# CHAPTER 144

# DEPARTMENT OF HEALTH



## 144.05 GENERAL DUTIES OF COMMISSIONER; REPORTS.

*[For text of subds 1 and 2, see M S 1998]*

Subd 3 **Appropriation transfers to be reported.** When the commissioner transfers operational money between programs under section 16A 285, in addition to the requirements of that section the commissioner must provide the chairs of the legislative committees that have jurisdiction over the agency's budget with sufficient detail to identify the account to which the money was originally appropriated, and the account to which the money is being transferred

**History:** *1999 c 245 art 1 s 14*

## 144.065 PREVENTION AND TREATMENT OF SEXUALLY TRANSMITTED INFECTIONS.

The state commissioner of health shall assist local health agencies and organizations throughout the state with the development and maintenance of services for the detection and treatment of sexually transmitted infections These services shall provide for research, screening and diagnosis, treatment, case finding, investigation, and the dissemination of appropriate educational information The state commissioner of health shall determine the composition of such services and shall establish a method of providing funds to boards of health as defined in section 145A 02, subdivision 2, state agencies, state councils, and nonprofit corporations, which offer such services The state commissioner of health shall provide technical assistance to such agencies and organizations in accordance with the needs of the local area Planning and implementation of services and technical assistance may be conducted in collaboration with boards of health, state agencies, including the University of Minnesota and the department of children, families, and learning, state councils, nonprofit organizations, and representatives of affected populations

**History:** *1999 c 245 art 2 s 15*

**144.0723** [Repealed, 1999 c 245 art 3 s 51]

## RADIATION HAZARDS PROGRAM

### 144.1201 DEFINITIONS.

Subdivision 1 **Applicability.** For purposes of sections 144 1201 to 144 1204, the terms defined in this section have the meanings given to them

Subd 2 **By–product nuclear material.** "By–product nuclear material" means a radioactive material, other than special nuclear material, yielded in or made radioactive by exposure to radiation created incident to the process of producing or utilizing special nuclear material

Subd 3 **Radiation.** "Radiation" means ionizing radiation and includes alpha rays, beta rays, gamma rays, x–rays, high energy neutrons, protons, or electrons, and other atomic particles

Subd 4 **Radioactive material.** "Radioactive material" means a matter that emits radiation Radioactive material includes special nuclear material, source nuclear material, and by–product nuclear material

Subd 5 **Source nuclear material.** "Source nuclear material" means uranium or thorium, or a combination thereof, in any physical or chemical form, or ores that contain by weight 1/20 of one percent (0 05 percent) or more of uranium, thorium, or a combination thereof Source nuclear material does not include special nuclear material

Subd 6 **Special nuclear material.** "Special nuclear material" means

(1) plutonium, uranium enriched in the isotope 233 or in the isotope 235, and any other material that the Nuclear Regulatory Commission determines to be special nuclear material according to United States Code, title 42, section 2071, except that source nuclear material is not included, and

(2) a material artificially enriched by any of the materials listed in clause (1), except that source nuclear material is not included

**History:** *1999 c 245 art 2 s 16*

### 144.1202 UNITED STATES NUCLEAR REGULATORY COMMISSION AGREEMENT.

Subdivision 1 **Agreement authorized.** In order to have a comprehensive program to protect the public from radiation hazards, the governor, on behalf of the state, is authorized to enter into agreements with the United States Nuclear Regulatory Commission under the Atomic Energy Act of 1954, section 274b, as amended The agreement shall provide for the discontinuance of portions of the Nuclear Regulatory Commission's licensing and related regulatory authority over by–product, source, and special nuclear materials, and the assumption of regulatory authority over these materials by the state

Subd 2 **Health department designated lead.** The department of health is designated as the lead agency to pursue an agreement on behalf of the governor and for any assumption of specified licensing and regulatory authority from the Nuclear Regulatory Commission under an agreement with the commission The commissioner of health shall establish an advisory group to assist in preparing the state to meet the requirements for reaching an agreement The commissioner may adopt rules to allow the state to assume regulatory authority under an agreement under this section, including the licensing and regulation of radioactive materials Any regulatory authority assumed by the state includes the ability to set and collect fees

Subd 3 **Transition.** A person who, on the effective date of an agreement under this section, possesses a Nuclear Regulatory Commission license that is subject to the agreement is deemed to possess a similar license issued by the department of health A department of health license obtained under this subdivision expires on the expiration date specified in the federal license

Subd 4 **Agreement; conditions of implementation.** (a) An agreement entered into before August 2, 2002, must remain in effect until terminated under the Atomic Energy Act of 1954, United States Code, title 42, section 2021, paragraph (j) The governor may not enter into an initial agreement with the Nuclear Regulatory Commission after August 1, 2002 If

an agreement is not entered into by August 1, 2002, any rules adopted under this section are repealed effective August 1, 2002

(b) An agreement authorized under subdivision 1 must be approved by law before it may be implemented

**History:** *1999 c 245 art 2 s 17*

## 144.1203 TRAINING; RULEMAKING.

The commissioner shall adopt rules to ensure that individuals handling or utilizing radioactive materials under the terms of a license issued by the commissioner under section 144 1202 have proper training and qualifications to do so The rules adopted must be at least as stringent as federal regulations on proper training and qualifications adopted by the Nuclear Regulatory Commission Rules adopted under this section may incorporate federal regulations by reference

**History:** *1999 c 245 art 2 s 18*

## 144.1204 SURETY REQUIREMENTS.

Subdivision 1 **Financial assurance required.** The commissioner may require an applicant for a license under section 144 1202, or a person who was formerly licensed by the Nuclear Regulatory Commission and is now subject to sections 144 1201 to 144 1204, to post financial assurances to ensure the completion of all requirements established by the commissioner for the decontamination, closure, decommissioning, and reclamation of sites, structures, and equipment used in conjunction with activities related to licensure The financial assurances posted must be sufficient to restore the site to unrestricted future use and must be sufficient to provide for surveillance and care when radioactive materials remain at the site after the licensed activities cease The commissioner may establish financial assurance criteria by rule In establishing such criteria, the commissioner may consider

(1) the chemical and physical form of the licensed radioactive material,

(2) the quantity of radioactive material authorized,

(3) the particular radioisotopes authorized and their subsequent radiotoxicity,

(4) the method in which the radioactive material is held, used, stored, processed, transferred, or disposed of, and

(5) the potential costs of decontamination, treatment, or disposal of a licensee's equipment and facilities

Subd 2 **Acceptable financial assurances.** The commissioner may, by rule, establish types of financial assurances that meet the requirements of this section Such financial assurances may include bank letters of credit, deposits of cash, or deposits of government securities

Subd 3 **Trust agreements.** Financial assurances must be established together with trust agreements Both the financial assurances and the trust agreements must be in a form and substance that meet requirements established by the commissioner

Subd 4 **Exemptions.** The commissioner is authorized to exempt from the requirements of this section, by rule, any category of licensee upon a determination by the commissioner that an exemption does not result in a significant risk to the public health or safety or to the environment and does not pose a financial risk to the state

Subd 5 **Other remedies unaffected.** Nothing in this section relieves a licensee of a civil liability incurred, nor may this section be construed to relieve the licensee of obligations to prevent or mitigate the consequences of improper handling or abandonment of radioactive materials

**History:** *1999 c 245 art 2 s 19*

## 144.121 X-RAY MACHINES AND FACILITIES USING OTHER SOURCES OF IONIZING RADIATION.

*[For text of subds 1 to 6, see M S 1998]*

Subd 7 [Repealed, 1999 c 86 art 2 s 6]

Subd 8 **Exemption from examination requirements; operators of certain bone densitometers.** (a) This subdivision applies to a bone densitometer that is used on humans to estimate bone mineral content and bone mineral density in a region of a finger on a person's nondominant hand, gives an x-ray dose equivalent of less than 0 001 microsieverts per scan, and has an x-ray leakage exposure rate of less than two milliroentgens per hour at a distance of one meter, provided that the bone densitometer is operating in accordance with manufacturer specifications

(b) An individual who operates a bone densitometer that satisfies the definition in paragraph (a) and the facility in which an individual operates such a bone densitometer are exempt from the requirements of subdivisions 5 and 6

**History:** *1999 c 245 art 2 s 20*

## 144.147 RURAL HOSPITAL PLANNING AND TRANSITION GRANT PROGRAM.

*[For text of subd 1, see M S 1998]*

Subd 2 **Grants authorized.** The commissioner shall establish a program of grants to assist eligible rural hospitals The commissioner shall award grants to hospitals and communities for the purposes set forth in paragraphs (a) and (b)

(a) Grants may be used by hospitals and their communities to develop strategic plans for preserving or enhancing access to health services At a minimum, a strategic plan must consist of

(1) a needs assessment to determine what health services are needed and desired by the community The assessment must include interviews with or surveys of area health professionals, local community leaders, and public hearings,

(2) an assessment of the feasibility of providing needed health services that identifies priorities and timeliness for potential changes, and

(3) an implementation plan

The strategic plan must be developed by a committee that includes representatives from the hospital, local public health agencies, other health providers, and consumers from the community

(b) The grants may also be used by eligible rural hospitals that have developed strategic plans to implement transition projects to modify the type and extent of services provided, in order to reflect the needs of that plan Grants may be used by hospitals under this paragraph to develop hospital-based physician practices that integrate hospital and existing medical practice facilities that agree to transfer their practices, equipment, staffing, and administration to the hospital The grants may also be used by the hospital to establish a health provider cooperative, a telemedicine system, or a rural health care system or to cover expenses associated with being designated as a critical access hospital for the Medicare rural hospital flexibility program Not more than one-third of any grant shall be used to offset losses incurred by physicians agreeing to transfer their practices to hospitals

Subd 3 **Consideration of grants.** In determining which hospitals will receive grants under this section, the commissioner shall take into account

(1) improving community access to hospital or health services,

(2) changes in service populations,

(3) availability and upgrading of ambulatory and emergency services,

(4) the extent that the health needs of the community are not currently being met by other providers in the service area,

(5) the need to recruit and retain health professionals,

(6) the extent of community support,

(7) the integration of health care services and the coordination with local community organizations, such as community development and public health agencies, and

(8) the financial condition of the hospital

Subd 4 **Allocation of grants.** (a) Eligible hospitals must apply to the commissioner no later than September 1 of each fiscal year for grants awarded for that fiscal year A grant may be awarded upon signing of a grant contract

(b) The commissioner must make a final decision on the funding of each application within 60 days of the deadline for receiving applications

(c) Each relevant community health board has 30 days in which to review and comment to the commissioner on grant applications from hospitals in their community health service area

(d) In determining which hospitals will receive grants under this section, the commissioner shall consider the following factors

(1) Description of the problem, description of the project, and the likelihood of successful outcome of the project The applicant must explain clearly the nature of the health services problems in their service area, how the grant funds will be used, what will be accomplished, and the results expected The applicant should describe achievable objectives, a timetable, and roles and capabilities of responsible individuals and organizations

(2) The extent of community support for the hospital and this proposed project The applicant should demonstrate support for the hospital and for the proposed project from other local health service providers and from local community and government leaders Evidence of such support may include past commitments of financial support from local individuals, organizations, or government entities, and commitment of financial support, in–kind services or cash, for this project

(3) The comments, if any, resulting from a review of the application by the community health board in whose community health service area the hospital is located

(e) In evaluating applications, the commissioner shall score each application on a 100 point scale, assigning the maximum of 70 points for an applicant's understanding of the problem, description of the project, and likelihood of successful outcome of the project, and a maximum of 30 points for the extent of community support for the hospital and this project The commissioner may also take into account other relevant factors

(f) Any single grant to a hospital, including hospitals that submit applications as consortia, may not exceed $50,000 a year and may not exceed a term of two years Prior to the receipt of any grant, the hospital must certify to the commissioner that at least one–half of the amount of the total cost of the planning or transition project, which may include in–kind services, is available for the same purposes from nonstate sources A hospital receiving a grant under this section may use the grant for any expenses incurred in the development of strategic plans or the implementation of transition projects with respect to which the grant is made Project grants may not be used to retire debt incurred with respect to any capital expenditure made prior to the date on which the project is initiated Hospitals may apply to the program each year they are eligible

(g) The commissioner may adopt rules to implement this section

Subd 5 **Evaluation.** The commissioner shall evaluate the overall effectiveness of the grant program The commissioner may collect, from the hospital, and communities receiving grants, quarterly progress reports to evaluate the grant program Information related to the financial condition of individual hospitals shall be classified as nonpublic data

**History:** *1999 c 247 s 2–5*

## 144.148 RURAL HOSPITAL CAPITAL IMPROVEMENT GRANT PROGRAM.

Subdivision 1 **Definition.** (a) For purposes of this section, the following definitions apply

(b) "Eligible rural hospital" means any nonfederal, general acute care hospital that

(1) is either located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405 1041, or located in a community with a population of less than 5,000, according to United States Census Bureau Statistics, outside the seven–county metropolitan area,

(2) has 50 or fewer beds, and

(3) is not for profit

(c) "Eligible project" means a modernization project to update, remodel, or replace aging hospital facilities and equipment necessary to maintain the operations of a hospital

Subd 2 **Program.** The commissioner of health shall award rural hospital capital improvement grants to eligible rural hospitals A grant shall not exceed $300,000 per hospital Prior to the receipt of any grant, the hospital must certify to the commissioner that at least one–quarter of the grant amount, which may include in–kind services, is available for the same purposes from nonstate resources

Subd 3 **Applications.** Eligible hospitals seeking a grant shall apply to the commissioner Applications must include a description of the problem that the proposed project will address, a description of the project including construction and remodeling drawings or specifications, sources of funds for the project, uses of funds for the project, the results expected, and a plan to maintain or operate any facility or equipment included in the project The applicant must describe achievable objectives, a timetable, and roles and capabilities of responsible individuals and organization Applicants must submit to the commissioner evidence that competitive bidding was used to select contractors for the project

Subd 4 **Consideration of applications.** The commissioner shall review each application to determine whether or not the hospital's application is complete and whether the hospital and the project are eligible for a grant In evaluating applications, the commissioner shall score each application on a 100 point scale, assigning a maximum of 40 points for an applicant's clarity and thoroughness in describing the problem and the project, a maximum of 40 points for the extent to which the applicant has demonstrated that it has made adequate provisions to assure proper and efficient operation of the facility once the project is completed, and a maximum of 20 points for the extent to which the proposed project is consistent with the hospital's capital improvement plan or strategic plan The commissioner may also take into account other relevant factors During application review, the commissioner may request additional information about a proposed project, including information on project cost Failure to provide the information requested disqualifies an applicant

Subd 5 **Program oversight.** The commissioner shall determine the amount of a grant to be given to an eligible rural hospital based on the relative score of each eligible hospital's application and the funds available to the commissioner The grant shall be used to update, remodel, or replace aging facilities and equipment necessary to maintain the operations of the hospital The commissioner may collect, from the hospitals receiving grants, any information necessary to evaluate the program

Subd 6 [Repealed by amendment, 1999 c 245 art 2 s 21]

Subd 7 [Repealed by amendment, 1999 c 245 art 2 s 21]

Subd 8 **Expiration.** This section expires June 30, 2001

**History:** *1999 c 245 art 2 s 21*

## 144.1483 RURAL HEALTH INITIATIVES.

The commissioner of health, through the office of rural health, and consulting as necessary with the commissioner of human services, the commissioner of commerce, the higher education services office, and other state agencies, shall

(1) develop a detailed plan regarding the feasibility of coordinating rural health care services by organizing individual medical providers and smaller hospitals and clinics into referral networks with larger rural hospitals and clinics that provide a broader array of services,

(2) develop and implement a program to assist rural communities in establishing community health centers, as required by section 144 1486,

(3) administer the program of financial assistance established under section 144 1484 for rural hospitals in isolated areas of the state that are in danger of closing without financial assistance, and that have exhausted local sources of support,

(4) develop recommendations regarding health education and training programs in rural areas, including but not limited to a physician assistants' training program, continuing education programs for rural health care providers, and rural outreach programs for nurse practitioners within existing training programs,

(5) develop a statewide, coordinated recruitment strategy for health care personnel and maintain a database on health care personnel as required under section 144 1485,

(6) develop and administer technical assistance programs to assist rural communities in (i) planning and coordinating the delivery of local health care services, and (ii) hiring physicians, nurse practitioners, public health nurses, physician assistants, and other health personnel,

(7) study and recommend changes in the regulation of health care personnel, such as nurse practitioners and physician assistants, related to scope of practice, the amount of on-site physician supervision, and dispensing of medication, to address rural health personnel shortages,

(8) support efforts to ensure continued funding for medical and nursing education programs that will increase the number of health professionals serving in rural areas,

(9) support efforts to secure higher reimbursement for rural health care providers from the Medicare and medical assistance programs,

(10) coordinate the development of a statewide plan for emergency medical services, in cooperation with the emergency medical services advisory council,

(11) establish a Medicare rural hospital flexibility program pursuant to section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, by developing a state rural health plan and designating, consistent with the rural health plan, rural nonprofit or public hospitals in the state as critical access hospitals. Critical access hospitals shall include facilities that are certified by the state as necessary providers of health care services to residents in the area. Necessary providers of health care services are designated as critical access hospitals on the basis of being more than 20 miles, defined as official mileage as reported by the Minnesota department of transportation, from the next nearest hospital or being the sole hospital in the county or being a hospital located in a designated medical underserved area or health professional shortage area. A critical access hospital located in a designated medical underserved area or a health professional shortage area shall continue to be recognized as a critical access hospital in the event the medical underserved area or health professional shortage area designation is subsequently withdrawn, and

(12) carry out other activities necessary to address rural health problems.

**History:** *1999 c 245 art 2 s 22*

## 144.1484 RURAL HOSPITAL FINANCIAL ASSISTANCE GRANTS.

Subdivision 1. **Sole community hospital financial assistance grants.** (a) The commissioner of health shall award financial assistance grants to rural hospitals in isolated areas of the state. To qualify for a grant, a hospital must (1) be eligible to be classified as a sole community hospital according to the criteria in Code of Federal Regulations, title 42, section 412.92 or be located in a community with a population of less than 5,000 and located more than 25 miles from a like hospital currently providing acute short-term services, (2) have experienced net operating income losses in two of the previous three most recent consecutive hospital fiscal years for which audited financial information is available, (3) consist of 40 or fewer licensed beds, and (4) demonstrate to the commissioner that it has obtained local support for the hospital and that any state support awarded under this program will not be used to supplant local support for the hospital.

(b) The commissioner shall review audited financial statements of the hospital to assess the extent of local support. Evidence of local support may include bonds issued by a local government entity such as a city, county, or hospital district for the purpose of financing hospital projects, and loans, grants, or donations to the hospital from local government entities, private organizations, or individuals.

(c) The commissioner shall determine the amount of the award to be given to each eligible hospital based on the hospital's operating loss margin (total operating losses as a percentage of total operating revenue) for two of the previous three most recent consecutive fiscal years for which audited financial information is available and the total amount of funding available. For purposes of calculating a hospital's operating loss margin, total operating revenue does not include grant funding provided under this subdivision. One hundred percent of the available funds will be disbursed proportionately based on the operating loss margins of the eligible hospitals.

(d) Before awarding a grant contract to an eligible hospital, the commissioner shall require the eligible hospital to submit a budget for the use of grant funds For grants above $30,000, the commissioner shall also require the eligible hospital to submit a brief annual work plan that includes objectives and activities intended to improve the hospital's financial viability and maintain the quality of the hospital's services

(e) Hospitals receiving a grant under this section shall submit brief semiannual reports to the commissioner reporting progress toward meeting annual plan objectives

*[For text of subd 2, see M S 1998]*

**History:** *1999 c 247 s 6*

## 144.1486 RURAL COMMUNITY HEALTH CENTERS.

*[For text of subds 1 and 2, see M S 1998]*

Subd 3 **Grants.** The commissioner shall provide grants to communities for planning, establishing, and operating community health centers through the Minnesota community health center program Grant recipients shall develop and implement a strategy that allows them to become self–sufficient and qualify for other supplemental funding and enhanced reimbursement The commissioner shall coordinate the grant program with the federal rural health clinic, federally qualified health center, and migrant and community health center programs to encourage federal certification

Subd 4 **Eligibility requirements.** In order to qualify for community health center program funding, a project must

(1) be located in a rural shortage area that is a medically underserved, federal health professional shortage, or governor designated shortage area "Rural" means an area of the state outside the seven–county Twin Cities metropolitan area and outside of the Duluth, St Cloud, East Grand Forks, Moorhead, Rochester, and LaCrosse census defined urbanized areas,

(2) represent or propose the formation of a nonprofit corporation with local resident governance, or be a governmental or tribal entity Applicants in the process of forming a nonprofit corporation may have a nonprofit coapplicant serve as financial agent through the remainder of the formation period With the exception of governmental or tribal entities, all applicants must submit application for nonprofit incorporation and 501(c)(3) tax–exempt status within six months of accepting community health center grant funds, and

(3) for an application for an operating expense grant, demonstrate that expenses exceed revenues or demonstrate other extreme need that cannot be met from other sources

*[For text of subds 5 to 7, see M S 1998]*

Subd 8 **Requirements.** The commissioner shall develop a list of requirements for community health centers and a tracking and reporting system to assess benefits realized from the program to ensure that projects are on schedule and effectively utilizing state funds

The commissioner shall require community health centers established or supported through the grant program to

(1) provide ongoing active local governance to the community health center and pursue community support, integration, collaboration, and resources,

(2) offer primary care services responsive to community needs and maintain compliance with requirements of all cognizant regulatory authorities, health center funders, or health care payers,

(3) maintain policies and procedures that ensure that no person will be denied services because of inability to pay, and

(4) submit brief quarterly activity reports and utilization data to the commissioner

*[For text of subds 9 and 10, see M S 1998]*

**History:** *1999 c 247 s 7–9*

## 144.1488 PROGRAM ADMINISTRATION AND ELIGIBILITY.

Subdivision 1 **Duties of commissioner of health.** The commissioner shall administer the state loan repayment program The commissioner shall

(1) ensure that federal funds are used in accordance with program requirements established by the federal National Health Services Corps,

(2) notify potentially eligible loan repayment sites about the program,

(3) develop and disseminate application materials to sites,

(4) review and rank applications using the scoring criteria approved by the federal Department of Health and Human Services as part of the Minnesota department of health's National Health Services Corps state loan repayment program application,

(5) select sites that qualify for loan repayment based upon the availability of federal and state funding,

(6) carry out other activities necessary to implement and administer sections 144 1487 to 144 1492,

(7) verify the eligibility of program participants,

(8) sign a contract with each participant that specifies the obligations of the participant and the state,

(9) arrange for loan repayment of qualifying educational loans for program participants,

(10) monitor the obligated service of program participants,

(11) waive or suspend service or payment obligations of participants in appropriate situations,

(12) place participants who fail to meet their obligations in default, and

(13) enforce penalties for default

Subd 3 **Eligible loan repayment sites.** Nonprofit private and public entities located in and providing health care services in federally designated primary care health professional shortage areas are eligible to apply for the program The commissioner shall develop a list of Minnesota health professional shortage areas in greatest need of health care professionals and shall select loan repayment sites from that list The commissioner shall ensure, to the greatest extent possible, that the geographic distribution of sites within the state reflects the percentage of the population living in rural and urban health professional shortage areas

Subd 4 **Eligible health professionals.** (a) To be eligible to apply to the commissioner for the loan repayment program, health professionals must be citizens or nationals of the United States, must not have any unserved obligations for service to a federal, state, or local government, or other entity, must have a current and unrestricted Minnesota license to practice, and must be ready to begin full–time clinical practice upon signing a contract for obligated service

(b) Eligible providers are those specified by the federal Bureau of Primary Health Care in the policy information notice for the state's current federal grant application A health professional selected for participation is not eligible for loan repayment until the health professional has an employment agreement or contract with an eligible loan repayment site and has signed a contract for obligated service with the commissioner

**History:** *1999 c 247 s 10–12*

## 144.1489 OBLIGATIONS OF PARTICIPANTS.

*[For text of subd 1, see M S 1998]*

Subd 2 **Obligated service.** A participant shall agree in the contract to fulfill the period of obligated service by providing primary health care services in full–time clinical practice The service must be provided in a nonprofit private or public entity that is located in and providing services to a federally designated health professional shortage area and that has been designated as an eligible site by the commissioner under the state loan repayment program

*[For text of subd 3, see M S 1998]*

Subd 4 **Affidavit of service required.** Before receiving loan repayment, annually thereafter, and as requested by the commissioner, a participant shall submit an affidavit to the commissioner stating that the participant is providing the obligated service and which is

signed by a representative of the organizational entity in which the service is provided Participants must provide written notice to the commissioner within 30 days of a change in name or address, a decision not to fulfill a service obligation, or cessation of clinical practice

*[For text of subds 5 and 6, see M S 1998]*

**History:** *1999 c 247 s 13,14*

## 144.1490 RESPONSIBILITIES OF LOAN REPAYMENT PROGRAM.

*[For text of subd 1, see M S 1998]*

Subd 2 **Procedure for loan repayment.** Program participants, at the time of signing a contract, shall designate the qualifying loan or loans for which the commissioner is to make payments The participant shall submit to the commissioner proof that all payments made by the commissioner have been applied toward the designated qualifying loans The commissioner shall make payments in accordance with the terms and conditions of the state loan repayment grant agreement or contract, in an amount not to exceed $20,000 when annualized If the amount paid by the commissioner is less than $20,000 during a 12–month period, the commissioner shall pay during the 12th month an additional amount towards a loan or loans designated by the participant, to bring the total paid to $20,000 The total amount paid by the commissioner must not exceed the amount of principal and accrued interest of the designated loans

**History:** *1999 c 247 s 15*

## 144.1492 STATE RURAL HEALTH NETWORK REFORM INITIATIVE.

*[For text of subds 1 and 2, see M S 1998]*

Subd 3 **Eligible applicants and criteria for awarding of grants to rural communities.** (a) Funding which the department receives to award grants to rural communities to establish health care networks shall be awarded through a request for proposals process Planning grant funds may be used for community facilitation and initial network development activities including incorporation as a nonprofit organization or cooperative, assessment of network models, and determination of the best fit for the community Implementation grant funds can be used to enable incorporated nonprofit organizations and cooperatives to purchase technical services needed for further network development such as legal, actuarial, financial, marketing, and administrative services

(b) In order to be eligible to apply for a planning or implementation grant under the federally funded health care network reform program, an organization must be located in a rural area of Minnesota excluding the seven–county Twin Cities metropolitan area and the census–defined urbanized areas of Duluth, Rochester, St Cloud, and Moorhead The proposed network organization must also meet or plan to meet the criteria for a community integrated service network

(c) In determining which organizations will receive grants, the commissioner may consider the following factors

(1) the applicant's description of their plans for health care network development, their need for technical assistance, and other technical assistance resources available to the applicant The applicant must clearly describe the service area to be served by the network, how the grant funds will be used, what will be accomplished, and the expected results The applicant should describe achievable objectives, a timetable, and roles and capabilities of responsible individuals and organizations,

(2) the extent of community support for the applicant and the health care network The applicant should demonstrate support from private and public health care providers in the service area and local community and government leaders Evidence of such support may include a commitment of financial support, in–kind services, or cash, for development of the network,

(3) the size and demographic characteristics of the population in the service area for the proposed network and the distance of the service area from the nearest metropolitan area, and

(4) the technical assistance resources available to the applicant from nonstate sources and the financial ability of the applicant to purchase technical assistance services with nonstate funds

**History:** *1999 c 245 art 2 s 23*

## 144.1494 RURAL PHYSICIANS.

*[For text of subd 1, see M S 1998]*

Subd 2 **Eligibility.** To be eligible to participate in the program, a medical resident must submit an application to the commissioner A resident who is accepted must sign a contract to agree to serve a minimum three–year service obligation within a designated rural area, which shall begin no later than March following completion of residency

Subd 3 **Loan forgiveness.** For each fiscal year after 1995, the commissioner may accept up to 12 applicants who are medical residents for participation in the loan forgiveness program The 12 resident applicants may be in any year of residency training, however, priority must be given to the following categories of residents in descending order third year residents, second year residents, and first year residents Applicants are responsible for securing their own loans Applicants chosen to participate in the loan forgiveness program may designate for each year of medical school, up to a maximum of four years, an agreed amount, not to exceed $10,000, as a qualified loan For each year that a participant serves as a physician in a designated rural area, up to a maximum of four years, the commissioner shall annually pay an amount equal to one year of qualified loans Participants who move their practice from one designated rural area to another remain eligible for loan repayment In addition, in any year that a resident participating in the loan forgiveness program serves at least four weeks during a year of residency substituting for a rural physician to temporarily relieve the rural physician of rural practice commitments to enable the rural physician to take a vacation, engage in activities outside the practice area, or otherwise be relieved of rural practice commitments, the participating resident may designate up to an additional $2,000, above tne $10,000 yearly maximum

*[For text of subd 4, see M S 1998]*

Subd 5 **Loan forgiveness; underserved urban communities.** For each fiscal year beginning on and after 1995, the commissioner may accept up to four applicants who are medical residents for participation in the urban primary care physician loan forgiveness program The resident applicants may be in any year of residency training, however, priority will be given to the following categories of residents in descending order third year residents, second year residents, and first year residents If the commissioner does not receive enough qualified applicants per fiscal year to fill the number of slots for urban underserved communities, the slots may be allocated to residents who have applied for the rural physician loan forgiveness program in subdivision 1 Applicants are responsible for securing their own loans Applicants chosen to participate in the loan forgiveness program may designate for each year of medical school, up to a maximum of four years, an agreed amount, not to exceed $10,000, as a qualified loan For each year that a participant serves as a physician in a designated underserved urban area, up to a maximum of four years, the commissioner shall annually pay an amount equal to one year of qualified loans Participants who move their practice from one designated underserved urban community to another remain eligible for loan repayment

**History:** *1999 c 247 s 16–18*

## 144.1495 MIDLEVEL PRACTITIONERS.

*[For text of subds 1 and 2, see M S 1998]*

Subd 3 **Eligibility.** To be eligible to participate in the program, a midlevel practitioner student must submit an application to the commissioner while attending a program of study designed to prepare the individual for service as a midlevel practitioner A midlevel practitioner student who is accepted into this program must sign a contract to agree to serve a mini-

mum two–year service obligation within a designated rural area, which shall begin no later than March following completion of training

Subd 4 **Loan forgiveness.** The commissioner may accept up to eight applicants per year for participation in the loan forgiveness program Applicants are responsible for securing their own loans Applicants chosen to participate in the loan forgiveness program may designate for each year of midlevel practitioner study, up to a maximum of two years, an agreed amount, not to exceed $7,000, as a qualified loan For each year that a participant serves as a midlevel practitioner in a designated rural area, up to a maximum of four years, the commissioner shall annually repay an amount equal to one–half a qualified loan Participants who move their practice from one designated rural area to another remain eligible for loan repayment

*[For text of subd 5, see M S 1998]*

**History:** *1999 c 247 s 19,20*

## 144.1496 NURSES IN NURSING HOMES OR ICFMRS.

*[For text of subd 1, see M S 1998]*

Subd 2 **Eligibility.** To be eligible to participate in the loan forgiveness program, a person enrolled in a program of study designed to prepare the person to become a registered nurse or licensed practical nurse must submit an application to the commissioner before completion of a nursing education program A nurse who is selected to participate must sign a contract to agree to serve a minimum one–year service obligation providing nursing services in a licensed nursing home or intermediate care facility for persons with mental retardation or related conditions, which shall begin no later than March following completion of a nursing program or loan forgiveness program selection

*[For text of subds 3 and 4, see M S 1998]*

Subd 5 **Rules.** The commissioner may adopt rules to implement this section

**History:** *1999 c 247 s 21,22*

## 144.1761 ACCESS TO ADOPTION RECORDS.

Subdivision 1 **Request.** (a) Whenever an adopted person requests the state registrar to disclose the information on the adopted person's original birth certificate, the state registrar shall act in accordance with the provisions of section 259 89

(b) The state registrar shall provide a copy of an adopted person's original birth certificate to an authorized representative of a federally recognized American Indian tribe for the sole purpose of determining the adopted person's eligibility for enrollment or membership Information contained on the birth certificate may not be used to provide the adopted person information about the person's birth parents except as provided in this section or section 259 83

**History:** *1999 c 245 art 8 s 1*

## 144.382 DEFINITIONS.

*[For text of subds 1 to 3, see M S 1998]*

Subd 4 **Public water supply.** "Public water supply" has the meaning given to "public water system" in the federal Safe Drinking Water Act, United States Code, title 42, section 300f, clause (4)

*[For text of subd 5, see M S 1998]*

**History:** *1999 c 18 s 1*

## TOBACCO USE PREVENTION AND LOCAL PUBLIC HEALTH ENDOWMENT FUND

## 144.395 TOBACCO USE PREVENTION AND LOCAL PUBLIC HEALTH ENDOWMENT FUND.

Subdivision 1 **Creation.** The tobacco use prevention and local public health endowment fund is created in the state treasury The state board of investment shall invest the fund

under section 11A.24. All earnings of the fund must be credited to the fund. The principal of the fund must be maintained inviolate.

Subd. 2. **Expenditures.** (a) Earnings of the fund, up to five percent of the fair market value of the fund on the preceding July 1, must be spent to reduce the human and economic consequences of tobacco use among the youth of this state through state and local tobacco prevention measures and efforts, and for other public health initiatives.

(b) Notwithstanding paragraph (a), on January 1, 2000, up to five percent of the fair market value of the fund is appropriated to the commissioner of health to distribute as grants under section 144.396, subdivisions 5 and 6, in accordance with allocations in paragraph (c), clauses (1) and (2). Up to $200,000 of this appropriation is available to the commissioner to conduct the statewide assessments described in section 144.396, subdivision 3.

(c) Beginning July 1, 2000, and on July 1 of each year thereafter, the money in paragraph (a) is appropriated as follows, except as provided in paragraphs (d) and (e):

(1) 67 percent to the commissioner of health to distribute as grants under section 144.396, subdivision 5, to fund statewide tobacco use prevention initiatives aimed at youth;

(2) 16.5 percent to the commissioner of health to distribute as grants under section 144.396, subdivision 6, to fund local public health initiatives aimed at tobacco use prevention in coordination with other local health-related efforts to achieve measurable improvements in health among youth; and

(3) 16.5 percent to the commissioner of health to distribute in accordance with section 144.396, subdivision 7.

(d) A maximum of $150,000 of each annual appropriation to the commissioner of health in paragraphs (b) and (c) may be used by the commissioner for administrative expenses associated with implementing this section.

(e) Beginning July 1, 2001, $1,100,000 of each annual appropriation to the commissioner under paragraph (c), clause (1), may be used to provide base level funding for the commissioner's tobacco prevention and control programs and activities. This appropriation must occur before any other appropriation under this subdivision.

**History:** *1999 c 245 art 11 s 4*

## 144.396 TOBACCO USE PREVENTION.

Subdivision 1. **Purpose.** The legislature finds that it is important to reduce the prevalence of tobacco use among the youth of this state. It is a goal of the state to reduce tobacco use among youth by 30 percent by the year 2005, and to promote statewide and local tobacco use prevention activities to achieve this goal.

Subd. 2. **Measurable outcomes.** The commissioner, in consultation with other public, private, or nonprofit organizations involved in tobacco use prevention efforts, shall establish measurable outcomes to determine the effectiveness of the grants receiving funds under this section in reducing the use of tobacco among youth.

Subd. 3. **Statewide assessment.** The commissioner of health shall conduct a statewide assessment of tobacco-related behaviors and attitudes among youth to establish a baseline to measure the statewide effect of tobacco use prevention activities. The commissioner of children, families, and learning must provide any information requested by the commissioner of health as part of conducting the assessment. To the extent feasible, the commissioner of health should conduct the assessment so that the results may be compared to nationwide data.

Subd. 4. **Process.** (a) The commissioner shall develop the criteria and procedures to allocate the grants under this section. In developing the criteria, the commissioner shall establish an administrative cost limit for grant recipients. The outcomes established under subdivision 2 must be specified to the grant recipients receiving grants under this section at the time the grant is awarded.

(b) A recipient of a grant under this section must coordinate its tobacco use prevention activities with other entities performing tobacco use prevention activities within the recipient's service area.

Subd. 5. **Statewide tobacco prevention grants.** (a) The commissioner of health shall award competitive grants to eligible applicants for projects and initiatives directed at the prevention of tobacco use. The project areas for grants include:

(1) statewide public education and information campaigns which include implementation at the local level, and

(2) coordinated special projects, including training and technical assistance, a resource clearinghouse, and contracts with ethnic and minority communities

(b) Eligible applicants may include, but are not limited to, nonprofit organizations, colleges and universities, professional health associations, community health boards, and other health care organizations Applicants must submit proposals to the commissioner The proposals must specify the strategies to be implemented to target tobacco use among youth, and must take into account the need for a coordinated statewide tobacco prevention effort

(c) The commissioner must give priority to applicants who demonstrate that the proposed project

(1) is research based or based on proven effective strategies,

(2) is designed to coordinate with other activities and education messages related to other health initiatives,

(3) utilizes and enhances existing prevention activities and resources, or

(4) involves innovative approaches preventing tobacco use among youth

Subd 6 **Local tobacco prevention grants.** (a) The commissioner shall award grants to eligible applicants for local and regional projects and initiatives directed at tobacco prevention in coordination with other health areas aimed at reducing high–risk behaviors in youth that lead to adverse health–related problems The project areas for grants include

(1) school–based tobacco prevention programs aimed at youth and parents,

(2) local public awareness and education projects aimed at tobacco prevention in coordination with locally assessed community public health needs pursuant to chapter 145A, or

(3) local initiatives aimed at reducing high–risk behavior in youth associated with tobacco use and the health consequences of these behaviors

(b) Eligible applicants may include, but are not limited to, community health boards, school districts, community clinics, Indian tribes, nonprofit organizations, and other health care organizations Applicants must submit proposals to the commissioner The proposals must specify the strategies to be implemented to target tobacco use among youth, and must be targeted to achieve the outcomes established in subdivision 2

(c) The commissioner must give priority to applicants who demonstrate that the proposed project or initiative is

(1) supported by the community in which the applicant serves,

(2) is based on research or on proven effective strategies,

(3) is designed to coordinate with other community activities related to other health initiatives,

(4) incorporates an understanding of the role of community in influencing behavioral changes among youth regarding tobacco use and other high–risk health–related behaviors, or

(5) addresses disparities among populations of color related to tobacco use and other high–risk health–related behaviors

(d) The commissioner shall divide the state into specific geographic regions and allocate a percentage of the money available for distribution to projects or initiatives aimed at that geographic region If the commissioner does not receive a sufficient number of grant proposals from applicants that serve a particular region or the proposals submitted do not meet the criteria developed by the commissioner, the commissioner shall provide technical assistance and expertise to ensure the development of adequate proposals aimed at addressing the public health needs of that region In awarding the grants, the commissioner shall consider locally assessed community public health needs pursuant to chapter 145A

Subd 7 **Local public health promotion and protection.** The commissioner shall distribute the funds available under section 144 395, subdivision 2, paragraph (c), clause (3) to community health boards for local health promotion and protection activities for local health initiatives other than tobacco prevention aimed at high risk health behaviors among youth The commissioner shall distribute these funds to the community health boards based on demographics and other need–based factors relating to health

Subd 8 **Coordination.** The commissioner shall coordinate the projects and initiatives funded under this section with the tobacco use prevention efforts of the Minnesota partnership for action against tobacco, community health boards, and other public, private, and nonprofit organizations and the tobacco prevention efforts that are being conducted on the national level

Subd 9 **Evaluation.** (a) Using the outcome measures established in subdivision 2, the commissioner of health shall conduct a biennial evaluation of the statewide and local tobacco use prevention projects and community health board activities funded under this section The evaluation must include

(1) the effect of these activities on the amount of tobacco use by youth and rates at which youth start to use tobacco products, and

(2) a longitudinal tracking of outcomes for youth

Grant recipients and community health boards shall cooperate with the commissioner in the evaluation and provide the commissioner with the information necessary to conduct the evaluation Beginning January 15, 2003, the results of each evaluation must be submitted to the chairs and members of the house health and human services finance committee and the senate health and family security budget division

(b) A maximum of $150,000 of the annual appropriation described in section 144 395, subdivision 2, paragraph (c), that is appropriated on July 1, 2000, and in every odd-numbered year thereafter, may be used by the commissioner to establish and maintain tobacco use monitoring systems and to conduct the evaluations This appropriation is in addition to the appropriation in section 144 395, subdivision 2, paragraph (d)

Subd 10 **Report.** The commissioner of health shall submit an annual report to the chairs and members of the house health and human services finance committee and the senate health and family security budget division on the statewide and local projects and community health board prevention activities funded under this section These reports must include information on grant recipients, activities that were conducted using grant funds, and evaluation data and outcome measures, if available These reports are due by January 15 of each year, beginning in 2001

Subd 11 **Audits required.** The legislative auditor shall audit endowment fund expenditures to ensure that the money is spent for tobacco use prevention measures

Subd 12 **Endowment fund not to supplant existing funding.** Appropriations from the account must not be used as a substitute for traditional sources of funding tobacco use prevention activities or public health initiatives Any local unit of government receiving money under this section must ensure that existing local financial efforts remain in place

Subd 13 **Sunset.** The tobacco use prevention and local public health endowment fund expires June 30, 2015 Upon expiration, the commissioner of finance shall transfer the principal and only remaining interest to the general fund

**History:** *1999 c 245 art 11 s 5*

## 144.413 DEFINITIONS.

*[For text of subd 1, see M S 1998]*

Subd 2 **Public place.** "Public place" means any enclosed, indoor area used by the general public or serving as a place of work, including, but not limited to, restaurants, retail stores, offices and other commercial establishments, public conveyances, educational facilities other than public schools, as defined in section 120A 05, subdivisions 9, 11, and 13, hospitals, nursing homes, auditoriums, arenas, meeting rooms, and common areas of rental apartment buildings, but excluding private, enclosed offices occupied exclusively by smokers even though such offices may be visited by nonsmokers

*[For text of subds 3 and 4, see M S 1998]*

**History:** *1999 c 245 art 2 s 24*

## 144.414 PROHIBITIONS.

Subdivision 1 **Public places.** No person shall smoke in a public place or at a public meeting except in designated smoking areas This prohibition does not apply in cases in

which an entire room or hall is used for a private social function and seating arrangements are under the control of the sponsor of the function and not of the proprietor or person in charge of the place Furthermore, this prohibition shall not apply to places of work not usually frequented by the general public, except that the state commissioner of health shall establish rules to restrict or prohibit smoking in factories, warehouses, and those places of work where the close proximity of workers or the inadequacy of ventilation causes smoke pollution detrimental to the health and comfort of nonsmoking employees

*[For text of subds 2 and 3, see M S 1998]*

**History:** *1999 c 245 art 2 s 25*

## 144.4165 TOBACCO PRODUCTS PROHIBITED IN PUBLIC SCHOOLS.

No person shall at any time smoke, chew, or otherwise ingest tobacco or a tobacco product in a public school, as defined in section 120A 05, subdivisions 9, 11, and 13 This prohibition extends to all facilities, whether owned, rented, or leased, and all vehicles that a school district owns, leases, rents, contracts for, or controls Nothing in this section shall prohibit the lighting of tobacco by an adult as a part of a traditional Indian spiritual or cultural ceremony For purposes of this section, an Indian is a person who is a member of an Indian tribe as defined in section 260 755 subdivision 12

**History:** *1999 c 139 art 4 s 2, 1999 c 245 art 2 s 26*

## 144.56 STANDARDS.

*[For text of subds 1 to 2a, see M S 1998]*

Subd 2b **Boarding care homes.** The commissioner shall not adopt or enforce any rule that limits

(1) a certified boarding care home from providing nursing services in accordance with the home's Medicaid certification, or

(2) a noncertified boarding care home registered under chapter 144D from providing home care services in accordance with the home's registration

*[For text of subds 3 and 4, see M S 1998]*

**History:** *1999 c 245 art 2 s 27*

## 144.651 PATIENTS AND RESIDENTS OF HEALTH CARE FACILITIES; BILL OF RIGHTS.

*[For text of subds 1 to 32, see M S 1998]*

Subd 33 **Restraints.** (a) Competent nursing home residents, family members of residents who are not competent, and legally appointed conservators, guardians, and health care agents as defined under section 145C 01, have the right to request and consent to the use of a physical restraint in order to treat the medical symptoms of the resident

(b) Upon receiving a request for a physical restraint, a nursing home shall inform the resident, family member, or legal representative of alternatives to and the risks involved with physical restraint use The nursing home shall provide a physical restraint to a resident only upon receipt of a signed consent form authorizing restraint use and a written order from the attending physician that contains statements and determinations regarding medical symptoms and specifies the circumstances under which restraints are to be used

(c) A nursing home providing a restraint under paragraph (b) must

(1) document that the procedures outlined in that paragraph have been followed,

(2) monitor the use of the restraint by the resident, and

(3) periodically, in consultation with the resident, the family, and the attending physician, reevaluate the resident's need for the restraint

(d) A nursing home shall not be subject to fines, civil money penalties, or other state or federal survey enforcement remedies solely as the result of allowing the use of a physical

restraint as authorized in this subdivision Nothing in this subdivision shall preclude the commissioner from taking action to protect the health and safety of a resident if

(1) the use of the restraint has jeopardized the health and safety of the resident, and

(2) the nursing home failed to take reasonable measures to protect the health and safety of the resident

(e) For purposes of this subdivision, "medical symptoms" include

(1) a concern for the physical safety of the resident, and

(2) physical or psychological needs expressed by a resident A resident's fear of falling may be the basis of a medical symptom

A written order from the attending physician that contains statements and determinations regarding medical symptoms is sufficient evidence of the medical necessity of the physical restraint

(f) When determining nursing facility compliance with state and federal standards for the use of physical restraints, the commissioner of health is bound by the statements and determinations contained in the attending physician's order regarding medical symptoms For purposes of this order, "medical symptoms" include the request by a competent resident, family member of a resident who is not competent, or legally appointed conservator, guardian, or health care agent as defined under section 145C 01, that the facility provide a physical restraint in order to enhance the physical safety of the resident

**History:** *1999 c 83 s 1*

## 144.664 DUTIES OF COMMISSIONER.

*[For text of subds 1 to 3, see M S 1998]*

Subd 4 [Repealed, 1999 c 86 art 2 s 6]

*[For text of subd 5, see M S 1998]*

## 144.9504 SECONDARY PREVENTION.

*[For text of subds 1 to 6, see M S 1998]*

Subd 7 **Relocation of residents.** (a) Within the limits of appropriations, the assessing agency shall ensure that residents are relocated from rooms or dwellings during a lead hazard reduction process that generates leaded dust, such as removal or disruption of lead–based paint or plaster that contains lead Residents shall not remain in rooms or dwellings where the lead hazard reduction process is occurring An assessing agency is not required to pay for relocation unless state or federal funding is available for this purpose The assessing agency shall make an effort to assist the resident in locating resources that will provide assistance with relocation costs Residents shall be allowed to return to the residence or dwelling after completion of the lead hazard reduction process An assessing agency shall use grant funds under section 144 9507 if available, in cooperation with local housing agencies, to pay for moving costs and rent for a temporary residence for any low–income resident temporarily relocated during lead hazard reduction For purposes of this section, "low–income resident" means any resident whose gross household income is at or below 185 percent of federal poverty level

(b) A resident of rental property who is notified by an assessing agency to vacate the premises during lead hazard reduction, notwithstanding any rental agreement or lease provisions

(1) shall not be required to pay rent due the landlord for the period of time the tenant vacates the premises due to lead hazard reduction,

(2) may elect to immediately terminate the tenancy effective on the date the tenant vacates the premises due to lead hazard reduction, and

(3) shall not, if the tenancy is terminated, be liable for any further rent or other charges due under the terms of the tenancy

(c) A landlord of rental property whose tenants vacate the premises during lead hazard reduction shall

(1) allow a tenant to return to the dwelling unit after lead hazard reduction and clearance inspection, required under this section, is completed, unless the tenant has elected to terminate the tenancy as provided for in paragraph (b), and

(2) return any security deposit due under section 504B 178 within five days of the date the tenant vacates the unit, to any tenant who terminates tenancy as provided for in paragraph (b)

*[For text of subds 8 to 11, see M S 1998]*

**History:** *1999 c 199 art 2 s 3*

## 144.9507 LEAD–RELATED FUNDING.

*[For text of subds 1 to 3, see M S 1998]*

Subd 4 [Repealed, 1999 c 245 art 2 s 45]

*[For text of subd 5, see M S 1998]*

**144.9511** [Repealed, 1999 c 245 art 2 s 45]

## 144.98 CERTIFICATION OF ENVIRONMENTAL LABORATORIES.

*[For text of subds 1 and 2, see M S 1998]*

Subd 3 **Fees.** (a) An application for certification under subdivision 1 must be accompanied by the biennial fee specified in this subdivision The fees are for

(1) base certification fee, $500, and

(2) test category certification fees

| Test Category | Certification Fee |
|---|---|
| Bacteriology | $200 |
| Inorganic chemistry, fewer than four constituents | $100 |
| Inorganic chemistry, four or more constituents | $300 |
| Chemistry metals, fewer than four constituents | $200 |
| Chemistry metals, four or more constituents | $500 |
| Volatile organic compounds | $600 |
| Other organic compounds | $600 |

(b) The total biennial certification fee is the base fee plus the applicable test category fees The biennial certification fee for a contract laboratory is 1 5 times the total certification fee

(c) Laboratories located outside of this state that require an on–site survey will be assessed an additional $1,200 fee

(d) Fees must be set so that the total fees support the laboratory certification program Direct costs of the certification service include program administration, inspections, the agency's general support costs, and attorney general costs attributable to the fee function

*[For text of subds 4 and 5, see M S 1998]*

**History:** *1999 c 250 art 3 s 21*

**NOTE** The amendment to subdivision 3 by Laws 1999 chapter 250, article 3 section 21 is effective July 1 2001 Laws 1999 chapter 250 article 3 section 29

## 144.99 ENFORCEMENT.

Subdivision 1 **Remedies available.** The provisions of chapters 103I and 157 and sections 115 71 to 115 77, 144 12, subdivision 1, paragraphs (1), (2), (5), (6), (10), (12), (13), (14), and (15), 144 1201 to 144 1204, 144 121, 144 1222, 144 35, 144 381 to 144 385,

144 411 to 144 417, 144 495, 144 71 to 144 74, 144 9501 to 144 9509, 144 992, 326 37 to 326 45, 326 57 to 326 785, 327 10 to 327 131, and 327 14 to 327 28 and all rules, orders, stipulation agreements, settlements, compliance agreements, licenses, registrations, certificates, and permits adopted or issued by the department or under any other law now in force or later enacted for the preservation of public health may, in addition to provisions in other statutes, be enforced under this section

*[For text of subds 2 to 11, see M S 1998]*

Subd 12 **Securing radioactive materials.** (a) In the event of an emergency that poses a danger to the public health, the commissioner shall have the authority to impound radioactive materials and the associated shielding in the possession of a person who fails to abide by the provisions of the statutes, rules, and any other item listed in subdivision 1 If impounding the source of these materials is impractical, the commissioner shall have the authority to lock or otherwise secure a facility that contains the source of such materials, but only the portions of the facility as is necessary to protect the public health An action taken under this paragraph is effective for up to 72 hours The commissioner must seek an injunction or take other administrative action to secure radioactive materials beyond the initial 72–hour period

(b) The commissioner may release impounded radioactive materials and the associated shielding to the owner of the radioactive materials and associated shielding, upon terms and conditions that are in accordance with the provisions of statutes, rules, and other items listed in subdivision 1 In the alternative, the commissioner may bring an action in a court of competent jurisdiction for an order directing the disposal of impounded radioactive materials and associated shielding or directing other disposition as necessary to protect the public health and safety and the environment The costs of decontamination, transportation, burial, disposal, or other disposition shall be borne by the owner or licensee of the radioactive materials and shielding or by any other person who has used the radioactive materials and shielding for business purposes

**History:** *1999 c 245 art 2 s 28,29*