in section [19a-77](#), if the grounds of such family child care home are not owned or under the control of the licensee.

(d) No licensee or designee of a licensee shall permit any child enrolled in such licensee's child care facility to enter an area where a pesticide has been applied in accordance with this section until it is safe to do so according to the provisions on the pesticide label.

(e) On and after October 1, 2009, prior to providing for any application of pesticide on the grounds of any child care facility, the licensee or a designee of the licensee shall, within the existing budgetary resources of such child care facility, notify the parents or guardians of each child enrolled in such licensee's child care facility by any means practicable no later than twenty-four hours prior to such application, except that for an emergency application made in accordance with this section, such notice shall be given as soon as practicable. Notice under this subsection shall include (1) the name of the active ingredient of the pesticide being applied, (2) the target pest, (3) the location of the application on the child care facility property, and (4) the date or proposed date of the application. A copy of the record of each pesticide application at a child care facility shall be maintained at such facility for a period of five years.

(P.A. 99-165, S. 5, 6; P.A. 05-252, S. 1; P.A. 09-56, S. 1; P.A. 15-227, S. 25; P.A. 16-163, S. 23.)

History: P.A. 99-165 effective July 1, 1999; P.A. 05-252 added new provisions as Subsec. (a) defining “pesticide” and “lawn care pesticide”, designated existing language as Subsec. (b) and made technical changes therein, and added Subsec. (c) prohibiting the application of lawn care pesticides on the grounds of day care facilities; P.A. 09-56 amended Subsec. (a) to define “certified pesticide applicator”, “licensee” and “day care center”, amended Subsec. (b) to permit only certified pesticide applicators to apply pesticide, with exception for emergency applications, amended Subsec. (c) to add Subdiv. (1) re determination of necessity and Subdiv. (2) designator and to exempt certain family day care homes, added Subsecs. (d) and (e) and made conforming changes; pursuant to P.A. 15-227, “child day care center”, “group day care home”, “family day care home” and “child day care services” were changed editorially by the Revisors to “child care center”, “group child care home”, “family child care home” and “child care services”, respectively, in Subsecs. (a) and (c), effective July 1, 2015; P.A. 16-163 replaced references to day care center with references to child care facility, effective June 9, 2016.

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Sec. 19a-80. (Formerly Sec. 19-43e). License required for child care centers and group child care homes. Fees. Comprehensive background checks. Notification of changes in regulations. (a) No person, group of persons, association, organization, corporation, institution or agency, public or private, shall maintain a

child care center or group child care home without a license issued in accordance with this section and sections [19a-77](#) to [19a-79a](#), inclusive, and [19a-82](#) to [19a-87a](#), inclusive. Applications for such license shall be made to the Commissioner of Early Childhood on forms provided by the commissioner and shall contain the information required by regulations adopted under said sections. The forms shall contain a notice that false statements made therein are punishable in accordance with section [53a-157b](#).

(b) (1) Upon receipt of an application for a license, the commissioner shall issue such license if, upon inspection and investigation, said commissioner finds that the applicant, the facilities and the program meet the health, educational and social needs of children likely to attend the child care center or group child care home and comply with requirements established by regulations adopted under this section and sections [19a-77](#) to [19a-79a](#), inclusive, and sections [19a-82](#) to [19a-87a](#), inclusive. Any such inspection under this subsection of a group child care home located in a residence shall include an inspection for evident sources of lead poisoning and shall provide for chemical analysis of any paint chips found on such premises. The commissioner shall offer an expedited application review process for an application submitted by a municipal agency or department. A currently licensed person or entity, as described in subsection (a) of this section, seeking a change of operator, ownership or location shall file a new license application, except such person or entity may request the commissioner to waive the requirement that a new license application be filed. The commissioner may grant or deny such request. Each license shall be for a term of four years, shall be nontransferable, and may be renewed upon receipt by the commissioner of a renewal application and accompanying licensure fee. The commissioner may suspend or revoke such license after notice and an opportunity for a hearing as provided in section [19a-84](#) for violation of the regulations adopted under this section and sections [19a-77](#) to [19a-79a](#), inclusive, and sections [19a-82](#) to [19a-87a](#), inclusive. In the case of an application for renewal of a license that has expired, the commissioner may renew such expired license within thirty days of the date of such expiration upon receipt of a renewal application and accompanying licensure fee.

(2) The commissioner shall collect from the licensee of a child care center a fee of five hundred dollars prior to issuing or renewing a license for a term of four years. The commissioner shall collect from the licensee of a group child care home a fee of two hundred fifty dollars prior to issuing or renewing a license for a term of four years. The commissioner shall require only one license for a child care center operated in two or more buildings, provided the same licensee provides child care services in each building and the buildings are joined together by a contiguous playground that is part of the licensed space.

(3) The commissioner, or the commissioner's designee, shall make an unannounced visit, inspection or investigation of each licensed child care center and group child care home at least once each year. At least once every two years, the local health director, or the local health director's designee, shall inspect each licensed child care center and group child care home.

(4) A municipality may not subject the operation of a licensed group child care home located in a residence to any conditions, other than those imposed by the commissioner pursuant to this subsection, if the group child care home complies with all codes and ordinances applicable to single and multifamily dwellings.

(c) The commissioner shall require each prospective employee of a child care center or group child care home for a position that requires the provision of care to a child or involves unsupervised access to any child in such child care center or group child care home, to submit to comprehensive background checks, including state and national criminal history records checks. The criminal history records checks required pursuant to this subsection shall be conducted in accordance with section [29-17a](#). The commissioner shall also request a check of the state child abuse registry established pursuant to section [17a-101k](#). The Commissioner of Early Childhood shall notify each licensee of the provisions of this subsection. No such prospective employee shall begin working in such child care center or group child care home until the provisions of 45 CFR 98.43(d)(4), as amended from time to time, have been satisfied.

(d) The commissioner shall inform each licensee, by way of a plain language summary provided not later than sixty days after the regulation's effective date, of new or changed regulations adopted under this

section and sections [19a-77](#) to [19a-79a](#), inclusive, or sections [19a-82](#) to [19a-87a](#), inclusive, with which a licensee must comply.

(1967, P.A. 696, S. 2, 3; P.A. 77-157, S. 4, 11; 77-614, S. 323, 610; P.A. 82-256, S. 2; P.A. 85-613, S. 42, 154; May Sp. Sess. P.A. 92-6, S. 7, 117; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; 95-360, S. 9, 32; P.A. 97-259, S. 33, 41; P.A. 98-250, S. 14, 39; June Sp. Sess. P.A. 99-2, S. 69; P.A. 01-175, S. 15, 32; P.A. 03-243, S. 11; P.A. 05-207, S. 9; P.A. 07-22, S. 1; 07-129, S. 2; P.A. 09-232, S. 104; June Sp. Sess. P.A. 09-3, S. 168; P.A. 10-117, S. 30; P.A. 11-97, S. 1; 11-242, S. 16; P.A. 14-39, S. 50; P.A. 15-143, S. 5; 15-227, S. 21, 25; P.A. 16-100, S. 1; 16-163, S. 35; June Sp. Sess. P.A. 17-2, S. 174; P.A. 18-172, S. 3; P.A. 21-172, S. 7; P.A. 23-142, S. 4.)

History: P.A. 77-157 added references to group day care homes; P.A. 77-614 replaced commissioner of health with commissioner of health services, effective January 1, 1979; P.A. 82-256 required that application forms contain a notice that false statements are punishable in accordance with Sec. 53a-157 and increased the license fee for day care centers from \$25 to \$100 and the fee for group day care homes from \$25 to \$50; Sec. 19-43e transferred to Sec. 19a-80 in 1983; P.A. 85-613 made technical changes; May Sp. Sess. P.A. 92-6 amended Subsec. (b) to raise fee for day care center two-year term license or renewal from \$100 to \$200, six-month license or renewal from \$15 to \$50, and for group day care home two-year term license or renewal from \$50 to \$100 and a six-month license or renewal from \$15 to \$30; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 95-360 allowed license revocation or suspension after “an opportunity for” a hearing rather than requiring a hearing and substituted Sec. 19a-82 for Sec. 19a-81, effective July 13, 1995; P.A. 97-259 added Subsec. (c) re criminal records checks and state child abuse registry checks, effective July 1, 1997; P.A. 98-250 added new Subsec. (d) re plain language summary, effective July 1, 1998; June Sp. Sess. P.A. 99-2 amended Subsec. (c) by changing “criminal records check” and “criminal history records check” to “fingerprint criminal records check” and “fingerprint criminal history records check”; P.A. 01-175 amended Subsec. (c) by replacing language re fingerprint criminal records checks as a permissive request with language re mandatory state and national criminal history records checks pursuant to Sec. 29-17a, deleted language re fee and made technical changes, effective July 1, 2001; P.A. 03-243 added “for perpetrator information” in Subsec. (c); P.A. 05-207 amended Subsec. (c) to delete requirement that commissioner check state child abuse registry for perpetrator information; P.A. 07-22 made technical changes in Subsecs. (a) and (b) and added provision in Subsec. (b) specifying licensing requirements for child day care centers operated by the same licensee in 2 or more buildings joined together by a contiguous playground, effective May 9, 2007; P.A. 07-129 amended Subsec. (b) by adding Subdiv. designators (1) to (3), disallowing issuance of temporary licenses, extending license term from 2 to 4 years on and after October 1, 2008, increasing licensing fee from \$200 to \$400 on and after October 1, 2008, and making technical changes; P.A. 09-232 amended Subsec. (b)(1) by adding provision requiring commissioner to offer expedited review process for application submitted by municipal agency or department, effective July 8, 2009; June Sp. Sess. P.A. 09-3 amended Subsec. (b)(3) to increase license fees; P.A. 10-117 amended Subsec. (b)(1) by substituting “nontransferable” for “transferable” re licenses, effective June 8, 2010; P.A. 11-97 amended Subsecs. (a), (b) and (d) by substituting “19a-87a” for “19a-87”, amended Subsec. (b)(1) by adding provision re commissioner’s discretion to determine whether change of operator, ownership or location requires filing of a new license application by license holder and by making technical changes, deleted former Subsec. (b)(2) re license fees prior to October 1, 2008, redesignated existing Subsec. (b)(3) as Subsec. (b)(2) and made technical changes in same; P.A. 11-242 amended Subsec. (b)(1) by adding provision re renewal of license upon receipt of renewal application and accompanying license fee and by making technical changes, deleted former Subsec. (b)(2) re license fees prior to October 1, 2008, redesignated existing Subsec. (b)(3) as Subsec. (b)(2) and amended same by replacing “for each license issued or renewed” with “prior to issuing or renewing a license” and making technical changes; P.A. 14-39 replaced references to Commissioner and Department of Public Health with references to Commissioner and Office of Early Childhood and amended Subsec. (b) by adding Subdiv. (3) re unannounced visit, inspection or investigation, effective July 1, 2014; P.A. 15-143 amended Subsec. (c) by deleting reference to Sec. 10-16s

and replacing “commissioner” with “Commissioner of Early Childhood”, effective June 30, 2015; P.A. 15-227 amended Subsec. (b)(1) by replacing “child day care center” with “child care center” and “group day care home” with “group child care home”, adding provision re renewal of expired license, and making technical changes, effective July 1, 2015; pursuant to P.A. 15-227, “child day care center”, “group day care home” and “child day care services” were changed editorially by the Revisors to “child care center”, “group child care home” and “child care services”, respectively, in Subsecs. (a), (b)(2) and (3), and (c), effective July 1, 2015; P.A. 16-100 amended Subsec. (b)(1) by adding provision re currently licensed person or entity seeking change of operator, ownership or location to file new license application and making a conforming change; P.A. 16-163 amended Subsec. (b)(2) by replacing “day care center” with “child care center”, effective June 9, 2016; June Sp. Sess. P.A. 17-2 amended Subsec. (c) by adding “comprehensive background checks, including” and adding provision re prospective employee not to have unsupervised access to children until comprehensive background check is completed and commissioner permits prospective employee to work, effective October 31, 2017; P.A. 18-172 amended Subsec. (b)(1) by deleting “if such person or entity submits such request prior to the change of operator, ownership or location” re request for commissioner to waive requirement that new license application be filed, effective July 1, 2018; P.A. 21-172 amended Subsec. (c) by deleting “, within available appropriations,”, adding provision re position involving unsupervised access to any child in child care center or group child care home, deleting provision re Department of Social Services agreeing to transfer funds to office for criminal history records checks, and replacing provision re prospective employee not to have unsupervised access to children until comprehensive background check is completed and commissioner permits prospective employee to work with provision re prospective employee not to begin working until provisions of 45 CFR 98.43(d)(4) are satisfied; P.A. 23-142 amended Subsec. (a) to replace reference to Sec. 19a-80 with 19a-79a, amended Subsec. (b)(1) to add provision re inspection for evident sources of lead poisoning in group child care home located in a residence, added Subsec. (b)(4) re prohibition on municipality imposing additional conditions on licensed group child care home located in a residence, and made technical and conforming changes.

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Secs. 19a-80a to 19a-80d. Transferred to Chapter 368v, Secs. [19a-507a](#) to [19a-507d](#), inclusive.

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Sec. 19a-80e. Parental participation in state-funded child care centers and group child care homes. Each child care center and group child care home, as defined in section [19a-77](#), that is funded by the state pursuant to section [8-210](#), [17b-737](#) or [17b-752](#) shall: (1) Provide for parents' participation in setting goals for and evaluating the progress of their children; (2) assist parents with their responsibility of educating their children; (3) assist parents in working with child care programs, communicating with teachers and other child care program personnel, and participating in decisions relating to the education of their children; (4) assist staff with their responsibility of working with the child's parents to promote parent-education partnerships; and (5) take other actions, when appropriate, to support the active involvement of parents with child care programs, school personnel and with the transition to school-related organizations.

(P.A. 91-292, S. 4; P.A. 97-259, S. 34, 41; 97-295, S. 10, 25; P.A. 98-262, S. 14, 22; P.A. 15-227, S. 25.)

History: P.A. 97-259 expanded requirements by adding Subdivs. (2) to (5), inclusive, effective July 1, 1997; P.A. 97-295 deleted reference to Secs. 17b-740 and 17b-741, effective July 8, 1997, and applicable to income years commencing on or after January 1, 1998; P.A. 98-262 revised effective date of P.A. 97-295, but without affecting this section; pursuant to P.A. 15-227, “child day care center”, “group day care home”, “child day care programs” and “child day care program” were changed editorially by the Revisors to “child care center”, “group child care home”, “child care programs” and “child care program”, respectively, effective July 1, 2015.

Sec. 19a-80f. Investigation of child abuse or neglect involving licensed facilities. Information sharing between agencies. Compilation of listing of substantiated allegations. (a) As used in this section, “facility” means a child care center, a group child care home and a family child care home, as defined in section [19a-77](#), and a youth camp, as defined in section [19a-420](#).

(b) Notwithstanding any provision of the general statutes, the Commissioner of Children and Families, or the commissioner's designee, shall provide to the Office of Early Childhood all records concerning reports and investigations of child abuse or neglect that have been reported to, or are being investigated by, the Department of Children and Families pursuant to section [17a-101g](#), including records of any administrative hearing held pursuant to section [17a-101k](#): (1) Occurring at any facility, and (2) by any staff member or licensee of any facility and by any household member of any family child care home, as defined in section [19a-77](#), irrespective of where the abuse or neglect occurred.

(c) The Department of Children and Families and the Office of Early Childhood shall jointly investigate reports of abuse or neglect occurring at any facility. All information, records and reports concerning such investigation shall be shared between agencies as part of the investigative process.

(d) The Commissioner of Early Childhood shall compile a listing of allegations of violations that have been substantiated by the Office of Early Childhood concerning a facility during the prior three-year period. The commissioner shall disclose information contained in the listing to any person who requests it, provided the information may be disclosed pursuant to sections [17a-101g](#) and [17a-101k](#) and does not identify children or family members of those children.

(e) Notwithstanding any provision of the general statutes, when the Commissioner of Children and Families has made a finding substantiating abuse or neglect: (1) That occurred at a facility, or (2) by any staff member or licensee of any facility, or by any household member of any family child care home and such finding is included on the state child abuse or neglect registry, maintained by the Department of Children and Families pursuant to section [17a-101k](#), such finding may be included in the listing compiled by the Office of Early Childhood pursuant to subsection (d) of this section and may be disclosed to the public by the Office of Early Childhood.

(f) Notwithstanding any provision of the general statutes, when the Commissioner of Children and Families, pursuant to section [17a-101j](#), has notified the Office of Early Childhood of a recommended finding of child abuse or neglect at a facility and if such child abuse or neglect resulted in or involves (1) the death of a child; (2) the risk of serious physical injury or emotional harm of a child; (3) the serious physical harm of a child; (4) the arrest of a person due to abuse or neglect of a child; (5) a petition filed by the Commissioner of Children and Families pursuant to section [17a-112](#) or [46b-129](#); or (6) sexual abuse of a child, the Commissioner of Early Childhood may include such finding of child abuse or neglect in the listing under subsection (d) of this section and may disclose such finding to the public. The Commissioner of Children and Families, or the commissioner's designee, shall immediately notify the Commissioner of Early Childhood when such child abuse or neglect is not substantiated after an investigation has been completed pursuant to subsection (b) of section [17a-101g](#) or a recommended finding of child abuse or neglect is reversed after a hearing or appeal conducted in accordance with the provisions of section [17a-101k](#). The Commissioner of Early Childhood shall immediately remove such information from the listing and shall not further disclose any such information to the public.

(g) Notwithstanding any provision of the general statutes, all records provided by the Commissioner of Children and Families, or the commissioner's designee, to the Office of Early Childhood regarding child abuse or neglect occurring at any facility, may be utilized in an administrative proceeding or court proceeding relative to facility licensing. In any such proceeding, such records shall be confidential, except as provided under section [4-177c](#), and such records shall not be subject to disclosure pursuant to section [1-210](#).

(P.A. 97-259, S. 9, 41; P.A. 09-232, S. 98; P.A. 11-242, S. 57; P.A. 14-39, S. 51; P.A. 15-227, S. 25.)

History: P.A. 97-259 effective July 1, 1997; P.A. 09-232 replaced former provisions with Subsecs. (a) to (g) re joint investigations between Departments of Children and Families and Public Health concerning allegations of suspected child abuse or neglect involving child day care facilities and youth camps licensed by Department of Public Health, information and record sharing between said departments and compilation of a listing by Department of Public Health of substantiated allegations of abuse or neglect; P.A. 11-242 amended Subsec. (b) to require Commissioner of Children and Families to provide records re reports or investigations of child abuse “that have been reported to, or are being investigated by, the Department of Children and Families pursuant to section 17a-101g”, amended Subsec. (d) to add provisions re disclosure of information pursuant to Secs. 17a-101g and 17a-101k, and amended Subsec. (f) by substituting “a recommended finding of child abuse or neglect” for “suspected child abuse or neglect” re notification and, in Subdiv. (6), by adding references to Secs. 17a-101g and 17a-101k re findings of abuse or neglect that are not substantiated or reversed after investigation, hearing or appeal; P.A. 14-39 replaced references to Commissioner and Department of Public Health with references to Commissioner and Office of Early Childhood, and made a technical change in Subsec. (g), effective July 1, 2014; pursuant to P.A. 15-227, “child day care center”, “group day care home” and “family day care home” were changed editorially by the Revisors to “child care center”, “group child care home” and “family child care home”, respectively, effective July 1, 2015.

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Sec. 19a-80g. Child care center waiting list fees and deposits. Any child care center, as described in section [19a-77](#), that collects a registration fee or deposit from any person for the placement of a child on a waiting list for such child care center shall, upon written request by the person who has paid such registration fee or deposit, return the full amount of such fee or deposit at any time after such child remains on such waiting list and is not admitted to such child care center after a period of six months from the date of such placement on such waiting list.

(P.A. 01-23; P.A. 15-227, S. 25.)

History: Pursuant to P.A. 15-227, “child day care center” was changed editorially by the Revisors to “child care center”, effective July 1, 2015.

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Sec. 19a-80h. Enrollment of certain children in preschool programs. Any child care center or group child care home that is licensed with a preschool endorsement, in accordance with regulations adopted pursuant to section [19a-79](#), may deem a child who is thirty-two to thirty-six months of age, inclusive, to be three years of age for purposes of enrolling such child in a preschool program provided by such center or home, provided such center or home receives written authorization from such child's parent or guardian and the program director to so enroll such child in the preschool program.

(P.A. 19-121, S. 14.)

History: P.A. 19-121 effective July 1, 2019.

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Sec. 19a-81. (Formerly Sec. 19-43f). Hearing on denial of license. Section [19a-81](#) is repealed, effective July 13, 1995.

(1967, P.A. 696, S. 8; P.A. 77-157, S. 5, 11; 77-603, S. 45, 125; 77-614, S. 323, 610; P.A. 85-613, S. 44, 154; P.A. 93-381, S. 9, 39; P.A. 95-360, S. 31, 32.)

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Sec. 19a-82. (Formerly Sec. 19-43g). Consultative services of state and municipal departments. Inspections. Assistance to licensees. The Commissioner of Early Childhood shall utilize consultative services and assistance from the Departments of Education, Mental Health and Addiction Services and Social Services and from municipal building, fire and health departments. The commissioner shall make periodic inspections of licensed child care centers, group child care homes and family child care homes and shall provide technical assistance to licensees and applicants for licenses to assist them to attain and maintain the standards established in regulations adopted under this section and sections [19a-77](#) to [19a-80](#), inclusive, [19a-84](#) to [19a-87](#), inclusive, and section [19a-87b](#).

(1967, P.A. 696, S. 6; P.A. 77-157, S. 6, 11; 77-614, S. 323, 521, 610; P.A. 85-613, S. 45, 154; P.A. 93-262, S. 1, 87; 93-381, S. 9, 39; P.A. 95-257, S. 11, 12, 21, 58; 95-360, S. 23, 32; P.A. 02-26, S. 1; P.A. 14-39, S. 52; P.A. 15-227, S. 25; P.A. 16-163, S. 12.)

History: P.A. 77-157 replaced welfare department with department of social services in accordance with provisions of P.A. 75-420 and required inspection of group day care homes; P.A. 77-614 replaced commissioner of health with commissioner of health services and department of social services with department of human resources, effective January 1, 1979; Sec. 19-43g transferred to Sec. 19a-82 in 1983; P.A. 85-613 made technical change; P.A. 93-262 authorized substitution of commissioner and department of social services for commissioner and department of human resources, effective July 1, 1993; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health and replaced Commissioner and Department of Mental Health with Commissioner and Department of Mental Health and Addiction Services, effective July 1, 1995; P.A. 95-360 substituted Sec. 19a-82 for Sec. 19a-81, effective July 13, 1995; P.A. 02-26 required the commissioner to make periodic inspection of family day care homes, and to provide technical assistance, rather than consultative services, to licensees and applicants, and added reference to Sec. 19a-87b; P.A. 14-39 replaced reference to Commissioner of Public Health with reference to Commissioner of Early Childhood, effective July 1, 2014; pursuant to P.A. 15-227, “group day care homes” and “family day care homes” were changed editorially by the Revisors to “group child care homes” and “family child care homes”, respectively, effective July 1, 2015; P.A. 16-163 replaced “day care centers” with “child care centers” and made technical changes, effective June 9, 2016.

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Sec. 19a-83. (Formerly Sec. 19-43h). Reports of licensees. Section [19a-83](#) is repealed, effective July 1, 2014.

(1967, P.A. 696, S. 7; P.A. 77-614, S. 323, 610; P.A. 85-613, S. 46, 154; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; 95-360, S. 24, 32; P.A. 14-39, S. 88.)

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Sec. 19a-84. (Formerly Sec. 19-43i). Suspension or revocation of license. Denial of initial license application. Summary suspension or summary probation of license. (a) When the Commissioner of Early Childhood has reason to believe any person licensed under sections [19a-77](#) to [19a-80](#), inclusive, and sections [19a-82](#) to [19a-87](#), inclusive, has failed substantially to comply with the regulations adopted under said sections, the commissioner may notify the licensee in writing of the commissioner's intention to

suspend or revoke the license or to impose a licensure action. Such notice shall be served by certified mail stating the particular reasons for the proposed action. The licensee may, if aggrieved by such intended action, make application for a hearing in writing over the licensee's signature to the commissioner. The licensee shall state in the application in plain language the reasons why the licensee claims to be aggrieved. The application shall be delivered to the commissioner not later than thirty days after the licensee's receipt of notification of the intended action. The commissioner shall thereupon hold a hearing or cause a hearing to be held not later than sixty days after receipt of such application and shall, at least ten days prior to the date of such hearing, mail a notice, giving the time and place of the hearing, to the licensee. The hearing may be conducted by the commissioner or by a hearing officer appointed by the commissioner in writing. The licensee and the commissioner or hearing officer may issue subpoenas requiring the attendance of witnesses. The licensee shall be entitled to be represented by counsel and a transcript of the hearing shall be made. If the hearing is conducted by a hearing officer, the hearing officer shall state the hearing officer's findings and make a recommendation to the commissioner on the issue of revocation or suspension or the intended licensure action. The commissioner, based upon the findings and recommendation of the hearing officer, or after a hearing conducted by the commissioner, shall render the commissioner's decision in writing suspending, revoking or continuing the license or regarding the intended licensure action. A copy of the decision shall be sent by certified mail to the licensee. The decision revoking or suspending the license or a decision imposing a licensure action shall become effective thirty days after it is mailed by registered or certified mail to the licensee. A licensee aggrieved by the decision of the commissioner may appeal as provided in section [19a-85](#). Any licensee whose license has been revoked pursuant to this subsection shall be ineligible to apply for a license for a period of one year from the effective date of revocation.

(b) The provisions of this section shall not apply to the denial of an initial application for a license under sections [19a-77](#) to [19a-80](#), inclusive, and [19a-82](#) to [19a-87](#), inclusive, provided the commissioner shall notify the applicant of any such denial and the reasons for such denial by mailing written notice to the applicant at the applicant's address shown on the license application.

(c) If the commissioner finds that public health, safety or welfare imperatively requires emergency action, and incorporates a finding to that effect in his or her order, the commissioner may order summary suspension or summary probation of a license issued under sections [19a-77](#) to [19a-80](#), inclusive, and [19a-82](#) to [19a-87](#), inclusive, pending proceedings for revocation or other action. These proceedings shall be promptly instituted and determined.

(1967, P.A. 696, S. 9; P.A. 77-157, S. 7, 11; 77-603, S. 46, 125; 77-614, S. 323, 610; P.A. 85-613, S. 47, 154; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; 95-360, S. 10, 25, 32; P.A. 00-135, S. 3, 21; P.A. 07-129, S. 3; P.A. 14-39, S. 69; P.A. 19-121, S. 5.)

History: P.A. 77-157 substituted "certified" for "registered" mail; P.A. 77-603 deleted references to superior court in appeals provisions; P.A. 77-614 replaced commissioner of health with commissioner of health services, effective January 1, 1979; Sec. 19-43i transferred to Sec. 19a-84 in 1983; P.A. 85-613 made technical changes; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 95-360 eliminated the requirement that the notice automatically set a date for a hearing, requiring instead that the aggrieved person request a hearing, established procedures for such a request, eliminated a stay of the decision when appealed, expanded reference to licenses to include license applicants and expanded reference to revocation or suspension to include "intended licensure denial or licensure action" and substituted reference to Sec. 19a-82 for reference to repealed Sec. 19a-81, effective July 13, 1995; P.A. 00-135 designated existing provisions as Subsec. (a), deleting language re license applicant and licensure denial and making technical changes therein, and added new Subsec. (b) re denial of initial license application, effective May 26, 2000; P.A. 07-129 amended Subsec. (a) by making a technical change and adding one-year ineligibility provision for any licensee whose license is revoked pursuant to subsection; P.A. 14-39 amended Subsec. (a) by replacing reference to Commissioner of Public Health with reference to Commissioner of Early Childhood, adding "or cause a hearing to be held not

later than” and making technical changes, effective July 1, 2014; P.A. 19-121 added Subsec. (c) re summary suspension and summary probation of license, effective July 1, 2019.

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Sec. 19a-85. (Formerly Sec. 19-43j). Appeal. Any person aggrieved by a decision of the Commissioner of Early Childhood rendered under section [19a-82](#) or [19a-84](#) may appeal the decision of the commissioner in accordance with section [4-183](#), except venue for such appeal shall be in the judicial district of New Britain. Such appeal shall have precedence in the order of trial as provided in section [52-192](#).

(1967, P.A. 696, S. 10; 1971, P.A. 870, S. 50; P.A. 76-436, S. 276, 681; P.A. 77-157, S. 8, 11; 77-603, S. 47, 125; 77-614, S. 323, 610; P.A. 78-280, S. 5, 127; P.A. 88-230, S. 1, 12; P.A. 90-98, S. 1, 2; P.A. 93-142, S. 4, 7, 8; 93-381, S. 9, 39; P.A. 95-220, S. 4-6; 95-257, S. 12, 21, 58; 95-360, S. 26, 32; P.A. 99-215, S. 24, 29; P.A. 14-39, S. 70.)

History: 1971 act replaced superior court with court of common pleas, effective September 1, 1971, except that courts with cases pending retain jurisdiction unless pending matters deemed transferable; P.A. 76-436 replaced court of common pleas with superior court, effective July 1, 1978; P.A. 77-157 substituted “certified” for “registered” mail; P.A. 77-603 replaced previous appeal provisions with statement that appeals be in accordance with Sec. 4-183, retained Hartford county as site of appeal and retained provision re precedence in order of trial; P.A. 77-614 replaced commissioner of health with commissioner of health services, effective January 1, 1979; P.A. 78-280 replaced Hartford county with judicial district of Hartford-New Britain; Sec. 19-43j transferred to Sec. 19a-85 in 1983; P.A. 88-230 replaced “judicial district of Hartford-New Britain” with “judicial district of Hartford”, effective September 1, 1991; P.A. 90-98 changed the effective date of P.A. 88-230 from September 1, 1991, to September 1, 1993; P.A. 93-142 changed the effective date of P.A. 88-230 from September 1, 1993, to September 1, 1996, effective June 14, 1993; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-220 changed the effective date of P.A. 88-230 from September 1, 1996, to September 1, 1998, effective July 1, 1995; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 95-360 substituted Sec. 19a-82 for Sec. 19a-81, effective July 13, 1995; P.A. 99-215 replaced “judicial district of Hartford” with “judicial district of New Britain”, effective June 29, 1999; P.A. 14-39 replaced reference to Commissioner of Public Health with reference to Commissioner of Early Childhood, effective July 1, 2014.

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Sec. 19a-86. (Formerly Sec. 19-43k). Injunction against illegal operation. The Commissioner of Early Childhood may request the Attorney General to bring an action in the superior court for the judicial district of Hartford to enjoin any person, group of persons, association, organization, corporation, institution, or agency, public or private, from maintaining a child care center or group child care home without a license or operating a child care center or group child care home in violation of regulations adopted under sections [19a-77](#) to [19a-80](#), inclusive, and [19a-82](#) to [19a-87](#), inclusive.

(1967, P.A. 696, S. 11; P.A. 77-157, S. 9, 11; P.A. 78-280, S. 2, 6, 127; P.A. 85-613, S. 48, 154; P.A. 88-230, S. 1, 12; P.A. 90-98, S. 1, 2; P.A. 93-142, S. 4, 7, 8; P.A. 95-220, S. 4-6; 95-360, S. 27, 32; P.A. 14-39, S. 53; P.A. 15-227, S. 25.)

History: P.A. 77-157 included references to group day care homes; P.A. 78-280 replaced Hartford county with judicial district of Hartford-New Britain; Sec. 19-43k transferred to Sec. 19a-86 in 1983; P.A. 85-613 made technical changes; P.A. 88-230 replaced “judicial district of Hartford-New Britain” with “judicial district of Hartford”, effective September 1, 1991; P.A. 90-98 changed the effective date of P.A. 88-230

from September 1, 1991, to September 1, 1993; P.A. 93-142 changed the effective date of P.A. 88-230 from September 1, 1993, to September 1, 1996, effective June 14, 1993; P.A. 95-220 changed the effective date of P.A. 88-230 from September 1, 1996, to September 1, 1998, effective July 1, 1995; P.A. 95-360 substituted Sec. 19a-82 for Sec. 19a-81, effective July 13, 1995; P.A. 14-39 replaced “commissioner” with “Commissioner of Early Childhood”, effective July 1, 2014; pursuant to P.A. 15-227, “child day care center” and “group day care home” were changed editorially by the Revisors to “child care center” and “group child care home”, respectively, effective July 1, 2015.

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Sec. 19a-86a. Accepting voluntary surrender of license as resolution of disciplinary action. The Commissioner of Early Childhood may resolve any disciplinary action against a licensee pursuant to sections [19a-84](#) and [19a-87e](#) by accepting the voluntary surrender of the license of such licensee.

(P.A. 15-227, S. 16.)

History: P.A. 15-227 effective July 1, 2015.

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Sec. 19a-86b. Validity of license during investigation or disciplinary action. Any person or entity who is the subject of an investigation or disciplinary action pursuant to section [19a-80f](#), [19a-84](#), [19a-87a](#), [19a-87e](#), [19a-423](#) or [19a-429](#) while holding a license issued by the Office of Early Childhood or having held such a license within eighteen months of the commencement of such investigation or disciplinary action, shall be considered to hold a valid license for purposes of such investigation or disciplinary action.

(P.A. 15-227, S. 19.)

History: P.A. 15-227 effective July 1, 2015.

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Sec. 19a-86c. Failure to provide written notice of proposed closure. Penalty. (a) Any licensee child care center or group child care home, as described in section [19a-77](#), that fails to provide written notice to (1) the Office of Early Childhood, (2) all staff employed at such child care center or group child care home, and (3) the parents or guardians of children receiving child care services, as described in section [19a-77](#), at such child care center or group child care home, at least thirty days prior to the effective date of a proposed closure of such child care center or group child care home, shall be subject to a civil penalty of not more than five thousand dollars.

(b) If the Commissioner of Early Childhood has reason to believe that a violation has occurred for which a civil penalty is authorized by subsection (a) of this section, he or she may send to such licensee by certified mail, return receipt requested, or personally serve upon such licensee, a notice which shall include: (1) A reference to the section or sections of the general statutes or regulations involved; (2) a short and plain statement of the matters asserted or charged; (3) a statement of the maximum civil penalty which may be imposed for such violation; and (4) a statement of the licensee's right to request a hearing, such request to be submitted in writing to the commissioner not later than thirty days after the notice is mailed or served.

(c) If such licensee so requests, the commissioner shall cause a hearing to be held. The hearing shall be held in accordance with the provisions of chapter 54. If such licensee fails to request a hearing or fails to appear at the hearing or if, after the hearing, the commissioner finds that the licensee has committed such

violation, the commissioner may, in his or her discretion, order that a civil penalty be imposed that is not greater than the penalty stated in the notice. The commissioner shall send a copy of any order issued pursuant to this subsection by certified mail, return receipt requested, to the licensee named in such order.

(P.A. 19-121, S. 7.)

History: P.A. 19-121 effective July 1, 2019.

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Sec. 19a-87. (Formerly Sec. 19-43I). Penalty for operation without a license. Notice and hearing. (a) Any person or officer of an association, organization or corporation who establishes, conducts, maintains or operates a child care center or group child care home without a current and valid license shall be subject to a civil penalty of not more than one hundred dollars a day for each day that such center or home is operated without a license.

(b) If the Commissioner of Early Childhood has reason to believe that a violation has occurred for which a civil penalty is authorized by subsection (a) of this section, he or she may send to such person or officer by certified mail, return receipt requested, or personally serve upon such person or officer, a notice which shall include: (1) A reference to the section or sections of the general statutes or regulations involved; (2) a short and plain statement of the matters asserted or charged; (3) a statement of the maximum civil penalty which may be imposed for such violation; and (4) a statement of the party's right to request a hearing, such request to be submitted in writing to the commissioner not later than thirty days after the notice is mailed or served.

(c) If such person or officer so requests, the commissioner shall cause a hearing to be held. The hearing shall be held in accordance with the provisions of chapter 54. If such person or officer fails to request a hearing or fails to appear at the hearing or if, after the hearing, the commissioner finds that the person or officer has committed such violation, the commissioner may, in his or her discretion, order that a civil penalty be imposed that is not greater than the penalty stated in the notice. The commissioner shall send a copy of any order issued pursuant to this subsection by certified mail, return receipt requested, to the person or officer named in such order.

(1967, P.A. 696, S. 12; P.A. 77-157, S. 10, 11; P.A. 82-256, S. 1; P.A. 85-613, S. 49, 154; P.A. 95-257, S. 12, 21, 58; 95-360, S. 11, 28, 32; P.A. 14-39, S. 54; P.A. 15-227, S. 25; P.A. 16-163, S. 13.)

History: P.A. 77-157 included group day care homes; P.A. 82-256 applied the penalty to operation in violation of regulations and increased penalty from \$100 for each offense to \$100 a day for each day of operation without a license or in violation of the regulations; Sec. 19-43I transferred to Sec. 19a-87 in 1983; P.A. 85-613 made technical change; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 95-360, Sec. 11 changed reference to being “fined” to “subject to a civil penalty”, deleted reference to violation of specific statutes or regulations and added Subsecs. (b) and (c) re sending notice and a hearing and Sec. 28 substituted Sec. 19a-82 for Sec. 19a-81 in list of specific statutes deleted by Sec. 11, effective July 13, 1995; P.A. 14-39 amended Subsec. (a) by replacing “shall establish, conduct, maintain or operate” with “establishes, conducts, maintains or operates”, amended Subsec. (b) by replacing reference to Commissioner of Public Health with reference to Commissioner of Early Childhood, amended Subsec. (c) by replacing “hold a hearing on the violation asserted” with “cause a hearing to be held”, and made technical changes, effective July 1, 2014; pursuant to P.A. 15-227, “group day care home” was changed editorially by the Revisors to “group child care home” in Subsec. (a), effective July 1, 2015; P.A. 16-163 amended Subsec. (a) by replacing “day care center” with “child care center”, effective June 9, 2016.

Sec. 19a-87a. Discretion in the issuance of licenses. Suspension. Revocation. Notification of criminal conviction. False statements: Class A misdemeanor. Reporting of violations. Enforcement powers of the Office of Early Childhood. (a) The Commissioner of Early Childhood shall have the discretion to refuse to license under sections [19a-77](#) to [19a-80](#), inclusive, and [19a-82](#) to [19a-87](#), inclusive, a person to conduct, operate or maintain a child care center or a group child care home, as described in section [19a-77](#), or to suspend or revoke the license or take any other action set forth in regulation that may be adopted pursuant to section [19a-79](#) if, the person who owns, conducts, maintains or operates such center or home or a person employed therein in a position connected with the provision of care to a child receiving child care services, has been convicted in this state or any other state of a felony as defined in section [53a-25](#) involving the use, attempted use or threatened use of physical force against another person, of cruelty to persons under section [53-20](#), injury or risk of injury to or impairing morals of children under section [53-21](#), abandonment of children under the age of six years under section [53-23](#), or any felony where the victim of the felony is a child under eighteen years of age, or of a violation of section [53a-70b](#) of the general statutes, revision of 1958, revised to January 1, 2019, or section [53a-70](#), [53a-70a](#), [53a-71](#), [53a-72a](#), [53a-72b](#) or [53a-73a](#), or has a criminal record in this state or any other state that the commissioner reasonably believes renders the person unsuitable to own, conduct, operate or maintain or be employed by a child care center or group child care home. However, no refusal of a license shall be rendered except in accordance with the provisions of sections [46a-79](#) to [46a-81](#), inclusive.

(b) Any person who is licensed to conduct, operate or maintain a child care center or group child care home shall notify the commissioner of any criminal conviction of the owner, conductor, operator or maintainer of the center or home or of any person employed therein in a position connected with the provision of care to a child receiving child care services, immediately upon obtaining knowledge of the conviction. Failure to comply with the notification requirement may result in the suspension or revocation of the license or the imposition of any action set forth in regulation, and shall subject the licensed person to a civil penalty of not more than one hundred dollars per day for each day after the person obtained knowledge of the conviction.

(c) It shall be a class A misdemeanor for any person seeking employment in a position connected with the provision of care to a child receiving child care services to make a false written statement regarding prior criminal convictions pursuant to a form bearing notice to the effect that such false statements are punishable, which statement he does not believe to be true and is intended to mislead the prospective employer.

(d) Any person having reasonable cause to believe that a child care center or a group child care home is operating without a current and valid license or in violation of regulations adopted under section [19a-79](#) or in a manner which may pose a potential danger to the health, welfare and safety of a child receiving child care services, may report such information to the Office of Early Childhood. The office shall investigate any report or complaint received pursuant to this subsection. The name of the person making the report or complaint shall not be disclosed unless (1) such person consents to such disclosure, (2) a judicial or administrative proceeding results therefrom, or (3) a license action pursuant to subsection (a) of this section results therefrom. All records obtained by the office in connection with any such investigation shall not be subject to the provisions of section [1-210](#) for a period of thirty days from the date of the petition or other event initiating such investigation, or until such time as the investigation is terminated pursuant to a withdrawal or other informal disposition or until a hearing is convened pursuant to chapter 54, whichever is earlier. A formal statement of charges issued by the office shall be subject to the provisions of section [1-210](#) from the time that it is served or mailed to the respondent. Records which are otherwise public records shall not be deemed confidential merely because they have been obtained in connection with an investigation under this section.

(e) In addition to any powers the office may have, in any investigation (1) concerning an application, reinstatement or renewal of a license for a child care center, a group child care home or a family child care home, as such terms are defined in section [19a-77](#), (2) of a complaint concerning child care services, as described in section [19a-77](#), or (3) concerning the possible provision of unlicensed child care services, the office may administer oaths, issue subpoenas, compel testimony and order the production of books, records and documents. If any person refuses to appear, testify or produce any book, record or document when so ordered, a judge of the Superior Court may make such order as may be appropriate to aid in the enforcement of this section.

(P.A. 82-256, S. 3; P.A. 85-613, S. 50, 154; P.A. 89-206, S. 2; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; 95-360, S. 12, 29, 32; P.A. 97-259, S. 35, 41; P.A. 11-242, S. 76; P.A. 14-39, S. 55; P.A. 15-227, S. 25; P.A. 16-163, S. 11; P.A. 19-189, S. 5.)

History: P.A. 85-613 made technical change; P.A. 89-206 added a new Subsec. (d) re the reporting of child day care centers or group day care homes that are operating without a current and valid license or in violation of regulations or in a manner which may pose a potential danger to the health, welfare and safety of a child; P.A. 93-381 replaced department and commissioner of health services with department and commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 95-360 amended Subsec. (a) to replace reference to Sec. 19a-81 with “19a-82” and to allow any action set forth in regulation and Subsec. (d) re disclosure of investigation records, effective July 13, 1995; P.A. 97-259 amended Subsec. (a) to cover convictions in other states, to add a felony involving the use, attempted use or threatened use of physical force against another person, to add any felony where the victim of the felony is a child under 18 years of age and to make technical changes, effective July 1, 1997; P.A. 11-242 added Subsec. (e) re department's authority to administer oaths, issue subpoenas, compel testimony and order production of books, records and documents in connection with its investigations; P.A. 14-39 replaced references to Commissioner and Department of Public Health with references to Commissioner and Office of Early Childhood, effective July 1, 2014; pursuant to P.A. 15-227, “group day care home”, “child day care services”, “child day care center” and “family day care home” were changed editorially by the Revisors to “group child care home”, “child care services”, “child care center” and “family child care home”, respectively, effective July 1, 2015; P.A. 16-163 amended Subsec. (a) by replacing “day care center” with “child care center” and replacing “defined” with “described” in reference to Sec. 19a-77, effective June 9, 2016; P.A. 19-189 amended Subsec. (a) by replacing “53a-70b” with “section 53a-70b of the general statutes, revision of 1958, revised to January 1, 2019” and made a technical change.

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Sec. 19a-87b. (Formerly Sec. 17-585(b)–(d)). License required for family child care homes. Approval required to act as assistant or substitute staff member; provision of child care services by substitute staff members. Comprehensive background checks. Fees. Regulations; waivers. License to operate family child care home in facility that is not private family home. (a) No person, group of persons, association, organization, corporation, institution or agency, public or private, shall maintain a family child care home, as described in section [19a-77](#), without a license issued by the Commissioner of Early Childhood. Licensure forms shall be obtained from the Office of Early Childhood. Applications for licensure shall be made to the commissioner on forms provided by the office and shall contain the information required by regulations adopted under this section. The licensure and application forms shall contain a notice that false statements made therein are punishable in accordance with section [53a-157b](#). Applicants shall state, in writing, that they are in compliance with the regulations adopted by the commissioner pursuant to subsection (f) of this section. Before a family child care home license is granted, the office shall make an inquiry and investigation which shall include a visit and inspection of the premises for which the license is requested. Any inspection conducted by the office shall include an inspection for evident sources of lead poisoning. The office shall provide for a chemical analysis of any paint chips found on such premises.

Neither the commissioner nor the commissioner's designee shall require an annual inspection for homes seeking license renewal or for licensed homes, except that the commissioner or the commissioner's designee shall make an unannounced visit, inspection or investigation of each licensed family child care home at least once every year. A licensed family child care home shall not be subject to any conditions on the operation of such home by local officials, other than those imposed by the office pursuant to this subsection, if the home complies with all codes and ordinances applicable to single and multifamily dwellings.

(b) (1) No person shall act as an assistant or substitute staff member to a person or entity maintaining a family child care home, as defined in section [19a-77](#), without an approval issued by the commissioner. Any person seeking to act as an assistant or substitute staff member in a family child care home shall submit an application for such approval to the office. Applications for approval shall: (A) Be made to the commissioner on forms provided by the office, (B) contain the information required by regulations adopted under this section, and (C) be accompanied by a fee of fifteen dollars. The approval application forms shall contain a notice that false statements made in such form are punishable in accordance with section [53a-157b](#).

(2) A licensee of a family child care home who is attending a medical appointment, receiving medical treatment or completing education or training may use a substitute staff member who has been approved pursuant to this subsection to provide child care services for a duration of time that is greater than one hour while such licensee is absent, provided such licensee provides advance notice to the parents or guardians of children enrolled in the family child care home of the dates and times such substitute staff member will be providing such child care services and such licensee continues to maintain control of the day-to-day operations of the family child care home. No such use of a substitute staff member under this subdivision shall constitute a transfer or franchise of the family child care home.

(c) The commissioner shall require each initial applicant or prospective employee of a family child care home in a position requiring the provision of care to a child, including an assistant or substitute staff member, and each household member who is eighteen years of age or older, to submit to comprehensive background checks, including state and national criminal history records checks. The criminal history records checks required pursuant to this subsection shall be conducted in accordance with section [29-17a](#). The commissioner shall also request a check of the state child abuse registry established pursuant to section [17a-101k](#). The commissioner shall notify each licensee of the provisions of this subsection. For purposes of this subsection, "household member" means any person, other than the person who is licensed to conduct, operate or maintain a family child care home, who resides in the family child care home, such as the licensee's spouse or children, tenants and any other occupant.

(d) An application for initial licensure pursuant to this section shall be accompanied by a fee of forty dollars and such license shall be issued for a term of four years. An application for renewal of a license issued pursuant to this section shall be accompanied by a fee of forty dollars and a certification from the licensee that any child enrolled in the family child care home has received age-appropriate immunizations in accordance with regulations adopted pursuant to subsection (f) of this section. A license issued pursuant to this section shall be renewed for a term of four years. In the case of an applicant submitting an application for renewal of a license that has expired, and who has ceased operations of a family child care home due to such expired license, the commissioner may renew such expired license within thirty days of the date of such expiration upon receipt of an application for renewal that is accompanied by such fee and such certification.

(e) An application for initial staff approval or renewal of staff approval shall be accompanied by a fee of fifteen dollars. Such approvals shall be issued or renewed for a term of two years.

(f) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to ensure that family child care homes, as described in section [19a-77](#), meet the health, educational and social needs of children utilizing such homes. Such regulations shall (1) ensure that the family child care home is treated as a residence, and not an institutional facility, (2) specify that each child be protected as age-

appropriate by adequate immunization against diphtheria, pertussis, tetanus, poliomyelitis, measles, mumps, rubella, haemophilus influenzae type B and any other vaccine required by the schedule of active immunization adopted pursuant to section [19a-7f](#), (3) specify conditions under which family child care home providers may administer tests to monitor glucose levels in a child with diagnosed diabetes mellitus, and administer medicinal preparations, including controlled drugs specified in the regulations by the commissioner, to a child receiving child care services at a family child care home pursuant to a written order of a physician licensed to practice medicine in this or another state, an advanced practice registered nurse licensed to prescribe in accordance with section [20-94a](#) or a physician assistant licensed to prescribe in accordance with section [20-12d](#), and the written authorization of a parent or guardian of such child, (4) specify appropriate standards for extended care and intermittent short-term overnight care, (5) specify that a family child care home shall immediately notify the parent or guardian of a child enrolled in such home if such child exhibits or develops an illness or is injured while in the care of such home, (6) specify that a family child care home shall create a written record of any such illness or injury, which shall, (A) include, but not be limited to, (i) a description of such illness or injury, (ii) the date, time of occurrence and location of such illness or injury, (iii) any responsive action taken by an employee of such home, and (iv) whether such child was transported to a hospital emergency room, doctor's office or other medical facility as a result of such illness or injury, (B) be provided to the parent or guardian of such child not later than the next business day, and (C) be maintained by such home for a period of not less than two years and be made immediately available upon the request of the Office of Early Childhood, and (7) specify that a family child care home shall maintain any video recordings created at such home for a period of not less than thirty days, and make such recordings immediately available upon the request of the Office of Early Childhood. The commissioner shall inform each licensee, by way of a plain language summary provided not later than sixty days after the regulation's effective date, of any new or changed regulations adopted under this subsection with which a licensee must comply. For purposes of this subsection, "illness" means fever, vomiting, diarrhea, rash, headache, persistent coughing, persistent crying or any other condition deemed an illness by the Commissioner of Early Childhood.

(g) Any child who (1) presents a certificate, in a form prescribed by the Commissioner of Public Health pursuant to section [19a-7q](#), signed by a physician, a physician assistant or an advanced practice registered nurse stating that, in the opinion of such physician, physician assistant or advanced practice registered nurse, the immunizations required pursuant to regulations adopted pursuant to subsection (f) of this section are medically contraindicated, (2) in the case of a child who is enrolled in kindergarten through twelfth grade, presented a statement, prior to April 28, 2021, that such immunizations are contrary to the religious beliefs of such child or the parents or guardian of such child, or (3) in the case of a child who is enrolled in a preschool program or other prekindergarten program or below, (A) presented a statement, prior to April 28, 2021, that such immunizations are contrary to the religious beliefs of such child or the parents or guardian of such child, and (B) presents a written declaration, in a form prescribed by the Commissioner of Public Health, from a physician, physician assistant or advanced practice registered nurse stating that an immunization against diphtheria, pertussis, tetanus, poliomyelitis, measles, mumps, rubella, haemophilus influenzae type B and any other vaccine required by the schedule of active immunization adopted pursuant to section [19a-7f](#) has been given to such child and that any additional necessary immunizations of such student against diphtheria, pertussis, tetanus, poliomyelitis, measles, mumps, rubella, haemophilus influenzae type B and any other vaccine required by such schedule of active immunization are in process under guidelines specified by the Commissioner of Public Health or as recommended for the child by the physician, physician assistant or advanced practice registered nurse, shall be exempt from the immunization requirements set forth in such regulations. The statement described in subparagraph (A) of subdivision (3) of this subsection shall be acknowledged, in accordance with the provisions of sections [1-32](#), [1-34](#) and [1-35](#), by (i) a judge of a court of record or a family support magistrate, (ii) a clerk or deputy clerk of a court having a seal, (iii) a town clerk, (iv) a notary public, (v) a justice of the peace, or (vi) an attorney admitted to the bar of this state.

(h) Any child who is enrolled in a preschool program or other prekindergarten program or below on or before April 28, 2021, who presented, prior to April 28, 2021, the statement described in subparagraph (A) of subdivision (3) of subsection (g) of this section, but did not present the written declaration described in

subparagraph (B) of subdivision (3) of subsection (g) of this section shall comply, on or before September 1, 2022, or not later than fourteen days after applying to enroll in the family child care home, whichever is later, with the immunization requirements set forth in the regulations adopted pursuant to subsection (f) of this section.

(i) Upon the declaration by the Governor of a civil preparedness emergency pursuant to section [28-9](#) or a public health emergency pursuant to section [19a-131a](#), the commissioner may waive the provisions of any regulation adopted pursuant to this section if the commissioner determines that such waiver would not endanger the life, safety or health of any child. The commissioner shall prescribe the duration of such waiver, provided such waiver shall not extend beyond the duration of the declared emergency. The commissioner shall establish the criteria by which a waiver request shall be made and the conditions for which a waiver will be granted or denied. The provisions of section [19a-84](#) shall not apply to a denial of a waiver request under this subsection.

(j) Any family child care home may provide child care services to homeless children and youths, as defined in 42 USC 11434a, as amended from time to time, for a period not to exceed ninety days without complying with any provision in regulations adopted pursuant to this section relating to immunization and physical examination requirements. Any family child care home that provides child care services to homeless children and youths at such home under this subsection shall maintain a record on file of all homeless children and youths who have attended such home for a period of two years after such homeless children or youths are no longer receiving child care services at such home.

(k) Any family child care home may provide child care services to a foster child for a period not to exceed forty-five days without complying with any provision in regulations adopted pursuant to this section relating to immunization and physical examination requirements. Any family child care home that provides child care services to a foster child at such home under this subsection shall maintain a record on file of such foster child for a period of two years after such foster child is no longer receiving child care services at such home. For purposes of this subsection, “foster child” means a child who is in the care and custody of the Commissioner of Children and Families and placed in a foster home licensed pursuant to section [17a-114](#), foster home approved by a child-placing agency licensed pursuant to section [17a-149](#), facility licensed pursuant to section [17a-145](#) or with a relative or fictive kin caregiver pursuant to section [17a-114](#).

(l) For the fiscal year ending June 30, 2022, and each fiscal year thereafter, the Commissioner of Early Childhood may issue a license to maintain a family child care home anywhere in the state in accordance with the provisions of this chapter to a person or group of persons who have partnered with an association, organization, corporation, institution or agency, public or private, to provide child care services in a space provided by such association, organization, corporation, institution or agency, provided such space has been approved by the commissioner and is not in a private family home. The commissioner shall not approve more than twenty facilities throughout the state to be used for licenses issued under this subsection. The commissioner may approve more than one facility in each city or town to be used for licenses issued under this subsection. An application for a license under this subsection shall include a copy of the current fire marshal certificate of compliance with the Fire Safety Code, and written verification of compliance with the State Building Code, local zoning and building requirements and local health ordinances. The commissioner may require an applicant for a license under this subsection to comply with additional conditions relating to the health and safety of the children who will be served in such facility. The commissioner may waive any requirement that does not apply to such facility. Any license issued under this subsection shall be for a term of four years, except that the commissioner may suspend or revoke any such license at any time in accordance with the provisions of section [19a-87e](#).

(P.A. 94-181, S. 1, 7; P.A. 95-257, S. 12, 21, 58; 95-360, S. 13, 32; P.A. 96-19, S. 1; 96-180, S. 55, 166; P.A. 97-14, S. 2; 97-259, S. 36, 41; P.A. 98-250, S. 15, 39; June Sp. Sess. P.A. 98-1, S. 79, 121; June Sp. Sess. P.A. 99-2, S. 70; P.A. 00-27, S. 11, 12, 24; P.A. 01-175, S. 16, 32; P.A. 03-243, S. 12; P.A. 05-207, S. 10; P.A. 07-129, S. 4; June Sp. Sess. P.A. 09-3, S. 169; P.A. 11-242, S. 17; P.A. 13-208, S. 6; P.A. 14-39, S. 56; P.A. 15-

174, S. 3; 15-227, S. 8, 25; P.A. 16-131, S. 1; June Sp. Sess. P.A. 17-2, S. 175; P.A. 18-172, S. 2; P.A. 19-121, S. 3; P.A. 21-6, S. 6; 21-171, S. 1; 21-172, S. 8; P.A. 22-81, S. 15; P.A. 23-142, S. 3; P.A. 24-78, S. 39.)

History: P.A. 94-181 transferred responsibility for licensing family day care homes from social services department to public health and addiction services department, as a result of which Subsecs. (b) to (d), inclusive, were transferred editorially by the Revisors to Sec. 19a-87a in 1995; P.A. 94-181 also added provision in Subsec. (c) requiring regulations to ensure family day care homes are treated as residences rather than as institutional facilities, effective July 1, 1994; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 95-360 deleted department's authority to purchase services in Subsec. (a) and amended Subsec. (c) to establish increase in fees after 1995, effective July 13, 1995; P.A. 96-19 expanded written orders by physicians in Subsec. (b) to include advanced practice registered nurses and physician assistants; P.A. 96-180 made a technical change in Subsec. (a), substituting reference to Sec. 53a-157b for Sec. 53a-157, effective June 3, 1996; P.A. 97-14 added provision re diabetes monitoring in former Subsec. (b); P.A. 97-259 added new Subsec. (b) re criminal records checks and child abuse registry checks and redesignated for Subsecs. (b) and (c) as Subsecs. (c) and (d), effective July 1, 1997; P.A. 98-250 amended Subsec. (c) to require plain language summary of regulations, effective July 1, 1998; June Sp. Sess. P.A. 98-1 made a technical change in Subsec. (b), effective June 24, 1998; June Sp. Sess. P.A. 99-2 amended Subsec. (b) by changing "criminal records check" and "criminal history records checks" to "fingerprint criminal records check" and "fingerprint criminal history records checks"; P.A. 00-27 made technical changes in Subsecs. (a) and (d), effective May 1, 2000; P.A. 01-175 amended Subsec. (b) by replacing language re fingerprint criminal records checks as a permissive request with language re mandatory state and national criminal history records checks pursuant to Sec. 29-17a, deleted language re fee and made technical changes, effective July 1, 2001; P.A. 03-243 added "for perpetrator information" in Subsec. (b); P.A. 05-207 amended Subsec. (b) to delete requirement that commissioner request check of state child abuse registry for perpetrator information; P.A. 07-129 amended Subsec. (a) to prohibit commissioner's designee from requiring annual inspection and to allow commissioner's designee to make unannounced visits during customary business hours, amended Subsec. (d) to limit \$20 fee for initial licensure and license renewals to applications submitted prior to October 1, 2008, and added Subsec. (e) to extend the license term from 2 to 4 years and increase license fee from \$20 to \$40 for licenses issued on and after October 1, 2008; June Sp. Sess. P.A. 09-3 amended Subsec. (e) to increase license fee from \$40 to \$80; P.A. 11-242 added new Subsec. (b) re approval to act as assistant or substitute staff member in a family day care home, redesignated existing Subsec. (b) as Subsec. (c) and amended same to add provision re assistant or substitute staff member, added new Subsec. (d) re \$40 license fee, 4-year license term and child immunization requirements, added new Subsec. (e) re initial and renewal applications for staff approval, redesignated existing Subsec. (c) as Subsec. (f) and deleted former Subsecs. (d) and (e) re license applications submitted prior to October 1, 2008, and licenses issued on and after October 1, 2008; P.A. 13-208 amended Subsec. (b)(3) to increase fee from \$15 to \$20; P.A. 14-39 replaced references to Commissioner and Department of Public Health with references to Commissioner and Office of Early Childhood and amended Subsec. (a) by replacing provision re unannounced visits to at least 33 1/3 per cent of licensed family day care homes each year with provision re unannounced visit, inspection or investigation of each licensed family day care home at least once every year, effective July 1, 2014; P.A. 15-174 amended Subsec. (f) to add provision re objection on religious grounds to be accompanied by acknowledged statement that immunization would be contrary to religious beliefs, effective July 1, 2015; P.A. 15-227 replaced "family day care home" and "family day care homes" with "family child care home" and "family child care homes", respectively, amended Subsec. (d) by adding provisions re renewal of expired license, amended Subsec. (f) by replacing "day care services" with "child care services", and added Subsec. (g) re waiver of regulations during civil preparedness or public health emergency, effective July 1, 2015; P.A. 16-131 amended Subsec. (c) by adding provision re household member who is age 16 or older and adding definition of "household member", effective June 7, 2016; June Sp. Sess. P.A. 17-2 amended Subsec. (c) by adding "comprehensive background checks, including", effective October 31, 2017; P.A. 18-172 made a technical change in Subsec. (f) and added Subsec. (h) re provision of child care services to homeless children and youths for period not to exceed 90 days without complying with immunization and physical examination requirements, effective July 1, 2018; P.A. 19-121 added Subsec. (i)

re provision of child care services to foster child for period not to exceed 45 days without complying with immunization and physical examination requirements, effective July 1, 2019; P.A. 21-6 amended Subsec. (f) by making a technical change and deleting provisions re adoption of regulations re exemptions from immunization requirements, added new Subsec. (g) re exemptions from immunization requirements, add new Subsec. (h) re compliance with Subsec. (g)(3) for certain children and redesignated existing Subsecs. (g) to (i) as Subsecs. (i) to (k), effective April 28, 2021; P.A. 21-171 amended Subsec. (a) by replacing “defined” with “described”, amended Subsec. (b) by designating existing provisions as new Subdiv. (1) and redesignating existing Subdivs. (1) to (3) as Subparas. (A) to (C) and adding new Subdiv. (2) re provision of child care services by substitute staff members while licensee is absent, amended Subsec. (f) to replace “assure” with “ensure” and “defined” with “described”, and added Subsec. (j), codified by the Revisors as Subsec. (l) re license to maintain a family child care home in facility that is not a private family home in New Britain, New Haven, Bridgeport, Stamford, Hartford, Danbury or Waterbury, effective July 1, 2021; P.A. 21-172 amended Subsec. (c) by deleting “, within available appropriations,”, replacing “sixteen” with “eighteen”, and making a technical change; P.A. 22-81 amended Subsec. (f) by designating existing provision re ensuring family child care home is treated as residence as Subdiv. (1), designating existing provision re immunization as Subdiv. (2), designating existing provision re administration of glucose monitoring tests and medicinal preparations as Subdiv. (3), designating existing provision re standards for extended and intermittent short-term overnight care as Subdiv. (4), adding Subdiv. (5) re notification of illness or injury, adding Subdiv. (6) re written record of illness or injury, adding Subdiv. (7) re video recordings, defining “illness”, and making technical changes, effective July 1, 2022; P.A. 23-142 amended Subsec. (a) to specify that any licensed family child care home is subject to all applicable codes or ordinances; P.A. 24-78 amended Subsec. (l) by replacing “fiscal years ending June 30, 2022, to June 30, 2026, inclusive” with “fiscal year ending June 30, 2022, and each fiscal year thereafter”, “in New Britain, New Haven, Bridgeport, Stamford, Hartford, Danbury or Waterbury” with “anywhere in the state”, “The commissioner shall not approve more than one facility in each such city” with “The commissioner shall not approve more than twenty facilities throughout the state to be used for licenses issued under this subsection. The commissioner may approve more than one facility in each city or town” and “expire on June 30, 2026” with “be for a term of four years”, effective July 1, 2024.

Cited. 237 C. 272.

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Sec. 19a-87c. (Formerly Sec. 17-586). Family child care home: Penalty for operation without a license. Notice and hearing. (a) Any person or officer of an association, organization or corporation who shall establish, conduct, maintain or operate a family child care home, as defined in section [19a-77](#), without a current and valid license shall be subject to a civil penalty of not more than one hundred dollars a day for each day that such home is operated without a license.

(b) If the Commissioner of Early Childhood has reason to believe that a violation has occurred for which a civil penalty is authorized by subsection (a) of this section, the commissioner may send to such person or officer by certified mail, return receipt requested, or personally serve upon such person or officer, a notice which shall include: (1) A reference to the section or sections of the general statutes or regulations involved; (2) a short and plain statement of the matters asserted or charged; (3) a statement of the maximum civil penalty which may be imposed for such violation; and (4) a statement of the party's right to request a hearing. Such request shall be submitted in writing to the commissioner not later than thirty days after the notice is mailed or served.

(c) If such person or officer so requests, the commissioner shall cause a hearing to be held. The hearing shall be held in accordance with the provisions of chapter 54. If such person or officer fails to request a hearing or fails to appear at the hearing or if, after the hearing, the commissioner finds that the person or officer has committed such violation, the commissioner may, in his or her discretion, order that a civil penalty be imposed that is not greater than the penalty stated in the notice. The commissioner shall send a

copy of any order issued pursuant to this subsection by certified mail, return receipt requested, to the person or officer named in such order.

(P.A. 82-261, S. 3, 6; P.A. 86-417, S. 7, 15; P.A. 92-52, S. 1; P.A. 93-262, S. 45, 87; P.A. 94-181, S. 2, 7; P.A. 95-257, S. 12, 21, 58; 95-360, S. 14, 32; P.A. 14-39, S. 57; P.A. 15-227, S. 25.)

History: P.A. 86-417 substituted references to registration for references to licensure; Sec. 17-31r transferred to Sec. 17-586 in 1991; P.A. 92-52 amended Subsec. (a) by deleting “fined” and substituting “subject to a civil penalty” in lieu thereof and added Subsecs. (b) and (c) re procedure for imposition of penalty; P.A. 93-262 replaced the word “registration” with the word “license” and replaced commissioner of human resources with commissioner of social services, effective July 1, 1993; P.A. 94-181 transferred licensure program of family day care homes from the department of social services to the department of public health and addiction services effective July 1, 1994; Sec. 17-586 transferred to Sec. 19a-87c in 1995; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 95-360 deleted reference to violation of specific statutes and regulations and replaced automatic hearing with a hearing if requested, effective July 13, 1995; P.A. 14-39 amended Subsec. (b) by replacing reference to Commissioner of Public Health with reference to Commissioner of Early Childhood, amended Subsec. (c) by replacing “hold a hearing on the violation asserted” with “cause a hearing to be held”, and made technical changes, effective July 1, 2014; pursuant to P.A. 15-227 “family day care home” was changed editorially by the Revisors to “family child care home” in Subsec. (a), effective July 1, 2015.

Cited. 237 C. 272.

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Sec. 19a-87d. (Formerly Sec. 17-587). Family child care homes: Injunction against illegal operation. The Commissioner of Early Childhood may request the Attorney General to bring an action, in the superior court for the judicial district in which such home is located, to enjoin any person, group of persons, association, organization, corporation, institution or agency, public or private, from maintaining a family child care home, as defined in section [19a-77](#), without a license or in violation of regulations adopted under section [19a-87b](#), and satisfactory proof of the lack of a license or the violation of the regulations without more shall entitle the commissioner to injunctive relief.

(P.A. 82-261, S. 4, 6; P.A. 86-417, S. 8, 15; P.A. 93-262, S. 46, 87; P.A. 94-181, S. 3, 7; P.A. 95-257, S. 12, 21, 58; P.A. 14-39, S. 58; P.A. 15-227, S. 25.)

History: P.A. 86-417 substituted references to registration for references to licensure; Sec. 17-31s transferred to Sec. 17-587 in 1991; P.A. 93-262 replaced commissioner of human resources with commissioner of social services and replaced the word “registration” with the word “license”, effective July 1, 1993; P.A. 94-181 transferred licensure program of family day care homes from the department of social services to the department of public health and addiction services, effective July 1, 1994; Sec. 17-587 transferred to Sec. 19a-87d in 1995; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 14-39 replaced reference to Commissioner of Public Health with reference to Commissioner of Early Childhood, effective July 1, 2014; pursuant to P.A. 15-227, “family day care home” was changed editorially by the Revisors to “family child care home”, effective July 1, 2015.

Cited. 237 C. 272.

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Sec. 19a-87e. (Formerly Sec. 17-588). Family child care homes: Discretion in the issuance of a license or approval of an assistant or substitute staff member. Suspension. Revocation. Denial of initial license or approval application. Notice of criminal conviction. False statements. Reporting of violations. Summary suspension or summary probation of a license. (a) The Commissioner of Early Childhood may (1) refuse to license under section [19a-87b](#), a person to own, conduct, operate or maintain a family child care home, as defined in section [19a-77](#), (2) refuse to approve under section [19a-87b](#), a person to act as an assistant or substitute staff member in a family child care home, as defined in section [19a-77](#), or (3) suspend or revoke the license or approval or take any other action that may be set forth in regulation that may be adopted pursuant to section [19a-79](#) if the person who owns, conducts, maintains or operates the family child care home, the person who acts as an assistant or substitute staff member in a family child care home, a person employed in such family child care home in a position connected with the provision of care to a child receiving child care services or a household member, as defined in subsection (c) of section [19a-87b](#), who is sixteen years of age or older and resides therein, has been convicted, in this state or any other state of a felony, as defined in section [53a-25](#), involving the use, attempted use or threatened use of physical force against another person, or has a criminal record in this state or any other state that the commissioner reasonably believes renders the person unsuitable to own, conduct, operate or maintain or be employed by a family child care home, or act as an assistant or substitute staff member in a family child care home, or if such persons or a household member has been convicted in this state or any other state of cruelty to persons under section [53-20](#), injury or risk of injury to or impairing morals of children under section [53-21](#), abandonment of children under the age of six years under section [53-23](#), or any felony where the victim of the felony is a child under eighteen years of age, a violation of section [53a-70b](#) of the general statutes, revision of 1958, revised to January 1, 2019, or section [53a-70](#), [53a-70a](#), [53a-71](#), [53a-72a](#), [53a-72b](#) or [53a-73a](#), illegal manufacture, distribution, sale, prescription, dispensing or administration under section [21a-277](#) or [21a-278](#), or illegal possession under section [21a-279](#), or if such person, a person who acts as assistant or substitute staff member in a family child care home or a person employed in such family child care home in a position connected with the provision of care to a child receiving child care services, either fails to substantially comply with the regulations adopted pursuant to section [19a-87b](#), or conducts, operates or maintains the home in a manner which endangers the health, safety and welfare of the children receiving child care services. Any refusal of a license or approval pursuant to this section shall be rendered in accordance with the provisions of sections [46a-79](#) to [46a-81](#), inclusive. Any person whose license or approval has been revoked pursuant to this section shall be ineligible to apply for a license or approval for a period of one year from the effective date of revocation.

(b) When the commissioner intends to suspend or revoke a license or approval or take any other action against a license or approval set forth in regulation adopted pursuant to section [19a-79](#), the commissioner shall notify the licensee or approved staff member in writing of the commissioner's intended action. The licensee or approved staff member may, if aggrieved by such intended action, make application for a hearing in writing over the licensee's or approved staff member's signature to the commissioner. The licensee or approved staff member shall state in the application in plain language the reasons why the licensee or approved staff member claims to be aggrieved. The application shall be delivered to the commissioner within thirty days of the licensee's or approved staff member's receipt of notification of the intended action. The commissioner shall thereupon hold a hearing within sixty days from receipt of such application and shall, at least ten days prior to the date of such hearing, mail a notice, giving the time and place of the hearing, to the licensee or approved staff member. The provisions of this subsection shall not apply to the denial of an initial application for a license or approval under section [19a-87b](#), provided the commissioner shall notify the applicant of any such denial and the reasons for such denial by mailing written notice to the applicant at the applicant's address shown on the license or approval application.

(c) Any person who is licensed to conduct, operate or maintain a family child care home or approved to act as an assistant or substitute staff member in a family child care home shall notify the commissioner of any conviction of the owner, conductor, operator or maintainer of the family child care home or of any household member, as defined in subsection (c) of section [19a-87b](#), who is sixteen years of age or older, or any person employed in such family child care home in a position connected with the provision of care to a child receiving child care services, of a crime which affects the commissioner's discretion under subsection

(a) of this section, immediately upon obtaining knowledge of such conviction. Failure to comply with the notification requirement of this subsection may result in the suspension or revocation of the license or approval or the taking of any other action against a license or approval set forth in regulation adopted pursuant to section [19a-79](#) and shall subject the licensee or approved staff member to a civil penalty of not more than one hundred dollars per day for each day after the person obtained knowledge of the conviction.

(d) It shall be a class A misdemeanor for any person seeking employment in a position connected with the provision of care to a child receiving family child care home services to make a false written statement regarding prior criminal convictions pursuant to a form bearing notice to the effect that such false statements are punishable, which statement such person does not believe to be true and is intended to mislead the prospective employer.

(e) Any person having reasonable cause to believe that a family child care home, as defined in section [19a-77](#), is operating without a current and valid license or in violation of the regulations adopted under section [19a-87b](#) or in a manner which may pose a potential danger to the health, welfare and safety of a child receiving child care services, may report such information to the Office of Early Childhood. The office shall investigate any report or complaint received pursuant to this subsection. The name of the person making the report or complaint shall not be disclosed unless (1) such person consents to such disclosure, (2) a judicial or administrative proceeding results from such report or complaint, or (3) a license action pursuant to subsection (a) of this section results from such report or complaint. All records obtained by the office in connection with any such investigation shall not be subject to the provisions of section [1-210](#) for a period of thirty days from the date of the petition or other event initiating such investigation, or until such time as the investigation is terminated pursuant to a withdrawal or other informal disposition or until a hearing is convened pursuant to chapter 54, whichever is earlier. A formal statement of charges issued by the office shall be subject to the provisions of section [1-210](#) from the time that it is served or mailed to the respondent. Records which are otherwise public records shall not be deemed confidential merely because they have been obtained in connection with an investigation under this section.

(f) If the commissioner finds that public health, safety or welfare imperatively requires emergency action, and incorporates a finding to that effect in his or her order, the commissioner may order summary suspension or summary probation of a license issued under section [19a-87b](#) pending proceedings for revocation or other action. These proceedings shall be promptly instituted and determined.

(P.A. 82-261, S. 5, 6; P.A. 84-290; P.A. 86-417, S. 9, 15; P.A. 87-127; P.A. 89-8, S. 1, 2; 89-206, S. 1; P.A. 93-262, S. 47, 87; P.A. 94-181, S. 4, 7; P.A. 95-257, S. 12, 21, 58; 95-360, S. 15, 32; P.A. 97-259, S. 37, 41; P.A. 00-27, S. 13, 24; 00-135, S. 4, 21; P.A. 11-242, S. 46; P.A. 14-39, S. 59; P.A. 15-227, S. 17; P.A. 16-131, S. 2, 3; P.A. 19-121, S. 6; 19-189, S. 6.)

History: P.A. 84-290 amended Subsecs. (a) and (b) by adding the reference to a person residing in the household and also amended Subsec. (a) by adding sexual assault, illegal manufacture, distribution, sale, prescription, dispensing or administration and illegal possession to the list of crimes and amended Subsec. (b) by deleting the word “criminal” and adding “a crime which affects the commissioner's discretion under Subsec. (a)”; P.A. 86-417 substituted references to registration for references to licensure; P.A. 87-127 amended Subsec. (a) by adding language allowing the commissioner to suspend or revoke registration for noncompliance with regulations or for operation in a manner which endangers the health, safety and welfare of the children and language on ineligibility for one year from the effective date of revocation; P.A. 89-8 deleted provision in Subsec. (a) which had authorized commissioner to suspend or revoke registration of family day care home owner or operator and substituted reference to Sec. 17-31q for reference to Sec. 17-31a; P.A. 89-206 added a new Subsec. (d) re the reporting of family day care homes operating without a current and valid registration, in violation of regulations or in a manner which may pose a potential danger to the health, welfare and safety of a child; Sec. 17-31t transferred to Sec. 17-588 in 1991; P.A. 93-262 replaced commissioner and department of human resources with commissioner and department of social services and substituted references to licensure for references to registration, effective July 1, 1993; P.A. 94-181 transferred licensure program of family day care homes from the department of social

services to the department of public health and addiction services, effective July 1, 1994; Sec. 17-588 transferred to Sec. 19a-87e in 1995; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 95-360 amended Subsec. (a) and (c) to allow any action set forth in regulation, inserted new Subsec. (b) re sending notice and a hearing, relettering the remaining Subsecs., and added provisions in Subsec. (d) re disclosure of investigation records, effective July 13, 1995; P.A. 97-259 amended Subsec. (a) to cover convictions in other states, to add felonies involving the use, attempted use or threatened use of physical force against another person, to add any felony where the victim of the felony is a child under 18 years of age and to make technical changes, effective July 1, 1997; P.A. 00-27 made technical changes in Subsec. (c), effective May 1, 2000; P.A. 00-135 made technical changes and amended Subsec. (b) by deleting language re license applicant and refusing a license and adding provisions re denial of initial license application, effective May 26, 2000; P.A. 11-242 amended Subsec. (a) by adding Subdiv. (1) to (3) designators, by providing commissioner with authority to refuse to approve a person to act as assistant or substitute staff member in a family day care home in Subdiv. (2) and by authorizing commissioner to revoke approval of assistant or substitute staff member due to criminal history in Subdiv. (3), amended Subsec. (b) by adding provisions re suspension or revocation of approval to act as an assistant or substitute staff member, amended Subsec. (c) by requiring persons approved to act as assistant or substitute staff member to notify commissioner of a criminal conviction, and made conforming changes; P.A. 14-39 replaced references to Commissioner and Department of Public Health with references to Commissioner and Office of Early Childhood, effective July 1, 2014; P.A. 15-227 replaced “family day care home” with “family child care home” and “child day care services” with “child care services”, effective July 1, 2015; P.A. 16-131 amended Subsecs. (a) and (c) by adding provisions re household member who is age 16 or older and making conforming changes, effective June 7, 2016; P.A. 19-121 added Subsec. (f) re summary suspension and summary probation of license, effective July 1, 2019; P.A. 19-189 amended Subsec. (a)(3) by replacing “53a-70b” with “section 53a-70b of the general statutes, revision of 1958, revised to January 1, 2019”.

Cited. 237 C. 272.

Cited. 42 CA 92.

Cited. 44 CS 223.

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Sec. 19a-87f. Youth camp, child care center, group child care home or family child care home: Physical examination or health status certification. On and after July 1, 2014, any (1) youth camp, licensed in accordance with section [19a-422](#), (2) child care center or group child care home, licensed in accordance with section [19a-80](#), or (3) family child care home, licensed in accordance with section [19a-87b](#), may permit a child's physical examination that is required for school purposes, and the child's health assessment form described in section [10-206](#) or the state Department of Education's early childhood health assessment record form, to be used to satisfy any physical examination or health status certification required by such youth camp, child care center, group child care home or family child care home, provided any requirement established by the Commissioner of Early Childhood concerning the time for completion of such physical examination is satisfied.

(P.A. 14-15, S. 1; P.A. 15-227, S. 25.)

History: P.A. 14-15 effective July 1, 2014 (Revisor's Note: A reference to “Commissioner of the Office of Early Childhood” was changed editorially by the Revisors to “Commissioner of Early Childhood” for consistency); pursuant to P.A. 15-227, “child day care center”, “group day care home” and “family day care home” were changed editorially by the Revisors to “child care center”, “group child care home” and “family child care home”, respectively, effective July 1, 2015.

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Sec. 19a-87g. Notification of emergency situations to licensees of day care centers. (a) For purposes of this section, “licensee” means any person licensed pursuant to section [19a-80](#) or [19a-87b](#), and “day care center” means a child care center, a group child care home or a family child care home, as those terms are defined in section [19a-77](#).

(b) Each licensee shall provide written contact information for the licensee's day care center, including the name, address and telephone number of the day care center, to the Office of Early Childhood. Each licensee shall verify and update, as appropriate, such contact information.

(c) The Office of Early Childhood shall share, in accordance with a memorandum of understanding or other agreement, any information collected pursuant to subsection (b) of this section with the Department of Emergency Services and Public Protection for use in an emergency notification system, as defined in section [28-25](#), that notifies licensees of an emergency situation in the vicinity of a day care center that may endanger the safety or welfare of the children at such day care center. Such emergency situation may include, but need not be limited to, a fire, a criminal act, an emergency or an act of nature such as an earthquake, a tornado, a hurricane or a storm.

(P.A. 15-161, S. 1; 15-227, S. 25; P.A. 18-172, S. 6.)

History: Pursuant to P.A. 15-227, “child day care center”, “group day care home” and “family day care home” were changed editorially by the Revisors to “child care center”, “group child care home” and “family child care home”, respectively, effective July 1, 2015; P.A. 18-172 amended Subsec. (b) by replacing “local police department and state police troop having jurisdiction where such day care center is located” with “Office of Early Childhood”, and amended Subsec. (c) by replacing provision re local police department or state police troop to notify licensees of emergency conditions with provision re Office of Early Childhood to share information with Department of Emergency Services and Public Protection for use in emergency notification system that notifies licensees of emergency situations, effective July 1, 2018.

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Sec. 19a-88. (Formerly Sec. 19-45). License renewal by certain health care providers and other licensees of the department. On-line license renewal system. (a) Each person holding a license to practice dentistry, optometry, midwifery or dental hygiene shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of: (1) The professional services fee for class I, as defined in section [33-182i](#), plus ten dollars, in the case of a dentist, except as provided in sections [19a-88b](#) and [20-113b](#); (2) the professional services fee for class H, as defined in section [33-182i](#), plus five dollars, in the case of an optometrist; (3) twenty dollars in the case of a midwife; and (4) one hundred five dollars in the case of a dental hygienist. Such registration shall be on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address and such other information as the department requests. Each person holding a license to practice dentistry who has retired from the profession may renew such license, but the fee shall be ten per cent of the professional services fee for class I, as defined in section [33-182i](#), or ninety-five dollars, whichever is greater. Any license provided by the department at a reduced fee pursuant to this subsection shall indicate that the dentist is retired.

(b) Each person holding a license to practice medicine, surgery, podiatry, chiropractic or naturopathy shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of the professional services fee for class I, as defined in section [33-182i](#), plus five dollars. Each person holding a license to practice medicine or surgery shall pay five dollars in addition to such professional services fee. Such registration shall be on blanks to be furnished by the department for such

purpose, giving such person's name in full, such person's residence and business address and such other information as the department requests.

(c) (1) Each person holding a license to practice as a registered nurse, shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of one hundred ten dollars, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address and such other information as the department requests. Each person holding a license to practice as a registered nurse who has retired from the profession may renew such license, but the fee shall be ten per cent of the professional services fee for class B, as defined in section [33-182I](#), plus five dollars. Any license provided by the department at a reduced fee shall indicate that the registered nurse is retired.

(2) Each person holding a license as an advanced practice registered nurse shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of one hundred thirty dollars, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address and such other information as the department requests. No such license shall be renewed unless the department is satisfied that the person maintains current certification as either a nurse practitioner, a clinical nurse specialist or a nurse anesthetist from one of the following national certifying bodies which certify nurses in advanced practice: The American Nurses' Association, the Nurses' Association of the American College of Obstetricians and Gynecologists Certification Corporation, the National Board of Pediatric Nurse Practitioners and Associates or the American Association of Nurse Anesthetists. Each person holding a license to practice as an advanced practice registered nurse who has retired from the profession may renew such license, but the fee shall be ten per cent of the professional services fee for class C, as defined in section [33-182I](#), plus five dollars. Any license provided by the department at a reduced fee shall indicate that the advanced practice registered nurse is retired.

(3) Each person holding a license as a licensed practical nurse shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of seventy dollars, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address and such other information as the department requests. Each person holding a license to practice as a licensed practical nurse who has retired from the profession may renew such license, but the fee shall be ten per cent of the professional services fee for class A, as defined in section [33-182I](#), plus five dollars. Any license provided by the department at a reduced fee shall indicate that the licensed practical nurse is retired.

(4) Each person holding a license as a nurse-midwife shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of one hundred thirty dollars, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address and such other information as the department requests. No such license shall be renewed unless the department is satisfied that the person maintains current certification from the Accreditation Midwifery Certification Board.

(5) (A) Each person holding a license to practice physical therapy shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of the professional services fee for class B, as defined in section [33-182I](#), plus five dollars, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address and such other information as the department requests.

(B) Each person holding a physical therapist assistant license shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of the professional services fee for class A, as defined in section [33-182I](#), plus five dollars, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address and such other information as the department requests.

(d) No provision of this section shall be construed to apply to any person practicing Christian Science.

(e) (1) Each person holding a license or certificate issued under section [19a-514](#), [20-65k](#), [20-74s](#), [20-185k](#), [20-185l](#), [20-195cc](#) or 20-206// and chapters 370 to 373, inclusive, 375, 378 to 381a, inclusive, 383 to 383c, inclusive, 383g, 384, 384a, 384b, 385, 393a, 395, 399 or 400a and section [20-206n](#) or [20-206o](#) shall, annually, or, in the case of a person holding a license as a marital and family therapist associate under section [20-195c](#) on or before twenty-four months after the date of initial licensure, during the month of such person's birth, apply for renewal of such license or certificate to the Department of Public Health, giving such person's name in full, such person's residence and business address and such other information as the department requests.

(2) Each person holding a license or certificate issued under section [19a-514](#), and chapters 384a, 384c, 384d, 386, 387, 388 and 398 shall apply for renewal of such license or certificate once every two years, during the month of such person's birth, giving such person's name in full, such person's residence and business address and such other information as the department requests.

(3) Each person holding a certificate issued under section [20-195ttt](#) shall apply for renewal of such certificate once every three years, during the month of such person's birth, giving such person's name in full, such person's residence and business address and such other information as the department requests.

(4) Each person holding a license or certificate issued pursuant to chapter 400c shall, annually, during the month of such person's birth, apply for renewal of such license or certificate to the department. Each lead training provider certified pursuant to chapter 400c and each asbestos training provider certified pursuant to chapter 400a shall, annually, during the anniversary month of such training provider's initial certification, apply for renewal of such certificate to the department.

(5) Each entity holding a license issued pursuant to section [20-475](#) shall, annually, during the anniversary month of initial licensure, apply for renewal of such license or certificate to the department.

(6) Each person holding a license issued pursuant to section [20-162bb](#) shall, annually, during the month of such person's birth, apply for renewal of such license to the Department of Public Health, upon payment of a fee of three hundred twenty dollars, giving such person's name in full, such person's residence and business address and such other information as the department requests.

(f) Any person or entity which fails to comply with the provisions of this section shall be notified by the department that such person's or entity's license or certificate shall become void ninety days after the time for its renewal under this section unless it is so renewed. Any such license shall become void upon the expiration of such ninety-day period.

(g) (1) The Department of Public Health shall administer a secure on-line license renewal system for persons holding a license under chapters 370 to 373, inclusive, 375 to 378, inclusive, 379 to 381b, inclusive, 382a, 383 to 383d, inclusive, 383f to 388, inclusive, 393a, 395, 397a to 399, inclusive, 400a and 400c. The department shall require such persons to renew their licenses using the on-line renewal system and to pay professional services fees on-line by means of a credit card or electronic transfer of funds from a bank or credit union account, except in extenuating circumstances, including, but not limited to, circumstances in which a licensee does not have access to a credit card and submits a notarized affidavit affirming that fact, the department may allow the licensee to renew his or her license using a paper form prescribed by the department and pay professional service fees by check or money order.

(2) The department shall charge a service fee for each payment made by means of a credit card. The Commissioner of Public Health shall determine the rate or amount of the service fee for any such credit card in accordance with subsection (c) of section [1-1j](#). Such service fee may be waived by the commissioner for a category of fee if such waiver has been approved by the Secretary of the Office of Policy and Management pursuant to subsection (b) of section [1-1j](#).

(1949 Rev., S. 3821; 1953, S. 2041d; 1959, P.A. 616, S. 1; 1961, P.A. 501; 1963, P.A. 143; 1969, P.A. 410, S. 1; June, 1971, P.A. 8, S. 38, 39; 1972, P.A. 223, S. 1, 2; P.A. 76-276, S. 12, 22; P.A. 77-467; 77-614, S. 323, 610; P.A. 80-484, S. 3, 176; P.A. 81-471, S. 3, 71; 81-472, S. 44, 159; 81-473, S. 13, 43; P.A. 88-357, S. 2; P.A. 89-251, S. 69, 203; 89-389, S. 17, 22; P.A. 90-40, S. 3, 4; 90-211, S. 17, 23; P.A. 92-89, S. 19, 20; May Sp. Sess. P.A. 92-16, S. 46, 89; P.A. 93-381, S. 9, 39; P.A. 94-210, S. 2, 30; 94-220, S. 2, 12; P.A. 95-196, S. 14; 95-257, S. 12, 21, 58; P.A. 97-186, S. 10; 97-311, S. 8, 16; P.A. 98-247, S. 11; June Sp. Sess. P.A. 98-1, S. 17, 121; P.A. 99-102, S. 17; 99-249, S. 4, 10; June Sp. Sess. P.A. 99-2, S. 61; P.A. 00-27, S. 14, 24; 00-226, S. 9, 18, 20; June Sp. Sess. P.A. 01-4, S. 4, 5, 58; P.A. 03-124, S. 2; June 30 Sp. Sess. P.A. 03-3, S. 18, 19; P.A. 05-213, S. 12; 05-280, S. 74, 75; P.A. 07-82, S. 1; 07-185, S. 11; June Sp. Sess. P.A. 07-1, S. 139; P.A. 08-184, S. 50; June Sp. Sess. P.A. 09-3, S. 170; Sept. Sp. Sess. P.A. 09-8, S. 20; P.A. 13-234, S. 139; P.A. 15-198, S. 4; 15-244, S. 112; June Sp. Sess. 15-5, S. 474, 475; P.A. 16-66, S. 14; P.A. 17-66, S. 8; June Sp. Sess. P.A. 17-2, S. 192; P.A. 18-168, S. 19; P.A. 19-117, S. 161, 171, 182, 202; 19-118, S. 61; P.A. 21-121, S. 94; June Sp. Sess. P.A. 21-2, S. 441; P.A. 24-68, S. 6.)

History: 1959 act required that persons holding license to practice dentistry or optometry be registered, raised fee to \$5, provided for \$4 fee for certain persons and that no fee be charged for initial registration within one year from license date; 1961 act rearranged times for payment and amounts of fees, adding Subsecs. (b) and (c), deleted exception from payment for initial registration and provision for reporting unregistered practitioners to department and raised ceiling on fine from \$5 to \$100; 1963 act added provision re obtaining copy of list by other interested persons in Subsec. (d); 1969 act established different registration procedures for registered nurses, licensed practical nurses and physical therapists in Subsec. (c), previously procedure was same for all, i.e. biennial registration in January of even-numbered years; 1971 act increased fees: For dentists from \$5 to \$150, for optometrists from \$5 to \$100, for dental hygienists from \$4 to \$25, for practitioners of medicine, surgery, osteopathy, chiropractic or naturopathy from \$10 to \$150, for podiatrists from \$10 to \$100 and for licensed practical or registered nurses and physical therapists from \$8 to \$10 and deleted provisions in Subsec. (c) re transition period for changed registration dates; 1972 act reduced registration fee for dental hygienists to \$5, required annual, rather than biennial, registration in Subsec. (b) reducing fees of podiatrists to \$50 and of osteopaths, chiropractors and naturopaths to \$75, required annual, rather than biennial, registration of nurses and physical therapists and reduced fees from \$10 to \$5 for licensed practical nurses and physical therapists; P.A. 76-276 established registration fee for physicians licensed under chapter 370, except homeopathic physicians, at \$160; P.A. 77-467 changed registration month in Subsec. (a) from January to April and in Subsec. (c) for physical therapists from January to September, deleted reference to licensed person living outside state in Subsec. (c), imposed \$20 fee for registration of nonresidents in Subsec. (b) and in (a) with respect to dentists and optometrists only (previously registration of nonresidents in Subsecs. (a) to (c) had been free), removed specific date for mailing list in Subsec. (d), i.e. June first, requiring that list be mailed annually and replaced \$100 maximum fine in Subsec. (f) with late registration fee of \$50; P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; P.A. 80-484 required registration in month of birth in Subsecs. (a), (b) and (c)(2) as of January 1, 1981, deleted provision re registration of those retired from active practice in Subsecs. (a), (b) and (c)(1) and (2), deleted provision re fee for nonresidents in Subsecs. (a) and (b), deleted Subsec. (d) re mailing of lists of registered persons in its entirety, relettered Subsec. (e) as Subsec. (d), deleted Subsec. (f) re late registration fee and added new Subsecs. (e) and (f); P.A. 81-471 and 81-473 provided for renewal of licenses and certificates for physical therapists, sanitarians and subsurface sewage system installers and cleaners during the month of the holder's birth; P.A. 81-472 made technical changes; Sec. 19-45 transferred to Sec. 19a-88 in 1983; P.A. 88-357 removed obsolete provisions in Subsec. (c) and (e); P.A. 89-251 increased the fee for dentists from \$150 to \$450, increased the fee for optometrists from \$100 to \$300, increased the fee for midwives from \$5 to \$6, increased the fee for dental hygienists from \$5 to \$15, increased the fee for surgeons from \$150 to \$450, increased the fee for podiatrists from \$50 to \$150, increased the fee for osteopaths, chiropractors and naturopaths from \$75 to \$225, increased the fee for physicians licensed under chapter 370, except homeopathic physicians from \$160 to \$450, increased the fee for registered nurses from \$10 to \$30, increased the fee for licensed practical nurses from \$5 to \$15, and increased the fee for physical therapists from \$5 to \$50; P.A. 89-389 inserted language on advanced practice registered nurses and nurse-midwives, deleting prior provision re midwives, and made technical changes, relettering Subsecs as necessary; P.A.

90-40 added midwifery in Subsec. (a) and imposed \$5 registration fee; P.A. 90-211 added Subsec. (c)(6) pertaining to physician assistants; P.A. 92-89 amended Subsec. (a) to require an optometrist license fee of \$375 for the fiscal year ending June 30, 1993; May Sp. Sess. P.A. 92-16 amended Subsec. (a) to increase the annual license renewal fee for dental hygienists to \$50, and amended Subsecs. (a) to (c) to replace specified dollar amounts of license fees with references to professional service fee classes established under Sec. 33-182i; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 94-210 amended Subsec. (e) to add name, residence and business address and other requested information to renewal application, effective July 1, 1994; P.A. 94-220 amended Subsec. (e) by adding provisions re renewal of licenses and certificates issued under Secs. 20-475 and 20-476 and amended Subsec. (f) to apply to entities, effective July 1, 1994; P.A. 95-196 added reference to licenses or certificates issued under Ch. 400a; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 97-186 added reference to licensure or certification under Sec. 20-74s in Subsec. (e); P.A. 97-311 added reference to licensure or certification under Secs. 20-195cc and 20-206// in Subsec. (e); P.A. 98-247 made a technical change re reference to other statutes; June Sp. Sess. P.A. 98-1 amended Subsec. (c)(6) to add department-approved successor certification organizations, effective June 24, 1998; P.A. 99-102 amended Subsec. (b) by deleting obsolete reference to osteopathy and making a technical change; P.A. 99-249 amended Subsec. (c) by adding reduced fee for retired nurses in Subdivs. (1), (2) and (3) and making technical changes, effective January 1, 2000; June Sp. Sess. P.A. 99-2 amended Subsec. (e) by adding reference to Sec. 20-266c and making technical changes; P.A. 00-27 made technical changes, effective May 1, 2000; P.A. 00-226 amended Subsec. (c)(5) by designating existing provisions as Subpara. (A), making a technical change therein, and adding new Subpara. (B) re physical therapist assistant licenses and amended Subsec. (e) by making technical changes and adding reference to Sec. 20-65k, effective the later of October 1, 2000, or the date notice is published by the Commissioner of Public Health in the Connecticut Law Journal indicating that the licensing of athletic trainers and physical therapist assistants is being implemented by the commissioner, i.e. April 11, 2006; June Sp. Sess. P.A. 01-4 amended Subsec. (e) by deleting reference to Sec. 20-266c, effective July 1, 2001; P.A. 03-124 amended Subsec. (a) by adding exception to renewal fee for certain dentists as provided in Sec. 20-113b; June 30 Sp. Sess. P.A. 03-3 amended Subsec. (e) by adding new Subdiv. (2) providing for biennial licensure for certain persons, and dividing existing provisions into Subdivs. (1), (3) and (4), effective January 1, 2004; P.A. 05-213 amended Subsec. (a) by adding reference to Sec. 19a-88b; P.A. 05-280 added Subsec. (e)(5) providing for annual licensure of perfusionists; P.A. 07-82 amended Subsec. (a) to allow retired dentists to renew their licenses at a reduced fee; P.A. 07-185 added Subsec. (g) to require department to establish and implement by July 1, 2008, a secure on-line license renewal system for physicians, surgeons, dentists and nurses, effective July 10, 2007; June Sp. Sess. P.A. 07-1 amended Subsec. (c) to increase annual license renewal fees for registered nurses to \$100, for advanced practice registered nurses and nurse-midwives to \$120 and for licensed practical nurses to class C professional services fee, effective July 1, 2007; P.A. 08-184 amended Subsec. (g) by providing that on or before January 1, 2009, department shall submit report to public health committee on feasibility and implications of implementation of biennial license renewal system for nursing licenses, effective July 1, 2008; June Sp. Sess. P.A. 09-3 amended Subsecs. (a), (c)(6) and (e)(5) to increase fees; Sept. Sp. Sess. P.A. 09-8 amended Subsec. (c)(3) by changing fee for licensed practical nurse from professional services fee for class C to \$60, effective October 5, 2009; P.A. 13-234 amended Subsecs. (a) and (b) by increasing registration fee for class I by \$5 and making technical changes, amended Subsec. (c) by increasing registration fees by \$5 in Subdivs. (1) to (4), amended Subsec. (e) by adding reference to Ch. 384a in Subdiv. (1) and reference to Sec. 20-266o in Subdiv. (2), and amended Subsec. (g) by deleting obsolete date, substituting "administer" for "establish and implement" re on-line license renewal system, applying on-line license renewal system to nurse-midwifery licensees, replacing provision allowing use of on-line license renewal system for license renewals and payment of professional service fees with provision requiring use of same, deleting provision allowing imposition of service fee for on-line payments made by credit card or electronic funds transfer, deleting provision re report, and adding exception to using on-line renewal system, effective June 19, 2013, and applicable to registration periods beginning on and after October 1, 2013; P.A. 15-198 amended Subsec. (c)(6) to designate existing provisions re renewal criteria as Subparas. (A) and (B) and add Subpara. (C) re training or education in prescribing controlled substances and pain management; P.A. 15-244 amended Subsecs. (a), (b), (c) and (e) to increase renewal fees by \$5,

amended Subsec. (a) to designate existing provisions as Subdivs. (1) to (4), and made technical changes, effective July 1, 2015; June Sp. Sess. P.A. 15-5 changed effective date of P.A. 15-244, S. 112, from July 1, 2015, to October 1, 2015, and applicable to the renewal of a license or certificate that expires on or after that date, effective June 30, 2015, and amended Subsec. (b) to reduce additional fee for person holding license to practice medicine or surgery from \$10 to \$5, and added \$5 to professional service fee for class I for renewal of licenses, effective October 1, 2015, and applicable to the renewal of a license that expires on or after that date; P.A. 16-66 amended Subsec. (c)(4) by replacing “American College of Nurse-Midwives” with “Accreditation Midwifery Certification Board”; P.A. 17-66 amended Subsec. (e)(3) by replacing “section 20-475 or 20-476” with “chapter 400c”, effective July 1, 2017; June Sp. Sess. P.A. 17-2 amended Subsec. (e)(1) to add reference to Sec. 20-185k or 20-185l, effective July 1, 2018; P.A. 18-168 amended Subsec. (e)(3) by adding provision re lead training providers and asbestos training providers to apply for renewal of certificate; P.A. 19-117 amended Subsec. (e) by adding reference to Ch. 383g and adding provision re person holding license as marital and family therapist associate in Subdiv. (1), effective October 1, 2019, deleting reference to Sec. 20-266o and adding reference to Secs. 20-265b to 20-265d and 20-265f in Subdiv. (2), adding new Subdiv. (3) re renewal of certificate issued under Sec. 20-195ttt and redesignating existing Subdivs. (3) to (5) as Subdivs. (4) to (6), effective January 1, 2020 (Revisor's note: References to Secs. 20-265b to 20-265d and 20-265f in Subsec. (e)(2) were deleted for clarity because these sections are all in Ch. 387); P.A. 19-118 amended Subsec. (e) by deleting reference to Ch. 384d in Subdiv. (1) and adding reference to Ch. 384d in Subdiv. (2), effective July 1, 2019; P.A. 21-121 amended Subsec. (c) by deleting former Subdiv. (6) re physician assistant, effective July 1, 2021; June Sp. Sess. P.A. 21-2 amended Subsec. (g) by redesignating existing provision as Subdiv. (1) and adding Subdiv. (2) re requirement to charge a service fee, rate or amount of service fee and waiver approval, effective July 1, 2022; P.A. 24-68 added references to Chs. 371 to 373, inclusive, 375, 375a, 380 to 381b, inclusive, 382a, 383 to 383d, inclusive, 383f to 388, inclusive, 393a, 395, 397a to 399, inclusive, 400a and 400c re on-line license renewal system, effective July 1, 2024.

Annotation to former section 19-45:

Cited. 135 C. 709.

Annotation to present section:

Cited. 208 C. 492.

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Sec. 19a-88a. Regulations concerning retired nurses. For purposes of subsection (c) of section [19a-88](#), the commissioner shall adopt regulations, in accordance with the provisions of chapter 54, no later than January 1, 2000. Such regulations shall include, but not be limited to, (1) a definition of “retired from the profession” as that term applies to registered nurses, advanced practice registered nurses and licensed practical nurses, (2) procedures for the return to active employment of such nurses who have retired from the profession, (3) appropriate restrictions upon the scope of practice for such nurses who are retired from the profession, including restricting the license of such nurses to the provision of volunteer services without monetary compensation, and (4) the requirement that any registered nurse, advanced practice registered nurse, or licensed practical nurse seeking to renew a license under the provisions of subsection (c) of section [19a-14](#), subsection (c) of section [19a-88](#), this section, subdivision (3) of section [20-66](#), subsections (l) to (n), inclusive, of section [20-74s](#), section [20-206bb](#) and sections 7 to 9, inclusive, of public act 99-249* shall be a holder in good standing of a current license issued pursuant to chapter 378 as of the date of application for renewal.

(P.A. 99-249, S. 5, 10; P.A. 10-32, S. 72.)

*Note: Sections 7 to 9, inclusive, of public act 99-249 are special in nature and therefore have not been codified but remain in full force and effect according to their terms.

History: P.A. 99-249 effective January 1, 2000; P.A. 10-32 made a technical change in Subdiv. (4), effective May 10, 2010.

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Sec. 19a-88b. Renewal of license, certificate, permit or registration that becomes void while holder is on active duty with armed forces of the United States or ordered out with the National Guard. Exceptions. (a) (1) Notwithstanding section [19a-14](#) or any other provision of the general statutes relating to continuing education or refresher training, the Department of Public Health shall renew a license, certificate, permit or registration issued to an individual pursuant to chapters 368d, 368v, 371 to 378, inclusive, 379a to 388, inclusive, 393a, 395, 398, 399, 400a and 400c that becomes void pursuant to section [19a-88](#) while the holder of the license, certificate, permit or registration is on active duty in the armed forces of the United States, or such holder is a member of the National Guard ordered out by the Governor for military service, not later than one year from the date of discharge from active duty or ordered military service, upon completion of any continuing education or refresher training required to renew a license, certificate, registration or permit that has not become void pursuant to section [19a-88](#). A licensee applying for license renewal pursuant to this subdivision shall submit an application on a form prescribed by the department and other such documentation as may be required by the department.

(2) Notwithstanding section [19a-14](#) or any other provisions of the general statutes relating to continuing education, the Department of Public Health shall renew a license issued to an individual pursuant to chapter 370 that becomes void pursuant to section [19a-88](#) while the holder of the license is on active duty in the armed forces of the United States, not later than one year from the date of discharge from active duty, upon completion of twenty-five contact hours of continuing education that meet the criteria set forth in subsection (b) of section [20-10b](#). A licensee applying for license renewal pursuant to this subdivision shall submit an application on a form prescribed by the department and other such documentation as may be required by the department.

(3) Notwithstanding section [19a-14](#) or any other provision of the general statutes relating to continuing education, the Department of Public Health shall renew a license issued to an individual pursuant to chapter 379 that becomes void pursuant to section [19a-88](#) while the holder of the license is on active duty in the armed forces of the United States, not later than one year from the date of discharge from active duty, upon completion of twelve contact hours of continuing education that meet the criteria set forth in subsection (b) of section [20-126c](#). A licensee applying for license renewal pursuant to this subdivision shall submit an application on a form prescribed by the department and other such documentation as may be required by the department.

(4) Notwithstanding section [19a-14](#) or any other provision of the general statutes relating to continuing education, the Department of Public Health shall renew a license issued to an individual pursuant to chapter 381a that becomes void pursuant to section [19a-88](#) while the holder of the license is on active duty in the armed forces of the United States, not later than one year from the date of discharge from active duty, upon completion of six contact hours of continuing education that meet the criteria set forth in section [20-162r](#). A licensee applying for license renewal pursuant to this subdivision shall submit an application on a form prescribed by the department and other such documentation as may be required by the department.

(b) The provisions of this section shall not apply to reservists or National Guard members on active duty for annual training that is a regularly scheduled obligation for reservists or members of the National Guard for training that is not a part of mobilization.

(c) No license shall be issued under this section to any applicant (1) against whom professional disciplinary action is pending, or (2) who is the subject of an unresolved complaint.

(May 9 Sp. Sess. P.A. 02-7, S. 73; P.A. 05-213, S. 1; 05-275, S. 25; P.A. 06-195, S. 3; P.A. 07-157, S. 1; P.A. 15-223, S. 12.)

History: May 9 Sp. Sess. P.A. 02-7 effective August 15, 2002; P.A. 05-213 amended Subsec. (a) by designating existing language as Subdiv. (1), making technical changes therein and adding Subdiv. (3) requiring renewal of dental license that becomes void while holder is on active duty in the armed forces, upon the holder's completion of 12 contact hours of continuing education, and made technical changes in Subsec. (b); P.A. 05-275 amended Subsec. (a) by designating existing language as Subdiv. (1), amending said Subdiv. (1) to remove reference to chapter 370 and making technical changes and adding Subdiv. (2) requiring renewal of physician license that becomes void while holder is on active duty in the armed forces, upon the holder's completion of 25 contact hours of continuing education, and made technical changes in Subsec. (b); P.A. 06-195 added Subsec. (a)(4) re renewal of voided respiratory care practitioner licenses; P.A. 07-157 amended Subsec. (a)(1) to add member of National Guard ordered out by the Governor for military service, change not later than 6 months to not later than 1 year from date of discharge from active duty or ordered military service and substitute "subdivision" for "section", and made technical changes in Subsecs. (b) and (c), effective July 1, 2007; P.A. 15-223 amended Subsec. (a)(1) to delete references to Sec. 19a-195b.

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Sec. 19a-88c. Regulations re retired dentists. For purposes of subsection (a) of section [19a-88](#), the Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, not later than January 1, 2008. Such regulations shall include, but not be limited to, (1) a definition of "retired from the profession" as that term applies to dentists, (2) procedures for the return to active employment of such dentists who have retired from the profession, and (3) appropriate restrictions upon the scope of practice for such dentists who are retired from the profession, including restricting the license of such dentists to the provision of volunteer services without monetary compensation.

(P.A. 07-82, S. 2.)

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Sec. 19a-89. (Formerly Sec. 19-46). Change of office or residence address. Whenever any person holding a license, certificate or registration issued by the Department of Public Health changes his office or residence address, he shall, within thirty days thereafter, notify said department of his new office or residence address.

(1949 Rev., S. 3822; 1969, P.A. 71, S. 1; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 94-210, S. 3, 30; P.A. 95-257, S. 12, 21, 58.)

History: 1969 act required that notification of new office or residence address be sent to health department and deleted provision re notification of town clerk; P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; Sec. 19-46 transferred to Sec. 19a-89 in 1983; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 94-210 deleted reference to branches of the healing arts and added holding a license, certificate or registration issued by the department, effective July 1, 1994; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

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Sec. 19a-89a. Database on nursing personnel. The Department of Public Health, in consultation with the State Board of Examiners for Nursing, shall establish a database on nursing personnel to assist the department, the board, other state agencies, employers of nurses, educational institutions and professional and health care industry associations and societies in planning for nurse staffing patterns and practices, and in developing and implementing their respective programs and activities.

(P.A. 88-207, S. 4; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

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Sec. 19a-89b. Fees for pool design guidelines and food compliance guide. (a) The Department of Public Health shall charge a fee of fifteen dollars for a copy of its pool design guidelines.

(b) The department shall charge a fee of fifteen dollars for a copy of its food compliance guide.

(P.A. 89-251, S. 147, 203; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; June Sp. Sess. P.A. 09-3, S. 171.)

History: P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; June Sp. Sess. P.A. 09-3 amended Subsecs. (a) and (b) to increase fees from \$4 to \$15.

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Sec. 19a-89c. Auricular acupuncture pilot program. Section [19a-89c](#) is repealed, effective June 4, 1996.

(93-295, S. 1, 2; 93-381, S. 9, 39; 93-435, S. 59, 95; P.A. 94-210, S. 20, 30; P.A. 95-257, S. 5, 58; 95-321, S. 4, 5; P.A. 96-225, S. 3, 4.)

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Sec. 19a-89d. Nurse staffing and patient care data. The Department of Public Health shall: (1) Develop a single, uniform method for collecting and analyzing standardized data concerning the linkage between nurse staffing levels and the quality of acute care, long-term care and home care, including patient outcomes; (2) conduct an ongoing study of the relationship between nurse staffing patterns in hospitals and the quality of health care, including patient outcomes; (3) obtain relevant licensure and demographic data that may be available from other state agencies and make the data collected under this subsection available to the public in a standardized format; and (4) collaborate with hospitals and the nursing profession with respect to the collection of standardized data concerning patient care outcomes at such hospitals and make such data available to the public in a report card format.

(P.A. 00-216, S. 20.)

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Sec. 19a-89e. Development of prospective nurse staffing plan by hospitals. Report. (a) For purposes of this section:

(1) “Department” means the Department of Public Health;

(2) “Hospital” means an establishment for the lodging, care and treatment of persons suffering from disease or other abnormal physical or mental conditions and includes inpatient psychiatric services in general hospitals;

(3) “Assistive personnel” means personnel who are not licensed by the Department of Public Health and who engage in specifically delegated patient care activities; and

(4) “Direct care registered nurse” means a registered nurse licensed pursuant to chapter 378 whose primary responsibility is to provide direct patient care.

(b) Each hospital licensed by the department pursuant to chapter 368v shall report, not later than January first and July first annually, to the department on a prospective nurse staffing plan with a written certification that the nurse staffing plan developed pursuant to subsections (d) and (e) of this section is sufficient to provide adequate and appropriate delivery of health care services to patients in the ensuing period of licensure. Such plan shall promote a collaborative practice in the hospital that enhances patient care and the level of services provided by nurses and other members of the hospital's patient care team.

(c) (1) Each hospital shall establish a dedicated hospital staffing committee to assist in the preparation of the nurse staffing plan required pursuant to subsection (b) of this section. Direct care registered nurses employed by the hospital shall account for not less than fifty per cent and an odd number of members of the membership of each hospital's staffing committee. The total number of direct care registered nurses shall be one more than the total number of nondirect care registered nurses of such committee. Each hospital's staffing committee shall include broad-based representation across hospital services. When registered nurses employed by the hospital are members of a collective bargaining unit, (A) the collective bargaining unit shall select the direct care registered nurse members that comprise not less than fifty per cent of the total number of members of such committee, provided such selection is not prohibited conduct under the National Labor Relations Act, 29 USC 151, et seq., as amended from time to time, 5 USC 71, as amended from time to time, or the State Employee Relations Act, section [5-270](#), et seq., as amended from time to time, and (B) a representative of the collective bargaining unit shall provide the hospital with a list of multiple names of direct care registered nurses from which hospital management shall select the one additional direct care registered nurse member beyond the fifty per cent of the direct care registered nurse members. Direct care registered nurses who are not members of a collective bargaining unit shall be selected for the committee through a process determined by the direct care registered nurses of the hospital. The hospital staffing committee that was in existence prior to October 1, 2023, shall solicit feedback from all direct care registered nurses employed by the hospital regarding what such process should entail. The direct care registered nurses who are members of such existing hospital staffing committee shall decide, by majority vote, the parameters of such process. Hospital management shall select the remaining members of such committee.

(2) Each hospital shall pay each employee who serves on the hospital staffing committee such employee's regular rate of pay, including differentials, for participation on the committee and consider, to the extent possible by the hospital, the time such employee serves on the committee as part of such employee's regularly scheduled work week. Each hospital shall ensure that direct care registered nurses have coverage to attend hospital staffing committee meetings.

(3) Each hospital staffing committee shall include two cochairpersons who have direct patient care experience, one of whom is a direct care registered nurse at the hospital who shall be elected by members of the committee who are direct care registered nurses, and one of whom shall be elected by members of the committee who are not direct care registered nurses. The committee shall take minutes of every meeting, make such minutes available to any member of the hospital staff upon request and submit such

minutes to the Department of Public Health when requested by the department. A majority of the members of the staffing committee shall constitute a quorum for the transaction of staffing committee business. A decision made by the hospital staffing committee shall be made by a vote of a majority of the members present at the meeting. If a quorum of members present at a meeting comprises an equal number of members who are direct care registered nurses and members who are not direct care registered nurses, a sufficient number of members who are not direct care registered nurses shall abstain from voting to allow a majority of the voting members to consist of direct care registered nurses.

(4) Each hospital shall notify each nurse on the nurse's date of hire, and annually thereafter, about the hospital staffing committee, including, but not limited to, the purpose of the committee, the criteria and process for becoming a member of the committee, the hospital's process for internal review of the nurse staffing plan and the hospital's mechanism for obtaining input from direct care staff, including direct care registered nurses and other members of the hospital's patient care team, in the development of the nurse staffing plan.

(d) Each hospital staffing committee shall develop the nurse staffing plan for the hospital. In developing such plan, the committee shall evaluate the most recent research regarding patient outcomes, share with hospital staff the procedures for communicating concerns to the committee regarding such plan and staffing assignments and review all reports regarding any such concerns and any objections or refusals by a registered nurse to participate in a staffing assignment made pursuant to subsection (h) of this section that were communicated to the committee. Each hospital shall implement such plan. Such plan shall: (1) Include the minimum professional skill mix for each patient care unit in the hospital, including, but not limited to, inpatient services, critical care and the emergency department; (2) identify the hospital's employment practices concerning the use of temporary and traveling nurses; (3) set forth the level of administrative staffing in each patient care unit of the hospital that ensures direct care staff are not utilized for administrative functions; (4) set forth the hospital's process for internal review of the nurse staffing plan; and (5) include the hospital's mechanism of obtaining input from direct care staff, including nurses and other members of the hospital's patient care team, in the development of the nurse staffing plan. In addition to the information described in subdivisions (1) to (5), inclusive, of this subsection, nurse staffing plans developed and implemented after January 1, 2016, shall include: (A) The number of registered nurses providing direct patient care and the ratio of patients to such registered nurses by patient care unit; (B) the number of licensed practical nurses providing direct patient care and the ratio of patients to such licensed practical nurses, by patient care unit; (C) the number of assistive personnel providing direct patient care and the ratio of patients to such assistive personnel, by patient care unit; (D) the method used by the hospital to determine and adjust direct patient care staffing levels; and (E) a description of assistive personnel on each patient care unit. In addition to the information described in subdivisions (1) to (5), inclusive, of this subsection and subparagraphs (A) to (E), inclusive, of this subdivision, nurse staffing plans developed and implemented after January 1, 2017, shall include: (i) A description of any differences between the staffing levels described in the staffing plan and actual staffing levels for each patient care unit; and (ii) any actions the hospital intends to take to address such differences or adjust staffing levels in future staffing plans.

(e) On and after January 1, 2024, in addition to the information required pursuant to subsection (d) of this section, each nurse staffing plan shall include:

(1) Information about any objections to or refusals to comply with the nurse staffing plan by hospital staff that were communicated to the hospital staffing committee;

(2) Measurements of and evidence to support successful implementation of the nurse staffing plan;

(3) Retention, turnover and recruitment metrics for direct care registered nursing staff, including, but not limited to, the turnover rate per hospital unit during the preceding twelve months and the average years of experience of permanent direct care registered nursing staff per unit;

(4) The number of instances since the last nurse staffing plan was submitted when the hospital was not in compliance with such plan, including, but not limited to, the nurse staffing ratios set forth in such plan, and a description of how and why such plan was not complied with and plans to avoid future noncompliance with such plan; and

(5) Certification that the hospital and its hospital staffing committee are meeting the requirements set forth in this section and a description of how each requirement is being met.

(f) Each hospital shall post the nurse staffing plan developed and adopted pursuant to subsections (d) and (e), inclusive, of this section on each patient care unit in a conspicuous location visible and accessible to staff, patients and members of the public. Each hospital shall maintain accurate records, for not less than the preceding three years, of the ratios of patients to direct care registered nurses and patients to assistive personnel providing patient care in each direct care unit for each shift. Such records shall include the number of (1) patients in each unit on each shift, (2) direct care registered nurses assigned to each patient in each unit on each shift, and (3) assistive personnel providing patient care assigned to each patient in each unit on each shift. Each hospital shall make such records available, upon request, to the Department of Public Health, the staff of the hospital, any collective bargaining unit representing such staff, the patients of the hospital and members of the general public.

(g) No hospital shall require a registered nurse to undertake any patient care task that is beyond the scope of the nurse's license.

(h) A registered nurse may object to or refuse to participate in any activity, policy, practice or task assigned by a hospital if the registered nurse is not competently able based on education, training or experience to participate in the activity, policy, practice or task without compromising the safety of a specific patient. If a registered nurse objects or refuses to participate, the nurse shall immediately contact a supervisor for assistance or to allow the hospital to find a suitable replacement. Not later than twelve hours after objecting or refusing to participate, the registered nurse shall submit a form, developed by the hospital and approved by the Department of Public Health, that includes the following: (1) A detailed statement of the reasons that the nurse objects or refuses to participate in the activity, policy, practice or task; (2) a description of how performing the activity, policy, practice or task would have compromised patient safety; and (3) the ways in which the activity, policy, practice or task was not consistent with the nurse's education, training, experience or job description. A hospital shall review and analyze each form submitted pursuant to this subsection through one or more of the hospital's committees or functions, including, but not limited to, the quality assessment and performance improvement program, risk management or patient safety, and make adjustments to nurse staffing assignments if necessary to improve patient safety. Each hospital shall provide the Department of Public Health with confidential access to the forms submitted to the hospital pursuant to this subsection upon request.

(i) If a registered nurse reasonably believes his or her participation in an activity, policy, practice or task would violate a provision of a nurse staffing plan or policy approved by the hospital's nurse staffing committee, the nurse may file a complaint with the nurse staffing committee on a form developed by the hospital and approved by the Department of Public Health. The hospital and its nurse staffing committee shall analyze the complaint and provide the Department of Public Health with an analysis of actions taken in response to such complaint. The department shall submit all complaint forms provided to it pursuant to this subsection with its biannual report required pursuant to subsection (n) of this section.

(j) No hospital shall discharge, retaliate against, discriminate against or take any other adverse action against a registered nurse or any aspect of the registered nurse's employment, including, but not limited to, discharge, promotion, reduction in compensation or changes to terms, conditions or privileges of employment, as a result of such nurse taking any of the actions described in this section, participation by the registered nurse in a hospital staffing committee or raising of concerns by the registered nurse regarding unsafe staffing or workplace violence, racism or bullying.

(k) Nothing in this section shall be construed to allow a nurse to abandon a patient or refuse to perform patient care activities (1) during an ongoing surgical procedure until such procedure is completed; (2) in a critical care unit, labor and delivery or emergency department until such nurse is relieved by another nurse; (3) in the case of a public health emergency; (4) in the case of an institutional emergency; or (5) in any instance where inaction or abandonment by the nurse would jeopardize patient safety.

(l) Nothing in this section shall prohibit a hospital, the Department of Public Health or the State Board of Examiners for Nursing from requiring a nurse to obtain additional training or continuing education consistent with the nurse's assigned roles and job description.

(m) Not later than January 1, 2016, and annually thereafter, the Commissioner of Public Health shall report, in accordance with the provisions of section [11-4a](#), to the joint standing committee of the General Assembly having cognizance of matters relating to public health concerning hospital compliance with reporting requirements under this section and recommendations concerning any additional reporting requirements.

(n) Not later than October 1, 2024, and biannually thereafter, a hospital shall report to the Department of Public Health, in a form and manner prescribed by the Commissioner of Public Health, whether it has been in compliance, for the previous six months, with at least eighty per cent of the nurse staffing assignments as required by any component outlined in the nurse staffing plan developed pursuant to subsections (d) and (e) of this section.

(o) For a failure by a hospital to (1) establish or maintain a hospital staffing committee pursuant to subsection (c) of this section, (2) submit the report required by subsection (n) of this section to the Department of Public Health, (3) post the staffing plan pursuant to subsection (f) of this section, or (4) comply with at least eighty per cent of the nurse staffing assignments set forth in the nurse staffing plan, the Commissioner of Public Health shall issue an order that: (A) Requires the hospital to submit a corrective action plan to correct such noncompliance and implement such plan unless disapproved by the department not later than twenty business days after its submission; and (B) (i) imposes a civil penalty of three thousand five hundred dollars for the first violation, or (ii) imposes a civil penalty of five thousand dollars for each subsequent violation.

(p) (1) A hospital shall, not later than five business days after receipt of an order pursuant to subsection (o) of this section, submit a request in writing to the Department of Public Health for a hearing to contest the order. If the hospital fails to submit such a request not later than five business days after such receipt, the order shall be deemed a final order of the department, effective upon the expiration of such five business days. After receipt of a timely request for a hearing, the department shall set the matter down for a hearing as a contested case in accordance with the provisions of chapter 54.

(2) Each hospital shall pay any civil penalties imposed pursuant to subsection (o) of this section not later than fifteen days after the final date by which an appeal may be taken as provided in section [4-183](#) or, if an appeal is taken, not later than fifteen days after the final judgment on such appeal. If such penalties or the expenses of an audit ordered under subsection (q) of this section are not paid by the hospital, the Commissioner of Public Health shall notify the Commissioner of Social Services who shall be authorized to immediately withhold from the hospital's next medical assistance payment, an amount equal to the amount of the civil penalty and audit expenses.

(q) The Commissioner of Public Health may order an audit of the nurse staffing assignments of each hospital to determine compliance with the nurse staffing assignments for each hospital unit set forth in the nurse staffing plan developed pursuant to subsections (d) and (e) of this section. Such audit may include an assessment of the hospital's compliance with the requirements of this section for the content of such plan, accuracy of reports submitted to the department and the membership of the hospital staffing committee. In determining whether to order an audit, the commissioner shall consider whether there has been consistent noncompliance by the hospital with the nurse staffing plan, fear of false reporting by the hospital or any other health care quality safety concerns. The hospital that is subject to the audit shall pay

the cost of the audit. The audit shall not affect the conduct by the hospital of peer review as defined in section [19a-17b](#).

(P.A. 08-79, S. 1; P.A. 15-91, S. 1; P.A. 23-204, S. 54; P.A. 24-68, S. 46.)

History: P.A. 15-91 amended Subsec. (b) to replace provision re plan made available upon request with provision re annual report on plan, amended Subsec. (c) to add provisions re information to be included in nurse staffing plans developed and implemented after January 1, 2016, and after January 1, 2017, and added Subsec. (d) re report concerning compliance and recommendations, effective July 1, 2015; P.A. 23-204 amended Subsec. (a) by adding Subdiv. (3) defining “assistive personnel” and Subdiv. (4) defining “direct care registered nurse”, Subsec. (b) by adding January and July first deadlines and reference to Subsecs. (d) and (e), Subsec. (c) by designating existing provisions re establishing a hospital staffing committee as Subdiv. (1) and amending same by inserting “dedicated”, replacing reference to “registered” with “direct care registered”, making technical changes, adding provision requiring direct care registered nurses to account for an odd number of members of the hospital staffing committee, replacing existing provisions re utilization of existing committees to assist in preparation of plan with provisions re membership of the committee, adding Subdiv. (2) re payment for services, adding Subdiv. (3) re chairpersons, taking minutes, quorum requirements and voting and adding Subdiv. (4) re notification re the hospital staffing committee, added new Subsec. (d) designator before existing provisions re implementation of the nurse staffing plan, made technical changes thereto and added new provisions re development of the plan by the hospital staffing committee, added Subsec. (e) re requirements for nurse staffing plan on and after January 1, 2024, added Subsec. (f) re posting of the nurse staffing plan and maintaining records of ratios of patients to direct care registered nurses and assistive personnel, added Subsec. (g) prohibiting hospital from requiring registered nurses to undertake any task beyond their scope, added Subsec. (h) re registered nurse's authority to object to or refuse to participate in certain activities, policies, practices or tasks, added Subsec. (i) re registered nurse's authority to file a complaint with the nurse staffing committee, added Subsec. (j) re prohibition on hospital's ability to discharge, retaliate against, discriminate against or take any other adverse action against a registered nurse, added Subsec. (k) prohibiting a nurse from abandoning a patient or refusing to perform certain patient care activities, added Subsec. (l) re authority of the department to require additional training or continuing education, redesignated existing Subsec. (d) as Subsec. (m) and made a technical change thereto, added Subsec. (n) re reporting to the department re compliance with the nurse staffing assignments, added Subsec. (o) re penalties for failure to establish or maintain a hospital staffing committee, submit the required report, post staffing plan or comply with at least 80 per cent of the staffing assignments, added Subsec. (p) re hearing to contest an order and payment of civil penalties, and added Subsec. (q) re ordering an audit of nurse staffing assignments; P.A. 24-68 amended Subsec. (q) by making a technical change, effective May 28, 2024.

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Sec. 19a-90. (Formerly Sec. 19-47). Blood testing of pregnant women for syphilis and HIV. (a) A health care provider giving prenatal care to a pregnant woman in this state during gestation shall order a blood sample of such woman for each of the following serological tests: (1) Not later than thirty days after the date of the first prenatal examination, a serological test for HIV and syphilis; (2) not later than twenty-eight to thirty-two weeks of gestation, a serological test for syphilis; (3) not later than thirty-two to thirty-six weeks of gestation, a serological test for HIV; and (4) at the time of delivery, a serological test for HIV and syphilis, provided the woman presents to labor and delivery without documentation of the required serological testing prescribed under subdivisions (2) and (3) of this subsection. No pregnant woman shall be subject to serological testing more than once during each of the time frames outlined in subdivisions (1) to (4), inclusive. A pregnant woman's consent to the HIV-related test, as defined in section [19a-581](#), shall be consistent with the consent given for the HIV-related test prescribed under section [19a-582](#). The laboratory tests required by this section shall be made on request without charge by the Department of Public Health. For purposes of this subsection, “health care provider” means a physician licensed

pursuant to chapter 370, advanced practice registered nurse licensed pursuant to chapter 378, physician assistant licensed pursuant to chapter 370 or nurse midwife licensed pursuant to chapter 377.

(b) The provisions of this section shall not apply to any woman who objects to a blood test as being in conflict with her religious tenets and practices.

(1949 Rev., S. 3836; P.A. 77-614, S. 323, 610; P.A. 79-39; P.A. 90-13, S. 3; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; June Sp. Sess. P.A. 99-2, S. 31; P.A. 17-6, S. 1; 17-146, S. 42.)

History: P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; P.A. 79-39 simplified language and required blood sample taken during final trimester of pregnancy; Sec. 19-47 transferred to Sec. 19a-90 in 1983; P.A. 90-13 amended Subsec. (a) to specify that the test during the final trimester be done between the twenty-sixth and twenty-eighth week of gestation and added Subsec. (b); P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; June Sp. Sess. P.A. 99-2 added HIV-related test requirement in Subsec. (a); P.A. 17-6 amended Subsec. (a) by replacing “each physician” with “a health care provider”, replacing provisions re time and frequency of serological testing with provisions re same, adding a definition of “health care provider” and making technical changes, effective July 1, 2017; P.A. 17-146 amended Subsec. (a) by replacing reference to Ch. 372 with reference to Ch. 377 re definition of health care provider, effective July 1, 2017.

See Sec. 19a-55 re newborn infant health screening.

See Sec. 19a-215 re required reporting of communicable diseases.

See Sec. 19a-593 re testing of pregnant women and newborns.

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Sec. 19a-91. (Formerly Sec. 19-49). Preparation, transportation and disposition of deceased persons. Definitions. Requirements. Death resulting from reportable diseases, emergency illnesses and health conditions. Disposition of burial or cremation materials. Regulations. (a) As used in this section:

- (1) “Wash” means to bathe or treat the entire surface of a dead human body with a disinfecting and deodorizing solution or to treat the entire surface of the dead human body with embalming powder.**
- (2) “Embalm” means to inject the circulatory system of a dead human body with embalming fluid in an amount not less than five per cent of the body weight, or to inject the body cavity of a dead human body with embalming fluid in an amount necessary to properly preserve the body and render it sanitary.**
- (3) “Wrap” means to place a dead human body in a burial or cremation pouch made of not less than four millimeters of plastic.**
- (4) “Embalming fluid” means a fluid containing not less than four per cent formaldehyde gas by weight.**
- (5) “Disinfecting solution” means an aqueous solution or spray containing not less than five per cent phenol by weight, or an equivalent in germicidal action.**

(b) (1) No licensed embalmer or funeral director shall remove a dead human body from the place of death to another location for preparation until the body has been temporarily wrapped. If the body is to be transported by common carrier, the licensed embalmer or funeral director having charge of the body shall have the body washed or embalmed unless it is contrary to the religious beliefs or customs of the deceased

person, as determined by the person who assumes custody of the body for purposes of burial, and then enclosed in a casket and outside box or, in lieu of such double container, by being wrapped.

(2) Any deceased person who is to be entombed in a crypt or mausoleum shall be in a casket that is placed in a zinc-lined or nationally accepted composite plastic container or, if permitted by the cemetery where the disposition of the body is to be made, a nonoxidizing nationally accepted composite plastic tray.

(c) In addition to the requirements set forth in subsection (b) of this section, in the case of death resulting from a disease on the current list of reportable diseases, emergency illnesses and health conditions developed pursuant to section [19a-2](#), the licensed embalmer or funeral director having charge of the dead human body shall prepare such body for burial or cremation by having the body washed, embalmed or wrapped as soon as practicable after the body arrives at the licensed embalmer's or licensed funeral director's place of business. The provisions of this subsection do not apply if death is not the result of a disease on the current list of reportable diseases, emergency illnesses and health conditions developed pursuant to section [19a-2](#), provided the licensed embalmer or funeral director having charge of the body takes appropriate measures to ensure that the body does not pose a threat to the public health.

(d) A licensed embalmer or funeral director shall dispose of any burial or cremation pouch used to wrap a dead human body after each use or clean and wash such pouch with a disinfecting solution after each use. No licensed embalmer or funeral director may use a solution for disinfecting that does not meet the standard specified in the definition under subdivision (5) of subsection (a) of this section unless such solution is approved, in writing, by the Department of Public Health.

(e) The Department of Public Health may adopt such regulations, in accordance with chapter 54, concerning the preparation and transportation of the bodies of deceased persons to be removed from or into the limits of any town or into any adjoining state, as the public health and welfare may require. Such regulations shall be signed by the Commissioner of Public Health, and a copy thereof shall be mailed to each town clerk, licensed embalmer and funeral director at least fifteen days before such regulations take effect. Any person who violates any regulation of the department adopted pursuant to the provisions of this section shall be fined not more than fifty dollars.

(1949 Rev., S. 3838; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 00-27, S. 15, 24; P.A. 07-104, S. 5; 07-252, S. 85; P.A. 09-232, S. 1; P.A. 10-117, S. 48; P.A. 11-242, S. 22.)

History: P.A. 77-614 replaced department and commissioner of health with department and commissioner of health services, effective January 1, 1979; Sec. 19-49 transferred to Sec. 19a-91 in 1983; P.A. 93-381 replaced department and commissioner of health services with department and commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 00-27 made technical changes, effective May 1, 2000; P.A. 07-104 redesignated existing provisions as Subsec. (e) and added new Subsecs. (a) to (d) establishing definitions and requirements for preparing and transporting dead human bodies and disinfecting burial and cremation materials, effective June 11, 2007; P.A. 07-252 amended Subsec. (a)(5) to redefine "disinfecting solution" to include an equivalent in germicidal action, effective July 12, 2007; P.A. 09-232 amended Subsec. (b) by designating existing language as Subdiv. (1), adding provision therein re body washed or embalmed unless it is contrary to religious beliefs or customs of deceased person, and adding Subdiv. (2) re container requirements for deceased persons that are to be entombed in a crypt or mausoleum; P.A. 10-117 amended Subsec. (b)(2) by replacing "an acrylonitrile butadiene styrene (ABS) sheet" with "nationally accepted composite" and by replacing "metal or ABS plastic sheeting" with "nationally accepted composite plastic"; P.A. 11-242 amended Subsec. (c) by substituting "list of reportable diseases, emergency illnesses and health conditions" for "list of reportable diseases" and by substituting "19a-2" for "19a-36-A2 of the regulations of Connecticut state agencies".

See chapter 368i re anatomical donations.

See chapter 368j re cemeteries.

See chapter 368k re crematories.

See chapter 385 re embalmers and funeral directors.

See Secs. 7-64 to 7-71, inclusive, re disposal of bodies, disinterment and removal of bodies and re sexton's duties.

See Sec. 19a-504 re removal of bodies of deceased persons from presence of patients in hospitals, residential care homes and rest homes.

See Secs. 53-331 to 53-334, inclusive, re penalties for offenses concerning burial practices and unlawful disinterment.

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Sec. 19a-91a. Out-of-state funeral director access to electronic death registry system. The Commissioner of Public Health shall provide funeral directors licensed pursuant to chapter 385 who operate or are affiliated with a funeral home or funeral service business that (1) is located in another state, and (2) has a reciprocal agreement on file with the Department of Public Health, with access to the electronic death registry system.

(P.A. 23-31, S. 49.)

History: P.A. 23-31 effective January 1, 2024.

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Sec. 19a-92. (Formerly Sec. 19-49b). Regulations concerning the licensing of massage parlors, masseurs and masseuses. Section [19a-92](#) is repealed.

(P.A. 75-517, S. 1, 2; P.A. 77-604, S. 14, 84; 77-614, S. 323, 610; P.A. 78-303, S. 85, 136; P.A. 83-487, S. 32, 33.)

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Sec. 19a-92a. Regulation of persons engaged in tattooing. Penalty. Section [19a-92a](#) is repealed, effective July 1, 2014.

(P.A. 94-105, S. 1, 4; P.A. 95-257, S. 12, 21, 58; P.A. 99-102, S. 18; P.A. 12-80, S. 170; P.A. 13-234, S. 157.)

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Secs. 19a-92b to 19a-92f. Reserved for future use.

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Sec. 19a-92g. Body piercing. (a) No person may perform body piercing on an unemancipated minor under eighteen years of age without the written permission of the minor's parent. For purposes of this

subsection, “body piercing” means piercing or creating a channel through any part of the body other than the ear lobe for the purpose of inserting a decorative object, and “ear lobe” means the lower portion of the auricle having no cartilage.

(b) Any municipal health authority established under chapter 368e and any district department of health established under chapter 368f may, within its available resources, enforce the provisions of this section.

(June Sp. Sess. P.A. 99-2, S. 11.)

History: (Revisor's note: References in Subsec. (b) to “chapter 368c” and “section 368f” were changed editorially by the Revisors to “chapter 368e” and “chapter 368f”, respectively, for accuracy).

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Secs. 19a-93 to 19a-94a. Transferred to Chapter 440, Secs. [22a-45b](#) to [22a-45d](#), inclusive.

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Sec. 19a-95. Transferred to Chapter 491, Sec. [26-192i](#).

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Secs. 19a-96 to 19a-101. Transferred to Chapter 491, Secs. [26-192c](#) to [26-192h](#), inclusive.

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Sec. 19a-102. (Formerly Sec. 19-59a). Regulation of sale of turtles. Section [19a-102](#) is repealed.

(P.A. 73-75; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 94-29, S. 3.)

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Sec. 19a-102a. Regulation of sale of turtles. (a) As used in this section, “turtle” means any reptile commonly known as turtles, tortoises or terrapins but shall not include a turtle used solely for agricultural, scientific or educational purposes.

(b) No turtle with a carapace length of less than four inches or with viable turtle eggs may be sold in this state.

(c) No person may sell a live turtle with a carapace length of four inches or greater unless (1) a caution notice is posted by the person selling turtles which warns that the transmission of salmonella disease by turtles is possible; (2) at the time of the sale of the turtle, the seller furnishes the buyer with a copy of the caution notice and information obtained from a veterinarian regarding the proper care and feeding for the species of turtle which is being sold; (3) the buyer signs a form stating that he has read the notice provided if the buyer is less than sixteen years of age, such form shall be signed by a parent or guardian; (4) the turtle is not a species identified by the Commissioner of Energy and Environmental Protection as endangered, threatened or of special concern in regulations adopted under section [26-306](#); and (5) the seller receives, and retains on file for inspection by the Commissioner of Agriculture, written verification

that such turtle was bred at a licensed commercial fish farm or commercial aquaculture facility and was not collected from the wild.

(d) Any person who violates any provision of this section or section [19a-102b](#) shall be fined not more than one hundred dollars. The Commissioner of Agriculture may suspend the pet shop license of any pet shop, as defined in section [22-327](#), which violates any provision of this section or section [19a-102b](#).

(e) On or before October 1, 1996, the Commissioner of Public Health shall evaluate the public health effect of the sale of turtles in this state and shall submit a report of his findings to the General Assembly.

(f) The Commissioner of Public Health may adopt regulations, in accordance with the provisions of chapter 54, to carry out the provisions of this section.

(P.A. 94-29, S. 1; P.A. 95-257, S. 12, 21, 58; June 30 Sp. Sess. P.A. 03-6, S. 146(e); P.A. 04-189, S. 1; P.A. 11-80, S. 1.)

History: P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; June 30 Sp. Sess. P.A. 03-6 replaced Commissioner of Agriculture with Commissioner of Agriculture and Consumer Protection, effective July 1, 2004; P.A. 04-189 repealed Sec. 146 of June 30 Sp. Sess. P.A. 03-6, thereby reversing the merger of the Departments of Agriculture and Consumer Protection, effective June 1, 2004; pursuant to P.A. 11-80, “Commissioner of Environmental Protection” was changed editorially by the Revisors to “Commissioner of Energy and Environmental Protection” in Subsec. (c)(4), effective July 1, 2011.

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Sec. 19a-102b. Importation of turtles. No person may import turtles into this state unless such person has obtained a permit under section [26-55](#).

(P.A. 94-29, S. 2.)

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Sec. 19a-103. (Formerly Sec. 19-60). Control of communicable diseases in institutions. Any person confined or imprisoned in the Connecticut Correctional Institution, Somers, or in a community correctional center or in any other institution for a period of ten days or longer may be examined for any communicable disease, and, if found infected with any such disease, he shall be treated during the term of his confinement and, if not cured at the date of his discharge, the local director of health shall be notified. The person in charge of each such institution shall provide for such examination and necessary treatment of all such persons admitted thereto. The Department of Public Health may make such regulations or orders as, in its judgment, are necessary to carry out the provisions of this section.

(1949 Rev., S. 3804; 1969, P.A. 297; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: 1969 act replaced jails with community correctional centers; P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; Sec. 19-60 transferred to Sec. 19a-103 in 1983; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

See Sec. 18-94 re retention of diseased inmates in correctional or charitable institutions.

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Sec. 19a-104. (Formerly Sec. 19-61). Sale of rags to be used as wiping cloths; cleaning. Section [19a-104](#) is repealed, effective October 1, 2002.

(1949 Rev., S. 4178; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 02-89, S. 90.)

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Sec. 19a-105. (Formerly Sec. 19-62). Public toilets. All persons, firms or corporations which own or have control of any public pay toilets shall cause the same to be equipped with devices, approved by the Commissioner of Public Health, to keep them clean and sterile. Each such person, firm or corporation shall maintain and equip at least one free public toilet in each restroom. At least one-half of any additional toilets in each restroom shall be free. Every public toilet shall be equipped with a door which may be locked by the occupant. Any such person, firm or corporation which fails to comply with the provisions of this section shall be fined not more than five hundred dollars.

(1949 Rev., S. 3811; P.A. 76-76, S. 2; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: P.A. 76-76 added provisions re required free public toilets, deleted minimum fine of \$10 and raised maximum fine from \$50 to \$500; P.A. 77-614 replaced commissioner of health with commissioner of health services, effective January 1, 1979; Sec. 19-62 transferred to Sec. 19a-105 in 1983; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

See Sec. 19a-211 re duties of municipal health authorities with respect to toilets in public places.

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Sec. 19a-106. (Formerly Sec. 19-62a). “Restroom” defined. For the purposes of section [19a-105](#), “restroom” means a room containing a toilet.

(P.A. 76-76, S. 1; P.A. 14-122, S. 117.)

History: Sec. 19-62a transferred to Sec. 19a-106 in 1983; P.A. 14-122 made a technical change.

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Sec. 19a-106a. Customer access to employee restrooms in retail establishments. (a) As used in this section:

- (1) “Customer” means an individual who is lawfully on the premises of a retail establishment;
- (2) “Eligible medical condition” means Crohn's disease, ulcerative colitis, inflammatory bowel disease, irritable bowel syndrome, celiac disease or a medical condition that requires use of an ostomy device;
- (3) “Licensed health care provider” means a physician or a physician assistant licensed under chapter 370 or an advanced practice registered nurse licensed under chapter 378;

(4) “Restroom” means a room containing a toilet; and

(5) “Retail establishment” means a place of business open to the general public for the sale of goods or services.

(b) Any retail establishment that has a restroom for employee use, which typically does not permit customer access to such employee restroom, shall permit a customer to use the employee restroom during normal business hours if the restroom is maintained in a reasonably safe manner and all of the following conditions are met:

(1) The customer requesting access to the employee restroom presents written evidence, issued by a licensed health care provider, that documents that the customer suffers from an eligible medical condition;

(2) A public restroom is not immediately accessible to the customer;

(3) At the time that the request for access to the employee restroom is made, three or more employees of the retail establishment are working; and

(4) The employee restroom is located in an area of the retail establishment that does not present an obvious risk to the health or safety of the customer or an obvious security risk to the retail establishment.

(c) A retail establishment or employee of a retail establishment shall not be liable for any acts or omissions in providing a customer access to an employee restroom pursuant to the provisions of this section, if such acts or omissions: (1) Do not constitute gross, wilful or wanton negligence on the part of the retail establishment or employee of the retail establishment; (2) occurred in an area of the retail establishment that is not otherwise accessible to customers; and (3) resulted in injury or death of a customer or individual other than an employee accompanying the customer to the restroom.

(d) No retail establishment shall be required to make a physical change to the employee restroom to effectuate the purposes of this section.

(e) Any violation of subsection (b) of this section shall be an infraction.

(P.A. 09-129, S. 1.)

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Sec. 19a-107. (Formerly Sec. 19-63). Towels in hotels and public lavatories. All towels provided by any hotel, for the use of guests therein, or by any public lavatory shall be individual towels, or toweling may be provided so arranged in locked cabinets that each user may pull out a clean portion and the used portion shall be automatically drawn into a separate compartment and mechanically locked to prevent withdrawal for reuse. Any such towel or toweling which has been used and discarded by an individual shall not be used again until thoroughly washed and dried. Each guest occupying a room in any hotel shall be furnished with such towels in such room; and, in the public washroom, if any, in such hotel, there shall be kept at all times, in sight of, and easy of access to, guests a sufficient supply of individual towels or toweling so arranged in locked cabinets that each user may pull out a clean portion and the used portion shall be automatically drawn into a separate compartment and mechanically locked to prevent withdrawal for reuse. The owner, manager, agent or person in charge of any hotel or public lavatory who fails to comply with any of the provisions hereof shall be fined not less than ten dollars nor more than one hundred dollars for each offense.

(1949 Rev., S. 4149.)

History: Sec. 19-63 transferred to Sec. 19a-107 in 1983.

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Sec. 19a-108. (Formerly Sec. 19-64). Common drinking cups. Section [19a-108](#) is repealed, effective October 1, 2002.

(1949 Rev., S. 4151; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 02-89, S. 90.)

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Sec. 19a-109. (Formerly Sec. 19-65). Heating and provision of utilities for buildings. Hot water. Termination of services. When any building or part thereof is occupied as a home or place of residence or as an office or place of business, either mercantile or otherwise, a temperature of less than sixty-five degrees Fahrenheit in such building or part thereof shall, for the purpose of this section, be deemed injurious to the health of the occupants thereof, except that the Commissioner of Public Health may adopt regulations establishing a temperature higher than sixty-five degrees Fahrenheit when the health, comfort or safety of the occupants of any such building or part thereof so requires. In any such building or part thereof where, because of physical characteristics or the nature of the business being conducted, a temperature of sixty-five degrees Fahrenheit cannot reasonably be maintained in certain areas, the Labor Commissioner may grant a variance for such areas. The owner of any building or the agent of such owner having charge of such property, or any lessor or his agent, manager, superintendent or janitor of any building, or part thereof, the lease or rental agreement whereof by its terms, express or implied, requires the furnishing of heat, cooking gas, electricity, hot water or water to any occupant of such building or part thereof, who, wilfully and intentionally, fails to furnish such heat to the degrees herein provided, cooking gas, electricity, hot water or water and thereby interferes with the cooking gas, electricity, hot water or water and thereby interferes with the comfortable or quiet enjoyment of the premises, at any time when the same are necessary to the proper or customary use of such building or part thereof, shall be guilty of a class D misdemeanor. No public service company or electric supplier, as defined in section [16-1](#), shall, at the request of any such owner, agent, lessor, manager, superintendent or janitor, cause heat, cooking gas, electricity, hot water or water services to be terminated with respect to any such leased or rented property unless the owner or lessor furnishes a statement signed by the lessee agreeing to such termination or a notarized statement signed by the lessor to the effect that the premises are vacant.

(1949 Rev., S. 4150; 1967, P.A. 442; 1971, P.A. 434; P.A. 73-244; P.A. 77-2, S. 1, 4; P.A. 79-631, S. 101, 111; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 98-28, S. 65, 117; P.A. 12-80, S. 122; P.A. 13-208, S. 75.)

History: 1967 act added provision for variance and added owner as a responsible person; 1971 act prohibited termination of utility services unless lessee agrees in signed statement or lessor furnishes notarized statement that premises are vacant; P.A. 73-244 included among utilities covered in provisions cooking gas, electricity and water and deleted "light"; P.A. 77-2 changed minimum temperature to be maintained from sixty-eight to sixty-five degrees and added exception re higher minimum temperature when health, comfort or safety requires it; P.A. 79-631 replaced public health council with commissioner of health services; Sec. 19-65 transferred to Sec. 19a-109 in 1983; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 98-28 added electric suppliers, effective July 1, 1998; P.A. 12-80 changed penalty from a fine of not more than \$100 or imprisonment of not more than 60 days or both to a class D misdemeanor; P.A. 13-208 made a technical change.

Annotation to former section 19-65:

If lessor is obligated to heat premises, his failure to do so constitutes an eviction. 115 C. 247.

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Secs. 19a-109a to 19a-109z. Reserved for future use.

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Sec. 19a-109aa. (Formerly Sec. 19a-111f). Environmentally safe housing for children and families program. (a) For purposes of this section:

- (1) “Commissioner” means the Commissioner of Public Health;
- (2) “Eligible families” means any household which (A) is eligible for the federal Medicaid program, (B) includes a child who is six years of age or younger, and (C) is residing in a building built prior to 1978; and
- (3) “The program” or “this program” means the program established by this section.

(b) The Commissioner of Public Health may establish a program to promote environmentally safe housing for children and families through education, medical screening and appropriate and cost-effective repairs. Such program may (A) identify eligible families and, through voluntary home visits, provide education about the problems caused by exposure to lead and how to avoid or lessen the effects of such exposure, (B) provide blood lead screening for children who are six years of age or younger, (C) identify measures to be taken to lessen the effects from the presence of lead, including window repair or replacement, and (D) apply to federal programs and to other funding sources which will pay for some of the costs of this program. The commissioner may contract with a nonprofit entity to operate the program.

(c) Eligible costs by a nonprofit entity operating this program shall include costs and expenses incurred in providing lead-safety education, interim measures and window repair or replacement or other remediation for dwelling units, administrative and management expenses, planning and start-up costs, and any other costs and expenses found by the commissioner to be necessary and reasonable and in accordance with existing state regulations.

(P.A. 00-216, S. 26, 28; P.A. 23-31, S. 28.)

History: P.A. 00-216 effective July 1, 2000; Sec. 19a-111f transferred to Sec. 19a-109aa in 2009; P.A. 23-31 amended Subsec. (a)(2)(B) by deleting “as of July 1, 2000,” and amended Subsec. (b) by deleting Subpara. (E) re continual evaluation of program progress and making a conforming change.

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Sec. 19a-110. (Formerly Sec. 19-65e). Report of lead poisoning. Parental notification. Availability of information regarding lead poisoning. (a) As used in this section, and sections [19a-110a](#) to [19a-111k](#), inclusive:

- (1) “Abatement” means any set of measures designed to reduce or eliminate lead hazards, including, but not limited to, the encapsulation, replacement, removal, enclosure or covering of paint, plaster, soil or other material containing toxic levels of lead and all preparation, clean-up, disposal and reoccupancy clearance testing;
- (2) “Epidemiological investigation” means an examination and evaluation by a lead inspector certified under chapter 400c to determine the cause of elevated blood levels, detect lead-based paint and report findings and (A) includes (i) an on-site inspection and, if applicable, an inspection of other dwellings or areas frequented by a person with elevated blood lead levels that may be the source of a lead hazard, and

(ii) an evaluation of other potential sources of lead hazards, including, but not limited to, drinking water, soil, dust, pottery, gasoline, toys or occupational exposure, and (B) may include isotopic analysis of lead-containing items;

(3) “Lead screening” means a blood lead test from a finger-prick or venous blood draw;

(4) “On-site inspection” means an examination of a residential dwelling to identify lead hazards, including, but not limited to, an examination of the dwelling for deteriorating paint, lead dust, bare soil near the perimeter of the dwelling, household items that may present a potential lead risk, such as toys, cookware, food products and cosmetics, and an inquiry into the water system serving the dwelling;

(5) “Remediation” means the process of remedying a lead hazard condition, including, but not limited to, investigation, abatement and, if appropriate, ongoing management measures; and

(6) “Risk assessment” means the collection of information about a person's potential lead exposures and a determination of whether such person has an increased likelihood of an elevated blood lead level.

(b) Not later than forty-eight hours after receiving or completing a report of a person found to have a level of lead in the blood equal to or greater than three and one-half micrograms per deciliter of blood or any other abnormal body burden of lead, each institution licensed under sections [19a-490](#) to [19a-503](#), inclusive, and each clinical laboratory licensed under section [19a-565](#) shall report to (1) the Commissioner of Public Health, and to the director of health of the town, city, borough or district in which the person resides: (A) The name, full residence address, date of birth, gender, race and ethnicity of each person found to have a level of lead in the blood equal to or greater than three and one-half micrograms per deciliter of blood or any other abnormal body burden of lead; (B) the name, address and telephone number of the health care provider who ordered the test; (C) the sample collection date, analysis date, type and blood lead analysis result; and (D) such other information as the commissioner may require, in a form and manner as prescribed by the commissioner, and (2) the health care provider who ordered the test, the results of the test. With respect to a child under three years of age, not later than twenty-four hours after the provider receives such results, the provider shall make reasonable efforts to notify the parent or guardian of the child of the blood lead analysis results. Any institution or laboratory making an accurate report in good faith shall not be liable for the act of disclosing such report to the Commissioner of Public Health or to the director of health. The commissioner shall determine the form and manner of transmission of data contained in such report.

(c) Each institution or laboratory that reports lead testing pursuant to this section shall, at least monthly, submit to the Commissioner of Public Health a comprehensive report that includes: (1) The name, full residence address, date of birth, gender, race and ethnicity of each person tested pursuant to subsection (b) of this section regardless of the level of lead in the blood; (2) the name, address and telephone number of the health care provider who ordered the test; (3) the sample collection date, analysis date, type and blood lead analysis result; (4) laboratory identifiers; and (5) such other information as the Commissioner of Public Health may require. Any institution or laboratory making an accurate report in good faith shall not be liable for the act of disclosing such report to the Commissioner of Public Health. The Commissioner of Public Health shall determine the form and manner of transmission of data contained in such report.

(d) Whenever an institutional laboratory or private clinical laboratory reporting blood lead tests pursuant to this section refers a blood lead sample to another laboratory for analysis, the laboratories may agree on which laboratory will report in compliance with subsections (b) and (c) of this section, but both laboratories shall be accountable to ensure that reports are made. The referring laboratory shall ensure that the requisition slip includes all of the information that is required in subsections (b) and (c) of this section and that this information is transmitted with the blood specimen to the laboratory performing the analysis.

(1971, P.A. 22, S. 1; P.A. 77-614, S. 323, 610; P.A. 87-394, S. 1, 7; P.A. 92-192, S. 1, 5; P.A. 93-321, S. 1, 6; 93-381, S. 9, 39; 93-435, S. 59, 95; P.A. 95-257, S. 12, 21, 58; June 18 Sp. Sess. P.A. 97-9, S. 23, 50; P.A. 98-

66; June Sp. Sess. P.A. 07-2, S. 49, 50; P.A. 11-51, S. 76; P.A. 15-172, S. 1, 2; P.A. 22-49, S. 1; 22-118, S. 149; P.A. 23-31, S. 29.)

History: P.A. 77-614 replaced commissioner of health with commissioner of health services, effective January 1, 1979; Sec. 19-65e transferred to Sec. 19a-110 in 1983; P.A. 87-394 substituted “.025” for “.04” milligrams in lead level measurement; P.A. 92-192 deleted requirement that practitioners of the healing arts report increased blood lead levels, deleted requirement of reports for suspected increase in blood lead level, changed reportable lead level from .025 milligrams per one hundred grams to ten micrograms per deciliter and added the requirement that the commissioner shall determine the method of transmission of data after consultation with the executive director of the office of information and technology; P.A. 93-321 added new Subsec. (b) requiring health directors to provide information to parents and guardians of children reported; P.A. 93-381 and P.A. 93-435 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; June 18 Sp. Sess. P.A. 97-9 amended Subsec. (a) by substituting “Chief Information Officer” for “executive director of the Office of Information and Technology”, effective July 1, 1997; P.A. 98-66 amended Subsec. (a) by changing “registered” laboratories to “licensed” laboratories, changing “address” to “full residence address”, replacing “such other relevant information as said commissioner may require” with “gender, race and ethnicity”, adding Subdivs. (2), (3) and (4), replacing “such a report” with “an accurate report”, deleting immunity from civil or criminal liability and adding “not liable for the act of disclosing said report to the commissioner or to the director of health”, made a technical change re title of Chief Information Officer and required commissioner to determine “format” as well as method, added new Subsecs. (b) and (c) and relettered Subsec. (b) as (d); June Sp. Sess. P.A. 07-2 amended Subsec. (a) to extend applicability to all clinical laboratories, not just private clinical laboratories, to trigger reporting requirements when blood lead analysis results equal or exceed 10 micrograms per deciliter of blood, to redesignate existing Subdivs. (1) to (4) as Subparas. (A) to (D), to designate as Subdiv. (1) existing provisions re reports to Commissioner of Public Health and local directors of health and to add new Subdiv. (2) re reports to health care providers and notice to parents and guardians, effective October 1, 2007, and amended Subsec. (d) to require local directors of health to provide parents and guardians with information about potential eligibility for birth-to-three services and to add provisions requiring such directors to conduct inspections and order remediation whenever a confirmed venous blood lead level equals or exceeds 15 micrograms per deciliter but is less than 20 micrograms per deciliter or, on and after January 1, 2012, equals or exceeds 10 micrograms per deciliter, effective January 1, 2009; pursuant to P.A. 11-51, “Chief Information Officer of the Department of Information Technology” was changed editorially by the Revisors to “Commissioner of Administrative Services” in Subsecs. (a) and (b), effective July 1, 2011; P.A. 15-172 amended Subsec. (a)(1) by adding reference to district and amended Subsec. (d) by adding reference to district, replacing provision re child reported pursuant to Subsec. (a) with Subdiv. (1) re child known to have certain confirmed venous blood lead level and Subdiv. (2) re child who is the subject of a report and adding provision re information to be provided on one occasion; P.A. 22-49 amended Subsec. (a) by decreasing the blood lead level minimum from 10 micrograms per deciliter to 3 and one-half micrograms per deciliter and making technical changes, Subsecs. (b) and (c) by making technical changes, and Subsec. (d) by decreasing the blood lead level minimum from 5 micrograms per deciliter to 3 and one-half micrograms per deciliter, replacing “17a-248g” with “17a-248i” and redesignating existing provisions re conducting an on-site inspection as Subsec. (e) and amended same by adding a January 1, 2024, deadline, decreasing the blood lead level minimum from 15 micrograms per deciliter to 10 micrograms per deciliter and the blood lead level maximum from 20 micrograms per deciliter to 15 micrograms per deciliter, making a technical change, deleting provisions re an on-site inspection on and after January 1, 2012, and adding provisions re an on-site inspection from January 1, 2024, to December 31, 2024, effective January 1, 2023; P.A. 22-118 made identical changes as P.A. 22-49, effective January 1, 2023; P.A. 23-31 added new Subsec. (a) re definitions of “abatement”, “epidemiological investigation”, “lead screening”, “on-site inspection”, “remediation” and “risk assessment”, redesignated existing Subsec. (a) as Subsec. (b), amended Subsec. (b)(1)(D) by adding “in a form and manner as prescribed by the commissioner,”, amended Subsec. (b)(2) by replacing “seventy-two hours” with “twenty-four hours”, redesignated existing Subsecs. (b) and (c) as Subsecs. (c)

and (d), deleted former Subsecs. (d) and (e), replaced references to conducting with references to reporting and “method and format” with “form and manner” throughout, deleted “, after consultation with the Commissioner of Administrative Services,” throughout, and made conforming changes throughout.

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Sec. 19a-110a. Regional lead poisoning treatment centers. Quarterly reports. (a) The Commissioner of Public Health may, within available appropriations, establish two regional lead poisoning treatment centers in different areas of the state by providing grants-in-aid to two participating hospitals, each with a demonstrated expertise in lead poisoning prevention and treatment as determined by the commissioner. Each center shall serve a designated area of the state, as determined by the commissioner, to provide services including, but not limited to, consultation services for pediatricians and other primary care practitioners regarding proper treatment of lead poisoning in children.

(b) Each regional lead poisoning treatment center shall report to the commissioner on a quarterly basis, in a form and manner prescribed by the commissioner, regarding the number of persons treated for lead poisoning, the residential town and race and ethnicity data for each such person and any other information that the commissioner may require.

(P.A. 92-192, S. 3, 5; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 23-31, S. 30.)

History: P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 23-31 designated existing provisions as Subsec. (a), amended Subsec. (a) by adding “participating”, “and treatment”, “, as determined by the commissioner,” and “in children”, replacing “physicians” with “pediatricians and other primary care practitioners”, and deleting provision restricting provision of grants prior to submission of task force report, and added Subsec. (b) re quarterly reports.

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Sec. 19a-111. (Formerly Sec. 19-65f). Informational materials. On-site inspection. Investigation. Preventive measures. Relocation of families. Reports. Regulations. (a) The Commissioner of Public Health shall develop informational materials describing the dangers of lead poisoning, precautions to reduce the risk of lead poisoning, potential eligibility for services for children from birth to three years of age pursuant to sections [17a-248](#) to [17a-248i](#), inclusive, laws and regulations concerning lead abatement and any other information as prescribed by the commissioner. The director of health of the town, city, borough or district shall provide, or cause to be provided, such informational materials to the parent or guardian of a child who is (1) known to have a blood lead level of three and one-half micrograms per deciliter of blood or more, or (2) the subject of a report by an institution or clinical laboratory, pursuant to section [19a-110](#). The director of health need only provide, or cause to be provided, such information to such parent or guardian on one occasion after receipt of an initial report of an abnormal blood lead level as described in section [19a-110](#).

(b) Upon receipt of each report of a child with a blood lead level (1) equal to or greater than ten micrograms per deciliter but less than fifteen micrograms per deciliter on or before January 1, 2024, and (2) equal to or greater than five micrograms per deciliter but less than ten micrograms per deciliter from January 1, 2024, to December 31, 2024, inclusive, the director shall conduct an on-site inspection to identify the source of the lead causing such blood lead level and order remediation of such source by the appropriate persons responsible for the conditions at such source.

(c) Upon receipt of each report of a blood lead level equal to or greater than fifteen micrograms per deciliter of blood from January 1, 2023, to December 31, 2023, inclusive, ten micrograms per deciliter of blood from January 1, 2024, to December 31, 2024, inclusive, and five micrograms per deciliter of blood on and after January 1, 2025, the local director of health shall make or cause to be made an epidemiological investigation of the source of the lead causing the increased lead level or abnormal body burden and shall order action to be taken by the appropriate person responsible for the condition that brought about such lead poisoning as may be necessary to prevent further exposure of persons to such poisoning. In the case of any residential unit where such action will not result in removal of the hazard within a reasonable time, the local director of health shall utilize such community resources as are available to effect relocation of any family occupying such unit. The local director of health may permit occupancy in said residential unit during abatement if, in such director's judgment, occupancy would not threaten the health and well-being of the occupants.

(d) The local director of health shall, not later than thirty days after the conclusion of such director's epidemiological investigation, report to the commissioner, using a web-based surveillance system as prescribed by the commissioner, the result of such investigation and the action taken to ensure against further lead poisoning from the same source, including any measures taken to effect relocation of families. Such report shall include information relevant to the identification and location of the source of lead poisoning and such other information as the commissioner may require pursuant to regulations adopted in accordance with the provisions of chapter 54. Nothing in this section shall be construed to prohibit a local building official from requiring abatement of sources of lead or to prohibit a local director of health from making or causing to be made an epidemiological investigation upon receipt of a report of a blood lead level that is less than the minimum blood level specified in this section.

(1971, P.A. 22, S. 2; P.A. 77-614, S. 323, 610; P.A. 87-394, S. 2, 7; P.A. 92-192, S. 2, 5; P.A. 93-321, S. 2, 6; 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 14-231, S. 8; P.A. 21-121, S. 5; P.A. 22-49, S. 2; 22-118, S. 150; P.A. 23-31, S. 31.)

History: P.A. 77-614 replaced commissioner of health with commissioner of health services, effective January 1, 1979; Sec. 19-65f transferred to Sec. 19a-111 in 1983; P.A. 87-394 added provisions re contents of reports, regulations, quarterly summaries and guidelines; P.A. 92-192 added provision that a blood lead level greater than twenty micrograms per deciliter of blood will cause an investigation to be conducted and added provisions that the guidelines established by the commissioner be consistent with those of the National Centers for Disease Control for assessment of the risk of lead poisoning, screening for lead poisoning and follow-up care; P.A. 93-321 added provision permitting occupancy during abatement, changed "may" to "shall" re establishment of guidelines, added treatment including children, pregnant women and women planning pregnancy and added provision affirming building officials' right to require abatement; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 14-231 deleted provision re quarterly summary of records and made technical changes; P.A. 21-121 added provision re use of web-based surveillance system as prescribed by the commissioner and made technical change; P.A. 22-49 decreased blood lead level minimum from 20 micrograms per deciliter to 15 micrograms per deciliter for January 1, 2023, to December 31, 2024, added provisions re minimum blood lead level from January 1, 2024, to December 31, 2024, and on and after January 1, 2025, and added provision permitting a director of health to investigate a report of a confirmed blood lead level less than the minimum specified in this section, effective January 1, 2023; P.A. 22-118 made identical changes as P.A. 22-49, effective January 1, 2023; P.A. 23-31 added Subsec. (a) re informational materials and Subsec. (b) re on-site inspections, designated existing provisions as Subsecs. (c) and (d), amended Subsecs. (c) and (d) by deleting "confirmed venous", "venous", and provisions re maintenance of comprehensive records and establishment of lead assessment and screening guidelines, and made technical and conforming changes.

See Sec. 20-474 for applicable definitions.

Cited. 45 CS 136.

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Sec. 19a-111a. Lead poisoning prevention program. Lead state agency. (a) The Department of Public Health shall be the lead state agency for lead poisoning prevention and control in this state. The Commissioner of Public Health shall (1) identify the state and local agencies in this state with responsibilities related to lead poisoning prevention, and (2) schedule a meeting of such state agencies and representative local agencies at least once annually in order to coordinate lead poisoning prevention efforts in this state.

(b) The commissioner shall establish, in consultation with recognized professional medical groups, guidelines consistent with the National Centers for Disease Control and Prevention's guidelines for assessment of the risk of lead poisoning, screening for lead poisoning and treatment and follow-up care of individuals, including children with lead poisoning and persons who are pregnant or are planning to become pregnant.

(c) The commissioner shall establish a lead poisoning prevention program to provide screening, diagnosis, consultation, inspection and treatment services, including, but not limited to, the prevention and elimination of lead poisoning through research, abatement, education and epidemiological and clinical activities. Such program shall include, but need not be limited to, the screening services provided pursuant to section [19a-111g](#).

(d) Within available appropriations, the commissioner may contract with individuals, groups or agencies for the provision of necessary services and enter into assistance agreements with municipalities, cities, boroughs or district departments of health or special service districts for the development and implementation of comprehensive lead poisoning prevention programs consistent with the provisions of sections [19a-110](#) to [19a-111c](#), inclusive.

(e) The commissioner shall maintain comprehensive records of all reports submitted pursuant to sections [19a-110](#) and [19a-111](#). Such records shall be geographically indexed for the purpose of determining the location of areas of relatively high incidences of lead poisoning.

(P.A. 87-394, S. 3, 7; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 03-252, S. 18; June Sp. Sess. P.A. 07-2, S. 47; P.A. 23-31, S. 32.)

History: P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 03-252 made a technical change in Subsec. (b); June Sp. Sess. P.A. 07-2 amended Subsec. (a) to designate Department of Public Health as lead state agency for lead poisoning prevention and establish duties as lead state agency, designated existing provisions re lead poisoning prevention program as new Subsec. (b) and expanded program to include lead screening services provided pursuant to Sec. 19a-111g and redesignated existing Subsec. (b) as Subsec. (c); P.A. 23-31 amended Subsec. (a) by adding “and control”, added new Subsec. (b) re establishment of guidelines for lead assessment and screening, redesignated existing Subsecs. (b) and (c) as Subsecs. (c) and (d), and added Subsec. (e) re maintenance of comprehensive records.

Cited. 31 CA 359.

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Sec. 19a-111b. Educational and publicity program. Early diagnosis program. Program for detection of sources of lead poisoning. Within the lead poisoning prevention program established pursuant to section [19a-111a](#):

(1) The commissioner shall institute an educational and publicity program in order to inform the general public, teachers, social workers and other human services personnel; residential property owners, and in particular, those that own buildings constructed prior to 1978; and health care providers of the danger, frequency and sources of lead poisoning and methods of preventing such poisoning;

(2) The commissioner shall establish an early diagnosis program to detect cases of lead poisoning. Such program shall include, but not be limited to, the routine examination of children under the age of six in accordance with protocols promulgated by the National Centers for Disease Control. Results equal to or greater than the levels specified in section [19a-110](#) from any examination pursuant to sections [19a-110](#) to [19a-111c](#), inclusive, shall be provided to the child's parent or legal guardian, the local director of health and the commissioner; and

(3) The commissioner shall establish a program for the detection of sources of lead poisoning. Within available appropriations, such program shall include the identification of dwellings in which paint, plaster or other accessible substances contain toxic levels of lead and the inspection of areas surrounding such dwellings for lead-containing materials. Any person who detects a toxic level of lead, as defined by the commissioner, shall report such findings to the commissioner. The commissioner shall inform all interested parties, including, but not limited to, the owner of the building, the occupants of the building, enforcement officials and other necessary parties.

(P.A. 87-394, S. 4, 7; P.A. 03-252, S. 19; P.A. 23-31, S. 33; P.A. 24-68, S. 56.)

History: P.A. 03-252 made a technical change in Subdiv. (2); P.A. 23-31 amended Subdiv. (1) by adding “those that own”, replacing “1950” with “1978” and “services personnel” with “care providers”, and making a technical change; P.A. 24-68 amended Subdiv. (3) by making a technical change.

Cited. 31 CA 359.

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Sec. 19a-111c. Abatement of lead in dwellings. List of encapsulant products. Regulations. (a) The owner of any dwelling in which the paint, plaster or other material is found to contain toxic levels of lead and in which children under the age of six reside, shall remediate such toxic levels of lead through testing, abatement or management of such materials consistent with regulations adopted pursuant to this section. The Commissioner of Public Health shall adopt regulations, in accordance with chapter 54, to establish requirements and procedures for testing, abatement and management of materials containing toxic levels of lead.

(b) The commissioner shall authorize the use of any liquid, cementitious or flexible lead encapsulant product which complies with an appropriate standard for such products developed by the American Society for Testing and Materials or similar testing organization acceptable to the commissioner for the abatement and remediation of lead hazards. The commissioner shall maintain a list of all such approved lead encapsulant products that may be used in this state for the remediation of lead hazards.

(c) (1) The Commissioner of Public Health may adopt regulations, in accordance with chapter 54, to regulate paint removal from the exterior of any building or structure where the paint removal project may present a health hazard related to lead exposure to neighboring premises. The regulations may establish: (A) Definitions, (B) applicability and exemption criteria, (C) procedures for submission of notifications, (D) appropriate work practices, and (E) penalties for noncompliance.

(2) The Commissioner of Public Health may adopt regulations, in accordance with chapter 54, to regulate the standards and procedures for remediation of lead hazards, including testing, abatement and management of materials containing toxic levels of lead in any premises.

(3) The commissioner may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulations, provided the department posts such policies and procedures on the eRegulations System prior to adopting them. Policies and procedures implemented pursuant to this section shall be valid until final regulations are adopted in accordance with the provisions of chapter 54.

(P.A. 87-394, S. 5, 7; P.A. 93-321, S. 3, 6; P.A. 95-204, S. 1, 2; 95-257, S. 12, 21, 58; June sp. Sess. P.A. 07-2, S. 54; P.A. 23-31, S. 34.)

History: P.A. 93-321 replaced requirement that dangerous materials be removed or covered with requirement that building owner “abate or manage” such materials “consistent with regulations adopted pursuant to this section”; P.A. 95-204 required the commissioner to authorize use of and keep a list of lead encapsulant products, effective June 28, 1995; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; June Sp. Sess. P.A. 07-2 designated provisions re owner's duty to abate and corresponding regulations as Subsec. (a) and expanded owner's duty to include remediation of dangerous materials, expanded scope of regulations to include requirements and procedures for testing, remediation and management of dangerous materials and defined “remediation”, designated provisions re approved lead encapsulant products as Subsec. (b) and added references to remediation of lead hazards therein and added Subsec. (c) authorizing Commissioner of Public Health to adopt regulations re paint removal from building exteriors and standards and procedures for testing, remediation, abatement and management of materials containing toxic levels of lead in any premises; P.A. 23-31 amended Subsec. (a) by replacing “abate, remediate or manage such dangerous” with “remediate such toxic levels of lead through testing, abatement or management of such” and “testing, remediation, abatement and management of materials” with “testing, abatement and management of materials” and deleting provision defining “remediation”, amended Subsec. (b) by replacing “abatement and remediation of lead hazards” with “remediation of lead hazards”, amended Subsec. (c)(1) by adding “related to lead exposure”, amended Subsec. (c)(2) by replacing “testing, remediation, as defined in this section” with “remediation of lead hazards, including testing”, and added Subsec. (c)(3) re implementation of policies and procedures.

Cited. 31 CA 359.

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Sec. 19a-111d. Regulations. Section [19a-111d](#) is repealed, effective October 1, 2003.

(P.A. 87-394, S. 6, 7; P.A. 03-252, S. 25.)

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Sec. 19a-111e. Federal funds for lead poisoning prevention programs. The Department of Public Health shall apply for, qualify for and accept any federal funds made available or allotted under any federal act for state lead poisoning prevention programs including lead abatement certification programs pursuant to the federal Residential Lead-Based Paint Hazard Reduction Act of 1992.

(P.A. 93-321, S. 5, 6; 93-381, S. 9, 39; 93-435, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: P.A. 93-321 effective June 29, 1993 (Revisor's note: Pursuant to P.A. 93-381 and P.A. 93-435 department of health services was changed editorially by the Revisors to department of public health and

addiction services); P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

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Sec. 19a-111f. Transferred to Sec. [19a-109aa](#).

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Sec. 19a-111g. Pediatric lead testing and risk assessment. Exemption. Prenatal guidance. Local health director epidemiological investigations. (a)(1) Each primary care provider giving pediatric care in this state, excluding a hospital emergency department and its staff shall conduct lead risk assessment and lead testing that includes, but need not be limited to:

(A) A complete medical risk assessment based on guidelines prescribed by the commissioner for each child from birth to six years of age, conducted at least annually;

(B) An annual lead screening test for each child who has an elevated risk of lead exposure based on findings of the medical risk assessment conducted pursuant to subparagraph (A) of this subdivision;

(C) A lead screening test for each child at twelve months of age and twenty-four months of age; and

(D) Follow-up testing, in accordance with a schedule established by the commissioner, for each child with a confirmed blood lead level equal to or greater than three and one-half micrograms per deciliter.

(2) Each primary care provider giving pediatric care in this state, excluding a hospital emergency department and its staff, shall provide educational materials and guidance information concerning lead poisoning prevention to each child's parent or guardian in accordance with the commissioner's recommendations for childhood lead screening.

(3) The requirements of this subsection shall not apply to any child whose parents or guardians object to blood testing as being in conflict with their religious tenets and practice.

(b) Each prenatal health care provider shall (1) provide each pregnant person anticipatory guidance on lead poisoning prevention during pregnancy, (2) assess each pregnant person at the initial prenatal visit for lead exposure using a risk assessment tool recommended by the commissioner, (3) screen or refer for blood lead screening each pregnant person found to be at risk for lead exposure, (4) notify the local health director serving the jurisdiction in which the pregnant person resides if such person has a blood lead level equal to or greater than three and one-half micrograms per deciliter, and (5) provide anticipatory guidance regarding the prevention of childhood lead poisoning to each patient at such patient's postpartum visit.

(c) Upon the receipt of any notice provided pursuant to subdivision (4) of subsection (b) of this section, a local health director shall conduct the epidemiological investigation and take such other actions as described in section [19a-111](#).

(June Sp. Sess. P.A. 07-2, S. 48; P.A. 14-231, S. 9; P.A. 22-49, S. 3; 22-118, S. 151; P.A. 23-31, S. 35.)

History: June Sp. Sess. P.A. 07-2 effective January 1, 2009; P.A. 14-231 amended Subsec. (a) by replacing “screening” with “testing” and making a conforming change, adding new Subdiv. (3) re educational materials and anticipatory guidance information, redesignating existing Subdiv. (3) re medical risk assessment as Subdiv. (4) and amending same by replacing “seventy-one” with “seventy-two”, and redesignating existing Subdiv. (4) as Subdiv. (5); P.A. 22-49 amended Subsec. (a) by replacing reference to

“Childhood Lead Poisoning Prevention Screening Advisory Committee” with “Advisory Committee on Childhood Lead Poisoning Prevention” in Subdiv. (1), adding new Subdiv. (2) re annual lead testing for a child 36 to 72 months of age determined to be at an elevated risk of lead exposure and redesignating existing Subdivs. (2) to (5) as Subdivs. (3) to (6), effective January 1, 2023; P.A. 22-118 made identical changes as P.A. 22-49, effective January 1, 2023; P.A. 23-31 amended Subsec. (a) by deleting Subdivs. (1) to (6) re pediatric lead testing criteria, adding new Subdiv. (1) re lead risk assessment and lead testing program, adding new Subdiv. (2) re educational materials and guidance information, redesignated existing Subsec. (b) as Subsec. (a)(3) and made a technical change in same, added new Subsec. (b) re requirements of prenatal health care providers, and added Subsec. (c) re local health director epidemiological investigation, effective January 1, 2024.

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Sec. 19a-111h. Review of lead poisoning data. Regulations. Section [19a-111h](#) is repealed, effective October 1, 2023.

(June Sp. Sess. P.A. 07-2, S. 53; P.A. 23-31, S. 52.)

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Sec. 19a-111i. Report re lead poisoning prevention efforts. (a) On or before October 1, 2023, and annually thereafter, the Commissioner of Public Health shall report, in accordance with section [11-4a](#), to the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services on the status of lead poisoning prevention and control efforts in the state for the preceding calendar year. Such report shall include, but need not be limited to, (1) the number of lead screenings of children, (2) the number of children diagnosed with elevated blood levels, and (3) the amount of testing, abatement and management of materials containing toxic levels of lead in all premises.

(b) On or before January 1, 2011, the Commissioner of Public Health shall (1) evaluate the lead screening and risk assessment conducted pursuant to sections [19a-110](#) and [19a-111g](#), and (2) report, in accordance with section [11-4a](#), to the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services on the effectiveness of such screening and assessment, including a recommendation as to whether such screening and assessment should be continued as specified in sections [19a-110](#) and [19a-111g](#).

(June Sp. Sess. P.A. 07-2, S. 58; P.A. 17-146, S. 28; P.A. 23-31, S. 36.)

History: P.A. 17-146 amended Subsec. (a) by replacing “January 1, 2009” with “October 1, 2017”, effective June 30, 2017; P.A. 23-31 amended Subsec. (a) by replacing “October 1, 2017” with “October 1, 2023” and “lead poisoning prevention efforts” with “lead poisoning prevention and control efforts”, adding “for the preceding calendar year”, adding “lead screenings of” and deleting “screened for lead poisoning during the preceding calendar year” in Subdiv. (1), deleting “during the preceding calendar year” in Subdiv. (2), replacing “testing, remediation, abatement and management of materials” with “testing, abatement and management of materials” and deleting “during the preceding calendar year” in Subdiv. (3), and making a technical change, and amended Subsec. (b) by making a technical change, effective June 7, 2023.

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Sec. 19a-111j. Financial assistance to local health departments for lead poisoning prevention and control. (a) The Department of Public Health shall, within available appropriations, establish and administer a

program of financial assistance to local health departments for expenses incurred in complying with this section and the applicable provisions of sections [19a-110](#), [19a-111a](#), [19a-206](#), [47a-52](#) and [47a-54f](#). Local health departments shall use the funds disbursed through the program for lead poisoning prevention and control services as described in subsection (b) of this section and other lead poisoning prevention and control purposes approved by the Department of Public Health.

(b) To be eligible to receive program funding from the Department of Public Health, a local health department shall administer a local lead poisoning prevention and control program approved by the department. Such program shall include, but need not be limited to: (1) Case management services; (2) lead poisoning educational services; (3) environmental health services; (4) health education services, including, but not limited to, education concerning proper nutrition for good health and the prevention of lead poisoning; and (5) participation in the Department of Public Health's system for the collection, tabulation, analysis and reporting of lead poisoning prevention and control statistics.

(c) A local health department may directly provide lead poisoning prevention and control services within its geographic coverage area or may contract for the provision of such services. A local health department's case management services shall include medical, behavioral, epidemiological and environmental intervention strategies for each child having a blood lead level that is equal to, or greater than, three and one-half micrograms of lead per deciliter of blood. A local health department shall initiate case management services for such child not later than five business days after the local health department receives the results of a test confirming that the child has a blood lead level as described in this subsection.

(d) A local health department's educational services shall include the distribution of educational materials concerning lead poisoning prevention to the parent, legal guardian and the appropriate health care provider for each child with a blood lead level equal to, or greater than, three and one-half micrograms of lead per deciliter of blood. Such educational materials shall be provided in English, Spanish and any other language common to the persons in the local health department's jurisdiction.

(e) The Department of Public Health shall disburse program funds to the local health department on an annual basis. After approving a local health department's application for program funding, the funding period shall begin on July first each year. The amount of such funding shall be determined by the Department of Public Health based on the number of confirmed childhood lead poisoning cases reported in the local health department's geographic coverage area during the previous calendar year. The director of any local health department that applies for program funding shall submit, not later than September thirtieth, annually, to the Department of Public Health a report concerning the local health department's lead poisoning and prevention control program. Such report shall contain: (1) A proposed budget for the expenditure of program funds for the new fiscal year; (2) a summary of planned program activities for the new fiscal year; and (3) a summary of program expenditures, services provided and operational activities during the previous fiscal year. The Department of Public Health shall approve a local health department's proposed budget prior to disbursing program funds to the local health department.

(June Sp. Sess. P.A. 07-2, S. 59; P.A. 12-202, S. 1; P.A. 23-31, S. 37.)

History: June Sp. Sess. P.A. 07-2 effective July 1, 2007; P.A. 12-202 designated existing provisions as Subsec. (a) and amended same to add reference to compliance with “this section” re expenses incurred, delete provision re adoption of regulations and add provision re use of funds by local health departments and added Subsec. (b) re requirements for funding eligibility, Subsec. (c) re prevention and control services and case management services, Subsec. (d) re educational services and Subsec. (e) re disbursement of program funds to and reports by local health departments; P.A. 23-31 amended Subsec. (c) by replacing “one confirmed blood level” with “a blood level” and “twenty” with “three and one-half”, and deleting provision re case management services to include strategies for each child having 2 confirmed blood levels that are equal to, or greater than, 15 micrograms of lead but less than 20 micrograms of lead per deciliter of blood, and amended Subsec. (d) by replacing “confirmed blood lead level” with “blood lead level” and “ten” with “three and one-half” and adding provision re multilingual educational materials.

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Sec. 19a-111k. Applicability of OSHA standards to abatement and remediation of lead hazards. All standards adopted by the federal Occupational Safety and Health Administration, including, but not limited to, standards listed in 29 CFR 1910.1025 and 1926.62, as adopted pursuant to chapter 571 or 29 USC 651 et seq., as from time to time amended, as appropriate, and only as those standards apply to employers and employees, shall apply to the provisions of sections [19a-111c](#), [19a-206](#), [47a-52](#) and [47a-54f](#).

(June Sp. Sess. P.A. 07-2, S. 60.)

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Sec. 19a-111l. Guidelines on mold abatement protocols. On or before October 1, 2006, the Department of Public Health shall publish guidelines establishing mold abatement protocols that include acceptable methods for performing mold remediation or abatement work. Such guidelines shall not be deemed to be regulations, as defined in section [4-166](#).

(P.A. 06-195, S. 40.)

History: P.A. 06-195 effective June 7, 2006.

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Sec. 19a-111m. Evaluation of information or guidance regarding mold and development of uniform standards for identifying, assessing and remediating mold and guidelines for limiting exposure to mold. Public awareness campaign concerning mold in residential housing. Not later than January 1, 2024, the Department of Public Health shall (1) evaluate information or guidance published by the United States Environmental Protection Agency regarding identification of, assessment of, remediation of and limiting of exposure to mold; (2) develop the following: (A) Uniform standards for identifying and assessing mold in residential housing, (B) uniform standards for remediating mold, including, but not limited to, any necessary revisions to the guidelines establishing mold abatement protocols published by the department pursuant to section [19a-111l](#), and (C) guidelines for limiting exposure to mold in residential housing and uniform standards for assessing the health threat from such exposure, including, but not limited to, its effects on indoor air quality; (3) publish such standards and guidelines on the department's Internet web site; and (4) develop a public awareness campaign concerning mold in residential housing, including, but not limited to, public service announcements on the department's Internet web site and social media accounts regarding (A) mold prevention and identification in the home, and (B) the health risks associated with exposure to mold in the home.

(P.A. 23-42, S. 1.)

History: P.A. 23-42 effective July 1, 2023.

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Sec. 19a-112. (Formerly Sec. 19-66b). Sterilization procedures to be performed only by doctors of medicine. Consent required. Medical and surgical sterilization procedures for the prevention of human procreation shall be performed only by doctors of medicine duly licensed under chapter 370 and only after legal consent to such procedure, in accordance with applicable existing statutes, shall have been obtained.

(1971, P.A. 777.)

History: Sec. 19-66b transferred to Sec. 19a-112 in 1983.

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Sec. 19a-112a. Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations. Protocol. Sexual assault evidence collection kit. Electronic tracking, transfer, analysis and preservation of evidence. Costs. Training and sexual assault examiner programs. Victim access to information re evidence. (a) There is created a Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations composed of fifteen members as follows: (1) The Chief State's Attorney or a designee; (2) the executive director of the Commission on Women, Children, Seniors, Equity and Opportunity or a designee; (3) the Commissioner of Children and Families or a designee; (4) one member from the Division of State Police and one member from the Division of Scientific Services appointed by the Commissioner of Emergency Services and Public Protection; (5) one member from Connecticut Alliance to End Sexual Violence appointed by its board of directors; (6) one member from the Connecticut Hospital Association appointed by the president of the association; (7) one emergency physician appointed by the president of the Connecticut College of Emergency Physicians; (8) one obstetrician-gynecologist and one pediatrician appointed by the president of the Connecticut State Medical Society; (9) one nurse appointed by the president of the Connecticut Nurses' Association; (10) one emergency nurse appointed by the president of the Emergency Nurses' Association of Connecticut; (11) one police chief appointed by the president of the Connecticut Police Chiefs Association; (12) one member of the Office of Victim Services within the Judicial Department; and (13) one member of Disability Rights Connecticut, Inc. appointed by its board of directors. The Chief State's Attorney or a designee shall be chairman of the commission. The commission shall be within the Division of Criminal Justice for administrative purposes only.

(b) (1) For the purposes of this section, (A) “protocol” means the state of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault, including the Interim Sexual Assault Toxicology Screen Protocol, as revised from time to time and as incorporated in regulations adopted in accordance with subdivision (2) of this subsection, pertaining to the collection of evidence in any sexual assault investigation, and (B) “law enforcement agency” means the Division of State Police within the Department of Emergency Services and Public Protection or any municipal police department.

(2) The commission shall recommend the protocol to the Chief State's Attorney for adoption as regulations in accordance with the provisions of chapter 54. Such protocol shall include nonoccupational post-exposure prophylaxis for human immunodeficiency virus (nPEP), as recommended by the National Centers for Disease Control. The commission shall annually review the protocol and may annually recommend changes to the protocol for adoption as regulations.

(c) (1) The commission shall design a sexual assault evidence collection kit and may annually recommend changes in the kit to the Chief State's Attorney. Each kit shall include instructions on the proper use of the kit, standardized reporting forms, standardized tests which shall be performed if the victim so consents and standardized receptacles for the collection and preservation of evidence. The commission shall provide the kits to all health care facilities in the state at which evidence collection examinations are performed at no cost to such health care facilities.

(2) Not later than October 1, 2018, the Division of Scientific Services within the Department of Emergency Services and Public Protection shall (A) implement an electronic tracking system for sexual assault evidence collection kits, and (B) notify health care facilities at which evidence collection examinations are performed of such kit-tracking system.

(3) Not later than October 1, 2018, the commission shall develop guidelines for (A) the use by such health care facilities of kit-tracking software to record (i) when a sexual assault evidence collection kit is used,

and (ii) when and to which law enforcement agency the kit is transferred, (B) the use by the Division of Scientific Services within the Department of Emergency Services and Public Protection of such software to record the receipt of each kit submitted by a law enforcement agency to the division, and (C) training employees of such health care facilities and the division who are subject to the guidelines, including instruction on the use of such kit-tracking software.

(d) Each health care facility in the state that provides for the collection of sexual assault evidence shall follow the protocol adopted under subsection (b) of this section, contact a sexual assault counselor, as defined in section [52-146k](#), when a person who identifies himself or herself as a victim of sexual assault arrives at such health care facility and, with the consent of the victim, shall collect sexual assault evidence. After the collection of any evidence, the health care facility shall contact a law enforcement agency to receive the evidence. Not later than ten days after the collection of the evidence, the law enforcement agency shall transfer the evidence, in a manner that maintains the integrity of the evidence, to the Division of Scientific Services within the Department of Emergency Services and Public Protection or the Federal Bureau of Investigation laboratory. If the evidence is transferred to the division, the division shall analyze the evidence not later than sixty days after the collection of the evidence or, if the victim chose to remain anonymous and not report the sexual assault to the law enforcement agency at the time of collection, shall hold the evidence for at least five years after the collection of the evidence. If a victim reports the sexual assault to the law enforcement agency after the collection of the evidence, such law enforcement agency shall notify the division that a report has been filed not later than five days after filing such report and the division shall analyze the evidence not later than sixty days after receiving such notification. The division shall hold any evidence received and analyzed pursuant to this subsection until the conclusion of any criminal proceedings. The failure of a law enforcement agency to transfer the evidence not later than ten days after the collection of the evidence, or the division to analyze the evidence not later than sixty days after the collection of the evidence or after receiving a notification from a law enforcement agency, shall not affect the admissibility of the evidence in any suit, action or proceeding if the evidence is otherwise admissible. The failure of any person to comply with this section or the protocol shall not affect the admissibility of the evidence in any suit, action or proceeding if the evidence is otherwise admissible.

(e) (1) No costs incurred by a health care facility for the examination of a victim of sexual assault, when such examination is performed for the purpose of gathering evidence as prescribed in the protocol, including the costs of testing for pregnancy and sexually transmitted diseases and the costs of prophylactic treatment as provided in the protocol, and no costs incurred for a medical forensic assessment interview conducted by a health care facility or provider or by an examiner working in conjunction with a multidisciplinary team established pursuant to section [17a-106a](#) or with a child advocacy center, shall be charged directly or indirectly to such victim. Any such costs shall be charged to the Forensic Sex Evidence Exams account in the Judicial Department.

(2) No costs incurred by a health care facility for any toxicology screening of a victim of sexual assault, when such screening is performed as prescribed in the protocol, shall be charged directly or indirectly to such victim. Any such costs shall be charged to the Division of Scientific Services within the Department of Emergency Services and Public Protection.

(f) The commission shall advise the Chief State's Attorney on the establishment of a mandatory training program for health care facility staff regarding the implementation of the regulations, the use of the sexual assault evidence collection kit and kit-tracking software and procedures for handling evidence.

(g) The commission shall advise the Chief State's Attorney not later than July 1, 1997, on the development of a sexual assault examiner program and annually thereafter on the implementation and effectiveness of such program.

(h) Not later than October 1, 2018, the commission shall develop policies and procedures to ensure each victim has access to information regarding the victim's sexual assault evidence collection kit, including, but not limited to, information regarding when the kit was tested, whether DNA (deoxyribonucleic acid) obtained from the testing of the kit was entered into the DNA data bank established under section [54-102j](#),

a national DNA data bank or any other data bank of another state, and if so, whether the sample derived from the kit satisfactorily matches a profile in any such DNA data bank.

(P.A. 88-210, S. 1, 3; P.A. 92-151, S. 1, 2; P.A. 93-91, S. 1, 2; 93-340, S. 6, 19; 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 97-257, S. 2, 13; P.A. 98-5; 98-24; P.A. 99-218, S. 7, 16; June 30 Sp. Sess. P.A. 03-6, S. 162, 163; P.A. 05-272, S. 16; P.A. 10-102, S. 1; P.A. 11-51, S. 134; June Sp. Sess. P.A. 12-1, S. 141; P.A. 15-207, S. 1; May Sp. Sess. P.A. 16-3, S. 159; P.A. 18-83, S. 1; P.A. 19-117, S. 130.)

History: P.A. 92-151 added new Subsecs. (d) and (e) concerning the holding of evidence and costs associated with gathering evidence; P.A. 93-91 substituted commissioner and department of children and families for commissioner and department of children and youth services, effective July 1, 1993; P.A. 93-340 amended Subsec. (a) to increase the membership of the commission from 11 to 13 members, add the commissioner of children and youth services or his designee as a member, specify that one member shall be from the division of state police rather than from the state police major crimes division, specify that the member from the state police forensic science laboratory be appointed by the commissioner of public safety rather than the director of said laboratory, replace “emergency room physician” with “emergency physician” and specify that said physician be appointed by the president of the Connecticut College of Emergency Physicians rather than the president of the Connecticut State Medical Society, specify that the president of the Connecticut Nurses' Association appoint one nurse rather than one emergency room nurse, add one emergency nurse appointed by the president of the Emergency Nurses' Association as a member, designate the chief state's attorney or his designee as chairman and specify that the commission be within the division of criminal justice, rather than the department of administrative services, for administrative purposes, amended Subsec. (b) to replace “hospital protocol” with “health care facility protocol”, require the commission to recommend the protocol to the chief state's attorney rather than to the commissioner of health services, require the regulations to be adopted by January 1, 1994, rather than by May 26, 1989, require the commission to review the protocol annually and authorize the commission to recommend changes to the protocol annually rather than every two years, amended Subsec. (c) to require the commission to design a sexual assault evidence kit “not later than January 1, 1994”, authorize the commission to annually recommend changes in the kit to the chief state's attorney and replace “institutions in the state with emergency rooms or trauma center facilities” with “health care facilities in the state at which evidence collection examinations are performed”, amended Subsec. (d) to replace “institution in the state with an emergency room or trauma center facility” with “health care facility in the state”, amended Subsec. (e) to replace “hospital or other medical facility” with “health care facility” and added Subsecs. (f) and (g) requiring the commission to advise the chief state's attorney on the establishment of a training program for health care facility staff and on the development, implementation and effectiveness of a sexual assault examiner program, respectively, effective July 1, 1993; P.A. 93-381 replaced department and commissioner of health services with department and commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 97-257 amended Subsecs. (b) and (g) by changing “January 1, 1994” to “July 1, 1997”, amended Subsec. (c) by deleting reference to January 1, 1994, and amended Subsec. (d) by changing “request” to “consent” and amending procedure for the analysis of evidence by the state police forensic science laboratory or the Department of Health toxicology laboratory, effective July 1, 1997; P.A. 98-5 amended Subsec. (a) to increase the membership of the commission from 13 to 14 members by adding one police chief appointed by the president of the Connecticut Police Chiefs Association; P.A. 98-24 amended Subsec. (d) to authorize the transfer of evidence to the Federal Bureau of Investigation laboratory; P.A. 99-218 deleted the Commissioner of Public Health from membership on the commission, replaced state police forensic science laboratory with Division of Scientific Services, deleted reference to the Department of Public Health toxicological laboratory and made technical changes, effective July 1, 1999; June 30 Sp. Sess. P.A. 03-6 amended Subsec. (b) to insert Subdiv. designators, redefine “protocol” as “the state of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault, including the Interim Sexual Assault Toxicology Screen Protocol, as revised from time to time and as incorporated in regulations adopted in accordance with subdivision (2) of this subsection, pertaining to the collection of evidence in any sexual assault investigation” rather than “the state of Connecticut health care facility

protocol for victims of sexual assault which shall consist of regulations adopted in accordance with this subsection pertaining to the collection of evidence in any sex offense crime” and delete obsolete provision requiring the regulations to be adopted not later than July 31, 1997, and amended Subsec. (e) to designate existing provisions as Subdiv. (1) and amend said Subdiv. to include “the costs of testing for pregnancy and sexually transmitted diseases and the costs of prophylactic treatment as provided in the protocol” in the costs incurred by a health care facility that shall not be charged to the victim and make technical changes and to add new Subdiv. (2) prohibiting the charging to the victim of costs incurred for any toxicology screening performed as prescribed in the protocol and requiring the costs be charged to the Division of Scientific Services within the Department of Public Safety, effective August 20, 2003; P.A. 05-272 amended Subsec. (b)(2) by requiring protocol for health care response to victims of sexual assault to include nonoccupational post-exposure prophylaxis for HIV (nPEP), as recommended by the National Centers for Disease Control, effective July 1, 2005; P.A. 10-102 amended Subsec. (e)(1) to require costs to be charged to Office of Victim Services within Judicial Department rather than Division of Criminal Justice, effective June 2, 2010; pursuant to P.A. 11-51, “Commissioner of Public Safety” and “Department of Public Safety” were changed editorially by the Revisors to “Commissioner of Emergency Services and Public Protection” and “Department of Emergency Services and Public Protection”, respectively, effective July 1, 2011; June 12 Sp. Sess. P.A. 12-1 amended Subsec. (a) to add 1 member of the Office of Victim Services to the commission, and amended Subsec. (e)(1) to prohibit charging the victim costs incurred for a medical forensic assessment interview conducted by a health care facility or a provider or examiner working with a multidisciplinary team or child advocacy center, and require that costs be charged to the Forensic Sex Evidence Exams account in the Judicial Department, rather than to the Office of Victim Services; P.A. 15-207 amended Subsec. (d) by adding provisions re police department to transfer sexual assault evidence not later than 10 days after collection and re Division of Scientific Services to analyze sexual assault evidence not later than 60 days after collection or after receiving notification from a police department, and to hold sexual assault evidence for at least 5 years, rather than 60 days, when collected from a victim who chose to remain anonymous, and adding provision re failure to transfer or analyze sexual assault evidence not to affect admissibility of the evidence; May Sp. Sess. P.A. 16-3 amended Subsec. (a) by replacing “Permanent Commission on the Status of Women” with “Commission on Women, Children and Seniors”, effective July 1, 2016; P.A. 18-83 amended Subsec. (a) to increase membership of commission from 14 to 15 members by adding one member of Disability Rights Connecticut, Inc., and to replace Connecticut Sexual Assault Crisis Services, Inc. with Connecticut Alliance to End Sexual Violence, amended Subsec. (b)(1) to designate existing provision defining “protocol” as Subpara. (A) and add Subpara. (B) re definition of “law enforcement agency”, amended Subsec. (c) to designate existing provision re design of sexual assault evidence collection kit as Subdiv. (1), add Subdiv. (2) re implementation of electronic tracking system by Division of Scientific Services, and add Subdiv. (3) re guidelines for use of kit-tracking software, amended Subsec. (d) to add provision re sexual assault counselor, add provision re failure to comply with section or protocol not to affect admissibility of evidence, and make technical and conforming changes, amended Subsec. (f) to add reference to kit-tracking software and make a technical change, and added Subsec. (h) re policies and procedures for access to information from sexual assault evidence collection kit, effective July 1, 2018; P.A. 19-117 amended Subsec. (a) by adding Subdiv. designators (1) to (13) and replacing “Commission on Women, Children and Seniors” with “Commission on Women, Children, Seniors, Equity and Opportunity”, effective July 1, 2019.

See Sec. 4-38f for definition of “administrative purposes only”.

Cited. 242 C. 1. Statute does not render statements made to physicians and nurses at health care facility where rape kit for collection of forensic evidence is being administered testimonial in nature; section is part of a statutory scheme that provides for health and well-being of victims of sexual assault. 285 C. 162.

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Sec. 19a-112b. Services to victims of sexual acts. The Department of Public Health shall provide to victims of a sexual act constituting a violation of section [53a-70b](#) of the general statutes, revision of 1958, revised to January 1, 2019, or section [53-21](#), [53a-70](#), [53a-70a](#), [53a-71](#), [53a-72a](#), [53a-72b](#), [53a-73a](#) or [53a-192a](#), regardless of whether any person is convicted or adjudicated delinquent for such violation, the following services: (1) Counseling regarding human immunodeficiency virus and acquired immune deficiency syndrome; (2) HIV-related testing; and (3) referral service for appropriate health care and support services. Such services shall be provided through counseling and testing sites funded by the Department of Public Health.

(May Sp. Sess. P.A. 94-6, S. 25, 28; P.A. 95-257, S. 12, 21, 58; P.A. 15-195, S. 1; P.A. 19-189, S. 7.)

History: May Sp. Sess. P.A. 94-6 effective June 21, 1994; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 15-195 added reference to Sec. 53a-192a and made technical changes; P.A. 19-189 replaced “53a-70b” with “section 53a-70b of the general statutes, revision of 1958, revised to January 1, 2019” and making a technical change.

Cited. 242 C. 1.

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Sec. 19a-112c. Educational materials for sexual assault victims. The Department of Public Health shall work with the Connecticut Sexual Assault Crises Services, Inc. to develop educational materials about human immunodeficiency virus and acquired immune deficiency syndrome, specifically as they relate to sexual assault, for distribution to sexual assault victims through hospitals, rape crisis centers, HIV testing sites, the Division of Criminal Justice and other appropriate agencies. The materials shall include, but not be limited to, the following subjects: (1) The risks associated with HIV and sexual violence; (2) information about available testing options; (3) risk reduction information; and (4) referrals and information regarding rape crisis centers and HIV testing sites.

(May Sp. Sess. P.A. 94-6, S. 26, 28; P.A. 95-257, S. 12, 21, 58.)

History: May Sp. Sess. P.A. 94-6 effective June 21, 1994; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

Cited. 242 C. 1.

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Sec. 19a-112d. Sexual assault victims account. There is established a sexual assault victims account which shall be a separate, nonlapsing account within the General Fund. The account shall contain the moneys authorized pursuant to section [54-143c](#), and any other moneys required by law to be deposited in the account, and shall be held in trust separate and apart from all other moneys, funds and accounts. Any balance remaining in the account at the end of any fiscal year shall be carried forward in the account for the fiscal year next succeeding. Investment earnings credited to the account shall become part of the account. Amounts in the account shall be expended only pursuant to appropriations by the General Assembly, for the fiscal year ending June 30, 2006, and each fiscal year thereafter, for the purpose of providing funds to the Department of Public Health for sexual assault crisis services furnished to victims of sexual assault in this state, provided such amounts so expended shall not supplant any state or federal funds otherwise available for such services.

(P.A. 04-121, S. 1.)

History: P.A. 04-121 effective July 1, 2004.

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Sec. 19a-112e. Provision of emergency treatment to a victim of sexual assault. Standard of care. Title protection for sexual assault forensic examiners. (a) As used in this section and sections [19a-112f](#) and [19a-112g](#):

- (1) “Emergency contraception” means one or more prescription drugs used separately or in combination administered to or self-administered by a patient to prevent pregnancy, within a medically recommended amount of time after sexual intercourse and provided for that purpose, in accordance with professional standards of practice, and determined to be safe by the United States Food and Drug Administration.
 - (2) “Emergency treatment” means any medical examination or treatment provided in a licensed health care facility to a victim of sexual assault following an alleged sexual assault.
 - (3) “Medically and factually accurate and objective” means verified or supported by the weight of research conducted in compliance with accepted scientific methods and published in peer-reviewed journals, where applicable.
 - (4) “Victim of sexual assault” means any person who alleges or is alleged to have suffered an injury as a result of a sexual offense.
 - (5) “Sexual offense” means a violation of section [53a-70b](#) of the general statutes, revision of 1958, revised to January 1, 2019, or subsection (a) of section [53a-70](#) or section [53a-70a](#), subsection (a) of section [53a-71](#), section [53a-72a](#) or [53a-72b](#), subdivision (2) of subsection (a) of section [53a-86](#), subdivision (2) of subsection (a) of section [53a-87](#) or section [53a-90a](#), [53a-196a](#) or [53a-196b](#).
 - (6) “Independent provider” means a physician licensed under chapter 370, a physician assistant licensed under chapter 370, an advanced practice registered nurse or registered nurse licensed under chapter 378, or a nurse-midwife licensed under chapter 377, all of whom are trained and certified pursuant to the certification process implemented by the Chief Court Administrator pursuant to subsection (c) of section [19a-112f](#) to conduct a forensic exam in accordance with the state of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault, published by the Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations pursuant to section [19a-112a](#).
 - (7) “Sexual assault forensic examiner” means a physician or physician assistant licensed pursuant to chapter 370, a registered nurse or advanced practice registered nurse licensed pursuant to chapter 378 or nurse midwife licensed pursuant to chapter 377 who has successfully completed the certification process and met all continuing education and recertification requirements implemented by the Chief Court Administrator pursuant to subsection (c) of section [19a-112f](#).
 - (8) “Sexual assault nurse examiner” means a registered nurse or an advanced practice registered nurse licensed pursuant to chapter 378 who has provided care and treatment to a victim of sexual assault and collected evidence from said victim without successfully completing the training and certification process implemented by the Chief Court Administrator pursuant to subsection (c) of section [19a-112f](#).
 - (9) “Health care facility” means (A) a hospital licensed under chapter 368v that has an emergency department, including any free-standing emergency department, or (B) an infirmary operated by The University of Connecticut at Storrs.
- (b) The standard of care for each health care facility that provides emergency treatment to a victim of sexual assault shall include promptly:

(1) Providing each victim of sexual assault with medically and factually accurate and objective information relating to emergency contraception;

(2) Informing such victim of sexual assault of the availability of emergency contraception, its use and efficacy; and

(3) Providing emergency contraception to such victim of sexual assault at the facility upon the request of such victim, except that a health care facility shall not be required to provide emergency contraception to a victim of sexual assault who has been determined to be pregnant through the administration of a pregnancy test approved by the United States Food and Drug Administration.

(c) In order to comply with the standard of care requirements prescribed in subsection (b) of this section, a health care facility shall: (1) Ensure compliance at the facility with the standard of care requirements prescribed in said subsection (b), and (2) conduct at the facility a forensic exam of the sexual assault victim in accordance with the state of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault, published by the Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations pursuant to section [19a-112a](#). A health care facility may contract with one or more independent providers who has been certified as a sexual assault forensic examiner pursuant to the certification process implemented by the Chief Court Administrator pursuant to subsection (c) of section [19a-112f](#).

(d) No health care facility that provides emergency treatment to a victim of sexual assault shall determine such facility's protocol for complying with the standard of care requirements prescribed in subsection (b) of this section on any basis other than a pregnancy test approved by the United States Food and Drug Administration.

(e) No person shall use the title “sexual assault forensic examiner” or “sexual assault nurse examiner”, or any variant of such titles, without successfully completing the certification requirements imposed by the Chief Court Administrator pursuant to subsection (c) of section [19a-112f](#).

(P.A. 07-24, S. 1; P.A. 19-114, S. 2; 19-118, S. 43, 44; 19-189, S. 8.)

History: P.A. 19-114 amended Subsec. (a) by adding references to Secs. 19a-112f and 19a-112g, redefining “victim of sexual assault” in Subdiv. (4), redefining “independent provider” in Subdiv. (6) and adding Subdivs. (7) and (8) defining “sexual assault forensic examiner” and “health care facility”, respectively, amended Subsec. (c) by replacing “may contract with one or more independent providers to” with “shall”, and adding provision permitting health care facility to contract with one or more sexual assault forensic examiners, added Subsec. (e) re use of sexual assault forensic examiner title and made technical changes, effective July 1, 2019; P.A. 19-118 amended Subsec. (a) by adding Subdiv. (8) defining “sexual assault nurse examiner” and redesignating existing Subdiv. (8) as Subdiv. (9), and amended Subsec. (e) by adding reference to sexual assault nurse examiner and making technical changes, effective July 1, 2019; P.A. 19-189 amended Subsec. (a)(5) by replacing “53a-70b” with “section 53a-70b of the general statutes, revision of 1958, revised to January 1, 2019” and made technical changes.

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Sec. 19a-112f. Sexual Assault Forensic Examiners Advisory Committee. Membership. Recommendation of policies and procedures re sexual assault forensic examiners program. Consideration of recommendations by Office of Victim Services. (a) There is established a Sexual Assault Forensic Examiners Advisory Committee consisting of the following: (1) The Chief Court Administrator, or the Chief Court Administrator's designee; (2) the Commissioner of Public Health, or the commissioner's designee; (3) the director of the Office of Victim Services, or the director's designee; (4) the chairperson of the Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations, or the chairperson's designee; (5) a representative from the Division of Scientific Services, appointed by the Commissioner of

Emergency Services and Public Protection; (6) the Victim Advocate, or the Victim Advocate's designee; (7) the president of the Connecticut Hospital Association, or the president's designee; (8) the president of the Connecticut College of Emergency Physicians, or the president's designee; (9) one member from Connecticut Alliance to End Sexual Violence, appointed by its board of directors; (10) one member from the Connecticut Emergency Nurses Association, appointed by the association; (11) one member from the Connecticut Chapter of the International Association of Forensic Nurses, appointed by the association; (12) one member from the Connecticut Nurses Association, appointed by the association; and (13) the program manager of the sexual assault forensic examiners program established pursuant to subdivision (14) of subsection (b) of section [54-203](#), or the program manager's designee.

(b) The committee shall recommend to the Office of Victim Services policies and procedures with regard to the sexual assault forensic examiners program established pursuant to subdivision (14) of subsection (b) of section [54-203](#) and section [19a-112g](#). Recommendations from the committee may include, but need not be limited to, the following: (1) The certification process for individuals qualified to participate as sexual assault forensic examiners, as defined in subsection (a) of section [19a-112e](#); (2) continuing education requirements for the maintenance and renewal of such certification; (3) the development of quality assurance measures to ensure the needs of victims of sexual assault are met; and (4) such other related recommendations as determined by the committee.

(c) Any recommendations of the committee made pursuant to subsection (b) of this section shall be presented to the director of the Office of Victim Services for consideration. The director of the Office of Victim Services may forward such recommendations to the Office of the Chief Court Administrator. The Chief Court Administrator, in his or her discretion, may direct the implementation of such recommendations as policies and procedures pursuant to section [54-207a](#). Individuals qualified to participate as sexual assault forensic examiners, as defined in subsection (a) of section [19a-112e](#), shall comply with all policies and procedures implemented by the Chief Court Administrator to obtain certification and to remain in good standing.

(Sept. Sp. Sess. P.A. 09-3, S. 47; P.A. 11-51, S. 134; P.A. 12-133, S. 30, 46; P.A. 17-99, S. 42; P.A. 18-83, S. 3; P.A. 19-114, S. 1.)

History: Sept. Sp. Sess. P.A. 09-3 effective October 6, 2009; pursuant to P.A. 11-51, "Commissioner of Public Safety" was changed editorially by the Revisors to "Commissioner of Emergency Services and Public Protection" in Subsec. (a), effective July 1, 2011; P.A. 12-133 amended Subsec. (c) to substitute "2013" for "2012", effective June 15, 2012, and amended Subsec. (b) substituting "subdivision (17)" for "subdivision (18)" of Sec. 54-203(b), effective October 1, 2012; P.A. 17-99 amended Subsec. (b) by replacing "subdivision (17)" with "subdivision (14)" re Sec. 54-203(b); P.A. 18-83 amended Subsec. (a)(9) to replace "Connecticut Sexual Assault Crisis Services, Inc." with "Connecticut Alliance to End Sexual Violence", effective July 1, 2018; P.A. 19-114 amended Subsec. (a) by deleting former Subdiv. (2) re Chief State's Attorney, redesignating existing Subdiv. (3) as new Subdiv. (2), adding new Subdivs. (3) and (4) re director of Office of Victim Services and chairperson of Commission on Standardization of the Collection of Evidence in Sexual Assault Investigations, respectively, redesignating existing Subdiv. (4) as new Subdiv. (5), deleting former Subdivs. (5) and (10) re representative from Division of State Police and member from Connecticut Police Chiefs Association, respectively, redesignating existing Subdivs. (11) and (12) as new Subdivs. (10) and (11) and adding Subdivs. (12) and (13) re member from Connecticut Nurses Association and program manager of sexual assault forensic examiner program, respectively, amended Subsec. (b) by replacing "advise" with "recommend to", replacing "on the establishment and implementation of" with "policies and procedures with regard to", replacing provisions re committee to make specific recommendations in former Subdivs. (1) to (6) with provisions re recommendations that may be included by committee in new Subdivs. (1) to (4) and amended Subsec. (c) by deleting provision re termination of committee and adding provisions re presenting recommendations to director of Office of Victim Services, forwarding recommendations to Chief Court Administrator, implementation of recommendations and compliance with policies and procedures, effective July 1, 2019.

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Sec. 19a-112g. Sexual assault forensic examiners. Responsibilities. A sexual assault forensic examiner may provide immediate care and treatment to a victim of sexual assault who is a patient in a health care facility and collect evidence pertaining to the investigation of any sexual assault in accordance with the State of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault, published by the Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations pursuant to section [19a-112a](#). Services provided by a sexual assault forensic examiner shall be: (1) In accordance with the policies and accreditation standards of the health care facility; and (2) pursuant to a written agreement entered into by the health care facility and the Office of Victim Services concerning the training of identified health care providers and participation of the health care facility in the sexual assault forensic examiners program. Nothing in this section shall be construed as altering the scope of the practice of nursing as set forth in section [20-87a](#).

(Sept. Sp. Sess. P.A. 09-3, S. 48; P.A. 15-16, S. 1; P.A. 19-114, S. 3.)

History: Sept. Sp. Sess. P.A. 09-3 effective October 6, 2009; P.A. 15-16 amended Subsec. (a) by designating existing provision re definition of “sexual assault forensic examiner” as Subdiv. (1) and adding Subdiv. (2) defining “health care facility”, amended Subsec. (b) by adding references to health care facility, and made technical and conforming changes, effective July 1, 2015; P.A. 19-114 deleted former Subsec. (a) re definitions of “sexual assault forensic examiner” and “health care facility”, deleted Subsec. (b) designator, deleted references to acute care hospital, deleted reference to Department of Public Health, added “training of identified health care providers” in Subdiv. (2), and made technical and conforming changes, effective July 1, 2019.

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Sec. 19a-112h. State-wide human immunodeficiency virus pre-exposure and post-exposure prophylaxis drug assistance program. Regulations. (a) The Commissioner of Public Health shall establish and contract for the administration of a state-wide human immunodeficiency virus pre-exposure prophylaxis and post-exposure prophylaxis drug assistance program using appropriated AIDS Services funding, provided such funding is equal to or greater than twenty-five thousand dollars annually. The program shall provide financial assistance to individuals at risk of acquiring human immunodeficiency for the purchase of pre-exposure and post-exposure prophylaxis for human immunodeficiency virus prescribed by a licensed physician consistent with the recommendations of the National Centers for Disease Control and Prevention. For the purposes of this subsection, “financial assistance” includes, but need not be limited to, payments for out-of-pocket costs, copayments, coinsurance, and up to full cost payments toward a deductible for individuals who are underinsured and for whom the program is the payer of last resort.

(b) The commissioner shall give priority for benefits under the program established pursuant to this section to individuals who have an increased risk of acquiring human immunodeficiency virus or who have had a recent exposure to such virus, but are unable to purchase pre-exposure and post-exposure prophylaxis for human immunodeficiency virus and for whom the program is a payer of last resort.

(c) The commissioner may adopt regulations in accordance with the provisions of chapter 54 to implement the provisions of this section. The commissioner may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulations, provided notice of intent to adopt regulations is published on the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

(P.A. 11-44, S. 173; P.A. 23-19, S. 17.)

History: P.A. 11-44 effective July 1, 2011; P.A. 23-19 designated existing provisions as Subsec. (a), substantially amended Subsec. (a) by substituting state-wide human immunodeficiency virus pre-exposure and post-exposure prophylaxis drug assistance program for financial assistance program for victims of sexual assault, and added Subsec. (b) re priority for benefits under program and Subsec. (c) re regulations, policies and procedures, effective June 7, 2023.

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Sec. 19a-112i. Community gun violence intervention and prevention program. (a) The Department of Public Health shall establish a community gun violence intervention and prevention program to (1) fund and support the growth of evidence-informed, community-centric community violence and gun violence prevention and intervention programs in the state, (2) strengthen partnerships among the community, state and federal agencies involved in community violence prevention and intervention, (3) collect timely data on firearm-involved injuries and deaths and make such data publicly available, (4) evaluate effectiveness of violence intervention and prevention strategies implemented under the program, (5) determine community-level needs by engaging with communities impacted by gun violence, and (6) secure state, federal and other funds for the purposes of reducing community gun violence.

(b) Not later than January 1, 2023, and annually thereafter, the Commissioner of Public Health shall submit a report to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section [11-4a](#), concerning the activities of the program during the preceding twelve-month period.

(P.A. 22-118, S. 80.)

History: P.A. 22-118 effective May 7, 2022.

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Sec. 19a-112j. Commission on Community Gun Violence Intervention and Prevention. Duties. Membership. Report. (a) There is established a Commission on Community Gun Violence Intervention and Prevention to advise the Commissioner of Public Health on the development of evidence-based, evidenced-informed, community-centric gun programs and strategies to reduce community gun violence in the state. The commission shall be within the Department of Public Health for administrative purposes only.

(b) The commission shall be composed of the following members:

(1) Two appointed by the speaker of the House of Representatives, one of whom shall be a representative of the Connecticut Hospital Association and one of whom shall be a representative of Compass Youth Collaborative;

(2) Two appointed by the president pro tempore of the Senate, one of whom shall be a representative of the Connecticut Violence Intervention Program and one of whom shall be a representative of the Regional Youth Adult Social Action Partnership;

(3) Two appointed by the majority leader of the House of Representatives, one of whom shall be a representative of Hartford Communities That Care, Inc. and one of whom shall be a representative of CT Against Gun Violence;

(4) Two appointed by the majority leader of the Senate, one of whom shall be a representative of Project Longevity and one of whom shall be a representative of Saint Francis Hospital and Medical Center;

(5) One appointed by the minority leader of the House of Representatives, who shall be a representative of Yale New Haven Hospital;

(6) One appointed by the minority leader of the Senate, who shall be a representative of Hartford Hospital;

(7) One appointed by the House chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to public health, who shall be a representative of the Greater Bridgeport Area Prevention Program;

(8) One appointed by the Senate chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to public health, who shall be a representative of a community gun violence reduction program;

(9) One appointed by the executive director of the Commission on Women, Children, Seniors, Equity and Opportunity, who shall be a representative of the Health Alliance for Violence Intervention;

(10) Two appointed by the Commissioner of Public Health;

(11) Two appointed by the Governor, one of whom shall be a member of the faculty at an academic institution and have experience in gun violence prevention and one of whom is an advocate for survivors of violent crime;

(12) One appointed by the minority leader of the House of Representatives, who shall be employed as the highest-ranking professional police officer of an organized police department of a municipality within the state;

(13) One appointed by the minority leader of the Senate, who shall be a youth representative of a group that advocates on behalf of justice-involved youth;

(14) The Commissioner of Public Health;

(15) The Commissioner of Children and Families, or the commissioner's designee;

(16) The Commissioner of Social Services, or the commissioner's designee;

(17) The Commissioner of Education, or the commissioner's designee;

(18) The executive director of the Commission on Women, Children, Seniors, Equity and Opportunity, or the executive director's designee;

(19) One appointed by the House ranking member of the joint standing committee of the General Assembly having cognizance of matters relating to public health, who shall be a municipal police chief; and

(20) One appointed by the Senate ranking member of the joint standing committee of the General Assembly having cognizance of matters relating to public health, who shall be a local director of health.

(c) The members of the community gun violence intervention and prevention advisory committee established under section 9 of public act 21-35* shall be deemed the initial appointments to the commission under subdivisions (1) to (10), inclusive, of subsection (b) of this section.

(d) In making appointments to the commission, the appointing authorities shall seek to select individuals for such appointments who are representative of the full geographic diversity of communities that experience community gun violence in the state.

(e) The first meeting of the commission shall be held not later than sixty days after May 7, 2022. The Commissioner of Public Health shall serve as the chairperson of the commission.

(f) A majority of the membership of the commission shall constitute a quorum for the transaction of any business and any decision shall be by a majority vote of those present at a meeting, except the commission may establish such subcommissions, advisory groups or other entities as it deems necessary to further the purposes of the commission, including, but not limited to, a subcommission, advisory group or other entity to evaluate the challenges associated with the provision of home health care to victims of gun violence and methods to foster a system that unites community service providers with adults and juveniles needing supports and services in order to address trauma suffered as a result of gun violence.

(g) The members of the commission shall serve without compensation, but shall, within the limits of available funds, be reimbursed for expenses necessarily incurred in the performance of their duties.

(h) The commission shall advise the Department of Public Health regarding the development of criteria for any grant opportunities that arise through the program established pursuant to section [19a-112i](#).

(i) Not later than January 1, 2023, and annually thereafter, the commission shall submit a report to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section [11-4a](#), and to the Commissioner of Public Health concerning the activities of the commission.

(P.A. 22-118, S. 81; P.A. 23-31, S. 13; 23-97, S. 24.)

***Note:** Section 9 of public act 21-35 is special in nature and therefore has not been codified but remains in full force and effect according to its terms.

History: P.A. 22-118 effective May 7, 2022; P.A. 23-31 amended Subsec. (b) by adding new Subdiv. (17) re membership of Commissioner of Education, or commissioner's designee, redesignating existing Subdiv. (17) as Subdiv. (18), adding Subdiv. (19) re appointment by House ranking member of joint standing committee on public health, adding Subdiv. (20) re appointment by Senate ranking member of joint standing committee on public health, and making conforming changes, effective June 7, 2023; P.A. 23-97 amended Subsec. (f) by allowing the commission to establish subcommissions, advisory groups and other entities to evaluate challenges in provision of home health care to victims of gun violence, effective July 1, 2023; (Revisor's note: In 2024, a reference to "the effective date of this section" in Subsec. (e) was changed editorially by the Revisors to "May 7, 2022" for accuracy).

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Sec. 19a-113. (Formerly Sec. 19-66c). Sale or distribution of compressed air for underwater breathing apparatus. The Commissioner of Public Health shall adopt, in accordance with chapter 54, and enforce regulations concerning the quality of the compressed air sold for use in self-contained underwater breathing apparatus. No compressed air shall be sold or distributed for such use unless it complies with the standards of quality established by the commissioner. Any person who violates the provisions of this section shall be fined not more than five hundred dollars.

(P.A. 73-60; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 00-27, S. 16, 24; P.A. 12-80, S. 11.)

History: P.A. 77-614 replaced commissioner of health with commissioner of health services, effective January 1, 1979; Sec. 19-66c transferred to Sec. 19a-113 in 1983; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner

and Department of Public Health, effective July 1, 1995; P.A. 00-27 made technical changes, effective May 1, 2000; P.A. 12-80 deleted provision authorizing a term of imprisonment of not more than 5 months.

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Sec. 19a-113a. Cardiopulmonary resuscitation certification of lifeguards. The Commissioner of Public Health shall adopt regulations, in accordance with chapter 54, requiring that persons who are employed as lifeguards shall be certified in cardiopulmonary resuscitation by the American Heart Association, the American Red Cross, the American Safety and Health Institute or an organization using guidelines for cardiopulmonary resuscitation and emergency cardiovascular care published by the American Heart Association and the International Liaison Committee on Resuscitation.

(P.A. 87-182; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 14-36, S. 1; P.A. 19-105, S. 1.)

History: P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 14-36 added provision re certification by the American Safety and Health Institute; P.A. 19-105 added reference to organization using guidelines for cardiopulmonary resuscitation and emergency cardiovascular care published by the American Heart Association and the International Liaison Committee on Resuscitation, and made technical changes, effective July 1, 2019.

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Sec. 19a-114. (Formerly Sec. 19-66d). Transfer of the staff of the Commission on Hospitals and Health Care to the Department of Public Health and Addiction Services. Section [19a-114](#) is repealed, effective July 1, 1995.

(P.A. 75-562, S. 6, 8; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 57, 58.)

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Sec. 19a-115. (Formerly Sec. 19-66f). Regulation of medical test units. Section [19a-115](#) is repealed, effective October 1, 2007.

(P.A. 77-500; 77-614, S. 323, 587, 610; P.A. 78-303, S. 85, 136; P.A. 79-68; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 07-252, S. 90.)

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Sec. 19a-116. (Formerly Sec. 19-66g). Regulation of facilities which offer abortion services. The Commissioner of Public Health shall adopt regulations, in accordance with chapter 54, establishing standards to control and ensure the quality of medical care provided to any pregnant woman undergoing an induced abortion at any outpatient clinic regulated under the Public Health Code. Such standards shall include, but are not limited to, provisions concerning: (1) The verification of pregnancy and a determination of the duration of such pregnancy; (2) preoperative instruction and counseling; (3) operative permission and informed consent; (4) postoperative counseling including family planning; and (5) minimum qualifications for counselors.

(P.A. 79-140; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: Sec. 19-66g transferred to Sec. 19a-116 in 1983; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

See chapter 368y re abortion.

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Sec. 19a-116a. Reports required re in-vitro fertilization, gamete intra-fallopian transfer or zygote intra-fallopian transfer procedures covered by insurance. Section [19a-116a](#) is repealed, effective October 1, 2007.

(P.A. 05-196, S. 3; P.A. 07-252, S. 90.)

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Secs. 19a-117 and 19a-117a. Respite care: Definitions; program; report. Regulation of respite care programs. Sections [19a-117](#) and [19a-117a](#) are repealed.

(P.A. 81-440, S. 1, 2, 7; June Sp. Sess. P.A. 83-14, S. 1, 3; P.A. 87-432, S. 1, 2; June Sp. Sess. P.A. 91-11, S. 24.)

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Sec. 19a-118. Temporary nursing services agencies. Registration. Prohibition on business in state without registration. Reporting. Regulations. (a) As used in this section and sections [19a-118a](#) and [19a-118b](#), (1) “health care facility” means a hospital, nursing home facility or residential care home as those terms are defined in section [19a-490](#); (2) “nursing personnel” means an advanced practice registered nurse, a licensed practical nurse or a registered nurse licensed or issued a temporary permit to practice pursuant to chapter 378, or a nurse’s aide registered pursuant to chapter 378a; (3) “temporary nursing services” means services provided to a health care facility on a per diem or other temporary basis; and (4) “temporary nursing services agency” means any person, firm, corporation, limited liability company, partnership or association that is engaged for hire in the business of providing temporary nursing services to a health care facility but does not include an individual who offers only his or her own temporary nursing services.

(b) Not later than October 1, 2022, the Commissioner of Public Health shall develop a system for a temporary nursing services agency that provides services in the state to register annually with the Department of Public Health. The commissioner may assess an annual registration fee of not more than seven hundred fifty dollars.

(c) Not later than January 1, 2023, no temporary nursing services agency shall provide temporary nursing services in the state unless it is registered pursuant to subsection (b) of this section.

(d) The Commissioner of Public Health shall establish requirements for a temporary nursing services agency, including, but not limited to, minimum qualifications for nursing personnel provided by such agency.

(e) Beginning not later than July 1, 2023, each temporary nursing services agency shall submit, in a form and manner prescribed by the Commissioner of Public Health, in consultation with the Commissioner of Social Services, an annual cost report for the previous calendar year. Such report shall be filed with the

Commissioner of Public Health and may include, but shall not be limited to, (1) itemized revenues and costs for each such agency; (2) average number of nursing personnel employed by such agency; (3) average fees charged by such agency by type of nursing personnel and type of health care facility; (4) the states of the permanent residences of nursing personnel supplied by the agency to health care facilities in the state, aggregated by type of nursing personnel; and (5) any other information prescribed by the Commissioner of Public Health. Each such agency shall make available records, books, reports and other data relating to its operation at the request of the Commissioner of Public Health, or the commissioner's designee. Records provided by a temporary nursing services agency pursuant to this subsection shall not be considered public records subject to disclosure pursuant to section [1-210](#).

(f) The Commissioner of Public Health may adopt regulations in accordance with chapter 54 to implement the provisions of this section. The commissioner may adopt policies and procedures to implement the provisions of this section in advance of adopting regulations, provided notice of intent to adopt such regulations is posted on the eRegulations System not later than twenty days after adoption of such policies and procedures.

(P.A. 22-57, S. 1.)

History: P.A. 22-57 effective July 1, 2022.

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Sec. 19a-118a. Temporary nursing services agencies. Written agreement requirement. Discipline. Exemption from written agreement requirement. (a) A temporary nursing services agency shall enter into a written agreement with each health care facility to which the agency assigns its nursing personnel. Any such agreement entered into, amended or renewed on and after July 1, 2022, shall contain an assurance that assigned nursing personnel have appropriate credentials. Such agreement shall be on file at such temporary nursing services agency and such health care facility not later than fourteen days from the date of assignment of nursing personnel by such agency to the health care facility.

(b) Any health care facility that fails to have the written agreement described in subsection (a) of this section on file may be subject to disciplinary action in accordance with the provisions of chapter 368v and any applicable licensing regulations.

(c) Notwithstanding the provisions of subsections (a) and (b) of this section, no health care facility or subsidiary thereof that supplies temporary nursing services only to its own facility and does not charge a fee to such facility shall be subject to the provisions of this section.

(P.A. 22-57, S. 2.)

History: P.A. 22-57 effective July 1, 2022.

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Sec. 19a-118b. Temporary nursing services agencies. Grievances against agencies. Civil actions, penalties. Injunctions. (a) Any person aggrieved by any action of a temporary nursing services agency may petition the superior court for the judicial district in which the agency's temporary nursing services were rendered for relief, including temporary and permanent injunctions, or may bring a civil action for damages.

(b) Any temporary nursing services agency that violates any provision of section [19a-118](#) or [19a-118a](#) may be assessed a civil penalty by the court not to exceed three hundred dollars for each offense. Each violation shall be a separate and distinct offense and, in the case of a continuing violation, each day of continuance thereof shall be deemed to be a separate and distinct offense. The Commissioner of Public Health may

request the Attorney General to bring a civil action in the superior court for the judicial district of Hartford for injunctive relief to restrain any further violation of section [19a-118](#) or [19a-118a](#). The Superior Court may grant such relief upon notice and hearing.

(P.A. 22-57, S. 3.)

History: P.A. 22-57 effective July 1, 2022.

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Sec. 19a-119. Reserved for future use.

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Secs. 19a-120 to 19a-120b. Elderly services program; objectives. Selection of hospitals for participation in program; criteria. Evaluation of program; criteria. Sections [19a-120](#) to [19a-120b](#), inclusive, are repealed.

(June Sp. Sess. P.A. 83-32, S. 1–3, 8; P.A. 84-546, S. 55, 173; P.A. 90-237, S. 2, 3.)

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Sec. 19a-121. HIV and AIDS: Grant program. Section [19a-121](#) is repealed, effective October 1, 2016.

(P.A. 87-389, S. 1, 6; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 07-252, S. 7; P.A. 16-87, S. 5.)

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Sec. 19a-121a. AIDS: Funding to local health departments. The Department of Public Health shall provide funds to local health departments for the purpose of providing innovative educational and preventative programs on AIDS.

(P.A. 87-389, S. 2, 6; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

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Sec. 19a-121b. Regulations. Section [19a-121b](#) is repealed, effective June 11, 2014.

(P.A. 87-389, S. 5, 6; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 14-187, S. 55.)

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Sec. 19a-121c. HIV and AIDS: Public information program. Section [19a-121c](#) is repealed, effective October 1, 2014.

(P.A. 87-389, S. 3, 6; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 07-252, S. 8; P.A. 14-231, S. 72.)

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Sec. 19a-121d. Grants for mass mailing of report on AIDS. Section [19a-121d](#) is repealed, effective October 1, 2007.

(P.A. 87-527, S. 2, 7; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 07-252, S. 90.)

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Secs. 19a-121e to 19a-121g. AIDS: Task force. Grants for programs established for the study or treatment of HIV or AIDS. Program of services for AIDS-affected children and youths. Sections [19a-121e](#) to [19a-121g](#), inclusive, are repealed, effective October 1, 2014.

(P.A. 87-389, S. 4, 6; 87-527, S. 3, 7; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 96-238, S. 24, 25; P.A. 06-196, S. 148; P.A. 07-252, S. 9; P.A. 14-231, S. 72.)

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Sec. 19a-122. Hospice care for the homeless. Obsolete.

(P.A. 87-118, S. 1, 3.)

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Sec. 19a-122a. Hospice care for the homeless. Termination of pilot program. Obsolete.

(P.A. 87-118, S. 2, 3; P.A. 89-339, S. 1, 6.)

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Sec. 19a-122b. Hospice care programs and services. Initial licensing requirements. Prohibited use of terms “hospice” and “hospice care program”. (a) An organization licensed as a hospice by the Department of Public Health shall be authorized to (1) operate a hospice facility, including a hospice residence, that provides inpatient hospice services, or (2) provide hospice home care services for terminally ill persons. Such services shall be provided to those patients who would otherwise receive such care from family members. The facility or residence shall provide a homelike atmosphere for such patients for a time period deemed appropriate for home health care services under like circumstances. Any hospice that operates a facility or residence pursuant to the provisions of this section shall cooperate with the Commissioner of Public Health to develop standards for the licensure and operation of such facility or residence.

(b) On and after January 1, 2008, any organization seeking initial licensure as a hospice by the Department of Public Health shall (1) agree to provide hospice care services for terminally ill persons on a twenty-four-hour basis in all settings including, but not limited to, a private home, nursing home, residential care home or specialized residence that provides supportive services, and (2) present to the department satisfactory evidence that such organization has the necessary qualified personnel to provide services in such settings.

(c) No organization may use the title “hospice” or “hospice care program” or make use of any title, words, letters or abbreviations indicating or implying that such organization is licensed to provide hospice services unless such organization is licensed to provide such services by the Department of Public Health.

(P.A. 92-33, S. 1, 2; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 57; 95-297; June 18 Sp. Sess. P.A. 97-2, S. 118, 165; P.A. 00-135, S. 5, 21; May 9 Sp. Sess. P.A. 02-7, S. 96; June 30 Sp. Sess. P.A. 03-6, S. 204; P.A. 07-23, S. 1; P.A. 12-140, S. 1.)

History: P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 95-297 extended the program's expiration date from 1995 to 1997; June 18 Sp. Sess. P.A. 97-2 extended the pilot program from 1997 to 2000, effective July 1, 1997; P.A. 00-135 extended the pilot program from 2000 to 2001, effective May 26, 2000; May 9 Sp. Sess. P.A. 02-7 extended the pilot program from 2001 to 2006, effective August 15, 2002; June 30 Sp. Sess. P.A. 03-6 deleted references to operation of program “on a pilot basis” and expiration date of October 1, 2006, effective August 20, 2003; P.A. 07-23 designated existing provisions as Subsec. (a) and made technical changes therein, added Subsec. (b) re requirements for organizations seeking initial licensure as a hospice and added Subsec. (c) re use of the title “hospice” and “hospice care program”; P.A. 12-140 amended Subsec. (a) by deleting provision notwithstanding Chs. 368v and 368z, deleting references to public health code and federal statute, revising description of a hospice facility, and making conforming changes and amended Subsec. (c) by deleting provision re certification pursuant to federal statute, effective June 15, 2012.

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Sec. 19a-122c. Sunshine House, Inc.: Freestanding children's comfort care center pilot program. Services provided. Certificate of need and license requirements. (a) On or after September 21, 2009, Sunshine House, Inc. shall establish a pilot program creating a freestanding children's comfort care center that shall provide comfort care for children with limited life expectancy and their families. Such care may include, but need not be limited to: (1) Respite care for children and their families, such respite care being available to families intermittently during the course of their child's illness; (2) end-of-life care for children that includes whole child care in a child-centered, family-oriented, home-like setting for families who need a home-like option other than the family home; and (3) whole family care consisting of supportive care for the whole family including accommodation for parents, specialized support for siblings and others important to the child and bereavement support.

(b) On or before September 30, 2011, such pilot program shall comply with the provisions of sections [19a-638](#) and [19a-639a](#).

(c) On or before September 30, 2014, such pilot program shall comply with the provisions of section [19a-491](#).

(d) If Sunshine House, Inc. fails to comply with the provisions of subsections (b) and (c) of this section, the pilot program established pursuant to subsection (a) of this section shall terminate.

(P.A. 09-232, S. 70; P.A. 10-179, S. 124.)

History: P.A. 09-232 effective July 8, 2009; P.A. 10-179 replaced reference to Sec. 19a-639 with reference to Sec. 19a-639a.

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Sec. 19a-122d. Hospice Hospital at Home pilot program. (a) As used in this section:

(1) “Telehealth” means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient’s physical and mental health, and includes (A) interaction between the patient at the originating site and the telehealth provider at a distant site, and (B) synchronous interactions, asynchronous store and forward transfers or remote patient monitoring. Telehealth does not include the use of facsimile, audio-only telephone, texting or electronic mail;

(2) “Physician” means a physician licensed pursuant to chapter 370;

(3) “Advanced practice registered nurse” means an advanced practice registered nurse licensed pursuant to chapter 378;

(4) “Registered nurse” means a registered nurse licensed pursuant to chapter 378; and

(5) “Personal emergency response system” means a twenty-four-hour-per-day electronic alarm system placed in a patient’s home that enables the patient to obtain immediate help in case of an emergency.

(b) Not later than January 1, 2024, the Department of Public Health shall establish, in collaboration with a hospital in the state and the Department of Social Services, a Hospice Hospital at Home pilot program to provide hospice care to patients in the home through a combination of in-person visits and telehealth. The pilot program shall provide the following to such patients:

(1) A daily telehealth visit by a physician or an advanced practice registered nurse that the patient may attend using the patient’s computer or mobile device or, if the patient does not have access to a computer or mobile device in the home, using a tablet provided through the program;

(2) In-person visits by a registered nurse at least twice daily, or more frequently if necessary, as determined by a physician or an advanced practice registered nurse treating the patient;

(3) A personal emergency response system;

(4) Remote monitoring of the patient by physicians, advanced practice registered nurses and registered nurses participating in the pilot program, provided the patient and each person residing with the patient consent to such monitoring; and

(5) Telephone access to an on-call physician or advanced practice registered nurse if the patient, the patient’s caregiver or any person residing with the patient has any immediate questions or concerns regarding the patient’s condition.

(P.A. 23-174, S. 1.)

History: P.A. 23-174 effective July 1, 2023.

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Sec. 19a-122e. Administration of fluids or medications intravenously by an advance practice registered nurse or registered nurse providing hospice care. (a) As used in this section:

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

(2) “Registered nurse” means a registered nurse licensed pursuant to chapter 378;

(3) “Hospice care program” means a program to provide hospice services operated by an organization licensed by the Department of Public Health to provide hospice home care services pursuant to section

[19a-122b](#);

(4) “Supervision” means the overseeing of the work of a registered nurse through the continuous availability of direct communication between the registered nurse and a licensed physician;

(5) “Physician” means a physician licensed pursuant to chapter 370;

(6) “Infusion” means the administration of intravenous fluid or medication given over a period of time; and

(7) “Intravenous push” means the administration of intravenous medication rapidly through an injection with a syringe in the intravenous line.

(b) An advanced practice registered nurse who is providing hospice care through a hospice care program may administer fluids or medications intravenously to a patient, including, but not limited to, by performing an infusion or an intravenous push. A registered nurse who is providing hospice care through a hospice care program may, under the supervision of a physician, administer fluids or medications intravenously to a patient, including, but not limited to, by performing an infusion or an intravenous push.

(P.A. 23-174, S. 2.)

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Sec. 19a-123. Nursing pool: Definition. Section [19a-123](#) is repealed, effective July 1, 2022.

(P.A. 89-325, S. 5, 26; P.A. 95-79, S. 58, 189; P.A. 19-118, S. 72; P.A. 22-57, S. 15.)

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Sec. 19a-123a. Nursing pool: Registration with Department of Public Health and Addiction Services. Section [19a-123a](#) is repealed.

(P.A. 89-325, S. 6, 26; P.A. 93-381, S. 9, 39; P.A. 95-271, S. 39.)

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Sec. 19a-123b. Nursing pool: Written agreement with health care institution. Section [19a-123b](#) is repealed, effective July 1, 2022.

(P.A. 89-325, S. 7, 26; P.A. 22-57, S. 15.)

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Sec. 19a-123c. Regulation of rates charged by nursing pools. Section [19a-123c](#) is repealed, effective October 1, 2002.

(P.A. 89-325, S. 8, 26; P.A. 95-257, S. 39, 58; S.A. 02-12, S. 1.)

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Sec. 19a-123d. Aggrievement. Penalties. Section [19a-123d](#) is repealed, effective July 1, 2022.

(P.A. 88-230, S. 1, 12; 89-325, S. 9, 26; P.A. 90-98, S. 1, 2; P.A. 93-142, S. 4, 7, 8; 93-381, S. 9, 39; P.A. 95-220, S. 4-6; 95-257, S. 12, 21, 39, 58; P.A. 03-278, S. 72; Sept. Sp. Sess. P.A. 09-3, S. 31; P.A. 22-57, S. 15.)

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Sec. 19a-124. Syringe services programs. (a) The Department of Public Health shall establish, within available appropriations, syringe services programs to enhance health outcomes of people who inject drugs in any community impacted by the human immunodeficiency virus or hepatitis C. The department shall establish protocols in accordance with the provisions of subsection (b) of this section. The department may authorize programs, as determined by the commissioner, through local health departments or other local organizations.

(b) The programs shall: (1) Be incorporated into existing human immunodeficiency virus and hepatitis C outreach and prevention programs in the selected communities; (2) provide access to free and confidential exchanges of syringes; (3) provide for safe disposal or exchange of syringes; (4) provide that first-time applicants to the program receive an initial packet of syringes, educational material and a list of drug counseling services; (5) offer education on the human immunodeficiency virus, hepatitis C, reduction in harm caused by such viruses, and drug overdose prevention measures and assist program participants in obtaining drug treatment services; (6) provide referrals for substance abuse counseling or treatment; and (7) provide referrals for medical or mental health care.

(c) The department shall require programs to include an annual evaluation component to monitor (1) the number of syringes distributed and collected, (2) program participation rates, (3) the number of participants who are referred to treatment, and (4) the incidence of human immunodeficiency virus from injection drug use to determine if there is a reduction in the result of the syringe services program.

(d) The local health department or community-based organization of each community conducting a syringe services program shall submit a report evaluating the effectiveness of the program to the Department of Public Health.

(P.A. 90-214, S. 3, 5; May Sp. Sess. P.A. 92-3, S. 1, 2; May Sp. Sess. P.A. 92-11, S. 52, 70; P.A. 93-381, S. 9, 39; P.A. 94-16; P.A. 95-257, S. 12, 21, 58; June Sp. Sess. P.A. 99-2, S. 4; P.A. 06-195, S. 4; P.A. 11-242, S. 11; P.A. 16-87, S. 1; P.A. 17-6, S. 2.)

History: May Sp. Sess. P.A. 92-3 amended Subsec. (a) to authorize department to establish additional programs, Subsec. (b) to change requirement regarding marking of needles and syringes to apply only to first year of program, Subsec. (c) to require the department to establish evaluation and monitoring requirements and Subsec. (d) to provide for the department to compile information received from the programs; May Sp. Sess. P.A. 92-11 made a technical change in Subsec. (b); P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 94-16 removed limit of three additional programs and raised number of needles and syringes permitted per exchange from five to ten; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; June Sp. Sess. P.A. 99-2 amended Subsec. (b)(2) by replacing “ten syringes” with “thirty needles and syringes”, adding Subpara. (B) re first-time applicants and Subpara. (C) re assurance of one packet per person, and made technical changes; P.A. 06-195 amended Subsec. (b)(2)(A) by deleting cap of thirty needles and syringes per exchange, effective June 7, 2006; P.A. 11-242 amended Subsec. (a) by eliminating provisions specifying that programs be established in and evaluated by health departments and by requiring that programs be established in 3 cities having highest total number of HIV infections among injection drug users, amended Subsec. (b) by substituting HIV prevention programs for AIDS prevention and outreach projects in Subdiv. (1), by substituting “confidential” for “anonymous” re exchanges of needles and syringes in Subdiv. (2), by deleting former Subdiv. (2)(C) re limitation of receipt of initial

packages of needles and syringes, and by deleting former Subdiv. (4) re needles and syringes to be marked and checked for return dates, amended Subsec. (c) by requiring department to establish program monitoring requirements, deleting former Subdiv. (2) re monitoring of behavioral changes, redesignating existing Subdiv. (3) as Subdivs. (2) and (3) and deleting former Subdiv. (4) re monitoring of intravenous drug use, and amended Subsec. (d) by requiring organization conducting the program to submit a report on its effectiveness and by eliminating provision re report to General Assembly; P.A. 16-87 amended Subsec. (a) by adding “within available appropriations” and replacing provision re three cities having highest number of infections with provision re enhancing outcomes of people who inject drugs, amended Subsec. (b) by adding references to hepatitis C, deleting provision re maximum of 30 needles and syringes in initial packet in Subdiv. (2)(B), adding reference to drug overdose prevention in Subdiv. (3), adding Subdiv. (4) re referrals for substance abuse counseling or treatment and adding Subdiv. (5) re referrals for medical or mental health care, amended Subsec. (c) by replacing “establish requirements” with “require programs to include an evaluation component”, replacing provision re return rates with provision re number of syringes distributed and collected in Subdiv. (1), deleting former Subdiv. (3) re number of participants motivated to enter treatment, adding new Subdiv. (3) re number of participants referred to treatment and adding Subdiv. (4) re incidence of human immunodeficiency virus from injection drug use, and made technical and conforming changes; P.A. 17-6 amended Subsec. (a) by replacing “needle and syringe exchange programs” with “syringe services programs”, amended Subsec. (b) by replacing “hepatitis C prevention programs” with “hepatitis C outreach and prevention programs in the selected communities” in Subdiv. (1), deleted provision re receipt of equal number of needles and syringes for those returned in Subdiv. (2), adding new Subdiv. (3) re safe disposal or exchange of syringes, redesignating existing Subdiv. (2)(B) re first-time applicants as Subdiv. (4), redesignating existing Subdiv. (3) re education as Subdiv. (5) and amending same by adding “reduction in harm caused by such viruses”, redesignating existing Subdivs. (4) and (5) as Subdivs. (6) and (7), amended Subsec. (c) by adding “annual” re evaluation component, and adding “to determine if there is a reduction in the result of the syringe services program” in Subdiv. (4), and amended Subsec. (d) by adding reference to local health department, and made technical and conforming changes, effective July 1, 2017.

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Sec. 19a-124a. Donation of vans to entities operating needle exchange programs. Section [19a-124a](#) is repealed, effective October 1, 2016.

(P.A. 04-221, S. 31; P.A. 16-87, S. 5.)

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Sec. 19a-125. Adolescent Health Council. Section [19a-125](#) is repealed, effective October 1, 2011.

(P.A. 92-107; P.A. 93-91, S. 1, 2; 93-262, S. 1, 87; 93-381, S. 29, 39; 93-411, S. 1, 19; P.A. 95-257, S. 12, 21, 58; P.A. 11-242, S. 98.)

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Secs. 19a-126 to 19a-127j. Transferred to Chapter 319j, Secs. [17a-680](#) to [17a-701](#), inclusive.

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Sec. 19a-127k. Community benefit programs. Program reporting. Office of Health Strategy summary and analysis. (a) As used in this section:

- (1) “Community benefit partners” means federal, state and municipal government entities and private sector entities, including, but not limited to, faith-based organizations, businesses, educational and academic organizations, health care organizations, health departments, philanthropic organizations, organizations specializing in housing justice, planning and land use organizations, public safety organizations, transportation organizations and tribal organizations, that, in partnership with hospitals, play an essential role with respect to the policy, system, program and financing solutions necessary to achieve community benefit program goals;
- (2) “Community benefit program” means any voluntary program or activity to promote preventive health care, protect health and safety, improve health equity and reduce health disparities, reduce the cost and economic burden of poor health and improve the health status for all populations within the geographic service areas of a hospital, regardless of whether a member of any such population is a patient of such hospital;
- (3) “Community benefit program reporting” means the community health needs assessment, implementation strategy and annual report submitted by a hospital to the Office of Health Strategy pursuant to the provisions of this section;
- (4) “Community health needs assessment” means a written assessment, as described in 26 CFR 1.501(r)-(3);
- (5) “Health disparities” means health differences that are closely linked with social or economic disadvantages that adversely affect one or more groups of people who have experienced greater systemic social or economic obstacles to health or a safe environment based on race or ethnicity, religion, socioeconomic status, gender, age, mental health, cognitive, sensory or physical disability, sexual orientation, gender identity, geographic location or other characteristics historically linked to discrimination or exclusion;
- (6) “Health equity” means that every person has a fair and just opportunity to be as healthy as possible, which encompasses removing obstacles to health, such as poverty, racism and the adverse consequences of poverty and racism, including, but not limited to, a lack of equitable opportunities, access to good jobs with fair pay, quality education and housing, safe environments and health care;
- (7) “Hospital” means a nonprofit entity licensed as a hospital pursuant to chapter 368v that is required to annually file Internal Revenue Service form 990. “Hospital” includes a for-profit entity licensed as an acute care general hospital;
- (8) “Implementation strategy” means a written plan, as described in 26 CFR 1.501(r)-(3), that is adopted by an authorized body of a hospital and documents how such hospital intends to address the needs identified in the community health needs assessment; and
- (9) “Meaningful participation” means that (A) residents of a hospital's community, including, but not limited to, residents of such community that experience the greatest health disparities, have an appropriate opportunity to participate in such hospital's planning and decisions, (B) community participation influences a hospital's planning, and (C) participants receive information from a hospital summarizing how their input was or was not used by such hospital.
- (b) On and after January 1, 2023, each hospital shall submit community benefit program reporting to the Office of Health Strategy, or to a designee selected by the Commissioner of Health Strategy, in the form and manner described in subsections (c) to (e), inclusive, of this section.
- (c) Each hospital shall submit its community health needs assessment to the Office of Health Strategy not later than thirty days after the date on which such assessment is made available to the public pursuant to 26 CFR 1.501(r)-(3)(b), provided the Commissioner of Health Strategy, or the commissioner's designee,

may grant an extension of time to a hospital for the filing of such assessment. Such submission shall contain the following:

(1) Consistent with the requirements set forth in 26 CFR 1.501(r)-(3)(b)(6)(i), and as included in a hospital's federal filing submitted to the Internal Revenue Service:

(A) A definition of the community served by the hospital and a description of how the community was determined;

(B) A description of the process and methods used to conduct the community health needs assessment;

(C) A description of how the hospital solicited and took into account input received from persons who represent the broad interests of the community it serves;

(D) A prioritized description of the significant health needs of the community identified through the community health needs assessment, and a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs;

(E) A description of the resources potentially available to address the significant health needs identified through the community health needs assessment;

(F) An evaluation of the impact of any actions that were taken, since the hospital finished conducting its immediately preceding community health needs assessment, to address the significant health needs identified in the hospital's prior community health needs assessment; and

(2) Additional documentation of the following:

(A) The names of the individuals responsible for developing the community health needs assessment;

(B) The demographics of the population within the geographic service area of the hospital and, to the extent feasible, a detailed description of the health disparities, health risks, insurance status, service utilization patterns and health care costs within such geographic service area;

(C) A description of the health status and health disparities affecting the population within the geographic service area of the hospital, including, but not limited to, the health status and health disparities affecting a representative spectrum of age, racial and ethnic groups, incomes and medically underserved populations;

(D) A description of the meaningful participation afforded to community benefit partners and diverse community members in assessing community health needs, priorities and target populations;

(E) A description of the barriers to achieving or maintaining health and to accessing health care, including, but not limited to, social, economic and environmental barriers, lack of access to or availability of sources of health care coverage and services and a lack of access to and availability of prevention and health promotion services and support;

(F) Recommendations regarding the role that the state and other community benefit partners could play in removing the barriers described in subparagraph (E) of this subdivision and enabling effective solutions; and

(G) Any additional information, data or disclosures that the hospital voluntarily chooses to include as may be relevant to its community benefit program.

(d) Each hospital shall submit its implementation strategy to the Office of Health Strategy not later than thirty days after the date on which such implementation strategy is adopted pursuant to 26 CFR 1.501(r)-(3)(c), provided the Commissioner of Health Strategy, or the commissioner's designee, may grant an

extension to a hospital for the filing of such implementation strategy. Such submission shall contain the following:

(1) Consistent with the requirements set forth in 26 CFR 1.501(r)-(3)(b)(6)(i), and as included in a hospital's federal filing submitted to the Internal Revenue Service:

(A) With respect to each significant health need identified through the community health needs assessment, either (i) a description of how the hospital plans to address the health need, or (ii) identification of the health need as one which the hospital does not intend to address;

(B) For significant health needs described in subparagraph (A)(i) of this subdivision, (i) a description of the actions that the hospital intends to take to address the health need and the anticipated impact of such actions, (ii) identification of the resources that the hospital plans to commit to address the health need, and (iii) a description of any planned collaboration between the hospital and other facilities or organizations to address the health need;

(C) For significant health needs identified in subparagraph (A)(ii) of this subdivision, an explanation of why the hospital does not intend to address such health need; and

(2) Additional documentation of the following:

(A) The names of the individuals responsible for developing the implementation strategy;

(B) A description of the meaningful participation afforded to community benefit partners and diverse community members;

(C) A description of the community health needs and health disparities that were prioritized in developing the implementation strategy with consideration given to the most recent version of the state health plan prepared by the Department of Public Health pursuant to section [19a-7](#);

(D) Reference-citing evidence, if available, that shows how the implementation strategy is intended to address the corresponding health need or reduction in health disparity;

(E) A description of the planned methods for the ongoing evaluation of proposed actions and corresponding process or outcome measures intended for use in assessing progress or impact;

(F) A description of how the hospital solicited commentary on the implementation strategy from the communities within such hospital's geographic service area and revisions to such strategy based on such commentary; and

(G) Any other information that the hospital voluntarily chooses to include as may be relevant to its implementation strategy, including, but not limited to, data, disclosures, expected or planned resource outlay, investments or commitments, including, but not limited to, staff, financial or in-kind commitments.

(e) On or before October 1, 2023, and annually thereafter, each hospital shall submit to the Office of Health Strategy a status report on such hospital's community benefit program, provided the Commissioner of Health Strategy, or the commissioner's designee, may grant an extension to a hospital for the filing of such report. Such report shall include the following:

(1) A description of major updates regarding community health needs, priorities and target populations, if any;

(2) A description of progress made regarding the hospital's actions in support of its implementation strategy;

(3) A description of any major changes to the proposed implementation strategy and associated hospital actions; and

(4) A description of financial resources and other resources allocated or expended that supported the actions taken in support of the hospital's implementation strategy.

(f) Notwithstanding the provisions of section [19a-755a](#), and to the full extent permitted by 45 CFR 164.514(e), the Office of Health Strategy shall make data in the all-payer claims database available to hospitals for use in their community benefit programs and activities solely for the purposes of (1) preparing the hospital's community health needs assessment, (2) preparing and executing the hospital's implementation strategy, and (3) fulfilling community benefit program reporting, as described in subsections (c) to (e), inclusive, of this section. Any disclosure made by said office pursuant to this subsection of information other than health information shall be made in a manner to protect the confidentiality of such information as may be required by state or federal law.

(g) A hospital shall not be responsible for limitations in its ability to fulfill community benefit program reporting requirements, as described in subsections (c) to (e), inclusive, of this section, if the all-payer claims database data is not provided to such hospital, as required by subsection (f) of this section.

(h) On or before April 1, 2024, and annually thereafter, the Commissioner of Health Strategy shall develop a summary and analysis of the community benefit program reporting submitted by hospitals under this section during the previous calendar year and post such summary and analysis on its Internet web site and solicit stakeholder input through a public comment period. The Office of Health Strategy shall use such reporting and stakeholder input to:

(1) Identify additional stakeholders that may be engaged to address identified community health needs including, but not limited to, federal, state and municipal entities, nonhospital private sector health care providers and private sector entities that are not health care providers, including community-based organizations, insurers and charitable organizations;

(2) Determine how each identified stakeholder could assist in addressing identified community health needs or augmenting solutions or approaches reported in the implementation strategies;

(3) Determine whether to make recommendations to the Department of Public Health in the development of its state health plan; and

(4) Inform the state-wide health care facilities and services plan established pursuant to section [19a-634](#).

(i) Each for-profit entity licensed as an acute care general hospital shall submit community benefit program reporting consistent with the reporting schedules of subsections (c) to (e), inclusive, of this section, and reasonably similar to what would be included on such hospital's federal filings to the Internal Revenue Service, where applicable.

(P.A. 00-57; P.A. 03-80, S. 1; P.A. 08-184, S. 39; P.A. 22-58, S. 50; P.A. 24-81, S. 186.)

History: P.A. 03-80 amended Subsecs. (b), (d) and (e) to change frequency of reporting and commissioner's summary from annually to biennially, and added Subsec. (f) re civil penalty; P.A. 08-184 deleted Subsec. (a)(4) which defined "commissioner", amended Subsecs. (b), (e) and (f) by substituting "Healthcare Advocate" or designee for "commissioner" or designee and amended Subsec. (e) by adding "within available appropriations"; P.A. 22-58 amended Subsec. (a) by adding new Subdiv. (1) defining "community benefit partners", replacing "community benefits program" with "community benefit program" and redefining "community benefit program" in existing Subdiv. (1), redesignating existing Subdiv. (1) as Subdiv. (2), deleting existing Subdiv. (2) defining "managed care organization", adding new Subdivs. (3) to (6) defining "community benefit program reporting", "community health needs assessment", "health disparities" and "health equity", redefining "hospital" in existing Subdiv. (3),

redesignating existing Subdiv. (3) as Subdiv. (7) and adding Subdivs. (8) and (9) defining “implementation strategy” and “meaningful participation”, amended Subsec. (b) by adding provision re applicability on and after January 1, 2023, deleting existing provisions re reporting to the Healthcare Advocate and adding provision re reporting to Office of Health Strategy, deleted former Subsec. (c) re community benefit guidelines, added new Subsec. (c) re submission of community health needs assessment, deleted former Subsec. (d) re community benefit program reporting, added new Subsec. (d) re submission of implementation strategy, added new Subsec. (e) re submission of community benefit program status report, added new Subsec. (f) re availability of all-payer claims database information to hospitals for community benefit program purposes, added Subsec. (g) re hospital responsibility for limitations in ability to fulfill program reporting requirements, redesignated existing Subsec. (e) as Subsec. (h) and substantially revised same re Office of Health Strategy's summary and analysis of community benefit program reporting, deleted former Subsec. (f) and added Subsec. (i) re reporting by acute care general hospitals, effective January 1, 2023; P.A. 24-81 amended Subsecs. (b) to (e) and (h) by replacing references to executive director of the Office of Health Strategy with references to Commissioner of Health Strategy, effective May 30, 2024.

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Sec. 19a-127l. Quality of care program. Quality of Care Advisory Committee. (a) There is established a quality of care program within the Department of Public Health. The Commissioner of Public Health shall develop for the purposes of said program (1) a standardized data set to measure the clinical performance of health care facilities, as defined in section [19a-630](#), and require such data to be collected and reported periodically to the department, including, but not limited to, data for the measurement of comparable patient satisfaction, and (2) methods to provide public accountability for health care delivery systems by such facilities. The commissioner shall develop such set and methods for health care facilities and may revise such sets and methods as necessary, as determined by the commissioner. The commissioner shall consult with an association of hospitals in the state on the scope and timing of the data reporting requirements described in this section to reduce the administrative burden on hospitals in producing and disclosing such data. Data collected pursuant to the provisions of this section shall not include personally identifiable information of patients.

(b) In carrying out its responsibilities under subsection (a) of this section, the department shall develop the following for the quality of care program:

- (1) Comparable performance measures to be reported;
- (2) Selection of patient satisfaction survey measures and instruments;
- (3) Methods and format of standardized data collection;
- (4) Format for a public quality performance measurement report;
- (5) Human resources and quality measurements;
- (6) Medical error reduction methods;
- (7) Systems for sharing and implementing universally accepted best practices;
- (8) Systems for reporting outcome data;
- (9) Systems for continuum of care;
- (10) Recommendations concerning the use of an ISO 9000 quality auditing program;

(11) Recommendations concerning the types of statutory protection needed prior to collecting any data or information under this section and sections [19a-127m](#) and [19a-127n](#);

(12) Recommendations concerning the collection and analysis of data on patient malnutrition for the purposes of improving quality of care; and

(13) Any other issues that the department deems appropriate.

(c) (1) There is established a Quality of Care Advisory Committee which shall advise the Department of Public Health on the issues set forth in subdivisions (1) to (12), inclusive, of subsection (b) of this section. The advisory committee may meet at the discretion of the Commissioner of Public Health.

(2) Said committee shall create a standing subcommittee on best practices. The subcommittee shall (A) advise the department on effective methods for sharing with providers the quality improvement information learned from the department's review of reports and corrective action plans, including quality improvement practices, patient safety issues and preventative strategies, (B) not later than January 1, 2006, review and make recommendations concerning best practices with respect to when breast cancer screening should be conducted using comprehensive ultrasound screening or mammogram examinations, and (C) not later than January 1, 2008, study and make recommendations to the department concerning best practices with respect to communications between a patient's primary care provider and other providers involved in a patient's care, including hospitalists and specialists. The department shall, at least quarterly, disseminate information regarding quality improvement practices, patient safety issues and preventative strategies to the subcommittee and hospitals.

(d) The advisory committee shall consist of (1) four members who represent and shall be appointed by the Connecticut Hospital Association, including three members who represent three separate hospitals that are not affiliated of which one such hospital is an academic medical center; (2) one member who represents and shall be appointed by the Connecticut Nursing Association; (3) two members who represent and shall be appointed by the Connecticut Medical Society, including one member who is an active medical care provider; (4) two members who represent and shall be appointed by the Connecticut Business and Industry Association, including one member who represents a large business and one member who represents a small business; (5) one member who represents and shall be appointed by the Home Health Care Association; (6) one member who represents and shall be appointed by the Connecticut Association of Health Care Facilities; (7) one member who represents and shall be appointed by LeadingAge Connecticut, Inc.; (8) two members who represent and shall be appointed by the AFL-CIO; (9) one member who represents consumers of health care services and who shall be appointed by the Commissioner of Public Health; (10) one member who represents a school of public health and who shall be appointed by the Commissioner of Public Health; (11) the Commissioner of Public Health or said commissioner's designee; (12) the Commissioner of Social Services or said commissioner's designee; (13) the Secretary of the Office of Policy and Management or said secretary's designee; (14) two members who represent licensed health plans and shall be appointed by the Connecticut Association of Health Care Plans; (15) one member who represents and shall be appointed by the federally designated state peer review organization; and (16) one member who represents and shall be appointed by the Connecticut Pharmaceutical Association. The chairperson of the advisory committee shall be the Commissioner of Public Health or said commissioner's designee. The chairperson of the committee, with a vote of the majority of the members present, may appoint ex-officio nonvoting members in specialties not represented among voting members. Vacancies shall be filled by the person who makes the appointment under this subsection.

(e) The chairperson of the advisory committee may designate one or more working groups to address specific issues and shall appoint the members of each working group. Each working group shall report its findings and recommendations to the full advisory committee.

(f) The advisory committee shall establish methods for informing the public regarding access to the department's consumer and regulatory services.

(g) The Department of Public Health may seek out funding for the purpose of implementing the provisions of this section. Said provisions shall be implemented upon receipt of such funding.

(P.A. 02-125, S. 1; P.A. 04-164, S. 3; P.A. 05-167, S. 1; 05-272, S. 30; P.A. 06-195, S. 41; P.A. 08-184, S. 56; Sept. Sp. Sess. P.A. 09-3, S. 32; P.A. 10-122, S. 2; P.A. 12-197, S. 13; P.A. 17-146, S. 17; P.A. 18-168, S. 14; P.A. 19-157, S. 100; P.A. 23-31, S. 12.)

History: P.A. 04-164 amended Subsec. (c) by designating existing provisions as Subdiv. (1) and adding Subdiv. (2) re best practices subcommittee, effective July 1, 2004; P.A. 05-167 added new Subsec. (h) requiring advisory committee to examine, evaluate and report re data collection system for cardiac outcomes and redesignated existing Subsec. (h) as Subsec. (i), effective July 1, 2005; P.A. 05-272 amended Subsec. (c)(2) by designating existing provision re subcommittee duties as Subpara. (A) and adding Subpara. (B) requiring subcommittee to review and make recommendations concerning best practices re breast cancer screening; P.A. 06-195 amended Subsec. (c)(2) by adding Subpara. (C) re study and recommendations concerning best practices with respect to communications between the primary care provider and other providers involved in a patient's care; P.A. 08-184 amended Subsec. (c)(1) by substituting “semiannually” for “quarterly” re committee meeting, effective July 1, 2008; Sept. Sp. Sess. P.A. 09-3 amended Subsec. (d) by deleting former Subdiv. (11) re committee member appointed by Office of Health Care Access and redesignating existing Subdivs. (12) to (17) as Subdivs. (11) to (16), effective October 6, 2009; P.A. 10-122 added new Subsec. (i) re advisory committee's responsibility for establishing methods for informing public regarding department's consumer and regulatory services, redesignated existing Subsec. (i) as Subsec. (j) and made a technical change therein, effective July 1, 2010; P.A. 12-197 amended Subsec. (d)(7) by replacing reference to Connecticut Association of Not-For-Profit Providers for the Aging with reference to LeadingAge Connecticut, Inc; P.A. 17-146 amended Subsec. (c)(1) by replacing provision re advisory committee to meet at least semiannually with provision re advisory committee may meet at discretion of commissioner; P.A. 18-168 deleted Subsecs. (f) to (h) re reporting requirements and redesignated Subsecs. (i) and (j) as Subsecs. (f) and (g); P.A. 19-157 amended Subsec. (b) by adding new Subdiv. (12) re malnutrition data and redesignating existing Subdiv. (12) as Subdiv. (13), effective July 1, 2019; P.A. 23-31 amended Subsec. (a) by replacing references to department with references to Commissioner of Public Health, deleting provision re committee considering date set and accountability methods and recommending inclusion of other health care facilities in each subsequent year, and adding provisions allowing commissioner to revise sets and methods, requiring commissioner to consult with association of hospitals, and requiring data collection to not include personally identifiable information of patients, effective July 1, 2023.

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Sec. 19a-127m. Implementation of performance improvement plans by hospitals. Submission of plans to department. All hospitals, licensed pursuant to provisions of the general statutes, shall be required to implement performance improvement plans. Such plans shall be made available upon request to the Department of Public Health.

(P.A. 02-125, S. 2; P.A. 06-195, S. 24.)

History: P.A. 06-195 required hospitals to make plans available to Department of Public Health upon request, rather than annually on a specific date as a condition of licensure.

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Sec. 19a-127n. Adverse events. Reporting requirements. Regulations. Confidentiality of reports. Retaliatory action prohibited. (a)(1) For purposes of this section, an “adverse event” means any event that is identified on the National Quality Forum's List of Serious Reportable Events or on a list compiled by

the Commissioner of Public Health and adopted as regulations pursuant to subsection (c) of this section; and “corrective action plan” means a plan that (A) implements strategies that are reflective of evidenced-based best practices and that reduce the risk of similar adverse events occurring in the future, and (B) measures the effectiveness of such strategies by addressing the implementation, oversight and time lines of such strategies.

(2) The commissioner shall review the list of adverse events periodically, but not less than annually, to ascertain whether any additions, deletions or modifications to the list are necessary.

(b) On and after October 1, 2023, a hospital or birth center, as such terms are defined in section [19a-490](#), or outpatient surgical facility, as defined in section [19a-493b](#), shall report adverse events to the Department of Public Health on a form prescribed by the commissioner as follows: (1) A written report and the status of any corrective steps shall be submitted not later than seven days after the date on which the adverse event occurred; and (2) a corrective action plan shall be filed not later than thirty days after the date on which the adverse event occurred. Emergent reports, as defined in the regulations adopted pursuant to subsection (c) of this section, shall be made to the department immediately. Failure to implement a corrective action plan may result in disciplinary action by the commissioner, pursuant to section [19a-494](#).

(c) The commissioner shall adopt regulations, in accordance with chapter 54, to carry out the provisions of this section. Such regulations shall include, but shall not be limited to, a list of adverse events that are in addition to those contained in the National Quality Forum's List of Serious Reportable Events.

(d) On or before October first annually, the commissioner shall report, in accordance with the provisions of section [11-4a](#), on adverse event reporting, to the joint standing committee of the General Assembly having cognizance of matters relating to public health. For annual reports submitted on or after July 1, 2011, the commissioner shall include hospital and outpatient surgical facility adverse event information for each facility identified (1) by the National Quality Forum's List of Serious Reportable Events category, and (2) in accordance with any list compiled by the commissioner and adopted as regulations pursuant to subsection (c) of this section. Such reports shall be prepared in a format that uses relevant contextual information. For purposes of this subsection “contextual information” includes, but is not limited to, (A) the relationship between the number of adverse events and a hospital's total number of patient days or an outpatient surgical facility's total number of surgical encounters expressed as a fraction in which the numerator is the aggregate number of adverse events reported by each hospital or outpatient surgical facility by category as specified in this subsection and the denominator is the total of the hospital's patient days or the outpatient surgical facility's total number of surgical encounters, and (B) information concerning the patient population served by the hospital or outpatient surgical facility, including such hospital's or outpatient surgical facility's payor or case mix. In addition, a hospital or outpatient surgical facility may provide informational comments relating to any adverse event reported to the commissioner pursuant to this section. On and after July 1, 2011, any report submitted by the commissioner pursuant to this subsection shall include any informational comments received concerning an adverse event that is included in the report.

(e) Information collected pursuant to this section shall not be disclosed pursuant to subsection (a) of section [1-210](#) at any time, and information collected pursuant to this section shall not be subject to subpoena or discovery or introduced into evidence in any judicial or administrative proceeding except as otherwise specifically provided by law. Nothing in this section shall be construed to limit access to or disclosure of investigative files, including any adverse event report contained in such files, maintained by the department as otherwise provided in section [19a-499](#).

(f) If the department determines that it will initiate an investigation of an adverse event that has been reported, such investigation may include review by one or more practitioners with clinical expertise of the type involved in the reported adverse event.

(g) No hospital or outpatient surgical facility shall discharge, refuse to hire, refuse to serve, retaliate in any manner or take any adverse action against any employee, applicant for employment or health care provider because such employee, applicant for employment or health care provider takes or has taken any action in furtherance of the enforcement of the provisions of this section.

(P.A. 02-125, S. 3; P.A. 03-278, S. 123; P.A. 04-164, S. 1; P.A. 06-195, S. 25, 26; P.A. 10-122, S. 1; P.A. 23-147, S. 6.)

History: P.A. 02-125 effective July 1, 2002; P.A. 03-278 made a technical change in Subsec. (c), effective July 9, 2003; P.A. 04-164 amended Subsec. (a) by redefining “adverse event”, defining “corrective action plan” and requiring periodic review of list of adverse events, deleted former Subsec. (b) re classes of adverse events, redesignated existing Subsec. (c) as new Subsec. (b) and changed timing of required reports from 72 hours to 7 days and of corrective plans from 7 days to 30 days, but required immediate submittal of emergent reports, deleted former Subsec. (d) re corrective plans, redesignated existing Subsecs. (e) to (g) and (h) as new Subsecs. (c) to (e) and (g), respectively, changed reporting date in new Subsec. (d) from March first to October first, added provision in new Subsec. (e) re access to or disclosure of investigative files, added new Subsec. (f) re investigation of adverse event, and made technical and conforming changes throughout, effective July 1, 2004; P.A. 06-195 amended Subsec. (b) by requiring adverse event reports to be submitted on form prescribed by Commissioner of Public Health and making a technical change and amended Subsec. (c) by deleting provisions requiring prescribed form for reporting adverse events to be adopted by regulation; P.A. 10-122 amended Subsec. (a)(1) by redefining “corrective action plan” and making technical changes, amended Subsecs. (b) and (c) by making technical changes, amended Subsec. (d) by adding provisions re content and format of reports submitted by commissioner on or after July 1, 2011, and requiring that reports include hospital and outpatient surgical facility adverse event information for each facility and amended Subsec. (g) by replacing former provision re Quality of Care Advisory Committee with provision prohibiting retaliatory actions by hospital or outpatient surgical facility, effective July 1, 2010; P.A. 23-147 amended Subsec. (b) by replacing “October 1, 2002” with “October 1, 2023”, adding reference to birth center and adding provision re definition of outpatient surgical facility.

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Sec. 19a-127o. Patient safety organizations. (a) For purposes of this section:

- (1) “Patient safety organization” means any public or private organization, or component of any such organization, whose primary activity is to improve patient safety and the quality of health care delivery for patients receiving care through the collection, aggregation, analysis or processing of medical or health care-related information submitted to it by health care providers;**
 - (2) “Patient safety work product” means any information, documentation or communication, including, but not limited to, reports, records, memoranda, analyses, statements, root cause analyses, protocols or policies that (A) a health care provider prepares exclusively for the purpose of disclosing to a patient safety organization, (B) is created by a patient safety organization, or (C) contains the deliberations or analytical process of a patient safety organization or between a patient safety organization and health care providers participating in the evaluation of patient care; and**
 - (3) “Health care provider” or “provider” means any person, corporation, limited liability company, facility or institution operated, owned or licensed by this state to provide health care or professional services, or an officer, employee or agent thereof acting in the course and scope of his or her employment.**
- (b) (1) Any private or public organization or a component of any private or public organization may apply to the Department of Public Health to be designated as a patient safety organization.**

(2) The department may designate as a patient safety organization each applicant that (A) has a mission statement indicating its primary purpose is to conduct activities to improve patient safety, (B) has qualified staff and professionals capable of reviewing and producing patient safety work product, (C) is not a component of a health insurer or other entity that provides health insurance to individuals or group health plans, and (D) certifies that its mission does not create a conflict of interest with the health care providers who will submit patient safety work product to it. Each hospital or outpatient surgical facility shall seek to work with one or more patient safety organizations as they become available. The department shall assist hospitals and outpatient surgical facilities in developing working relationships with patient safety organizations.

(c) A health care provider shall enter into a written contract with each patient safety organization to which it sends patient safety work product. Each contract shall require the provider to maintain a document log itemizing the types of documents submitted to patient safety organizations without indicating the content of such documents. Such document log shall be accessible to the department for the sole purpose of allowing the department to verify the type of information submitted to patient safety organizations. The department shall not have access to patient safety work product. Notwithstanding the provisions of sections [1-210](#), [1-211](#) and [1-213](#), such document log shall not be subject to disclosure to, or use by, any person or entity, other than the patient safety organization and the provider with which it has contracted, and by the department for the sole purpose provided in this subsection.

(d) A patient safety organization shall, as appropriate, disseminate to health care providers, the department, the Quality of Care Advisory Committee, as established by section [19a-127l](#), and the public, information or recommendations, including suggested policies, procedures or protocols, on best medical practices or potential system changes designed to improve patient safety and the overall quality of care.

(e) A patient safety organization shall have in place appropriate safeguards and security measures to ensure the technical integrity and physical safety of any patient safety work product. Patient safety work product shall be confidential, and shall not be subject to any discovery, access or use by any person or entity other than the patient safety organization and the provider with which the patient safety organization has contracted. Patient safety work product, if submitted to a public or governmental organization, shall not be subject to the provisions of section [1-210](#), [1-211](#) or [1-213](#). Nothing in this subsection shall prohibit a patient safety organization from choosing to disclose patient safety work product, or portions of patient safety work product, in conformity with its mission and within its contractual obligations to the provider submitting the information. No patient safety organization may release protected health information or patient identifying information without meeting the requirements of state laws and the federal Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

(f) A provider's disclosure of patient safety work product to a patient safety organization shall not modify, limit or waive any existing privilege or confidentiality protection.

(P.A. 04-164, S. 2.)

History: P.A. 04-164 effective July 1, 2004 (Revisor's note: In Subsec. (d) the word "section" was added editorially by the Revisors before "[19a-127l](#)" for accuracy).

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Sec. 19a-127p. Requirement for hospitals to contract with patient safety organization. On or before January 1, 2006, each hospital licensed under chapter 368v shall (1) contract with a patient safety organization, as defined in section [19a-127o](#), to gather medical or health-care-related data from the hospital and make recommendations to the hospital on ways to improve patient care and safety, and (2) provide documentation to the Department of Public Health, in such form and manner as the department prescribes, that the hospital has complied with the provisions of subdivision (1) of this section.

(P.A. 05-275, S. 27.)

History: P.A. 05-275 effective July 13, 2005.

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Sec. 19a-127q. Overdoses of opioid drug. Reporting and mental health screening requirements. Provision of data to municipal health departments and district departments of health. Toxicology screenings for nonfatal overdoses. Confidentiality of data. (a) On and after January 1, 2019, any hospital licensed pursuant to chapter 368v or emergency medical services personnel, as defined in section [20-206jj](#), that treats a patient for an overdose of an opioid drug, as defined in section [20-14o](#), shall report such overdose to the Department of Public Health in a form and manner prescribed by the Commissioner of Public Health.

(b) On and after January 1, 2020, any hospital licensed pursuant to chapter 368v that treats a patient for a nonfatal overdose of an opioid drug, as defined in section [20-14o](#), shall administer a mental health screening or assessment of the patient if medically appropriate, and provide the results of such screening or assessment to the patient if medically appropriate, or to the patient's parent, guardian or legal representative, as applicable, if medically appropriate.

(c) On or before January 1, 2020, the Department of Public Health shall provide the data reported pursuant to subsection (a) of this section to the municipal health department or district department of health that has jurisdiction over the location in which such overdose occurred, or, if such location is unknown, the location in which the hospital or emergency medical services personnel treated the patient, as the department, in its discretion, deems necessary to develop preventive initiatives.

(d) (1) From January 1, 2025, until August 31, 2028, any hospital licensed pursuant to chapter 368v that treats a patient for a nonfatal overdose of an opioid drug, as defined in section [20-14o](#), shall administer, with the patient's consent, a toxicology screening of the patient, if medically appropriate. Such screening shall include, but need not be limited to, screening for opiates, opioids, benzodiazepines, cannabinoids, methadone, cocaine, gabapentin, xylazine and any other substance deemed appropriate by the commissioner. Any hospital that administers a toxicology screening pursuant to the provisions of this subsection shall report the screening results to the Department of Public Health in a form and manner prescribed by the commissioner.

(2) On or before January 1, 2026, and annually thereafter, until January 1, 2029, the commissioner shall report, in accordance with the provisions of section [11-4a](#), to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding toxicology screening results obtained pursuant to the provisions of this subsection. Such report shall include, but need not be limited to, (A) the identification and analysis of any trends identified as a result of toxicology screening results obtained pursuant to the provisions of this subsection, (B) the identification of any benefits experienced by patients seeking emergency department care for nonfatal overdoses as a result of the toxicology screening results obtained pursuant to this subsection, and (C) a recommendation regarding whether toxicology screening reporting performed pursuant to this subsection should continue after August 31, 2028.

(e) Data reported to the Department of Public Health by a hospital or emergency medical services personnel pursuant to the provisions of this section shall at all times remain confidential pursuant to section [19a-25](#).

(P.A. 18-166, S. 5; P.A. 19-191, S. 11; P.A. 24-120, S. 1.)

History: P.A. 18-166 effective July 1, 2018; P.A. 19-191 added new Subsec. (b) re mental health screening for nonfatal overdoses and redesignated existing Subsecs. (b) and (c) as Subsecs. (c) and (d); P.A. 24-120

added new Subsec. (d) re toxicology screening for nonfatal overdoses, redesignated existing Subsec. (d) as Subsec. (e) and added “pursuant to the provisions of this section”.

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Sec. 19a-127r. Connecticut AIDS drug assistance program and Connecticut Insurance Premium Assistance Program. Policies and procedures. Rebates and refunds. Enrollment in or demonstration of ineligibility for Medicare Part D. Payment of premium and coinsurance costs of Medicare Part D. (a) The Department of Public Health may, within available resources, administer the Connecticut AIDS drug assistance program and Connecticut Insurance Premium Assistance Program. The department may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulations, provided the department posts such policies and procedures on the eRegulations System prior to adopting them. Policies and procedures implemented pursuant to this section shall be valid until regulations are adopted in accordance with chapter 54.

(b) All rebates and refunds from the Connecticut AIDS drug assistance program and Connecticut Insurance Premium Assistance Program shall be paid to the Department of Public Health.

(c) Applicants for and recipients of benefits under the provisions of this section shall enroll in or demonstrate ineligibility for Medicare Part D.

(d) The Commissioner of Public Health may pay the premium and coinsurance costs of Medicare Part D coverage for eligible applicants or recipients.

(P.A. 18-168, S. 72; P.A. 19-118, S. 12.)

History: P.A. 18-168 effective July 1, 2018; P.A. 19-118 designated existing provisions re administering program as Subsec. (a) and amended same by deleting notwithstanding provision and making a technical change, amended Subsec. (b) by deleting notwithstanding provision, added Subsec. (c) re enrolling in or demonstrating ineligibility for Medicare Part D and added Subsec. (d) re payment of premium and coinsurance costs of Medicare Part D, effective July 1, 2019.

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Sec. 19a-127s. Centers of Excellence Program. (a) As used in this section: (1) “Center of Excellence” means a nursing home licensed under section [19a-491](#) that provides services that are consistent with evidence-based best practices for the delivery of person-centered care; (2) “Centers of Excellence Program” means a program that sets the standards for a nursing home to be designated as a Center of Excellence; and (3) “nursing home” has the same meaning as provided in section [19a-490](#).

(b) The Commissioner of Public Health shall design a state-wide Centers of Excellence Program to provide incentives to licensed nursing homes that provide services consistent with evidence-based best practices for the delivery of person-centered care.

(c) When designing the program, the Commissioner of Public Health shall:

(1) Study the extent to which a Centers of Excellence Program may improve the quality of care provided at nursing homes and what the best practices are in other similar programs nation-wide; and

(2) Consult with (A) nursing home owners and operators; (B) hospitals; (C) nursing home residents and their advocates; (D) the Office of the Long-Term Care Ombudsman; (E) the Commissioner of Social Services, or the commissioner's designee; (F) the Secretary of the Office of Policy and Management, or the

secretary's designee; and (G) other relevant stakeholders as deemed necessary by the Commissioner of Public Health.

(d) The design of the program shall, at a minimum, (1) identify evidence-based qualitative and quantitative standards for delivery of person-centered care a nursing home must meet to be designated as a Center of Excellence; (2) identify for each standard the measure or measures nursing homes must meet to qualify as a Center of Excellence; (3) identify a pathway through application, inspection or other means by which a nursing home may be designated as a Center of Excellence; (4) create a mechanism to designate nursing homes that meet or exceed the standards and qualify as a Center of Excellence; (5) determine potential incentives to nursing homes that meet the standards set for the Centers of Excellence Program; and (6) identify ways to maximize the use of available federal funding to support the Centers of Excellence Program.

(e) The Centers of Excellence Program shall be designed as a voluntary program. No nursing home shall be required to participate in said program, and nursing homes that choose not to participate shall not be penalized by the state.

(f) When developing the program, the Commissioner of Public Health may, within available appropriations, engage a consultant to identify best practices and design the Centers of Excellence Program.

(g) Upon completion of designing the Centers of Excellence Program, or not later than January 1, 2026, the Commissioner of Public Health shall report to the Secretary of the Office of Policy and Management on the plan developed.

(h) The Commissioner of Social Services may seek approval of an amendment to the state Medicaid plan or a waiver from federal law to provide incentives for the Centers of Excellence Program designees. The commissioner shall develop the incentives in a time frame and manner to ensure that such incentives do not duplicate other applicable federal or state funding.

(P.A. 24-39, S. 25.)

History: P.A. 24-39 effective July 1, 2024.

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Secs. 19a-128 to 19a-130. Reserved for future use.

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Sec. 19a-131. Public health emergency response authority. Definitions. As used in sections [19a-131](#) to [19a-131i](#), inclusive, and section [19a-221](#):

(1) “Animal” means all vertebrate and invertebrate species;

(2) “Bioterrorism” means the intentional use of any microorganism, virus, infectious substance or biological product that may be engineered as a result of biotechnology, or any naturally occurring or bioengineered component of any such microorganism, virus, infectious substance, or biological product, to cause death, disease or other biological malfunction in a human, animal, plant or another living organism in order to influence the conduct of government or to harm, intimidate or coerce a civilian population;

(3) “Commissioner” means Commissioner of Public Health;

- (4) “Communicable disease” means a disease or condition, the infectious agent of which may pass or be carried, directly or indirectly, from the body of one person or animal to the body of another person or animal;
- (5) “Contaminated” or “contamination” means contaminated or contamination by a biological toxin or a chemical, radioactive or any other substance sufficient to pose a substantial risk of death, disability, injury or harm to other persons;
- (6) “Isolation” means the physical separation and confinement of an individual, group of individuals or individuals present within a geographic area who are infected with a communicable disease or are contaminated, or whom the commissioner reasonably believes to be infected with a communicable disease or to be contaminated, in order to prevent or limit the transmission of the disease to the general public;
- (7) “Public health authority” means a person or entity authorized to respond to a public health emergency in accordance with the plan for emergency responses to a public health emergency prepared in accordance with section [19a-131g](#), including, but not limited to, licensed health care providers or local and district health directors;
- (8) “Public health emergency” means an occurrence or imminent threat of a communicable disease, except sexually transmitted disease, or contamination caused or believed to be caused by bioterrorism, an epidemic or pandemic disease, a natural disaster, a chemical attack or accidental release or a nuclear attack or accident that poses a substantial risk of a significant number of human fatalities or incidents of permanent or long-term disability;
- (9) “Quarantine” means the physical separation and confinement of an individual, group of individuals or individuals present within a geographic area who are exposed to a communicable disease or are contaminated, or whom the commissioner reasonably believes have been exposed to a communicable disease or to be contaminated or have been exposed to others who have been exposed to a communicable disease or contamination, to prevent transmission to the general public;
- (10) “Respondent” means an individual ordered isolated or quarantined under section [19a-131b](#) or [19a-221](#).

(P.A. 03-236, S. 1.)

History: P.A. 03-236 effective July 9, 2003.

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Sec. 19a-131a. Declaration of public health emergency by Governor. (a) In the event of a state-wide or regional public health emergency, the Governor shall make a good faith effort to inform the legislative leaders specified in subsection (b) of this section before declaring that the emergency exists and may do any of the following: (1) Order the commissioner to implement all or a portion of the public health emergency response plan developed pursuant to section [19a-131g](#); (2) authorize the commissioner to isolate or quarantine persons in accordance with section [19a-131b](#); (3) order the commissioner to vaccinate persons in accordance with section [19a-131e](#); (4) apply for and receive federal assistance; or (5) order the commissioner to suspend certain license renewal and inspection functions during the period of the emergency and during the six-month period following the date the emergency is declared to be over.

(b) (1) Any declaration issued pursuant to this section shall become effective upon its filing with the Secretary of the State and with the clerks of the House of Representatives and Senate. The declaration shall state the nature of the public health emergency, the political subdivisions or geographic area subject to the declaration, the conditions that have brought about the public health emergency, the duration of the public health emergency and the public health authority responding to the emergency. Any such

declaration issued by the Governor may be disapproved and nullified by majority vote of a committee consisting of the president pro tempore of the Senate, the speaker of the House of Representatives, the majority and minority leaders of both houses of the General Assembly and the cochairpersons and ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to public health. Such disapproval shall not be effective unless filed with the Secretary of the State not later than seventy-two hours after the filing of the Governor's declaration with the Secretary of the State.

(2) Any declaration issued pursuant to this section may be renewed by the Governor upon its filing with the Secretary of the State and with the clerks of the House of Representatives and Senate. The renewal declaration shall state the nature of the continuing public health emergency, the political subdivisions or geographic area subject to the renewal, the conditions that have brought about the renewal declaration, the duration of the renewal declaration and the public health authority responding to the public health emergency. Any such renewal declaration issued by the Governor may be disapproved and nullified by majority vote of a committee consisting of the legislative leaders specified in subsection (b) of this section. Such disapproval shall not be effective unless filed with the Secretary of the State not later than seventy-two hours after the filing of the Governor's renewal declaration with the Secretary of the State.

(3) The Governor shall declare a public health emergency to be terminated before the duration stated in the declaration, upon a finding, after informing the legislative leaders specified in subsection (b) of this section, that the circumstances that caused such emergency to be declared no longer pose a substantial risk of a significant number of human fatalities or incidents of permanent or long-term disability.

(c) The Governor shall ensure that any declaration or order issued pursuant to the provisions of this section shall be (1) published in full at least once in a newspaper having general circulation in each county, (2) provided to news media, and (3) posted on the state Internet web site. Failure to take the actions specified in subdivisions (1) to (3), inclusive, of this subsection shall not impair the validity of such declaration or order.

(d) Any individual who, during the course of a public health emergency declared under this section, violates the provisions of any order issued pursuant to sections [19a-131](#) to [19a-131i](#), inclusive, or who intentionally obstructs, resists, hinders or endangers any person who is authorized to carry out, and who is engaged in an activity that carries out, any of the provisions of the order shall be fined not more than one thousand dollars or imprisoned not more than one year, or both, for each offense.

(e) The commissioner may request the Attorney General to apply to the Superior Court for an order enforcing the provisions of any order issued by the commissioner pursuant to sections [19a-131](#) to [19a-131i](#), inclusive, and such other equitable relief as the court deems appropriate.

(f) The commissioner may delegate to an employee of the Department of Public Health or any local health director, as much of the authority of the commissioner described in this section as the commissioner determines appropriate. Such authorized employee or director shall act as an agent of the commissioner.

(P.A. 03-236, S. 2; P.A. 08-134, S. 3.)

History: P.A. 03-236 effective July 9, 2003; P.A. 08-134 added Subsec. (a)(5) re Governor's authority to order commissioner to suspend certain license renewal and inspection functions in times of emergency.

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Sec. 19a-131b. Orders of quarantine or isolation. Appeal of order. Hearing. (a) Notwithstanding the provisions of section [19a-221](#) or [19a-265](#), if the Governor has declared a public health emergency, the commissioner, if so authorized by the Governor pursuant to section [19a-131a](#), may order into quarantine or isolation, as appropriate, any individual, group of individuals or individuals present within a

geographic area whom the commissioner has reasonable grounds to believe to be infected with, or exposed to, a communicable disease or to be contaminated or exposed to contamination or at reasonable risk of having a communicable disease or being contaminated or passing such communicable disease or contamination to other persons if the commissioner determines that such individual or individuals pose a significant threat to the public health and that quarantine or isolation is necessary and the least restrictive alternative to protect or preserve the public health. No individual or group of individuals or individuals present in a geographic area shall be quarantined or isolated unless they meet the conditions in this subsection.

(b) The commissioner shall adhere to the following conditions and principles when quarantining or isolating individuals, groups of individuals or individuals present within a geographic area: (1) Quarantine and isolation shall be by the least restrictive means necessary to prevent the spread of a communicable disease or contamination to others and may include, but not be limited to, confinement to private homes or other private or public premises; (2) quarantined individuals shall be confined separately from isolated individuals; (3) the health status of quarantined or isolated individuals shall be monitored frequently to determine if they continue to require quarantine or isolation; (4) if a quarantined individual subsequently becomes infected or contaminated or is reasonably believed to have become infected with a communicable disease or contaminated, such individual shall be promptly moved to isolation; (5) quarantined or isolated individuals shall be immediately released when they are no longer infectious or capable of contaminating others or upon the order of a court of competent jurisdiction; (6) the needs of individuals quarantined or isolated shall be addressed in a systematic and competent fashion, including, but not limited to, providing adequate food, clothing, shelter, means of communication with those in quarantine or isolation and outside those settings, medication and competent medical care; (7) premises used for quarantine and isolation shall be maintained in a safe and hygienic manner and be designed to minimize the likelihood of further transmission of infection or other harms to individuals quarantined or isolated; (8) to the extent possible without jeopardizing the public health, family members and members of a household shall be kept together, and guardians shall stay with their minor wards; and (9) to the extent possible, cultural and religious beliefs shall be considered in addressing the needs of individuals and establishing and maintaining premises used for quarantine and isolation.

(c) An order to quarantine or isolate issued by the commissioner shall be in writing and shall include: (1) The name of any individual, group of individuals or individuals present within a geographic area to be quarantined or isolated, or the geographic area where such communicable disease is present or contamination exists; (2) the basis for the commissioner's belief regarding the presence of a communicable disease or that contamination exists within the geographical area; (3) the period of time during which the order shall remain effective; (4) the premises subject to quarantine or isolation, that may include, but need not be limited to, private homes or other private or public premises; and (5) other terms and conditions as may be necessary to protect and preserve the public health. In determining the length of such order, the commissioner shall consider, to the extent known, the length of incubation of the communicable disease or contamination, the date of the individual's exposure and the individual's medical risk of exposing others to such communicable disease or contamination. The order shall be effective for not more than twenty days, provided further orders of quarantine or isolation meeting the requirements of this section may be issued as to any respondent for successive periods of not more than twenty days if issued before the last business day of the preceding period of quarantine or isolation.

(d) Such order shall also inform the individuals quarantined or isolated that they have the right to consult an attorney, the right to a hearing pursuant to this section, clear instructions on how to request a hearing, and that if such a hearing is requested, such individual has the right to be represented by counsel, that counsel will be provided at the state's expense if such individual is unable to pay for such counsel, and that if such a hearing is requested, court fees shall be waived. A copy of the order shall be provided to each individual quarantined or isolated or notice of the order shall be provided by a means likely to reach those affected.

(e) Any individual subject to a quarantine or isolation order under this section shall be confined in a place designated by the commissioner until such time as the commissioner determines such individual is no

longer infectious or capable of contaminating others, or is released by order of a court of competent jurisdiction for the district in which such individual is isolated or quarantined. Any individual who desires treatment by prayer or spiritual means without the use of any drugs or material remedies, but through the use of the principles, tenets or teachings of any church incorporated under chapter 598 or any other religious or spiritual practice, may be so treated during such individual's quarantine or isolation.

(f) An individual subject to a quarantine or isolation order under this section may appeal such order to the Probate Court for the district in which such person is quarantined or isolated and, if such individual or such individual's representative asks the court, in writing, including, but not limited to, by means of first class mail, facsimile machine or the Internet, for a hearing, notwithstanding the form of such request, the court shall hold a hearing not later than seventy-two hours after receipt of such request, excluding Saturdays, Sundays and legal holidays. The court may extend the time for a hearing based on extraordinary circumstances. No fee shall be charged to file an appeal in the Probate Court under this section. If such individual cannot appear personally before the court, a hearing shall be conducted only if his or her representative is present. The commissioner shall be a party to the proceedings. Such hearing may be held via any means that allows all parties to fully participate in the event an individual may infect or contaminate others. A request for a hearing shall not stay the order of quarantine or isolation issued by the commissioner under this section. The hearing shall concern, but need not be limited to, a determination of whether (1) the individual ordered confined is infected with a communicable disease or is contaminated or has a reasonable risk of having a communicable disease or having been contaminated or passing a communicable disease or contamination to other individuals, (2) the individual poses a reasonable threat to the public health, and (3) the quarantine or isolation of the individual is necessary and the least restrictive alternative to prevent the spread of a communicable disease or contamination to others in order to protect and preserve the public health.

(g) Notice of the hearing shall be given to the respondent and shall inform the respondent that his or her representative has a right to be present at the hearing; that the respondent has a right to counsel; that the respondent, if indigent or otherwise unable to pay for or obtain counsel, has a right to have counsel appointed to represent the respondent; and that the respondent has a right to cross-examine witnesses testifying at the hearing. If the court finds such respondent is indigent or otherwise unable to pay for or obtain counsel, the court shall appoint counsel for such respondent, unless such respondent refuses counsel and the court finds that the respondent understands the nature of his or her refusal. The court shall provide such respondent a reasonable opportunity to select such respondent's own counsel to be appointed by the court. If the respondent does not select counsel or if counsel selected by the respondent refuses to represent the respondent or is not available for such representation, the court shall appoint counsel for the respondent from a panel of attorneys admitted to practice in this state provided by the Probate Court Administrator. If the order of quarantine or isolation applies to individuals present in a described geographic area, the court may appoint one or more attorneys to represent all the individuals present in the described geographic area where there is a commonality of interests of such individuals, except that an individual may choose to be represented by his or her own attorney on an individual basis. The reasonable compensation of appointed counsel shall be established by, and paid from funds appropriated to, the Judicial Department, but, if funds have not been included in the budget of the Judicial Department for such purposes, such compensation shall be established by the Probate Court Administrator and paid from the Probate Court Administration Fund.

(h) Prior to such hearing, the Probate Court, such respondent or such respondent's counsel and the commissioner shall be afforded access to all records including, but not limited to, hospital records if such respondent is hospitalized, and shall be entitled to take notes therefrom. If such respondent is hospitalized at the time of the hearing, the hospital, upon order of the Probate Court, shall make available at such hearing for use by the respondent or his or her counsel all records in its possession relating to the condition of the respondent. All records relating to the condition of the respondent shall be admissible at the request of any party or the Probate Court at the hearing. Nothing in this subsection shall prevent timely objection to the admissibility of evidence in accordance with the rules of civil procedure.

(i) The court shall cause a recording of the testimony at such hearing to be made, to be transcribed only in the event of an appeal from the order rendered. A copy of such transcript shall be furnished without charge to any appellant whom the Probate Court finds unable to pay for the same. The cost of such transcript shall be paid from the funds appropriated by the Judicial Department, but, if funds have not been included in the budget of the Judicial Department for such purposes, the cost of such transcription shall be established by the Probate Court Administrator and paid from the Probate Court Administration Fund.

(j) At such hearing, the commissioner shall have the burden of showing, by a preponderance of the evidence, that the conditions of this subsection are met. If the court, at such hearing, finds that the respondent is infected with a communicable disease or is contaminated, or is reasonably believed to have been exposed to a communicable disease or to contamination, or is at reasonable risk of having a communicable disease or having been contaminated and poses a reasonable threat to the public health and that quarantine or isolation of the respondent is necessary and the least restrictive alternative to protect and preserve the public health, it shall order (1) the continued quarantine or isolation of the respondent under such terms and conditions as the court deems necessary to prevent the exposure of others to a communicable disease or contamination, until such time as it is determined by the commissioner that release of the respondent would not constitute a reasonable threat to the public health, or (2) the release of the respondent under such terms and conditions as it deems appropriate to protect the public health.

(k) If the court, at such hearing, fails to find that the conditions required for an order for quarantine or isolation under subsection (a) of this section have been proven, it shall order the immediate release of the respondent.

(l) A respondent may, not more than every thirty days, move the court to terminate or modify an order made under subsection (j) of this section, in which case a hearing shall be held in accordance with this section. If the court, at a hearing held upon motion of the respondent or its own motion, fails to find that the conditions which required quarantine or isolation still exist, it shall order the immediate release of the respondent. If the court finds that such conditions still exist but that a different remedy is appropriate under this section, the court shall modify its order accordingly.

(m) Any person aggrieved by an order of the Probate Court under this section may appeal to the Superior Court. The appeal shall be confined to the record, which shall consist of the transcript of the hearing and all evidence received or considered by the Probate Court.

(P.A. 03-236, S. 3; June Sp. Sess. P.A. 15-5, S. 453.)

History: P.A. 03-236 effective July 9, 2003; June Sp. Sess. P.A. 15-5 amended Subsec. (f) by deleting provision re fees for hearing to be paid by Judicial Department or waived, adding provision re no fee to be charged to file an appeal in Probate Court under section and making a technical change, effective July 1, 2015.

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Sec. 19a-131c. Enforcement of order of quarantine or isolation. Notwithstanding the provisions of section [19a-220](#), in the event of a public health emergency declared by the Governor under section [19a-131a](#), if any individual refuses to obey an order of quarantine or isolation issued by the commissioner pursuant to section [19a-131b](#), the commissioner may direct any law enforcement officer to immediately take such individual into custody and place him or her into quarantine or isolation, as the case may be. The commissioner shall notify the law enforcement officer or other personnel concerning any necessary infection control procedures required.

(P.A. 03-236, S. 4.)

History: P.A. 03-236 effective July 9, 2003.

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Sec. 19a-131d. Entry into quarantine or isolation premises. Entry into quarantine or isolation premises shall be limited to authorized individuals. The authorized individuals shall be determined by the commissioner, and shall include, but need not be limited to, any physician licensed under chapter 370, other licensed, certified or registered health care providers or other individuals, including family or household members, the commissioner deems necessary to meet the needs of quarantined or isolated individuals.

(P.A. 03-236, S. 5.)

History: P.A. 03-236 effective July 9, 2003.

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Sec. 19a-131e. Orders of vaccination. Appeal of order. Hearing. (a) In the event of a public health emergency declared by the Governor under section [19a-131a](#), the commissioner, as authorized by the Governor pursuant to section [19a-131a](#), may issue an order for the vaccination of such individuals or individuals present within a geographic area as the commissioner deems reasonable and necessary in order to prevent the introduction or arrest the progress of the communicable disease or contamination that caused the declaration of such public health emergency. The commissioner shall inform individuals subject to such vaccination order of the benefits and risks of the vaccine and an individual's option to refuse to be vaccinated for any reason, including, but not limited to, health, religious or conscientious objections. No individual shall be vaccinated unless such individual or, if such individual is a minor, such individual's parent or guardian has provided written consent for such vaccination.

(b) The commissioner may issue an order pursuant to section [19a-131b](#) to quarantine or isolate, as the case may be, any individual or group of individuals who is unable or unwilling for any reason, including, but not limited to, health, religion or conscience to undergo vaccination pursuant to this section. A parent or legal guardian may refuse such vaccination on behalf of a minor in the case where an order of vaccination requires a minor to be vaccinated. For purposes of this subsection, a minor is any person under the age of eighteen. Refusal of such vaccination shall not be grounds for quarantine or isolation without a reasonable belief that the individual or group of individuals is infected with a communicable disease or is contaminated, or may be exposed to a communicable disease or contamination, or may have been exposed to a communicable disease or to contamination, or is at reasonable risk of having a communicable disease or having been contaminated, and poses a reasonable threat to the public health.

(c) Any individual subject to vaccination pursuant to this section may appeal to the probate court for the district in which such individual has been ordered vaccinated, and, if such individual or such individual's representative asks the court, in writing, including, but not limited to, by means of first class mail, facsimile machine or the Internet, for a hearing, notwithstanding the form of such request, the court shall hold a hearing not later than seventy-two hours after receipt of such request, excluding Saturdays, Sundays and legal holidays. Such request shall be received by the Probate Court not later than forty-eight hours after the individual receives the order. The commissioner may make application to the court to extend the time for a hearing based on extraordinary circumstances. Court fees for such hearing shall be paid from funds appropriated to the Judicial Department, but if funds have not been included in the budget of the Judicial Department for such purpose, such fees shall be waived by the court. In considering whether to grant such extension, the court shall give due regard to the rights of affected individuals, the protection of the public's health, the severity of the need and available witnesses and evidence. If such individual cannot appear personally before the court, a hearing shall be conducted only if his or her

representative is present. The commissioner shall be a party to the proceedings. The hearing may be held via any means that allow all parties to fully participate in the event an individual may infect or contaminate others.

(d) Notice of the hearing shall be given to the respondent and shall inform the respondent that such respondent or his or her representative has a right to be present at the hearing; that the respondent has a right to counsel; that the respondent has the right to present testimony from a licensed practitioner of the healing arts, as defined in section [20-1](#); that court fees shall be waived; that the respondent, if indigent or otherwise unable to pay for or obtain counsel, has a right to have counsel appointed to represent the respondent; and that the respondent has a right to cross-examine witnesses testifying at the hearing. If the court finds such respondent is indigent or otherwise unable to pay for or obtain counsel, the court shall appoint counsel for such respondent, unless such respondent refuses counsel and the court finds that the respondent understands the nature of his or her refusal. The court shall provide such respondent a reasonable opportunity to select such respondent's own counsel to be appointed by the court. If the respondent does not select counsel or if counsel selected by the respondent refuses to represent such respondent or is not available for such representation, the court shall appoint counsel for the respondent from a panel of attorneys admitted to practice in this state provided by the Probate Court Administrator. If the order of vaccination applies to individuals present in a described geographic area, the court may appoint one or more attorneys to represent all the individuals present within the described geographic area where there is a commonality of interests of such individuals, except that an individual may choose to be represented by his or her own attorney on an individual basis. The reasonable compensation of appointed counsel shall be established by, and paid from funds appropriated to, the Judicial Department, but, if funds have not been included in the budget of the Judicial Department for such purposes, such compensation shall be established by the Probate Court Administrator and paid from the Probate Court Administration Fund.

(e) Prior to such hearing, the Probate Court, such respondent or such respondent's counsel or the commissioner shall be afforded access to all records including, but not limited to, hospital records if such respondent is hospitalized, and shall be entitled to take notes therefrom. If such respondent is hospitalized at the time of the hearing, the hospital, upon order of the Probate Court, shall make available at such hearing for use by the respondent or his or her counsel all records in its possession relating to the condition of the respondent. All records relating to the condition of the respondent shall be admissible at the request of any party or the Probate Court at the hearing. Nothing in this subsection shall prevent timely objection to the admissibility of evidence in accordance with the rules of civil procedure.

(f) The court shall cause a recording of the testimony at such hearing to be made, to be transcribed only in the event of an appeal from the order rendered. A copy of such transcript shall be furnished without charge to any appellant whom the Probate Court finds unable to pay for the same. The cost of such transcript shall be paid from the funds appropriated by the Judicial Department, but, if funds have not been included in the budget of the Judicial Department for such purposes, the cost of such transcription shall be established by the Probate Court Administrator and paid from the Probate Court Administration Fund.

(g) At such hearing, the commissioner shall have the burden of showing, by a preponderance of the evidence, that the conditions of subsection (a) of this section are met. If the court, at such hearing, finds that vaccination of the respondent is necessary and the least restrictive alternative to protect and preserve the public health, the court shall order the respondent to undergo vaccination, provided the court may order the isolation or quarantine of any respondent who is unable or unwilling for reasons of health, religion or conscience to undergo vaccination, for a period of time sufficient to ensure such respondent is not able to infect or contaminate others.

(h) If the court, at such hearing, fails to find that the conditions required for an order for vaccination under subsection (a) of this section have been proven, it shall vacate the order of vaccination.

(i) Any person aggrieved by an order of the Probate Court under this section may appeal to the Superior Court. The appeal shall be confined to the record, which shall consist of the transcript of the hearing and all evidence received or considered by the Probate Court.

(P.A. 03-236, S. 6.)

History: P.A. 03-236 effective July 9, 2003.

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Sec. 19a-131f. Authorization to administer vaccinations. Notwithstanding any provision of the general statutes, if the Governor has declared a public health emergency pursuant to section [19a-131a](#), the Commissioner of Public Health may authorize any qualified person, including, but not limited to, any person licensed under chapter 379, 384 or 384d, to administer vaccinations, if the commissioner determines that such action is necessary to protect the health, safety and welfare of the public. Such authorization shall be in writing, and shall contain the categories of qualified persons included in the authorization, any additional training required before performance of the vaccination by such persons and the duration of the authorization.

(P.A. 03-236, S. 7.)

History: P.A. 03-236 effective July 9, 2003.

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Sec. 19a-131g. Public Health Preparedness Advisory Committee. The Commissioner of Public Health shall establish a Public Health Preparedness Advisory Committee for purposes of advising the Department of Public Health on matters concerning emergency responses to a public health emergency. The advisory committee shall consist of the Commissioner of Public Health, or his or her designee, the Commissioner of Emergency Services and Public Protection, or his or her designee, the president pro tempore of the Senate, or his or her designee, the speaker of the House of Representatives, or his or her designee, the majority and minority leaders of both houses of the General Assembly, or their designees, the chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to public health, public safety and the judiciary, or their designees, representatives of town, city, borough and district directors of health, as appointed by the commissioner, and any other organization or persons that the commissioner deems relevant to the issues of public health preparedness. Upon the request of the commissioner, the Public Health Preparedness Advisory Committee may meet to review the plan for emergency responses to a public health emergency and other matters as deemed necessary by the commissioner.

(P.A. 03-236, S. 8; P.A. 04-219, S. 25; P.A. 11-51, S. 134; P.A. 17-146, S. 18; P.A. 21-121, S. 38.)

History: P.A. 03-236 effective July 9, 2003; P.A. 04-219 substituted the Commissioner of Emergency Management and Homeland Security for the director of the Office of Emergency Management, effective January 1, 2005; pursuant to P.A. 11-51, “Commissioner of Emergency Management and Homeland Security” was changed editorially by the Revisors to “Commissioner of Emergency Services and Public Protection”, effective July 1, 2011; P.A. 17-146 added provision re purpose of advisory committee, deleted provisions re advisory committee to develop plan for emergency responses to public health emergency and submit report on status of plan and added provision re committee may meet to review plan and other matters as deemed necessary by commissioner; P.A. 21-121 added references to designee and made technical and conforming changes, effective July 6, 2021.

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Sec. 19a-131h. Registration of deaths. If the Governor declares a public health emergency, the commissioner, in consultation with the Chief Medical Examiner, may designate authorized personnel to register death certificates as needed and carry out other duties related to the registration of deaths, including, but not limited to, the issuance of burial transit, removal and cremation permits.

(P.A. 03-236, S. 9.)

History: P.A. 03-236 effective July 9, 2003.

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Sec. 19a-131i. Immunity from personal liability. The provisions of sections [4-165](#) and [5-141d](#) shall apply to any person acting on behalf of the state, within the scope of such person's practice or profession, and pursuant to sections [19a-131](#) to [19a-131h](#), inclusive. The provisions of this section shall not apply if a vaccination has been administered without consent.

(P.A. 03-236, S. 10.)

History: P.A. 03-236 effective July 9, 2003.

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Sec. 19a-131j. Temporary suspension of licensure, license renewal and inspection requirements upon declaration of a civil preparedness emergency or public health emergency. (a) The commissioner may issue an order to temporarily suspend, for a period not to exceed sixty consecutive days, the requirements for licensure, certification or registration, pursuant to chapters 368d, 370, 376 to 376c, inclusive, 378, 378a, 379, 379a, 381a, 382a, 383 to 383d, inclusive, 383f, 383g, 384b, 384d, 385, 395, 399, 400a, 400j and 474, to allow persons who are appropriately licensed, certified or registered in another state or territory of the United States or the District of Columbia, to render temporary assistance within the scope of the profession for which a person is licensed, certified or registered, in managing a public health emergency in this state, declared by the Governor pursuant to section [19a-131a](#). Nothing in this section shall be construed to permit a person to provide services beyond the scope allowed in the chapter specified in this section that pertains to such person's profession.

(b) Upon the declaration of a civil preparedness emergency pursuant to section [28-9](#) or a public health emergency pursuant to section [19a-131a](#), the Commissioner of Public Health may suspend any of the requirements for renewal of any license, as defined in section [4-166](#), that would otherwise be required to be renewed by the department pursuant to the general statutes or regulations. Any such suspension of the requirements for renewal of a license may extend for the duration of the declared emergency and for up to six months following the date the emergency is declared to be over. Any license not renewed by the department shall not expire during the period of the emergency and during the six-month period following the date that the emergency is declared to be over. Not later than six months from the date the emergency is declared to be over, the commissioner shall reinstate license renewal requirements that had been suspended. Any license, for which the commissioner had suspended license renewal requirements, that is not renewed in the six-month period following the date of the resumption of the license renewal requirements shall expire, unless the commissioner, for good cause shown, extends this period of time. The commissioner may, for good cause shown, grant no more than two ninety-day extensions.

(c) If, pursuant to subsection (b) of this section, the department renews a license on a date other than the customary renewal date, the period of licensure shall not extend beyond the customary renewal date provided pursuant to the general statutes or regulations. At the time of such renewal, the licensee shall be responsible for payment of all license fees to the department, including payment of fees not collected by the department due to the suspension of license renewal requirements in accordance with the provisions of this section.

(d) Upon the declaration of a civil preparedness emergency pursuant to section [28-9](#) or public health emergency pursuant to section [19a-131a](#), the Commissioner of Public Health may suspend the requirements concerning any inspection that is otherwise required to be conducted by the department pursuant to the general statutes or regulations. Any such suspension of the requirements for conducting any inspection may extend for the duration of the declared emergency and for up to six months following the date the emergency is declared to be over. Not later than six months from the date the emergency is declared to be over, the department shall conduct any inspection not conducted during the period of the emergency and the subsequent six-month period. Such resumed inspections shall be completed not later than six months from the date that the inspections resumed, unless the commissioner, for good cause shown, extends this period of time. The commissioner may, for good cause shown, grant no more than two such ninety-day extensions.

(e) Nothing in this section shall be construed to permit the Commissioner of Public Health to effectuate a suspension of the department's license renewal and inspection responsibilities due to the declaration of a civil preparedness emergency by the Governor, until such time as the Governor, pursuant to section [28-9](#), issues an order that modifies or suspends, in whole or in part, any statute, regulation or requirement or part thereof relating to license renewals and inspections by the Department of Public Health and sets forth the reasons therefor.

(P.A. 03-236, S. 11; P.A. 08-134, S. 1; P.A. 21-121, S. 43; P.A. 22-92, S. 14.)

History: P.A. 03-236 effective July 9, 2003; P.A. 08-134 redesignated existing provisions as Subsec. (a) and inserted reference to Ch. 474 therein, added Subsecs. (b) and (c) re temporary suspension of license renewal provisions, added Subsec. (d) re temporary suspension of inspection requirements and added Subsec. (e) re commissioner's suspension of license renewal and inspection requirements upon Governor's declaration of civil preparedness emergency; P.A. 21-121 amended Subsec. (a) by adding references to Chs. 376a, 376b, 376c, 379, 379a, 382a, 383d, 383f, 383g, 384b and 399, effective July 6, 2021; P.A. 22-92 amended Subsec. (a) by making a technical change, effective May 24, 2022.

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Sec. 19a-131k. Mandatory distribution of potassium iodide. (a) For purposes of this section:

(1) “Child care service” means a child care center, group child care home or family child care home, as defined in section [19a-77](#), and licensed pursuant to section [19a-80](#) or [19a-87b](#);

(2) “Public health emergency” means a public health emergency, as defined in section [19a-131](#);

(3) “Commissioner” means the Commissioner of Public Health;

(4) “Nursing home facility” means any nursing home, as defined in section [19a-521](#), but shall not include residential care homes; and

(5) “Youth camp” means any facility licensed pursuant to chapter 368r.

(b) Notwithstanding any provision of the general statutes, each nursing home facility, child care service or youth camp shall provide potassium iodide to residents, staff members, minors or other persons present in

such facility, service or camp when directed by the commissioner during a public health emergency. Each nursing home facility, child care service or youth camp shall (1) upon admitting a resident or minor to, or upon hiring a staff member for, such facility, notify each resident or representative of a resident, staff member or parent or guardian of a minor of the requirement for the provision of potassium iodide under this subsection and obtain prior written permission or written objection for such provision from each such person, and (2) prior to obtaining such written permission or written objection, advise each such person, in writing, (A) that the ingestion of potassium iodide is voluntary only, (B) about the contraindications of taking potassium iodide, and (C) about the potential side effects of taking potassium iodide.

(c) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to establish criteria and procedures for obtaining the required written permission, and for the storage and distribution of potassium iodide to residents, staff members, minors or other persons present in such facility, service or camp.

(P.A. 03-236, S. 15; P.A. 07-129, S. 5; P.A. 15-227, S. 25.)

History: P.A. 03-236 effective July 9, 2003; P.A. 07-129 amended Subsec. (b) to provide for mandatory distribution of potassium iodide by nursing home facilities, child day care services or youth camps during public health emergencies; pursuant to P.A. 15-227, “child day care center”, “group day care home” and “family day care home” were changed editorially by the Revisors to “child care center”, “group child care home” and “family child care home”, respectively, and references to child day care service were changed editorially by the Revisors to references to child care service, effective July 1, 2015.

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Sec. 19a-131l. Guidelines regarding provision of menstrual products by state agencies and emergency shelters operated by domestic violence agencies receiving state funding. On or before July 1, 2022, the Commissioner of Public Health shall establish guidelines regarding the manner in which menstrual products may be provided pursuant to sections [8-359a](#), [10-212k](#), [10a-151j](#), [17b-816](#), [18-69e](#) and [18-99b](#), without stigmatizing the person who requests such products. The commissioner shall post such guidelines on the Department of Public Health's Internet web site.

(P.A. 22-118, S. 89.)

History: P.A. 22-118 effective May 7, 2022.

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Sec. 19a-131m. Pandemic preparedness report. Not later than January 1, 2024, and annually thereafter, the Commissioner of Public Health shall report, in accordance with the provisions of section [11-4a](#), to the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies on the state's pandemic preparedness.

(P.A. 23-204, S. 62.)

History: P.A. 23-204 effective July 1, 2023.

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Sec. 19a-132. Transferred to Chapter 814g, Sec. [46a-175](#).

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Sec. 19a-133. Declaration of racism as a public health crisis. It is hereby declared that racism constitutes a public health crisis in this state and will continue to constitute a public health crisis until the goal set forth in subsection (c) of section [19a-133b](#) is attained.

(P.A. 21-35, S. 1.)

History: P.A. 21-35 effective June 14, 2021.

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Sec. 19a-133a. Commission on Racial Equity in Public Health. Membership of advisory body. (a) There is established a Commission on Racial Equity in Public Health, to document and make recommendations to decrease the effect of racism on public health. The commission shall be part of the Legislative Department.

(b) The commission shall have an advisory body that shall consist of the following members:

(1) Three appointed by the speaker of the House of Representatives, one of whom shall be a representative of a nonprofit organization that focuses on health policy and racial equity issues and shall serve as cochairperson of the advisory body, one of whom shall be a representative of a nonprofit organization that focuses on racial equity and community engagement and one of whom shall be an expert in immigration policy and law;

(2) Three appointed by the president pro tempore of the Senate, one of whom shall be a health disparities expert affiliated with an academic research institution and shall serve as cochairperson of the advisory board, one of whom shall be a representative of a violence intervention program using a health-based approach to examine individuals post-incarceration and policies for integration and one of whom shall be a representative of a philanthropic entity that focuses on racial equity;

(3) Two appointed by the majority leader of the House of Representatives, one of whom shall be a representative of a nonpartisan criminal justice policy and research entity and one of whom shall be a biostatistician or epidemiologist with knowledge of the effects of social-structural factors on health;

(4) Two appointed by the majority leader of the Senate, one of whom shall be a representative of a nonprofit that focuses on equitable housing policy and one of whom shall be a medical professional with expertise in diversity, equity and inclusion policy;

(5) Two appointed by the minority leader of the House of Representatives, one of whom shall be an expert in environmental impacts on human health who is affiliated with an academic institution and one of whom shall be a representative of a nonprofit that focuses on economic research and policy;

(6) Two appointed by the minority leader of the Senate, one of whom shall be a public health educator or researcher affiliated with an academic institution and one of whom shall be a current or former educator, school counselor or school nurse with public policy experience; and

(7) One appointed by the chairperson of the Black and Puerto Rican Caucus who shall be an education policy researcher affiliated with an academic research institution.

(c) Any member of the advisory body appointed under subdivisions (1) to (7), inclusive, of subsection (b) of this section may be a member of the General Assembly. All initial appointments to the advisory body made under subdivisions (1) to (7), inclusive, of subsection (b) of this section shall be made not later than sixty

days after June 14, 2021. Appointed members shall serve a term that is coterminous with the appointing official and may serve more than one term.

(d) The cochairpersons of the advisory body shall schedule the first meeting of the advisory body, which shall be held not later than sixty days after June 12, 2023. If appointments under subsection (b) of this section are not made within such sixty-day period, the chairpersons may designate individuals with the required qualifications stated for the applicable appointment to serve on the commission until appointments are made pursuant to subsection (b) of this section.

(e) Members shall continue to serve until their successors are appointed. Any vacancy shall be filled by the appointing authority. Any vacancy occurring other than by expiration of term shall be filled for the balance of the unexpired term.

(f) A majority of the membership shall constitute a quorum for the transaction of any business and any decision shall be by a majority vote of those present at a meeting, except the commission may establish such committees, subcommittees or other entities as it deems necessary to further the purposes of the commission. The advisory body may adopt rules of procedure.

(g) The members of the advisory body shall serve without compensation, but shall, within the limits of available funds, be reimbursed for expenses necessarily incurred in the performance of their duties.

(h) The advisory body, by majority vote, shall confirm the hire of an executive director of the commission.

(i) The commission shall have the following powers and duties: To (1) support collaboration by bringing together partners from many different sectors to recognize the links between health and other issues and policy areas and build new partnerships to promote health and equity and increase government efficiency; (2) create a comprehensive strategic plan to eliminate health disparities and inequities across sectors, in accordance with section [19a-133b](#); (3) study the impact that the public health crisis of racism has on vulnerable populations within diverse groups of the state population, including on the basis of race, ethnicity, sexual orientation, gender identity and disability, including, but not limited to, Black American descendants of slavery; (4) obtain from any legislative or executive department, board, commission or other agency of the state or any organization or other entity such assistance as necessary and available to carry out the purposes of this section; (5) accept any gift, donation or bequest for the purpose of performing the duties described in this section; (6) establish bylaws to govern its procedures; and (7) perform such other acts as may be necessary and appropriate to carry out the duties described in this section, including, but not limited to, the creation of subcommittees.

(j) The commission shall engage with a diverse range of community members, including people of color who identify as members of diverse groups of the state population, including on the basis of race, ethnicity, sexual orientation, gender identity and disability, who experience inequities in health, to make recommendations to the relevant state agencies or other entities on an ongoing basis concerning the following: (1) Structural racism in the state's laws and regulations impacting public health, where, as used in this subdivision, "structural racism" means a system that structures opportunity and assigns value in a way that disproportionately and negatively impacts Black, Indigenous, Latino or Asian people or other people of color; (2) racial disparities in the state's criminal justice system and its impact on the health and well-being of individuals and families, including overall health outcomes and rates of depression, suicide, substance use disorder and chronic disease; (3) racial disparities in access to the resources necessary for healthy living, including, but not limited to, access to adequate fresh food and physical activity, public safety and the decrease of pollution in communities; (4) racial disparities in health outcomes; (5) the impact of zoning restrictions on the creation of housing disparities and such disparities' impact on public health; (6) racial disparities in state hiring and contracting processes; and (7) any suggestions to reduce the impact of the public health crisis of racism within the vulnerable populations studied under subdivision (3) of subsection (i) of this section.

(k) Not later than January 1, 2022, and every six months thereafter, the commission shall submit a report to the Secretary of the Office of Policy and Management and the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations and the budgets of state agencies, in accordance with the provisions of section [11-4a](#), concerning (1) the activities of the commission during the prior six-month period; (2) any progress made in attaining the goal described in subsection (c) of section [19a-133b](#); (3) any recommended changes to such goal based on the research conducted by the commission, any disparity study performed by any state agency or entity, or any community input received; (4) the status of the comprehensive strategic plan required under section [19a-133b](#); and (5) any recommendations for policy changes or amendments to state law.

(P.A. 21-35, S. 2; P.A. 22-92, S. 15; P.A. 23-204, S. 188.)

History: P.A. 21-35 effective June 14, 2021; P.A. 22-92 amended Subsec. (b)(6) by making a technical change, effective May 24, 2022; P.A. 23-204 amended Subsec. (b) by adding reference to an advisory body and substantially revising membership, amended Subsec. (c) by replacing references to “commission” with “advisory body” and making technical changes, amended Subsec. (d) by replacing references to the Secretary of the Office of Policy and Management and “representative appointed under subdivision (1)” with “cochairpersons”, replacing “commission” with “advisory body” and replacing “June 14, 2021” with “June 12, 2023”, amended Subsecs. (f) to (h) by replacing “commission” with “advisory body”, and further amended Subsec. (h) by replacing “hire” with “confirm the hire of”, and deleting reference to serving as administrative staff and provisions re serving at pleasure of the commission, requesting assistance in hiring executive director and hiring executive assistants, effective June 12, 2023.

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Sec. 19a-133b. Commission on Racial Equity in Public Health. Strategic plan re elimination of health disparities and inequities. (a) The Commission on Racial Equity in Public Health, established under section [19a-133a](#), shall develop and periodically update a comprehensive strategic plan to eliminate health disparities and inequities across sectors, including consideration of the following: Air and water quality, natural resources and agricultural land, affordable housing, infrastructure systems, public health, access to quality health care, social services, sustainable communities and the impact of climate change.

(b) Such plan shall address the incorporation of health and equity into specific policies, programs and government decision-making processes including, but not limited to, the following: (1) Disparities in laws and regulations impacting public health; (2) disparities in the criminal justice system; (3) disparities in access to resources, including, but not limited to, healthy food, safe housing, public safety and environments free of excess pollution; and (4) disparities in access to quality health care.

(c) Not later than January 1, 2024, as part of such plan, the commission shall report, using available scientifically based measurements, the rates of disparity in the state based on race and ethnicity, in the following areas: (1) Education indicators, including kindergarten entry inventory, third grade reading proficiency, scores on the mastery examination, administered pursuant to section [10-14n](#), rates of school-based discipline, high school graduation rates and retention rates after the first year of study for institutions of higher education in the state, as defined in section [3-22a](#); (2) health care utilization and outcome indicators, including health insurance coverage rates, pregnancy and infant health outcomes, emergency room visits and deaths related to conditions associated with exposure to environmental pollutants, including respiratory ailments, quality of life, life expectancy, lead poisoning and access to adequate healthy nutrition and self-reported well-being surveys; (3) criminal justice indicators, including rates of involvement with the justice system; and (4) economic indicators, including rates of poverty, income and housing insecurity. It shall be the goal of the state to attain at least a seventy per cent reduction in the racial inequities set forth in subdivisions (1) to (4), inclusive, of this subsection from the rates of disparities determined by the commission on or before January 1, 2024.

(d) Upon completion of the initial comprehensive strategic plan, and thereafter of any update to such plan, the commission shall submit the plan to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section [11-4a](#), and to any other joint standing committee of the General Assembly having cognizance of matters relevant to what is contained in such plan, as determined by the commission.

(P.A. 21-35, S. 3; P.A. 23-204, S. 189.)

History: P.A. 21-35 effective June 14, 2021; P.A. 23-204 amended Subsec. (c) by replacing references to “2022” with “2024”, “determine” with “report”, “percentages” with “rates”, “readiness” with “entry inventory” and “disparities” with “inequities” and inserting “and ethnicity” after “race”, effective June 12, 2023.

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Sec. 19a-133c. Commission on Racial Equity in Public Health. Best practices for state agencies re structural racism. (a) As used in this section, “structural racism” means a system that structures opportunity and assigns value in a way that disproportionately and negatively impacts Black, Indigenous, Latino or Asian people or other people of color, and “state agency” has the same meaning as provided in section [1-79](#). The Commission on Racial Equity in Public Health, established under section [19a-133a](#), shall recommend best practices for state agencies to (1) evaluate structural racism within their own policies, practices and operations, and (2) create and implement a plan, which includes the establishment of benchmarks for improvement, to ultimately eliminate any such structural racism within the agency.

(b) Not later than January 1, 2024, the commission shall submit a report, in accordance with the provisions of section [11-4a](#), to the joint standing committee of the General Assembly having cognizance of matters relating to government administration. Such report shall include the best practices recommended by the commission under this section and a recommendation on any legislation to implement such practices within state agencies.

(P.A. 21-35, S. 4; P.A. 23-204, S. 190; P.A. 24-68, S. 47.)

History: P.A. 21-35 effective June 14, 2021; P.A. 23-204 amended Subsec. (a) by replacing “determine” with “recommend” and Subsec. (b) by replacing “2023” with “2024” and “established” with “recommended”, effective June 12, 2023; P.A. 24-68 amended Subsec. (a) by making a technical change, effective May 28, 2024.

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Sec. 19a-133d. Educational materials re pulse oximeters. (a) For the purposes of this section:

- (1) “Health care provider” has the same meaning as provided in section [38a-477aa](#);
- (2) “Health carrier” has the same meaning as provided in section [38a-1080](#);
- (3) “Insured” has the same meaning as provided in section [38a-1](#);
- (4) “Pharmacist” has the same meaning as provided in section [38a-479aaa](#);
- (5) “Pharmacy” has the same meaning as provided in section [38a-479aaa](#); and
- (6) “Pharmacy benefits manager” has the same meaning as provided in section [38a-479aaa](#).

(b) Not later than January 1, 2022, the Department of Public Health, in consultation with the Insurance Department, shall develop educational materials to ensure that each health care provider, health carrier, pharmacist, pharmacy and pharmacy benefits manager doing business in this state is informed that a pulse oximeter is more likely to produce an inaccurate blood oxygen level reading for an insured who is an individual of color as opposed to an insured who is a white individual.

(c) Not later than July 1, 2022, the Department of Public Health shall:

(1) Post the educational materials developed pursuant to subsection (b) of this section on the department's Internet web site; and

(2) Distribute the educational materials developed pursuant to subsection (b) of this section to each:

(A) Health care provider;

(B) Pharmacy; and

(C) Medical school located in this state for dissemination to such school's students.

(P.A. 21-57, S. 1.)

History: P.A. 21-57 effective July 1, 2021.

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Sec. 19a-133e. Declaration of homelessness as a public health crisis. It is hereby declared that homelessness constitutes a public health crisis in this state and will continue to constitute a public health crisis until the right of homeless persons to receive emergency medical care, as guaranteed pursuant to subdivision (3) of subsection (b) of section [1-500](#), is adequately safeguarded and protected.

(P.A. 23-195, S. 16.)

History: P.A. 23-195 effective June 29, 2023.

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Sec. 19a-134. Regulations concerning the licensure of psychiatric residential facilities at Albert J. Solnit Children's Center. (a) The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, concerning licensure by the Department of Public Health of the psychiatric residential treatment facilities, as defined in subsection (q) of section [19a-490](#) at the Albert J. Solnit Children's Center.

(b) The commissioner may implement policies and procedures concerning the licensure of the psychiatric residential treatment facilities of the Albert J. Solnit Children's Center while in the process of adopting regulations pursuant to subsection (a) of this section, provided (1) notice of intent to adopt regulations is published on the eRegulations System not later than twenty days after the date of implementation of such policies and procedures, and (2) such policies and procedures are consistent with the proposed regulations. Any policies and procedures implemented under this subsection shall be valid until the time final regulations are adopted.

(June Sp. Sess. P.A. 21-2, S. 31.)

History: June Sp. Sess. P.A. 21-2 effective June 23, 2021.

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