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General Laws of Rhode Island

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\*\*\* Current through the January 2008 Session \*\*\*  
\*\*\* Annotations current through August 5, 2008 \*\*\*

TITLE 23. HEALTH AND SAFETY  
CHAPTER 10. TUBERCULOSIS

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*R.I. Gen. Laws § 23-10-1 (2008)*

§ 23-10-1. Report of tubercular cases by state institutions

The superintendent or other person in charge or control of any hospital, school, reformatory, or other institution, deriving the whole or any part of its support from the public funds of the state, having in charge or under its care or custody any person or persons suffering with tuberculosis, shall, within forty-eight (48) hours after recognition of that disease, make or cause to be made in the manner and form prescribed by the state department of health a record of the name, age, sex, color, race, occupation, social condition, and residence of the person or persons, so affected, together with any other appropriate information that may be demanded by the state department of health. That information shall be furnished on blanks supplied by the state department of health, and that information shall be forwarded each week to the office of the director of health, on those blanks. Any superintendent, or any other person, charged with any duty under this section who shall fail or refuse to comply with the requirements of this section shall be guilty of a misdemeanor and upon conviction shall be fined not more than twenty-five dollars (\$ 25.00).

**HISTORY:** G.L. 1896, ch. 96, § 11; P.L. 1909, ch. 386, § 1; G.L. 1923, ch. 153, § 11; G.L. 1938, ch. 255, § 9; P.L. 1939, ch. 713, § 1; G.L. 1956, § 23-10-1.

**NOTES:**

**CROSS REFERENCES.**

- Animals, tuberculosis in, § 4-5-1 et seq.
- Functions of department of health, § 42-18-1.
- Hospital or camp for tuberculosis, local authorization required, § 23-6-8.
- Reports and quarantine of disease, § 23-8-1 et seq.

**COMPARATIVE LEGISLATION.** Tuberculosis:

*CONN. Gen. Stat. § 19a-250 et seq.*

*MASS. Ann. Laws, ch. 111, §§ 77 et seq., 94A et seq.*

**COLLATERAL REFERENCES.** Excessiveness or adequacy of damages awarded for injuries causing particular diseases or conditions. *16 A.L.R.4th 736.*

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*R.I. Gen. Laws § 23-10-2 (2008)*

§ 23-10-2. Reports by physicians

Whenever any physician knows that any person under his or her professional care is affected with tuberculosis, he or she shall transmit to the director of the state department of health within seven (7) days, upon blanks provided by the state department of health for that purpose, the name, sex, age, color, race, occupation, social condition, and residence of that person. Any physician failing or refusing to comply with the requirements of this section shall be guilty of a misdemeanor and on conviction shall be subject to a fine of ten dollars (\$ 10.00).

**HISTORY:** G.L. 1896, ch. 96, § 12; P.L. 1909, ch. 386, § 1; G.L. 1923, ch. 153, § 12; G.L. 1938, ch. 255, § 10; P.L. 1939, ch. 713, § 1; G.L. 1956, § 23-10-2.

**NOTES:**

**CROSS REFERENCES.**

Communicable diseases, failure to report, § 23-8-1.

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*R.I. Gen. Laws § 23-10-3 (2008)*

§ 23-10-3. Prosecution of violations

It shall be the duty of the director of health to report to the prosecuting officers of the different cities and towns in this state any violation of the requirements of §§ 23-10-1 and 23-10-2, and it shall be the duty of the prosecuting officers of the several cities and towns to immediately obtain warrants for the apprehension of persons violating the requirements of §§ 23-10-1 and 23-10-2.

**HISTORY:** G.L. 1896, ch. 96, § 13; P.L. 1909, ch. 386, § 1; G.L. 1923, ch. 153, § 13; G.L. 1938, ch. 255, § 11; impl. am. P.L. 1939, ch. 660, § 180; G.L. 1956, § 23-10-3.

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*R.I. Gen. Laws § 23-10-4 (2008)*

§ 23-10-4. Register of tubercular cases

It shall be the duty of the state department of health to keep a register of all persons in this state known to be affected with tuberculosis. The state department of health shall have sole, exclusive control of that register and shall not permit its inspection nor disclose any of its personal particulars except to officials authorized under the laws of this state to receive that information.

**HISTORY:** G.L. 1896, ch. 96, § 10; P.L. 1909, ch. 386, § 1; G.L. 1923, ch. 153, § 10; G.L. 1938, ch. 255, § 8; P.L. 1939, ch. 713, § 1; G.L. 1956, § 23-10-4.

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*R.I. Gen. Laws § 23-10-5 (2008)*

§ 23-10-5. Transmission of reports to local agencies

The state department of health shall be authorized to submit reports of cases of tuberculosis which it receives and has on file in its register to city and town health departments and to other community agencies, voluntary and official, properly organized to receive those reports, capable of maintaining an adequate system of tuberculosis control within their respective communities.

**HISTORY:** G.L. 1938, ch. 255, § 15; P.L. 1939, ch. 713, § 2; G.L. 1938, ch. 255, § 151/2; P.L. 1941, ch. 1014, § 2; G.L. 1956, § 23-10-5.

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*R.I. Gen. Laws § 23-10-6 (2008)*

§ 23-10-6. Quarantine for treatment of actively or chronically diseased persons

(a) For the purposes of this section, a person has active tuberculosis when: (1) a sputum smear or culture taken from a pulmonary, laryngeal, or other source has tested positive for tuberculosis and the person has not completed an appropriate prescribed course of medication for tuberculosis, or (2) a smear or culture from an extra-pulmonary source has tested positive for tuberculosis and there is clinical evidence or clinical suspicion of pulmonary tuberculosis disease and the person has not completed an appropriate prescribed course of medication for tuberculosis. A person also has active tuberculosis when, in those cases where sputum smears or cultures are unobtainable, the radiographic evidence, in addition to current clinical evidence and/or laboratory tests, is sufficient to establish a medical diagnosis of tuberculosis for which treatment is indicated.

(b) Where the director determines that the public health or the health of any other person is endangered by a case of tuberculosis, or a suspected case of tuberculosis, the director may issue any appropriate orders necessary to protect the public health or the health of any other person in accordance with this chapter, and may make application to a court for enforcement of any appropriate orders. In any court proceeding for enforcement, the director shall demonstrate the particularized circumstances constituting the necessity for an order. Detention shall not be authorized until all less-restrictive alternatives have been tried and no less-restrictive alternative is available. Those orders may include, but shall not be limited to:

(1) An order authorizing the removal to and/or detention in a hospital or other treatment facility for appropriate examination for tuberculosis of a person who has active tuberculosis or who is suspected of having active tuberculosis and who is unable or unwilling to voluntarily submit to an appropriate examination by a physician or by the department;

(2) An order requiring a person who has active tuberculosis to complete an appropriate prescribed course of medication for tuberculosis and, if necessary, to follow required contagion precautions for tuberculosis;

(3) An order requiring a person who has active tuberculosis and who is unable or unwilling otherwise to complete an appropriate prescribed course of medication for tuberculosis to follow a course of directly observed therapy. For the purposes of this provision, "directly observed therapy" means a course of treatment for tuberculosis in which the prescribed anti-tuberculosis medication is administered to the person or taken by the person under direct observation as specified by the department;

(4) An order for the removal to and/or detention in a hospital or other treatment facility of a person: (i) who has active tuberculosis that is infectious or who presents a substantial likelihood of having active tuberculosis that is infectious, based upon epidemiologic evidence, clinical evidence, x-ray readings, or laboratory test results; and (ii) where the department finds, based on recognized infection control principles, that there is a substantial likelihood the person may transmit to others tuberculosis because of his or her inadequate separation from others; or

(5) An order for the removal to and/or detention in a hospital or other treatment facility of a person: (i) who has active tuberculosis, or who has been reported to the department as having active tuberculosis with no subsequent report

to the department of the completion of an appropriate prescribed course of medication for tuberculosis; and (ii) where there is a substantial likelihood that the person poses a significant risk of harm to others and who refuses to report for treatment or who refuses to continue or complete treatment for tuberculosis, until the director determines that the person is no longer a danger to the public.

(c) After two (2) licensed physicians, including at least one board certified pulmonary or infectious disease specialist, have certified the diagnosis of tuberculosis, the director may remove to or detain in a hospital or other place for examination or treatment a person who is the subject of an order of removal or detention issued pursuant to subsection (a) without prior court order; provided, however, that when a person detained pursuant to subsection (a) has requested release, the director shall make an application for a court order authorizing detention within seventy-two (72) hours after a release request, or, if the seventy-two (72) hour period ends on a Saturday, Sunday or legal holiday, by the end of the first business day following the Saturday, Sunday or legal holiday, which application shall include a request for an expedited hearing. In the event that the detained person requests release thereby triggering this seventy-two (72) hour expedited hearing, the hearing shall be a preliminary hearing, shall be treated with priority on the court calendar, and may be continued only for good cause shown. If at this preliminary hearing the court determines that there is no probable cause to support detention, the director's petition shall be dismissed, the director's order vacated, and the person shall be discharged unless the person applies for voluntary admission to care and treatment. However, if the court is satisfied that there is probable cause to support the director's order, the director's order shall remain in full force and effect and the full hearing procedures as set forth at subsection (h) shall be effectuated. In any event, detention shall not continue for more than five (5) business days in the absence of a court-order authorizing detention. The court order shall be sought by the director pursuant to the hearing procedures as set forth at subsection (h). The director shall seek further court review of detention within forty-five (45) days following the initial court order authorizing detention and subsequently within forty-five (45) days of each subsequent court review. In any court proceeding to enforce a director's order for the removal or detention of a person issued pursuant to this chapter or for review of the continued detention of a person, the director shall prove the particularized circumstances constituting the necessity for detention by clear and convincing evidence. Any person who is subject to a detention order shall have the right to be represented by counsel and upon the request of the person, counsel shall be provided by the court. The person subject to detention shall be entitled to file a petition for release at any time, included but not limited to, a petition based upon compliance with therapy and a plan to complete therapy in another less restrictive setting.

(d) (1) An order of the director pursuant to subsection (b) shall set forth;

- (i) The legal authority under which the order is issued, including the particular sections of this chapter;
- (ii) An individualized assessment of the person's circumstances and/or behavior constituting the basis for the issuance of the order;
- (iii) The less restrictive treatment alternatives that were attempted and were unsuccessful and/or the less restrictive treatment alternatives that were considered and rejected, and the reasons those alternatives were rejected.

(2) In addition, an order for the removal and detention of a person shall:

- (i) Include the purpose of the detention;
- (ii) Advise the person being detained that he or she has the right to request release from detention by contacting a person designated on the director's order at a telephone number stated on the director's order, and that the detention shall not continue for more than five (5) business days after a release request in the absence of a court order authorizing the detention;
- (iii) Advise the person being detained that, whether or not he or she requests release from detention, the director must obtain a court order authorizing detention within five (5) days following the commencement of detention and thereafter must further seek court review of the detention within forty-five (45) days of the court order, and within forty-five (45) days of each subsequent court review;
- (iv) Advise the person being detained that he or she has the right to arrange to be represented by counsel or to have counsel appointed, and that if he or she chooses to have counsel appointed, the counsel will be notified that the person has requested legal representation.

(e) A person who is detained solely pursuant to subsection (b)(1) shall not continue to be detained beyond the minimum period of time required, with the exercise of all due diligence, to make a medical determination of whether a

person who is suspected of having tuberculosis has active tuberculosis or whether a person who has active tuberculosis is infectious. Further detention of the person shall be authorized only upon the issuance of a director's order pursuant to subsection (b)(4) or (b)(5);

(f) A person who is detained pursuant to this section solely for the reasons described in subsection (b)(4) shall not continue to be detained after the department ascertains that changed circumstances exist that permit him or her to be adequately separated from others so as to prevent transmission of tuberculosis after his or her release from detention or that a less-restrictive alternative to the detention is established.

(g) A person who is detained pursuant to this section for the reasons described in subsection (b)(5) shall not continue to be detained after he or she has completed an appropriate prescribed course of medication.

(h) (1) A verified petition may be filed in the district court, or family court in the case of a person who has not reached his or her eighteenth (18th) birthday, for the detention to a facility of any person who is subject to an order of the director pursuant to subsection (b). The petition may be filed by the director and shall be filed only after the petitioner has investigated what alternatives to detention are available and determined why the alternatives are not deemed suitable.

(2) A hearing scheduled under this section shall be conducted pursuant to the following requirements:

(i) All evidence shall be presented according to the usual rules of evidence that apply in civil, non-jury cases. The subject of the proceedings shall be given the right to present evidence in his or her own behalf, and to cross-examine all witnesses against him or her, including any physician who has certified the diagnosis of tuberculosis pursuant to subsection (c) of this section. The subject of the proceedings shall have the further right to subpoena witnesses and documents, the cost of subpoenaing witnesses and documents to be borne by the court where the court finds upon an application of the subject that the person cannot afford to pay for the cost of subpoenaing witnesses and documents.

(ii) A verbatim transcript or electronic recording shall be made of the hearing which shall be impounded and obtained or examined only with the consent of the subject of the hearing (or in the case of a person who has not yet attained his or her eighteenth (18th) birthday, his or her parent, guardian, or next of kin) or by order of the court.

(iii) The hearing may be held at a location other than a court, including any facility where the subject may then be a patient, where it appears to the court that holding the hearing at another location would be in the best interests of the subject of the hearing or any participants in the hearing.

(iv) The burden of proceeding and the burden of proof in a hearing held pursuant to this section shall be upon the petitioner. The petitioner has the burden of demonstrating that the subject of the hearing is in need of care and treatment in a facility, is one whose continued unsupervised presence in the community would create a likelihood of serious harm, and what alternatives to detention are available, what alternatives to detention were investigated, and why these alternatives were not deemed suitable.

(v) The court shall render a decision within forty-eight (48) hours after the hearing is concluded.

(3) If the court after a hearing finds by clear and convincing evidence that the subject of the hearing is in need of care and treatment in a facility, and is one whose continued unsupervised presence in the community would create a likelihood of serious harm, and that all alternatives to detention have been investigated and deemed unsuitable, it shall issue an order committing the person to the custody of the director for care and treatment in an appropriate facility. The person shall be cared for in a facility that imposes the least restraint upon the liberty of the person consistent with affording him or her the care and treatment necessary and appropriate to his or her condition. All detention orders shall be reviewed by the court within forty-five (45) days of the court order, and within forty-five (45) days of each subsequent court review.

(4) (i) A person detained under this section shall have a right to appeal from a court order of detention to the supreme court of the state within thirty (30) days of the entry of an order of detention. The person shall have the right to be represented on appeal by counsel of his or her choice or by court appointed counsel if the supreme court finds that he or she cannot afford to retain counsel. Upon a showing of indigency the supreme court shall permit an appeal to proceed without payment of costs, and a copy of the transcript of the proceedings below shall be furnished to the subject of the proceedings or to his or her attorney at the expense of the state. The court which issued the detention order shall advise the person of all his or her rights pursuant to this section immediately upon the entry of the detention order.

(ii) Appeals under this section shall be given precedence, insofar as practicable, on the supreme court dockets. The district and family courts shall promulgate rules with the approval of the supreme court to insure the expeditious transmission of the record and transcript in all appeals pursuant to this chapter.

(i) Where necessary, language interpreters and persons skilled in communicating with vision and hearing impaired individuals shall be provided.

(j) The provisions of this section shall not be construed to permit or require the forcible administration of any medication without a prior court order.

(k) No person, for religious or other reasons, may be compelled by the department of health to undergo treatment for tuberculosis as long as the individual is willing to place himself or herself in an environment that excludes others from risk of acquiring tuberculosis.

(l) The director of health shall ensure that appropriate treatment, monitoring, and care for tuberculosis are made available for every individual who is isolated and confined, and these services shall be provided with no restrictions as to the quarantined individual's ability to pay for those services.

(m) The department of health is authorized to promulgate rules and regulations in order to implement and enforce the provisions of this chapter.

**HISTORY:** P.L. 1993, ch. 253, § 5; P.L. 1993, ch. 406, § 3.

**NOTES:**

**COLLATERAL REFERENCES.** Determination of indigency entitling accused in state criminal case to appointment of counsel on appeal. *26 A.L.R. 5th 765.*



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*R.I. Gen. Laws § 23-10-7 (2008)*

§ 23-10-7. Laboratory culture for tuberculosis

All biological samples or specimens taken from Rhode Island residents for the purpose of performing laboratory culture for tuberculosis (*Mycobacterium tuberculosis*) or for determining antibiotic sensitivities of cases of tuberculosis, by or under the direction or order of any physician licensed to practice medicine in this state, shall be sent to the Rhode Island department of health laboratory for analysis. Those biological samples or specimens may be split at the time of procurement to permit one portion of the sample or specimen to be sent to the department of health laboratory for analysis and the other portion to be analyzed at another appropriately credentialed laboratory. In the case of split samples or specimens, third party payers shall pay both the department of health laboratory and the appropriately credentialed laboratory for analyzing those samples or specimens. The department of health shall waive the requirement for samples or specimens to be sent to the department of health laboratory and shall establish a written memorandum of agreement with any appropriately credentialed laboratory which can meet or exceed the most current laboratory standard of practice for tuberculosis testing, including maximum turnaround time.

**HISTORY:** P.L. 1994, ch. 374, § 1.

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WEIL'S CODE OF RHODE ISLAND RULES  
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\*\*\* THIS DOCUMENT REFLECTS CHANGES THROUGH DECEMBER 2008 \*\*\*

AGENCY 14. DEPARTMENT OF HEALTH  
 SUB-AGENCY 040. COMMUNICABLE DISEASE  
 CHAPTER 002. REPORTING OF COMMUNICABLE, ENVIRONMENTAL AND OCCUPATIONAL DISEASES

*CRIR 14-040-002 (2008)*

14 040 002. REPORTING OF COMMUNICABLE, ENVIRONMENTAL AND OCCUPATIONAL DISEASES

INTRODUCTION

These Rules and Regulations Pertaining to Reporting of Communicable, Environmental and Occupational Diseases (R23-10-DIS) are promulgated pursuant to the authority set forth in Chapters 23-5, 23-6, 23-10, 23-11, 23-24.6, and 23-24.5 and *sections 23-1-18 (2) and 23-8-1, of the General Laws of Rhode Island*, as amended, and are established for the purpose of adopting standards pertaining to confidentiality and reporting of communicable, occupational and environmentally related diseases in this state. Surveillance data will be used to initiate appropriate public health responses.

Pursuant to the provisions of *section 42-35-3(c) of the General Laws of Rhode Island*, as amended, consideration was given to: (1) alternative approaches to the regulations; and (2) duplication or overlap with other state regulations. No alternative approach, overlap or duplication nor any significant economic impact was identified, consequently the regulations are adopted in the best interest of the health, safety and welfare of the public.

These rules and regulations shall supersede all previous Rules and Regulations Pertaining to Reporting of Communicable and Environmentally Related Diseases, and all previous Rules and Regulations Pertaining to Reporting of Communicable, Environmental and Occupational Diseases (R23-5-6,10,11,24.6-CD/ERD and R23-24.5 ASB) promulgated by the Department of Health and filed with the Secretary of State.

PART I

Definitions and Reporting Requirements

Section 1.0 Definitions.

Wherever used in these rules and regulations, the following terms shall be construed as follows:

1.1 "Asbestos" means that unique group of naturally occurring minerals that separate into fibers of high tensile strength, resistant to heat, wear and chemicals, described as the following types: chrysotile, amosite, crocidolite, tremolite, anthophyllite, and actinolite, and every product containing any of these materials that have been chemically treated and/or altered which after manufacture are used for such products and end uses including but not limited to insulation, textiles, paper, cement, sheets, floor tile, wall covering, decorations, coating, sealants, cement pipe and reinforced plastics and other compounds.

1.2 "Asbestos-related disease" is any illness or disease, other than for benign conditions of the pleura, suspected of being related to asbestos exposure, including, but not limited to, mesothelioma, asbestosis and lung cancer believed to be caused by asbestos exposure.

1.3 "Carrier" means a person or animal that harbors a specific infectious agent without discernible clinical disease and serves as a potential source of infection.

1.4 "Case" or "patient" means the one who is ill, infected, injured or diagnosed with a reportable disease or injury.

1.5 "Clinical laboratory" means a facility for the biological, microbiological, serological, chemical, immunohematological, hematological, radiobioassay, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of human beings, pursuant to Chapter 23-16.2 of the Rhode Island General Laws, as amended, entitled "Laboratories."

1.6 "Communicable disease" means an illness due to a specific infectious agent or its toxic products that arises through transmission of that agent or its products from an infected person, animal or inanimate reservoir to a susceptible host.

1.7 "Department" means the Rhode Island Department of Health.

1.8 "Director" means the Director of Health.

1.9 "Disease report" means an official notice to the appropriate authority of the occurrence of a specified disease in humans or animals, in accordance with the requirements stated herein.

1.10 "Disease surveillance" means the practice of monitoring the occurrence and spread of disease. Included are the systematic collection and evaluation of: morbidity and mortality reports; special reports of field investigations, epidemics and individual cases; isolations and identifications of infectious agents in laboratories; data concerning the availability and use of vaccines; immune globulin, pesticides and other substances used in disease control; information regarding immunity levels in segments of the population, and of other relevant epidemiologic data. The procedure applies to all jurisdictional levels of public health, from local to international.

1.11 "Incidence" means a term used to characterize the frequency of new occurrences of a disease, infection, or other event over a period of time and in relation to the population in which it occurs. Incidence is expressed as a rate, commonly the number of new cases during a prescribed time in a unit of population. For example, one refers to the number of new cases of tuberculosis per 100,000 population per year.

1.12 "Laboratory test diagnostic of HIV infection" means a laboratory test approved by the U.S. Food and Drug Administration, performed by a clinical laboratory that indicates the presence of antibody to HIV, HIV structural components, or HIV ribonucleic acid in blood and other body fluid.

1.13 "Manufacturers' associated laboratory", as used herein, means a specialized laboratory that performs initial and confirmatory HIV testing, when approved to do so by the Department.

1.14 "Occupational disease" means a disease or condition which is believed to be caused or aggravated by conditions in the individual's workplace.

1.15 "Outbreak or cluster" means the occurrence in a community or region of cases of an illness clearly in excess of the number of cases normally expected.

1.16 "Perinatal case report for HIV" means the information that is provided to the Department related to a child aged less than eighteen (18) months of age born to an HIV-infected mother where the child does not meet the criteria for HIV infection or the criteria for "not infected" with HIV as defined in the most current surveillance case definition for HIV infection published by the federal CDC (Centers for Disease Prevention and Control).

1.17 "Physician" means any individual licensed to practice medicine in this state under the provisions of Chapter 5-37 of the General Laws of Rhode Island, as amended (i.e., M.D.s and D.O.s).

1.18 "Poisoning (food)" means a poisoning that results from eating foods contaminated with toxins. These toxins may occur naturally, as in certain mushrooms or seafoods; they may be chemical or biologic contaminants; or they may be metabolic products of infectious agents that are present in the food.

## Section 2.0 Reporting Requirements.

The HIPAA Privacy Rule expressly permits disclosures without individual authorization to public health authorities authorized by law to collect or receive the information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, public health surveillance, investigation, and intervention (see reference 19 herein).

### Responsibility for Reporting

2.1 The diseases listed in these regulations shall be reported in the manner set forth in the regulations herein. Reporting of diseases listed in these regulations is required and is the responsibility of the following:

- Physicians attending the case or suspected case or his/her designee;
- Physician assistants, certified registered nurse practitioners, and midwives;

-- Clinical laboratories;

-- Hospitals (from both inpatient and outpatient settings); When a diagnosis or suspected diagnosis of a case is made within a hospital, the facility administrator, or his/her designee (e.g., infection control practitioner), is charged with the responsibility of ensuring the reporting of the case in accordance with the procedures outlined herein.

-- All other health care facilities (i.e., organized ambulatory care facility, schoolbased health center, freestanding emergency care facility, home care/home nursing care provider, hospice, birth center, nursing facility, rehabilitation hospital center, freestanding ambulatory surgical center, kidney disease treatment center, physician office setting providing surgical treatments office operator ); When a diagnosis or suspected diagnosis of a case is made within a licensed health care facility, the facility administrator or medical director, or his/her designee (e.g., infection control practitioner), is charged with the responsibility of ensuring the reporting of the case in accordance with the procedures outlined herein.

-- Veterinarians who have knowledge of a single case of rare and unusual veterinary diagnosis that relates to or has the potential to cause illness in humans and/or clusters or outbreaks of unusual zoonotic vectorborne diseases that can cause illness in humans;

2.2 Reporting of diseases listed in these regulations is recommended by and the responsibility of the following:

-- Certified school nurse-teachers who have knowledge of a single case of rare and unusual diagnoses and/or clusters or outbreaks of unusual diseases or illnesses;

-- Dentists who have knowledge of a single case of rare and unusual diagnoses and/or clusters or outbreaks of unusual diseases or illnesses;

-- Other entities or persons (such as college/university health centers, day care centers, drug treatment facilities, prison health services, travel clinics, social service agencies that serve the homeless, school health centers that treat students in grades K--12 , camp counselors, funeral directors, transportation authority etc.) who have knowledge of a single case of rare and unusual diagnoses and/or clusters or outbreaks of unusual diseases or illnesses.

Exemptions

2.3 Reporting of the diseases listed in these regulations shall not be required in the following cases:

1. When laboratory tests are performed for insurance purposes (i.e., non-diagnostic testing) and

2. In research protocols where the person conducting the research is unaware of the identity of the person being tested. (In cases where the identity of the person being tested is known to the person conducting the research, the provisions of these regulations shall apply).

Public Health Response to Disease Reports

2.4 Any disease reported shall initiate a public health response by the provider and/or the Department in keeping with recommendations that are provided in the Guidelines for Communicable Disease Prevention and Control issued by the Rhode Island Department of Health, Center for Epidemiology and Infectious Disease.

Reporting of Outbreaks or Clusters

2.5 Any person who is required or recommended to report (cited in sections 2.1 herein) and has knowledge of an outbreak of infectious disease or a cluster of unexplained illness, infectious or non-infectious, whether or not listed in these regulations, shall promptly report the facts to the Department of Health. Exotic diseases and unusual group expressions of illness which may be of public health concern shall also be reported immediately. The number of cases indicating an outbreak or cluster will vary according to the infectious agent or the conditions/hazards, size and type of population exposed, previous experience or lack of exposure to the disease, and time and place of occurrence. A single case of a communicable disease long absent from a population or the first invasion by a disease not previously recognized in that area requires immediate reporting and epidemiologic investigation; two (2) cases of such a disease associated in time and place are sufficient evidence of transmission to be considered an outbreak. Outbreaks or clusters are therefore identified by significant increases in the usual incidence of the disease in the same area, among the specified population, at the same season of the year. Some examples of outbreaks are as follows: 1. Foodborne poisoning: the occurrence of two (2) or more cases of a similar illness resulting from the ingestion of a common food; 2. Institutional: cluster of similar illness in institutional settings, such as nursing homes, hospitals, schools, day care

centers, etc.; 3. Waterborne: at least two (2) persons experiencing a similar illness after ingestion of a common water source and epidemiologic evidence that implicates water as the probable source of the illness; 4. A single case of rare and unusual diagnoses, such as avian influenza, smallpox, ebola, SARS, or human rabies; 5. Outbreaks of unusual diseases or illness that may indicate acts of terrorism using biological agents, such as anthrax, botulism, ricinosis, epsilon toxin of *Clostridium perfringens*, and *Staphylococcus enterotoxin B* and 6. any condition compatible with exposure to nuclear, radiological, or chemical substances, which could be indicative of radiological or chemical terrorism events shall also be reportable.

#### Confidentiality Provisions

2.6 All information concerning cases or suspected cases shall be held in confidence in accordance with the provisions of Chapter 5-37.3 of the Rhode Island General Laws, as amended, ("Confidentiality of Health Care Communications and Information Act"), all other applicable state and federal statutes and regulations, and the HIV/AIDS Confidentiality and Security Policy of the Office of HIV/AIDS & Viral Hepatitis of the Rhode Island Department of Health.

#### Mechanism for Reporting

2.7 Clinical providers of care responsible for reporting shall use the most current electronic or paper version of the Rhode Island Department of Health Disease Report Form, if other specialized forms are not available. Reporting shall be via secured e-mail, telephone, facsimile, U.S. mail, or other secured electronic means of communication (such as web based systems), as approved by the Department.

2.8 Specialized report forms for communicable disease reporting may be obtained online: [www.health.ri.gov](http://www.health.ri.gov) by calling 401-222-2577, or by writing to the Center for Epidemiology and Infectious Disease, Room 106, Three Capitol Hill, Providence, RI 02908.

## PART II

### Reportable Diseases and Disease Surveillance Projects

#### Section 3.0 Reportable Diseases and Timeframe for Reporting.

3.1 The lists cited below\* pertain to individuals and facilities required or recommended to report (see section 2.1 herein). A case shall be reported to the Department of Health, Center for Epidemiology and Infectious Disease, 3 Capitol Hill, Room 201, Providence RI 02908-5097, within four (4) working days following diagnosis, except those diseases that shall be reported immediately upon recognition or strong suspicion of disease cited in bold text below. Laboratory confirmation is not necessary prior to reporting those diseases that are required to be reported immediately (by fax to 401-222-2488 or by phone to 401-222-2577 during working hours/401-272-5952 after hours, or by other prescribed secured electronic means).

\* Note that some conditions appear under more than one heading.

#### Invasive Diseases (Bacterial and Other Pathogens)

(Invasive disease: confirmed by isolation from blood, CSF, pericardial fluid, pleural fluid, peritoneal fluid, joint fluid, or other normally sterile site).

Encephalitis (primary, including arboviral, or parainfectious)

H. influenzae disease, all serotypes

Listeriosis

Meningitis (aseptic, bacterial, viral, or fungal)

Meningococcal disease (invasive)

Pneumococcal disease (invasive)

Streptococcal disease: all invasive disease caused by Groups A and B streptococci (including necrotizing fasciitis)

Streptococcal Toxic Shock Syndrome

Toxic Shock Syndrome

CRIR 14-040-002

Vancomycin resistant/intermediate Staphylococcus aureus (VRSA/VISA) infection

Tuberculosis

Tuberculous disease caused by Mycobacterium tuberculosis--all sites

PPD positives (Latent Tuberculosis Infection or LTBI) in all age groups must be reported.

Vaccine Preventable Diseases

Death resulting from complications of varicella

Varicella

Diphtheria

Hepatitis B surface antigen (HbsAg) positive pregnant women

Influenza associated pediatric deaths (<18 years age)

Influenza associated hospitalizations

Measles

Mumps (no longer 24-hour reportable)

Pertussis (no longer 24-hour reportable)

Poliomyelitis

Rubella (including congenital rubella) (no longer 24-hour reportable)

Tetanus

Blood Borne Pathogens

Acquired Immunodeficiency Syndrome (AIDS)

Hepatitis B, C, D, E, and unspecified viral hepatitis

(Also report AST, ALT, and bilirubin.)

Physicians must report acute cases, only. Laboratories shall report all positive results.

HIV-1 or HIV-2 infection

Name reporting shall be required on confirmatory laboratory testing forms and a unique identifier shall be required for anonymous testing. All case reports for HIV shall have names.

Sexually Transmitted Diseases

Chancroid

Chlamydia Trachomatis (genital and ophthalmic)

Gonorrhea

Granuloma Inguinale

Lymphogranuloma Venereum

Pelvic inflammatory disease (PID): all cases, based upon clinical diagnosis

Syphilis, late latent

Syphilis: primary, secondary, early latent

Vectorborne and Zoonotic Diseases

Babesiosis

Dengue fever

Ehrlichiosis  
Hantavirus Pulmonary Syndrome  
Leptospirosis  
Lyme disease  
Malaria  
Ornithosis (psittacosis)  
Rabies (human)  
Rocky Mountain Spotted Fever  
Trichinosis  
Yellow fever  
Enteric Diseases  
Amebiasis  
Botulism  
Campylobacteriosis  
Cholera  
Ciguatera poisoning  
Cryptosporidiosis  
Cyclosporiasis  
Enterohemorrhagic E. coli (including E. coli O157:H7)  
Giardiasis  
Hepatitis A (IgM positive, report liver function tests as well)  
Paralytic shellfish poisoning  
Salmonellosis  
Scombroid poisoning  
Shigellosis  
Typhoid fever  
Vibrio vulnificus or V. parahaemolyticus infection  
Yersiniosis  
Agents of Bioterrorism  
Anthrax (includes detection of gram positive rods in CSF, blood or other normally sterile site)  
Botulism  
Brucellosis  
Clostridium perfringens epsilon toxin poisoning  
Glanders  
Plague  
Q-fever

Ricin poisoning

Smallpox

Staphylococcal enterotoxin B poisoning

Tularemia

Viral hemorrhagic fevers (Ebola, Lassa, Marburg, etc)

Other Conditions

Animal bites

Coccidioidomycosis

Hansen's disease (leprosy)

Hemolytic uremic syndrome (HUS)

Legionellosis

Outbreaks and clusters (see section 1.15 herein)

Toxic Shock Syndrome

Transmissible spongiform encephalopathies (including Creutzfeldt Jakob Disease)

Unexplained deaths possibly due to unidentified infectious causes

Vancomycin resistant/intermediate Staphylococcus aureus (VRSA/VISA), noninvasive, or invasive.

Special Disease Surveillance Projects

3.2 Surveillance related to special and/or complex surveillance systems (e.g., West Nile Virus, latent TB infection, influenza, new and emerging disease threats, evaluation and validation projects related to surveillance) may be conducted in accordance with customized guidance issued by the Rhode Island Department of Health, Center for Epidemiology and Infectious Disease. Surveillance systems may be developed and required to prepare for or respond to public health threats on an ad-hoc basis, at any time.

Section 4.0 Special Instructions for Persons Responsible for Reporting (Excluding Laboratories).

Special instructions for Reporting LTBI

4.1 LTBI shall be reported on the LTBI Reporting Form, provided by the Center for Epidemiology and Infectious Disease.

Special Instructions for Reporting of Acquired Immunodeficiency Syndrome Cases (AIDS/HIV)

4.2 Persons with a laboratory test diagnostic of HIV infection shall be reported by those persons charged with reporting (cited in section 2.1 herein). Such HIV infection shall be reported by name and include all other information on the reporting form.

4.3 AIDS cases (HIV positive persons with AIDS-defining conditions as outlined in the Appendix of the most recent version of the CDC guidelines entitled, (Guidelines for National Human Immunodeficiency Virus Case Surveillance, Including Monitoring for Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome) shall be reported by name, within two (2) weeks of diagnosis, to the Office of HIV/AIDS & Viral Hepatitis, Surveillance Unit. This includes persons with a CD4+ T-lymphocyte count less than 200 cells/uL or a CD4+ lymphocyte percent less than fourteen percent (14%) of total lymphocytes.

4.4 HIV-1 and HIV-2 cases, including perinatal case reports for HIV, as defined in section 1.16 herein, shall be reported on the most recent version of the AIDS/HIV Case Report form, within two (2) weeks of diagnosis. This form shall be mailed in a stamped envelope marked "CONFIDENTIAL" and clearly addressed to the Office of HIV/AIDS & Viral Hepatitis Surveillance Unit.

Special Instructions for Reporting Sexually Transmitted Diseases (STDs)

4.5 Physicians must report gonorrhea, chlamydia and syphilis with details of treatment and partner notification activities on the Confidential Report for Sexually Transmitted Diseases form.

#### Section 5.0 Reporting by Laboratories.

5.1 Whenever a clinical laboratory performs tests or has the sample(s) tested out of state for those diseases cited in section 3.1 above, the laboratory shall submit to the Center for Epidemiology and Infectious Disease all positive findings. Certain negative laboratory results shall be reportable to the Department as deemed essential and necessary to maintain the health, safety and welfare of the community. The Department shall specify those laboratory reports that will require negative reporting of results via published guidelines (see reference 18 herein).

The report shall consist of a copy of the laboratory findings submitted to the physician or other licensed health care professional who ordered the test. This report shall indicate the name of the case, address of the case's residence, gender, date of birth, or if unavailable, age, telephone number, attending physician's name, and race and ethnicity of the case. (See reference 18 herein).

5.2 All laboratories must send an isolate, culture, slide or other appropriate specimen to the State Laboratory in accordance with the requirements of the most current version of the Rhode Island Epidemiology and Laboratory Reporting and Surveillance Manual issued by the Center for Epidemiology and Infectious Disease and State Health Laboratories (See reference 18).

#### Laboratory Testing and Reporting for Agents of Bioterrorism

5.3 Clinical laboratories receiving biological specimens that are suspected to contain agents of bioterrorism, even if a bioterrorist event is not suspected, shall perform testing or refer such specimens to the State Health Laboratory for analysis in accordance with the most current Lab Response Network (LRN) protocols. Clinical laboratories that isolate a potential agent of bioterrorism from a clinical specimen shall perform testing in accordance with the most current LRN Sentinel Laboratory protocol and shall submit the isolate to the State Health Laboratory for confirmation or further testing in accordance with the current Rhode Island LRN protocol.

5.4 Clinical laboratories that receive biological specimens that are suspected to contain agents of bioterrorism, or that isolate a potential agent of bioterrorism from a clinical specimen, shall immediately report such receipt or findings to the Department's Center for Epidemiology and Infectious Disease by telephone. If the specimen is received after normal Department business hours, the Department's after-hours on-call physician shall be informed.

#### Laboratory Reporting of Cultures for Tuberculosis

5.5 Clinical laboratories receiving biological samples or specimens for the purposes of tuberculosis testing must submit a portion of the specimen to the State Health Laboratory for analysis. Such specimens may be split to allow a portion to be analyzed at the clinical laboratory. This requirement is waived for a licensed hospital laboratory, provided a written memorandum of agreement is in place between the State Laboratory and the hospital laboratory.

5.6 A clinical laboratory performing AFB smears and/or cultures and sensitivities, or having the samples tested out of state, shall report positive results to the Center for Epidemiology and Infectious Disease, Department of Health. Positive culture results must be accompanied by all prior AFB smear results associated with the current episode of illness on the individual whether positive and negative.

#### HIV Testing and Reporting by Clinical Laboratories

5.7 Non-hospital clinical laboratories receiving serum specimens for the purposes of HIV antibody testing must submit a portion of the specimen to the State Health Laboratory for analysis. This requirement is waived for the testing of initial samples (e.g., ELISA) at a hospital laboratory, provided testing is done at the hospital laboratory. This requirement is also waived when the specimens are analyzed for the sole purpose of assuring the safety of the blood supply or for strictly research purposes. Testing sites using alternative, FDA approved methods of testing (e.g., rapid testing) may send confirmatory samples to manufacturers' associated laboratories upon receiving written permission from the Department to do so. Otherwise, all confirmatory testing shall be done by the State Health Laboratory.

5.8 Clinical laboratories performing (or having the samples tested in reference laboratories) for HIV viral loads and CD-4 lymphocyte counts shall report counts less than 200/uL, or less than fourteen percent (14%) of the total lymphocytes as well as any positive results of viral load tests by name directly to the Office of HIV/AIDS & Viral Hepatitis Surveillance Unit at the Department.

5.9 All licensed laboratories receiving and testing biological specimens for the purposes of HIV/AIDS testing shall report positive results to the Office of HIV/AIDS & Viral Hepatitis, regardless of the testing method being used.

### PART III

#### Other Diseases

##### Section 6.0 Childhood Lead Poisoning.

##### Reporting of Cases of Childhood Lead Poisoning

6.1 Any physician or employee of a licensed health care facility acting within the scope of his/her practice in making the diagnosis of childhood lead poisoning shall report such diagnosis to the Department within ten (10) business days using a form approved by the Department or by any other reporting method approved by the Department.

6.2 Utilization of the Department Laboratory shall constitute compliance with these reporting requirements.

##### Reporting by Laboratories:

6.3 Whenever a laboratory has the blood lead diagnostic sample(s) tested out-of-state for childhood lead poisoning, the laboratory shall submit to the Division of Family, Community Health, and Equity all positive and negative findings. If submitted electronically, these reports shall be in accordance with Rhode Island Department of Health standards for electronic reporting of blood lead results.

##### Section 7.0 Occupational Diseases.

7.1 Every physician licensed pursuant to the provisions of Chapter 5-37 or other person charged with reporting (cited in section 2.1 herein) attending on or called in to visit a patient whom he/she believes to be suffering from the following occupational diseases shall report such occurrences to the Rhode Island Department of Health.

7.1.1 Diseases diagnosed as being related to occupational exposures to any of the following substances:

- arsenic
- cadmium
- carbon monoxide
- lead (defined as  $\geq 25\mu\text{g}/\text{dl}$ )
- mercury

7.1.2 Any of the following occupational diseases:

- metal fume fever
- simple asphyxiation
- silicosis

7.2 Whenever a laboratory performs an analysis for, or has a blood sample tested out-of-state for a blood lead level in a person age sixteen (16) or over, the laboratory shall submit to the Department all results. The report, which shall be submitted electronically or in hard copy, shall consist of a copy of the laboratory result submitted to the physician or other person charged with reporting (cited in section 2.1 herein) who ordered the test.

##### Occupational Disease Reporting

7.3 The physician, or other person charged with reporting (cited in section 2.1 herein), immediately on being called in to visit a patient with carbon monoxide intoxication or simple asphyxiation and within thirty (30) days of attending on or being called in to visit a patient with any illness or condition specified in section 7.1 shall report the following information to the Rhode Island Department of Health:

- a) Name, address, phone number and occupation of patient;
- b) Name, address, phone number and business of employer;
- c) Nature of disease;
- d) Such other information as may be reasonably required by the Department of Health;

e) Name and phone number of the reporting physician or other person charged with reporting (cited in section 2.1 herein).

7.4 The Department of Health shall prepare and furnish standard schedule blanks for the reports required in this section.

#### Section 8.0 Asbestos-Related Disease.

##### Responsibility for Reporting

8.1 Any physician, facility administrator or other person charged with reporting (cited in section 2.1 herein) associated with making the diagnosis of mesothelioma, asbestosis, or any other asbestos-related disease, other than benign conditions of the pleura, shall report the disease to the Director of Health within six (6) months of the diagnosis.

8.2 The physician or licensed medical facility involved shall also inform the patient or patient's next-of-kin in a dated letter by first-class mail of the suspected role of asbestos as it relates to the patient's condition.

8.3 Reporting of asbestos-related diseases, such as asbestosis or any illness or disease suspected as being due to asbestos exposure, other than benign conditions of the pleura, shall be accomplished through the use of confidential reports of occupational disease, which shall be mailed directly by the attending physician or licensed health care facility to the Rhode Island Department of Health. The asbestos-related disease, mesothelioma, is also reportable under the provisions of the Rules and Regulations Pertaining to the Rhode Island Cancer Registry (R-23-12-CA).

8.4 Such reports of occupational disease are supplied by the Rhode Island Department of Health.

#### Section 9.0 Non-occupational Acute Carbon Monoxide Poisoning.

9.1 In addition to the requirements of Section 7.3 regarding the reporting of occupational carbon monoxide (CO) intoxication, any physician licensed pursuant to the provisions of Chapter 5-37 or other person charged with reporting (cited in section 2.1 herein) attending on or called in to visit a patient whom he/she believes to be suffering from acute CO poisoning shall report such occurrence(s) to the Department in accordance with the requirements of section 9.3 herein.

##### 9.2 Case Classification

###### a) Confirmed Case:

1) A patient with signs and symptoms consistent with acute CO poisoning<sup>[1]</sup> and a confirmed elevated carboxyhemoglobin (COHb) level, as determined by either a venous blood specimen or pulse Cooximetry; OR

[1 There is no consistent constellation of signs and symptoms resulting from acute CO poisoning, nor are there any pathognomonic clinical signs or symptoms which would unequivocally indicate a case of acute carbon monoxide poisoning. The clinical presentation of acute CO poisoning varies not only with the duration and magnitude of exposure, but also between individuals with the same degree of exposure and/or same venous COHb level. Clinical signs and symptoms of acute CO poisoning include, but are not limited to: headache, nausea, lethargy (or fatigue), weakness, abdominal discomfort/pain, confusion, and dizziness. Other signs and symptoms include: visual disturbances including blurred vision, numbness and tingling, ataxia, irritability, agitation, chest pain, dyspnea (shortness of breath) on exertion, palpitations, seizures, and loss of consciousness.]

2) A patient with signs and symptoms consistent with acute CO poisoning (in the absence of clinical or laboratory confirmation of an elevated COHb level), with supplementary evidence in the form of environmental monitoring data suggesting exposure from a specific poisoning source; OR

3) A laboratory report of a venous blood specimen (in the absence of clinical and environmental laboratory data) with a COHb level that is equal to or greater than a volume fraction of 0.12 (i.e., 12%).

###### b) Probable Case:

1) In the absence of clinical and environmental monitoring, a patient with signs and symptoms consistent with acute CO poisoning and the same history of environmental exposure as that of a confirmed case; OR,

2) A patient with signs and symptoms consistent with acute CO poisoning and history of smoke inhalation secondary to conflagration; OR

3) A non-smoking patient with a laboratory report of a blood specimen with a COHb level that is equal to or greater than a volume fraction of 0.09 and less than a volume fraction of 0.12 (i.e.,  $9 < \text{COHb}\% < 12$ ); OR

4) A patient who has an exposure history consistent with CO, and has received hyperbaric treatment for acute CO poisoning, regardless of COHb concentration reported, and regardless of the presence or absence of symptoms.

c) Suspected Case: A patient with signs and symptoms consistent with acute CO poisoning and a history of present illness consistent with exposure to CO.

### 9.3 Timeframe for Reporting

a) A case of acute CO poisoning shall be reported to the Department's Office of Environmental Risk Assessment (3 Capitol Hill, Room 201, Providence RI 02908 -5097) within four (4) working days following diagnosis.

b) The report shall contain no less than the following information:

- 1) Name, address and phone number of patient;
- 2) Type of case (i.e., confirmed, probable or suspect) and the basis for case type;
- 3) Such other information as may be reasonably required by the Department; AND
- 4) Name and phone number of the reporting physician or other person charged with reporting (cited in section 2.1 herein).

c) The Department shall prepare and furnish standard schedule blanks for the reports required in this section.

## PART IV

### Confidentiality and Severability

#### Section 10.0 Confidentiality.

10.1 All information and reports relative to testing and reporting of reportable diseases shall be confidential and subject to the provisions of all laws governing the confidentiality of this information including, but not limited to, Chapters 23-6, 23-11 and 5-37.3 of the General Laws of Rhode Island, as amended.

#### Section 11.0 Severability.

11.1 If any provisions of these rules and regulations or the application thereof to any persons or circumstances shall be held invalid, such invalidity shall not affect the provisions which can be given effect, and to this end the provisions of the rules and regulations are declared severable.

### References

1. Rules and Regulations for Asbestos Control (R23-24.5-ASB), Rhode Island Department of Health, September 2007 and subsequent amendments thereto. Available online:

<http://www2.sec.state.ri.us/dar/regdocs/released/pdf/DOH/4820.pdf>

2. Rules and Regulations Pertaining to HIV-1 Counseling, Testing, Reporting, and Confidentiality (R23-6-HIV-1), Rhode Island Department of Health, September 2001 and subsequent amendments thereto. Available online:

[http://www2.sec.state.ri.us/dar/regdocs/released/pdf/DOH/DOH\\_183\\_.pdf](http://www2.sec.state.ri.us/dar/regdocs/released/pdf/DOH/DOH_183_.pdf)

3. Rules and Regulations Pertaining to the Rhode Island Cancer Registry (R23-12-CA), Rhode Island Department of Health, December 1997 and subsequent amendments thereto. Available online:

[http://www2.sec.state.ri.us/dar/regdocs/released/pdf/DOH/DOH\\_202\\_.pdf](http://www2.sec.state.ri.us/dar/regdocs/released/pdf/DOH/DOH_202_.pdf)

4. Rhode Island General Laws, as amended, sections 23-6-25 ("Alternative Test Sites") Available online: <http://www.rilin.state.ri.us/Statutes/TITLE23/23-6/23-6-25.HTM> ;

Section 23-17-31 ("Human Immunodeficiency Virus [HIV] Testing--Hospitals"); Available online: <http://www.rilin.state.ri.us/Statutes/TITLE23/23-17/23-17-31.HTM>

Section 23-11-17 ("Human Immunodeficiency Virus [HIV] Testing"); Available online:

<http://www.rilin.state.ri.us/Statutes/TITLE23/23-11/23-11-17.HTM>

Section 23-13-19 ("Human Immunodeficiency Virus [HIV] Testing"); Available online:

<http://www.rilin.state.ri.us/Statutes/TITLE23/23-13/23-13-19.HTM>

Section 40.1-24-20 ("Human Immunodeficiency Virus [HIV] Testing--Facilities for Drug Abusers"); Available online:

<http://www.rilin.state.ri.us/Statutes/TITLE40.1/40.1-24/40.1-24-20.HTM>

Section 11-34-10 ("Human Immunodeficiency Virus [HIV] Testing"); Available online:

<http://www.rilin.state.ri.us/Statutes/TITLE11/11-34/11-34-10.HTM>

Section 21-28-4.20 ("Human Immunodeficiency Virus [HIV] Testing"); Available online:

<http://www.rilin.state.ri.us/Statutes/TITLE21/21-28/21-28-4.20.HTM>

Section 28-20-4.1 ("Adoption of Regulations Pertaining to HIV and Hepatitis"); Available online:  
<http://www.rilin.state.ri.us/Statutes/TITLE28/28-20/28-20-4.1.HTM>

5. "Confidentiality of Health Care Communications and Information Act," Chapter 5-37.3 of the General Laws of Rhode Island, as amended. Available online:

<http://www.rilin.state.ri.us/Statutes/TITLE5/5-37.3/INDEX.HTM>

6. "Board of Medical Licensure and Discipline", Chapter 5-37 of the Rhode Island General Laws, as amended. Available online:

<http://www.rilin.state.ri.us/Statutes/TITLE5/5-37/INDEX.HTM>

7. Rules and Regulations for the Licensure and Discipline of Physicians (R5-37-MD/DO), Rhode Island Department of Health, November 2007 and subsequent amendments thereto. Available online:

<http://www2.sec.state.ri.us/dar/regdocs/released/pdf/BMLD/4906.pdf>

8. "Laboratories", Chapter 23-16.2 of the Rhode Island General Laws, as amended. Available online:  
<http://www.rilin.state.ri.us/Statutes/TITLE23/23-16.2/INDEX.HTM>

9. Rules and Regulations for Licensing Clinical Laboratories and Stations (R23-16.2-C&S/LAB), Rhode Island Department of Health, September 2007 and subsequent amendments thereto. Available online:  
<http://www2.sec.state.ri.us/dar/regdocs/released/pdf/DOH/4860.pdf>

10. "Nurses", Chapter 5-34 of the Rhode Island General Laws, as amended. Available online:

<http://www.rilin.state.ri.us/Statutes/TITLE5/5-34/INDEX.HTM>

11. Rules and Regulations for the Licensing of Nurses & Standards for the Approval of Basic Nursing Education Programs (R5-34-NUR/ED), Rhode Island Department of Health, March 2008 and subsequent amendments thereto. Available online:

<http://www2.sec.state.ri.us/dar/regdocs/released/pdf/DOH/5128.pdf>

12. Rules and Regulations for Licensing of Midwives (R23-13-MID), Rhode Island Department of Health, September 2007 and subsequent amendments thereto. Available online:

<http://www2.sec.state.ri.us/dar/regdocs/released/pdf/DOH/4879.pdf>

13. "Physician Assistants", Chapter 5-54 of the Rhode Island General Laws, as amended. Available online:  
<http://www.rilin.state.ri.us/Statutes/TITLE5/5-54/INDEX.HTM>

14. Rules and Regulations for the Licensure of Physician Assistants (R5-54-PA), Rhode Island Department of Health, , September 2007 and subsequent amendments thereto. Available online:

<http://www2.sec.state.ri.us/dar/regdocs/released/pdf/DOH/4873.pdf>

15. "Licensing of Health Care Facilities", Chapter 23-17 of the Rhode Island General Laws, as amended. Available online:

<http://www.rilin.state.ri.us/Statutes/TITLE23/23-17/INDEX.HTM>

16. CDC Guidelines for National Human Immunodeficiency Virus Case Surveillance, Including Monitoring for Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome (see Appendix page 29), U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), Morbidity and Mortality Weekly Review (MMWR), December 10, 1999, vol. 48/No. RR-13. Available online:

<ftp://ftp.cdc.gov/pub/publications/mmwr/rr/rr4813.pdf>.

17. Office of Minority Health and Office of Health Statistics. Policy for Maintaining, Collecting, and Presenting Data on Race and Ethnicity. Providence, RI : Rhode Island Department of Health. July 2000. Available online:

<http://www.health.ri.gov/chic/statistics/data%20policy%20guide.pdf>

18. Center for Epidemiology and Infectious Disease and RI State Health Laboratories. Rhode Island Department of Health Epidemiology and Laboratory Reporting and Surveillance, 2003. Available online:

[http://www.health.ri.gov/disease/communicable/epi\\_labmanual2003.pdf](http://www.health.ri.gov/disease/communicable/epi_labmanual2003.pdf).

19. HIPAA Privacy Rule and Public Health: Guidance from CDC and the U.S. Department of Health and Human Services May 2, 2003/52 (S-1); 1-12. Available online:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/su5201a1.htm> STATUTORY AUTHORITY: *R.I.G.L. §§ 23-1-18; 23-8-1* and Chapters 23-5, -6, -10, -11, -24.5, -24.6 EFFECTIVE DATE: June 1966

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#### NOTES:

#### LexisNexis 50 State Surveys, Legislation & Regulations

Occupational Diseases



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\*\*\* THIS DOCUMENT REFLECTS CHANGES THROUGH DECEMBER 2008 \*\*\*

AGENCY 14. DEPARTMENT OF HEALTH  
SUB-AGENCY 040. COMMUNICABLE DISEASE  
CHAPTER 007. IMMUNIZATION AND TESTING FOR COMMUNICABLE DISEASES FOR STUDENTS  
ENTERING COLLEGES OR UNIVERSITIES

CRIR 14-040-007 (2008)

14 040 007 IMMUNIZATION AND TESTING FOR COMMUNICABLE DISEASES FOR STUDENTS ENTERING  
COLLEGES OR UNIVERSITIES

INTRODUCTION

These rules and regulations are promulgated under the authority of *section 23-1-18(9) of the General Laws of Rhode Island*, as amended, and are established in accordance with the most current recommendations of the Centers for Disease Control and Prevention for the purpose of adopting standards pertaining to requirements for immunizations and testing for communicable diseases for students entering colleges or universities in Rhode Island.

Pursuant to the provisions of *section 42-35-3(c) of the General Laws of Rhode Island*, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact placed on small business as defined in Chapter 42- 35 of the General Laws as a result of the amended regulations. No alternative approach, overlap or duplication nor any significant economic impact was identified, consequently the regulations are adopted in the best interest of the health, safety and welfare of the public.

These regulations shall supersede all previous Rules and Regulations Pertaining to Rubella and Measles Immunization for Persons Entering Colleges or Universities promulgated by the Rhode Island Department of Health and filed with the Secretary of State.

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Section 1.0 Definitions

Wherever used in these rules and regulations, the following terms shall be construed as follows:

1.1 "Advisory Committee on Immunization Practices (ACIP) recommendations", as used herein, means official federal recommendations for the use of vaccines in the United States and as published by the Centers for Disease Control and Prevention.

1.2 "College" or "university" means any public or private institution of higher learning in the state of Rhode Island.

1.3 "Department" means the Rhode Island Department of Health.

1.4 "Director" means the Director of the Rhode Island Department of Health.

1.5 "Entering" means formal registration by a student (as defined in section 1.7 herein) for initial attendance at a college or university to pursue a course or courses of study.

1.6 "Physician", as used herein, means an individual licensed under the provisions of Chapter 5-37 of the General Laws of Rhode Island, as amended, or an individual licensed to practice allopathic or osteopathic medicine under the laws of another state or territory of the United States, provided those laws are deemed to be substantially equivalent to Chapter 5-37 of the Rhode Island General Laws, as amended.

1.7 "Student", as used herein, means any person entering any public or private college or university in Rhode Island as a:

- . full-time undergraduate or graduate student;
- . part-time undergraduate or graduate student in a health science program who may be in contact with patients; and
- . full or part-time student entering an institution of higher education in Rhode Island while on a student or other visa, including a student attending or visiting classes or programs as part of a formal academic visitation or exchange program.

1.8 "Waiting period" means the time interval between scheduled doses of vaccine. The length of waiting periods are defined by the ACIP.

## Section 2.0 General Requirements

2.1 Colleges and universities shall adopt, at a minimum, the standards of immunization and communicable disease testing contained in section 3.0 of these regulations.

2.2 It shall be the responsibility of the administrative head, or his/her designee, of any college or university to secure compliance with these rules and regulations.

2.3 Persons charged with reporting communicable diseases (e.g., physicians, physician assistants, registered nurse practitioners, midwives, laboratories, certified school nurse teachers, and other entities or persons) shall comply with the most current version of the Rules and Regulations Pertaining to the Reporting of Communicable, Environmental and Occupational Diseases of reference 5 herein and the most current version of the Guidelines for Prevention and Control of Communicable Diseases issued by the Department.

2.4 In accordance with ACIP recommendations, for all vaccines discussed herein, vaccine doses administered less than or equal to four (4) days before the minimum interval or age shall be counted as valid. Doses administered five (5) or more days earlier than the minimum interval or age shall not be counted as valid doses and shall be repeated as age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval as provided in ACIP recommendations. (For more information, please see reference 1 herein).

## Section 3.0 Minimum Standards for Immunization and Communicable Disease Testing for Students Entering Colleges or Universities

3.1 Each student, upon entering any college or university in this state, shall furnish evidence to the administrative head of the college or university (pursuant to the requirements of section 3.4 of these rules and regulations) that the student has been immunized, as required in section 3.3, unless the student is in an exempt category (e.g., documented evidence of immunity).

3.2 For the immunization requirements stipulated in section 3.3 below, a student who is not in compliance with these requirements shall be excluded from attending college or university classes until the requirements are met, unless the student belongs in an exemption category or is in a waiting period between doses as described in sections 3.9 or 3.10 herein.

### College or University Entry: Immunization Requirements

3.3 Each student, upon entering any college or university, shall furnish evidence as required in section 3.4 herein of having received the vaccines described below:

#### 3.3.1 Tetanus, Diphtheria

Evidence of a booster dose of Td within the last ten (10) years shall be required.

### 3.3.2 Measles, Mumps, and Rubella Vaccines

All students who enter a college or university are required to have received two (2) doses of a measles-containing vaccine (preferably MMR vaccine), one (1) dose of a mumps vaccine, and one (1) dose of a rubella vaccine. The first dose of these three vaccines must be given on or after the first birthday. The second dose of a measles-containing vaccine (preferably MMR vaccine) must be given at least one (1) month after the first dose.

Students born on or before December 31, 1956 are required to have one dose of a measles containing vaccine, one dose of mumps, and one dose of rubella and thus are exempt from the two dose requirement of a measles containing vaccine.

Students vaccinated prior to 1968 shall be revaccinated, unless documentation is provided that indicates that a live virus vaccine was used in vaccinating the student.

### 3.3.3 Hepatitis B Vaccine

A completed series of hepatitis B vaccine is currently recommended, but shall be required for all students entering on or after August 1, 2006. Three (3) doses of hepatitis B vaccine shall be required for all health science students upon entering a college or university.

### 3.3.4 Varicella (Chickenpox) Vaccine

All health science students, upon entering a college or university, are required to have received one (1) dose of varicella (chickenpox) vaccine on or after his/her first birthday or, if the first dose is given on or after the student's thirteenth (13th) birthday, two (2) doses of varicella (chickenpox) vaccine, in accordance with the ACIP guidelines.

It is currently recommended that all other students (i.e., those not enrolled in a health science curriculum) meet the requirement for varicella vaccine stated above.

On or after August 1, 2006, all students, upon entering a college or university, are required to have received one (1) dose of varicella (chickenpox) vaccine on or after his/her first birthday or, if the first dose is given on or after the student's thirteenth (13th) birthday, two (2) doses of varicella (chickenpox) vaccine, or in accordance with the most current recommendations of the ACIP guidelines.

### 3.3.5 Meningococcal Vaccine

It is required that college health services provide information to students entering colleges or universities, and their parents, about meningococcal disease and meningococcal vaccine.

It is recommended that freshmen students entering colleges or universities living in dormitories be vaccinated against meningococcal disease with at least a single dose of quadrivalent meningococcal polysaccharide vaccine if they have not already been vaccinated, and/or in keeping with the most current ACIP recommendations.

## Immunization Records

3.4 Acceptable evidence of completion of immunizations shall include the day, month, year and type/name of each dose of vaccine administered. The record of such evidence shall be signed by a physician or his/her designee (the signature of the student's parents is not acceptable). This record may be submitted to the college or university by a health care provider, another college or university, the student, or a parent/guardian.

3.4.1 For students who initially entered primary school on or before December 31, 1989, existing immunization records shall be deemed acceptable, provided the record contains a valid exemption form or contains documentation that the student has completed the required immunizations.

3.4.2 Acceptable evidence of completion of immunization consists of:

(a) an official immunization record card, school immunization record, Medical Passport, World Health Organization immunization record, or other official immunization records acceptable to the Department; or

(b) an electronically stored and/or transmitted documentary record (facsimile transmission, computerized record, including, but not limited to, a record on magnetic media or similar record) as may be utilized by a school; or

(c) presentation of laboratory evidence of immunity is made in the case of measles, mumps, rubella, hepatitis B, and varicella (chickenpox); or

(d) a physician, physician assistant, certified registered nurse practitioner, or other licensed practitioner acting within his/her scope of practice signs a statement that the student has a history of chickenpox disease (varicella).

#### Provisions for Exclusions, Waiting Periods, and Exemptions

##### Exclusions

3.5 Students who have not received the minimum number of required immunizations, who are not in a prescribed waiting period between doses, as specified in section 3.9 herein and who are not exempt pursuant to section 3.10 herein, shall be excluded from the college or university by the administrative head of the college or university, pending the completion of the required dose(s) of vaccine(s).

3.6 Students upon entering any college or university shall be excluded unless evidence is submitted that the student has received initial dose(s) of required vaccine(s) for college or university entry as set forth in these rules and regulations herein.

3.7 If an outbreak of vaccine-preventable disease should occur, an exempt student shall be excluded from school by the administrative head of school for a period of time as determined by the Health Department based on a case-by-case analysis of public health risk.

3.8 The college or university shall have a written protocol in place for the exclusion of unvaccinated students in the event of an outbreak. An accurate and current listing of all unvaccinated students shall be maintained by the college or university for this purpose.

##### Waiting Periods

3.9 If, at college or university entry, a student is within a waiting period for the minimum number of doses for a given vaccine, the student shall be enrolled and/or admitted to the college or university. It shall be the responsibility of the administrative head of the college or university or his/her designee to ensure the completion of at least the minimum number of immunizations, following the prescribed waiting period(s) and consistent with the provisions of these rules and regulations.

##### Exemptions

3.10 A student may be exempt from the immunization requirements described herein provided that:

3.10.1 a physician, physician assistant, certified registered nurse practitioner, or other licensed practitioner acting within his/her scope of practice signs the Department's "Medical Immunization Exemption Certificate" provided by the college/university attesting that the student is exempt from a specific vaccine because of medical reasons, in accordance with ACIP guidelines, American Academy of Pediatrics (AAP) guidelines, or package insert instructions;

or

3.10.2 a parent or guardian or student if 18 years of age or older completes and signs the Department's "Religious Immunization Exemption Certificate" provided by the college/university, attesting that immunization conflicts with the tenets of their religious beliefs;

or

3.10.3 the administrative head of the college or university or his/her designee signs a Temporary Immunization Exemption Certificate, provided by the college/university, indicating that an appointment with a health care provider for the required immunization(s) has been made. This temporary exemption shall expire on the date of the immunization appointment.

#### Section 4.0 Tuberculosis Testing

4.1 Targeted tuberculosis (TB) testing is required for entering students who are from highly endemic countries of the world and have been resident in the United States for less than five (5) years. Testing should be conducted according

to the most current version of the Guidelines for Communicable Disease Prevention and Control of the Department of Health.

#### Section 5.0 Severability

5.1 If any provision of these rules and regulations or the application thereof to any person or circumstances shall be held invalid, such invalidity shall not affect the provisions or application of the rules and regulations which can be given effect, and to this end the provisions of the rules and regulations are declared to be severable.

#### REFERENCES

1. Recommendations of the Advisory Committee on Immunization Practices (ACIP), U.S. Public Health Service, Centers for Disease Control & Prevention, General Recommendations on Immunization Available online: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5102a1.htm>

2. Recommendations on Measles, Mumps, and Rubella--Vaccine Use and Strategies for Elimination of Measles, Rubella, and Congenital Rubella Syndrome and Control of Mumps Available online: <http://www.cdc.gov/mmwr/preview/mmwrhtml/00053391.htm>

3. Immunization of Health-Care Workers: Recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC), U.S. Public Health Service, Centers for Disease Control & Prevention, available online: [www.cdc.gov/mmwr/preview/mmwrhtml/00050577.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/00050577.htm)

4. "Department of Health", Chapter 23-1 of the Rhode Island General Laws, as amended.

5. Rules and Regulations Pertaining to the Reporting of Communicable, Environmental and Occupational Diseases (R23-10-DIS), Rhode Island Department of Health, September 2002 and subsequent amendments thereto.

6. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), Morbidity and Mortality Weekly Report, Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection, June 9, 2000 and subsequent revisions thereto, available online: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4906a1.htm>

7. Guidelines for Communicable Disease Prevention and Control, Rhode Island Department of Health, available online: <http://www.health.ri.gov/disease/communicable/providerguide.pdf>

*R.I.G.L. § 23-1-18*

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