NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the *Register* first as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council or the Attorney General. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the *Register* after the final rules have been submitted for filing and publication.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 6. DEPARTMENT OF HEALTH SERVICES
COMMUNICABLE DISEASES AND INFESTATIONS

PREAMBLE

1. Sections Affected	Rulemaking Action
Chapter 6	Amend
Article 1	Amend
R9-6-101	Amend
R9-6-102	Renumber
R9-6-102	New Section
R9-6-103	Renumber
R9-6-105	Renumber
R9-6-106	Renumber
Exhibit I-A	New Exhibit
Article 2	Amend
R9-6-201	Repeal
R9-6-201	Renumber
R9-6-201	Amend
R9-6-202	Amend
Table 1	New Table
R9-6-203	Renumber
R9-6-203	New Section
Table 2	New Table
R9-6-204	Renumber
R9-6-204	New Section
Table 3	New Table
R9-6-205	New Section
R9-6-206	Renumber
R9-6-206	Amend
R9-6-207	New Section
Article 3	Amend
R9-6-301	Repeal
R9-6-301	Renumber
R9-6-301	Amend
R9-6-302	Renumber
R9-6-302	Amend
R9-6-303	Renumber
R9-6-303	New Section
R9-6-304	Renumber
R9-6-304	Amend
R9-6-305	Renumber
R9-6-305	Amend
R9-5-306	Renumber
R9-6-306	Amend
R9-6-307	Renumber
R9-6-307	New Section
R9-6-308	Renumber
R9-6-308	Amend
R9-6-309	Renumber

R9-6-309	Amend
R9-6-310	Renumber
R9-6-310	Amend
R9-6-311	Renumber
R9-6-311	Amend
R9-6-312	Renumber
R9-6-312	Amend
R9-6-313	Renumber
R9-6-313	Amend
R9-6-314	Renumber
R9-6-314	Amend
R9-6-315	Renumber
R9-6-315	Amend
R9-6-316	Repeal
R9-6-316	Renumber
R9-6-316	Amend
R9-6-317	Renumber
R9-6-317	New Section
R9-6-318	Renumber
R9-6-318	Amend
R9-6-319	Renumber
R9-6-319	New Section
R9-6-320	Repeal
R9-6-320	New Section
R9-6-321	Renumber
R9-6-321	Amend
R9-6-322	Renumber
R9-6-322	Amend
R9-6-323	Renumber
R9-6-323	Amend
R9-6-324	Renumber
R9-6-324	Amend
R9-6-325	Renumber
R9-6-325	New Section
R9-6-326	Renumber
R9-6-326	Amend
R9-6-327	Renumber
R9-6-327	New Section
R9-6-328	Renumber
R9-6-328	New Section
R9-6-329	Repeal
R9-6-329	Renumber
R9-6-329	Amend
R9-6-330	Repeal
R9-6-330	Renumber
R9-6-330	Amend
R9-6-331	Renumber
R9-6-331	Amend
R9-6-332	Repeal
R9-6-332	Renumber
R9-6-332	Amend
R9-6-333	Renumber
R9-6-333	Amend
R9-6-334	Renumber
R9-6-334	New Section
R9-6-335	Renumber
R9-6-335	Amend
R9-6-336	Renumber
R9-6-336	Amend
R9-6-337	Renumber
R9-6-337	Amend
R9-6-338	Renumber
R9-6-338	New Section
R9-6-339	Renumber
R9-6-339	Amend

R9-6-340	Renumber
R9-6-340	New Section
R9-6-341	Renumber
R9-6-341	Amend
R9-6-342	Renumber
R9-6-342`	Amend
R9-6-343	Renumber
R9-6-343	Amend
R9-6-344	Renumber
R9-6-344	Amend
R9-6-345	Renumber
R9-6-345	New Section
R9-6-346	Renumber
R9-6-346	Amend
R9-6-347	Renumber
R9-6-347	Amend
R9-6-348	Renumber
R9-6-348	Amend
R9-6-349	Renumber
R9-6-349	Amend
R9-6-350	Renumber
R9-6-350	Amend
R9-6-351	Renumber
R9-6-351	Amend
R9-6-352	Renumber
R9-6-352	Amend
R9-6-353	Renumber
R9-6-353	Amend
R9-6-354	Renumber
R9-6-354	Amend
R9-6-355	Renumber
R9-6-355	Amend
R9-6-356	Renumber
R9-6-356	Amend
R9-6-357	Repeal
R9-6-357	Renumber
R9-6-357	Amend
R9-6-358	Renumber
R9-6-358	Amend
R9-6-359	Repeal
R9-6-359	Renumber
R9-6-359	Amend
R9-6-360	Renumber
R9-6-360	Amend
R9-6-361	Renumber
R9-6-361	Amend
R9-6-362	Renumber
R9-6-362	Amend
R9-6-363	Renumber
R9-6-363	Amend
R9-6-364	Renumber
R9-6-364	New Section
R9-6-365	Renumber
R9-6-365	Amend
R9-6-366	Renumber
R9-6-366	New Section
R9-6-367	Renumber
R9-6-367	Amend
R9-6-368	Renumber
R9-6-368	Amend
R9-6-369	Renumber
R9-6-369	Amend
R9-6-370	Renumber
R9-6-370	Amend
R9-6-371	Renumber

R9-6-371	Amend
R9-6-372	Renumber
R9-6-372	Amend
R9-6-373	Renumber
R9-6-373	Amend
R9-6-374	Renumber
R9-6-374	Amend
R9-6-375	Renumber
R9-6-375	Amend
R9-6-376	Renumber
R9-6-376	Amend
R9-6-377	New Section
R9-6-378	New Section
R9-6-379	Renumber
R9-6-379	Amend
R9-6-380	Renumber
R9-6-380	Amend
R9-6-381	Renumber
R9-6-381	Amend
R9-6-382	Renumber
R9-6-382	Amend
R9-6-383	Renumber
R9-6-383	Amend
R9-6-384	New Section
R9-6-385	New Section
R9-6-386	Renumber
R9-6-386	Amend
R9-6-387	Renumber
R9-6-387	Amend
R9-6-388	New Section
Exhibit III-A	New Exhibit
Exhibit III-B	New Exhibit
Exhibit III-C	New Exhibit
Exhibit III-D	New Exhibit
Exhibit III-E	New Exhibit
Exhibit III-F	New Exhibit
Exhibit III-G	New Exhibit
Exhibit III-H	New Exhibit
Exhibit III-I	New Exhibit
Exhibit III-J	New Exhibit
Exhibit III-K	New Exhibit
Exhibit III-L	New Exhibit
Exhibit III-M	New Exhibit
Exhibit III-N	New Exhibit
R9-6-501	Renumber
R9-6-501	Amend
R9-6-502	Renumber
R9-6-502	Amend
R9-6-503	Renumber
R9-6-503	Amend
R9-6-504	Renumber
R9-6-504	Amend
R9-6-601	Renumber
R9-6-601	Amend
R9-6-602	Repeal
R9-6-602	Renumber
R9-6-602	Amend
R9-6-603	Repeal
R9-6-603	New Section
R9-6-604	New Section

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statutes: A.R.S. §§ 36-104(3) and 36-136(A)(7) and (F)

Implementing statutes: A.R.S. §§ 11-1003, 32-1483, 36-132(A)(1), 36-136(H)(1) and (12) and (L), 36-624, 36-626, 36-662, 36-664, 36-714, 36-721, 36-723, 36-788, and 36-789

3. The effective date of the rules:

October 2, 2004

4. A list of all previous notices appearing in the Register addressing the final rule:

Notice of Rulemaking Docket Opening: 9 A.A.R. 1819, June 6, 2003

Notice of Proposed Rulemaking: 10 A.A.R. 96, January 9, 2004

Notice of Public Information: 10 A.A.R. 258, January 16, 2004

Notice of Supplemental Proposed Rulemaking: 10 A.A.R. 1450, April 16, 2004

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name:	Ken Komatsu, Surveillance Project Coordinator
Address:	Arizona Department of Health Services Office of Public Health Emergency Preparedness and Response 150 N. 18th Ave. Phoenix, AZ 85007
Telephone:	(602) 364-3289
Fax:	(602) 364-3265
E-mail:	kkomats@hs.state.az.us
or	
Name:	Kathleen Phillips, Rules Administrator
Address:	Arizona Department of Health Services Office of Administrative Rules 1740 W. Adams, Suite 202 Phoenix, AZ 85007
Telephone:	(602) 542-1264
Fax:	(602) 364-1150
E-mail:	kphilli@hs.state.az.us

6. An explanation of the rule, including the agency's reasons for initiating the rule:

The Arizona Department of Health Services (ADHS) completed a five-year-review report for 9 A.A.C. 6 in December 1999. The five-year review report was approved by the Governor's Regulatory Review Council in March 2000. As a result of the five-year review, ADHS intended to complete three separate rulemakings to take the actions proposed in the five-year-review report. Two of those rulemakings have already been completed. This represents the third of the three rulemakings.

A.R.S. § 36-136(H)(1) requires ADHS by rule to define and prescribe reasonably necessary measures for detecting, reporting, preventing, and controlling communicable and preventable diseases. The purpose of this rulemaking is to improve Arizona's system for detecting, reporting, controlling, and preventing communicable diseases and, thereby, to protect and improve the public health.

In this rulemaking, ADHS updates and clarifies existing definitions, adds definitions for terms previously undefined, and moves definitions into the Articles to which they pertain. In Articles 2, 3, 5, and 6, ADHS modifies the rules as necessary to update and clarify the rules and to make the rules more effective in detecting, preventing, and controlling communicable diseases. For example, this rulemaking adds tables to make reporting requirements easier to find and follow; adds reportable diseases; adds reporting requirements for shelters, correctional facilities, and pharmacies; adds language regarding federal and tribal entity reporting; and adds language to address the release of information under the federal Health Insurance Portability and Accountability Act (HIPAA). In addition, this rulemaking shortens the reporting time for some diseases and requires local health agencies to complete and submit ADHS forms or Centers for Disease Control and Prevention forms for specified diseases. This rulemaking also adds tuberculosis control measures for correctional facilities. Finally, this rulemaking brings the rules into compliance with current rulemaking format and style requirements.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

ADHS is relying on information in the following documents that ADHS does not believe to be "studies," but that contain information derived from studies:

American Public Health Association, *Control of Communicable Diseases Manual* (17th ed. 2000), available from the American Public Health Association, 800 I St., NW, Washington, DC 20001-3710;

American Academy of Pediatrics, *Red Book 2003: Report of the Committee on Infectious Diseases* (26th ed. 2003), available from the American Academy of Pediatrics, P.O. Box 927, 141 Northwest Point Blvd., Elk Grove Village, IL 60009-0927;

Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "Prevention and Control of Tuberculosis in Correctional Facilities: Recommendations of the Advisory Council for the Elimination of Tuberculosis," published in 45 *Morbidity and Mortality Weekly Report* 1-27 (June 7, 1996), available at http://www.cdc.gov/mmwr/preview/mmwrhtml/00042214.htm and http://www.cdc.gov/mmwr/PDF/RR/RR4508.pdf; and

Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "Guidelines for Environmental Infection Control in Health-Care Facilities: Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee," published in 52 *Morbidity and Mortality Weekly Report* 1-42 (June 6, 2003), available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5210a1.htm and http://www.cdc.gov/mmwr/PDF/RR/RR5210.pdf.

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

The changes in the rules will primarily benefit the public by enhancing the detection, reporting, control, and prevention of communicable diseases in Arizona, including communicable diseases that have been identified by the Centers for Disease Control and Prevention (CDC) as potential bioterrorism agents. ADHS; local health agencies (LHAs); health care institutions (HCIs); health care providers (HCPs); clinical laboratories (CLs); schools; child care establishments (CCEs); correctional facilities (CFs); establishments involved in the donation of blood, blood components, organs, milk, and tissues; and animal control agencies will also benefit from the changes in the rules. ADHS believes that the benefits of this rulemaking will far outweigh the burdens.

The changes in the rules will result in additional costs to ADHS, LHAs, CFs, HCIs, HCPs, shelters, CCEs, schools, pharmacies and pharmacists, CLs, food establishments, and animal control agencies.

As used in this summary, minimal means less than $1,000, moderate means $1,000 to $9,999, and substantial means $10,000 or more. This summary describes only those rule changes that will result in the most significant economic impacts.

In R9-6-101, ADHS adopts a definition of "school" that includes colleges, universities, institutions offering private vocational programs, and degree-granting institutions. In the absence of a definition, "school" has been interpreted to include only K-12 schools. Thus, postsecondary educational institutions were not required to comply with the requirements for schools. Requiring them to comply will result in no burden to a minimal-to-moderate burden for each postsecondary educational institution, depending on whether a relevant disease or outbreak occurs at the educational institution. Each required report or exclusion should result in a minimal burden.

R9-6-102 requires a person in possession of protected health information to release it to ADHS or an LHA if requested for the purpose of detecting, preventing, or controlling disease, injury, or disability. This will result in a potentially substantial benefit to ADHS, LHAs, and persons in possession of protected health information because it will enable the release of this information without concern about potential noncompliance with the Health Insurance Portability and Accountability Act (HIPAA).

R9-6-202 requires CF administrators to report for the same diseases and occurrences for which HCPs and HCI administrators are required to report. This will result in no burden to a minimal burden for CFs, which previously were not required to report unless their employees were required to report as physicians or health care facility administrators. The degree of impact will depend on whether a relevant disease or occurrence is detected at a CF. If a CF does need to report, the cost of each report should be minimal. ADHS is also broadening physician reporting to require all HCPs to report. ADHS is doing this because ADHS believes that registered nurse practitioners, physician assistants, and dentists are frequently in a position to diagnose reportable communicable diseases and to detect reportable occurrences. This change may result in a minimal burden for each non-physician HCP and will result in a significant benefit for ADHS, LHAs, and the public because it will result in more effective surveillance of communicable diseases and related occurrences in Arizona, which can lead to more effective control measures.

The rules add case or suspect case reporting by HCPs, HCI administrators, or CF administrators within 24 hours for: emerging or exotic diseases, enterohemorrhagic *E. coli* other than *E. coli* O157:H7 (EHEC), enterotoxigenic *E. coli* (ETEC), hemolytic uremic syndrome (HUS), severe acute respiratory syndrome (SARS), smallpox, unexplained death with a history of fever, viral hemorrhagic fever, and West Nile virus infection. This will result in a minimal burden for HCPs, HCI administrators, and CF administrators and in a minimal-to-moderate burden for LHAs. Because these diseases are uncommon, and the number of unexplained deaths with a history of fever is expected to be low, the number of case and suspect case reports should be low. In addition, West Nile virus infection is already reportable by physicians and health care facilities through an Emergency Order issued by the ADHS Director in August 2003, and

SARS is already reportable by HCPs and HCI administrators through an Emergency Order issued by the ADHS Director in December 2003. These reporting requirements will result in a significant benefit to LHAs, ADHS, and the public. Smallpox, viral hemorrhagic fevers, EHEC, ETEC, unexplained death with a history of fever, and emerging and exotic diseases could be signs of bioterrorism, so rapid detection of cases is essential. HUS is caused by EHEC and is a nationally notifiable disease. SARS is a serious health threat for which control measures, including isolation and quarantine, need to be implemented immediately upon detection. West Nile virus infection is potentially deadly, particularly in the elderly, so tracking its prevalence is important so that vectors can be controlled and disease prevented.

ADHS is also changing the reporting deadlines for some diseases and is adding reporting requirements for other diseases and occurrences, including basidiobolomycosis, Creutzfeldt-Jakob disease, *Cyclospora* infection, cysticercosis, Kawasaki syndrome, lymphocytic choriomeningitis, parasitic encephalitis, *Streptococcus pneumoniae*, and vaccinia-related adverse events. ADHS believes that the addition of these reporting requirements will result in a minimal burden to HCPs, HCI administrators, and CF administrators and a minimal-to-moderate burden to LHAs. Most of these diseases are relatively uncommon, and ADHS estimates that their addition will result in a combined total of approximately 1,000 annual reports.

R9-6-203 adds a requirement for shelter administrators to report for 17 communicable diseases or occurrences. This will result in no burden to a minimal burden for shelter administrators. The degree of impact will depend on whether a relevant disease or occurrence is detected at a shelter. ADHS estimates that there were approximately 4000 individual cases of these diseases reported in Arizona in 2003. Because only a very small percentage of the population resides in shelters, there are numerous shelters, and only outbreak reporting is required for four of these, ADHS believes that each individual shelter will be at most only minimally burdened.

R9-6-204 adds a requirement for a CL director to report to ADHS immediately when a specimen is received for testing for *Bacillus anthracis* (anthrax), *Clostridium botulinum* toxin (botulism), dengue virus, an emerging or exotic disease agent, *Francisella tularensis* (tularemia), variola virus (smallpox), a viral hemorrhagic fever agent, or *Yersinia pestis* (plague). This will result in a minimal burden for CLs, from the time spent reporting. Clinical testing for these agents is extremely rare, and ADHS believes that very few reports will be made. This will result in a significant benefit to ADHS, LHAs, and the public. These agents are all identified by the CDC as potential bioterrorism agents, so rapid detection of a potential case or suspect case is essential. Requiring laboratory reporting when a specimen is received for testing is designed as a safeguard for detection in the event that the HCP ordering the test has failed to report a suspect case.

R9-6-204 also requires weekly isolate submission by CLs for *Bacillus anthracis*, *Brucella* spp., *E. coli*: *Shiga*-toxin producing, *Francisella tularensis*, *Legionella* spp., *Listeria* spp., *Mycobacterium tuberculosis* complex, *Shigella* spp., *Streptococcus pneumoniae*, vancomycin-intermediate *Staphylococcus aureus*, vancomycin-resistant *Staphylococcus epidermidis*, *Vibrio* spp., *Yersinia* spp., and *Yersinia pestis*. This will result in a minimal-to-moderate burden for each CL, from the supplies used and shipping costs. ADHS estimates that each isolate submitted would have a cost of approximately $6.60-$17.27. In 2003, Arizona had 1647 reported cases of the diseases caused by these agents. Thus, ADHS estimates that the aggregate supply and shipping cost for all CLs would be approximately $10,870-$28,444. Each CL will also incur a minimal-to-moderate burden from the staff time involved in preparing isolates for shipment. This will result in a significant benefit to ADHS, LHAs, and the public. New technologies for strain-typing allow public health laboratories to identify related clones and clusters within the state and to share those patterns with a national database to identify interstate clusters, thus allowing public health to track possible sources of disease or the circumstances of exposure and to intervene and implement control measures to prevent disease. Also, for some of these agents, analyzing isolates will enable ADHS and LHAs to monitor the resistance patterns of the agents and thereby assist HCPs in their choice of antibiotic therapy.

R9-6-204 also adds CL reporting for 21 disease agents and test results and changes the reporting deadline for some others. ADHS believes that these changes will result in a minimal-to-moderate burden to each CL from the additional time spent reporting. A number of the new reporting requirements will result in very few reports. ADHS is mitigating the burden of reporting influenza virus and respiratory synctial virus results by allowing aggregate number reporting for those and the burden of reporting methicillin-resistant *Staphylococcus aureus* by only requiring reporting of the initial positive for an individual. In addition, the burden of the new reporting requirements will be mitigated for those CLs choosing to switch to electronic reporting when secure, web-based electronic reporting becomes available. ADHS anticipates that electronic reporting for CLs will be available by July 2004.

R9-6-205 requires pharmacist and pharmacy administrator reporting when two or more anti-tuberculosis drugs are initially prescribed (not when refilled). This will result in a minimal burden for each pharmacist and pharmacy administrator, from the time spent reporting. Because reporting is limited to initial prescriptions, ADHS estimates that the number of annual reports should be fewer than 500 (based on the 295 reported cases of tuberculosis (TB) in 2003). This will result in a significant benefit for ADHS, LHAs, and the public. Reporting from pharmacists and pharmacy administrators will enable ADHS and LHAs to track the true prevalence of TB in Arizona by providing information about TB cases or suspect cases who have not been reported by HCPs, HCIs, CFs, or CLs. It will also enable ADHS and LHAs to implement control measures as necessary for these cases and suspect cases and to target other prevention efforts, such as education, resulting in the prevention of disease.

R9-6-206 requires an LHA to report specific information to ADHS within one working day after receiving a report of an unexplained death with a history of fever and additional information within 30 days after receiving the report. This will result in a minimal-to-moderate burden for LHAs, from initially reporting and then completing the epidemiologic investigation and the later report. ADHS estimates that an epidemiologic investigation takes anywhere from five minutes to 160 hours, depending on the complexity of the investigation. However, ADHS estimates that the average duration for an epidemiologic investigation is one hour, because most epidemiologic investigations are completed over the telephone in a relatively short period of time. Based on an estimated salary of $40,000-$42,000 for an LHA's nurse investigator, the cost of a typical epidemiologic investigation is approximately $40, including the investigation and completion of the report. Completion of the report itself is estimated to take approximately 20 minutes to one hour. ADHS anticipates fewer than 100 annual reports of unexplained death with a history of fever. This will result in a significant benefit for ADHS and the public. Unexplained death with a history of fever could be a sign of bioterrorism or emergence of a new disease. Obtaining prompt reporting of standard information about each unexplained death with a history of fever will place ADHS in a position to detect bioterrorism or emerging disease and to act to prevent further disease and death. Obtaining additional information later will enable ADHS to study causes, determine trends, and identify system errors.

R9-6-206 also adds a requirement to include a summary profile of the signs and symptoms of illness and an epidemiologic curve in a report of an epidemiologic investigation of an outbreak. This will result in a minimal burden for LHAs, from the additional time spent preparing a report, which ADHS estimates to be one to two hours, depending on whether these are created using case information already entered into a computer or whether they are created by hand. This will result in a significant benefit for LHAs, ADHS, and the public because it will provide LHAs with important epidemiologic information in a concise format that will enable LHAs to better characterize the nature of an outbreak and thus the possible source of disease.

R9-6-207 requires a federal or tribal entity, to the extent permitted by law, to report as state entities do. ADHS believes that this will result in no burden to a minimal burden for federal or tribal entities, a number of which already report to ADHS voluntarily or through agreement, because they will only report if they believe that federal law permits them to do so and if they would have been inclined to do so absent the rule. This will result in a significant benefit to ADHS, LHAs, the public, and federal or tribal entities because it will enable federal or tribal entities to report to ADHS without worrying about potential noncompliance with HIPAA. Thus, ADHS and LHAs will have a more complete picture of the epidemiology of disease in Arizona and will be better able to ensure that appropriate control measures and educational campaigns are implemented as needed.

In 48 Sections in Article 3, the rules require LHAs to conduct, rather than allowing them to direct, epidemiologic investigations. This change will result in no economic burden for LHAs because A.R.S. § 36-624 already requires an LHA to investigate immediately when it is apprised that infectious or contagious disease exists within its jurisdiction. Additionally, ADHS believes that most LHAs are already conducting (rather than directing) epidemiologic investigations. This will result in a minimal benefit to ADHS, LHAs, and the public because it clarifies the responsibilities of LHAs related to epidemiologic investigations.

In 41 Sections in Article 3, the rules require LHAs to conduct epidemiologic investigations for reported suspect cases as well as reported cases. This change will result in no economic burden for LHAs because A.R.S. § 36-624 already requires an LHA to investigate immediately when it is apprised that infectious or contagious disease exists within its jurisdiction. The statute clearly contemplates suspect case investigations as well because it alludes to an investigation revealing that disease does not exist. This will result in a minimal benefit to ADHS, LHAs, and the public because it clarifies the responsibilities of LHAs related to epidemiologic investigations.

In 27 Sections in Article 3, the rules eliminate requirements for diagnosing HCPs or authorized representatives to counsel about handwashing or concurrent disinfection or disinfestation. This will result in a minimal-to-moderate benefit for HCPs, who will no longer provide this counseling unless they believe that to do so is consistent with the current standard of care in the medical community.

In 32 Sections in Article 3, the rules require LHAs to complete and submit CDC forms to ADHS for cases of diseases. This will result in a minimal-to-moderate burden for LHAs. The forms are generally brief (ranging from one to 14 pages, with most at two to three pages) and require information that should already be gathered in an epidemiologic investigation. Indeed, LHAs have been completing and submitting most of these forms to ADHS for years. This will result in a significant benefit to ADHS because, for nationally notifiable diseases and some other diseases that are reported to the CDC, it ensures that ADHS has the information needed to report to the CDC. For other diseases, it ensures that a thorough epidemiologic investigation is completed, which can lead to identification of the source of illness and prevention of further transmission of disease.

In 14 Sections in Article 3, the rules require LHAs to complete and submit ADHS forms to ADHS for cases or outbreaks of disease. This will result in a minimal-to-moderate burden for LHAs. The forms are brief (ranging from one to three pages) and require information that should already be gathered in an epidemiologic investigation. Indeed, LHAs have been completing and submitting most of these forms to ADHS for years. This will result in a significant benefit to ADHS because it ensures that a thorough epidemiologic investigation is completed, which can lead to identification of the source of illness and prevention of further transmission of disease.

In eight Sections in Article 3, the rules change the epidemiologic investigation requirement to require an investigation for each case or suspect case instead of an investigation for each outbreak. This will result in no burden for LHAs because A.R.S. § 36-624 already requires an LHA to investigate immediately when it is apprised that infectious or contagious disease exists within its jurisdiction. The statute clearly contemplates suspect case investigations as well because it alludes to an investigation revealing that disease does not exist. Based on reported cases in 2003, ADHS anticipates approximately 2,611 reported cases of these eight diseases each year. This will result in a significant benefit for ADHS, LHAs, and the public because investigating a case or suspect case can lead to identification of the source of illness and prevention of further transmission of disease. For example, in Pennsylvania recently, investigation of a hepatitis A case revealed an outbreak for which the source of illness was scallions served in a Mexican restaurant. The investigation also linked the outbreak to a multi-state outbreak from the same source.

In 20 Sections in Article 3, the rulemaking adds a requirement for an epidemiologic investigation of each case or suspect case. This will result in no burden for LHAs because A.R.S. § 36-624 already requires an LHA to investigate immediately when it is apprised that infectious or contagious disease exists within its jurisdiction. The statute clearly contemplates suspect case investigations as well because it alludes to an investigation revealing that disease does not exist. ADHS estimates that there will be approximately 48 to 89 reported cases of these 20 diseases each year. This will result in a significant benefit for ADHS, LHAs, and the public because investigating a case or suspect case can lead to identification of the source of illness and prevention of further transmission of disease. The new requirements for epidemiologic investigations of cases or suspect cases are particularly important for those diseases that have been identified by the CDC as potential signs of bioterrorism: emerging or exotic disease, smallpox, and viral hemorrhagic fever. Additionally, unexplained death with a history of fever could be a sentinel event for bioterrorism or emerging disease, so investigation of each case or suspect case is critical.

In seven Sections within Article 3, ADHS eliminates requirements prescribing how diagnosing HCPs are to treat or counsel cases. ADHS does not believe that any person will be burdened by these changes and believes that this will result in no burden and a minimal benefit to diagnosing HCPs, from the increased flexibility. ADHS believes that HCPs will continue to provide or arrange for this counseling and to prescribe antibiotics where appropriate because these practices are consistent with the current standard of care in the medical community.

In eight Sections within Article 3, ADHS eliminates restrictions related to donated blood, plasma, milk, organs, sperm, or other tissue. The restrictions varied somewhat by Section, but were related to prohibiting donations from cases, suspect cases, or carriers and to prohibiting the use of donations from cases, suspect cases, or carriers. ADHS believes that no person will be burdened by the elimination of these restrictions, but that entities involved in the procurement or use of blood, blood components, milk, organs, sperm, or other tissues will be significantly benefited by their elimination because these entities will be required to comply only with the requirements of the federal government or industry-specific guidelines, not with Arizona state requirements that may not be as current as and that may not be consistent with the other requirements. ADHS believes that these restrictions are unnecessary in light of federal regulation and industry-specific standards. ADHS also believes that, due to liability concerns, entities involved in the procurement or use of these items are extremely cautious about transmitting disease through donations and thus self-regulate where federal regulation is currently lacking. ADHS is retaining the requirements for blood bank or blood or plasma center operators to notify donors of positive hepatitis B, HIV, or syphilis test results because A.R.S. § 32-1483 requires ADHS to have a notification requirement in rule. However, ADHS is eliminating the 30-day deadline and just requiring compliance with 21 CFR 630.6.

In 18 Sections in Article 3, ADHS expands or adds new requirements for exclusion of cases, suspect cases, carriers, or contacts from certain settings or activities—generally working as a food handler, caring for children in or attending a CCE, attending a school, and caring for patients or residents in an HCI. The exclusion requirements already in rule vary, so the additional exclusion requirements vary from Section to Section. In each instance, an exclusion will result in a significant benefit for ADHS, LHAs, and the public because exclusion of a case, suspect case, carrier, or contact from these settings or activities will help to prevent transmission of disease. The new exclusion requirements will also benefit each individual who would otherwise have become infected. These changes will result in a minimal-to-moderate burden for LHAs because of the requirement to exclude new individuals. LHAs generally effect exclusion by telephoning the food establishment, HCI, school, or CCE from which a case, suspect case, carrier, or contact is to be excluded. Compliance with exclusion requirements is generally good and does not typically necessitate an LHA visit to the affected food establishment, HCI, school, or CCE. For five of these Sections, the rules require that exclusion be effected by a person other than the LHA—generally a school or CCE administrator, although the rule for pertussis includes HCI administrators, the rule for scabies includes HCI or shelter administrators, and the rule for streptococcal group A infection includes HCI administrators and persons in charge of food establishments. These requirements result in a minimal burden to the person responsible for effecting the exclusion. The extent of the burden to the individual excluded or, for a child who is excluded, the parent of the individual excluded depends on the duration of the exclusion and results from time lost from work or the cost of substitute care for an excluded child. For most exclusions, the burden will be minimal to moderate, but for exclusions of longer duration, such as for TB or typhoid fever, the burden can be moderate to substantial. ADHS estimates the following average durations of exclusion for cases of the different diseases: amebiasis, three to 20 days; campylobacteriosis, one to three days; cryptosporidiosis, one to 20 days with a mean of 10 days; EHEC, seven to 21 days; ETEC, seven to 21 days; giardiasis, five to seven days; HUS, seven to 21 days; hepatitis A, seven to 14 days; measles, four days; pertussis, five or 21 days; rubella, seven days (instead of four days, the current requirement); salmonellosis, three to seven days; scabies, one to

two days; shigellosis, one to eight days; streptococcal group A infection, one day; taeniasis, one day; TB, two to 12 weeks with a mean of two to four weeks; and typhoid fever, 33 days to 12 months, with a mean range of 33 to 90 days. In some instances, a case, suspect case, or symptomatic contact would be too ill to work even if not excluded, and thus will incur economic burden from the illness itself rather than from the exclusion requirement in rule.

In the Sections for diphtheria, Hansen's disease, and pertussis, ADHS expands the applicability of contact control measures to include close contacts rather than just household contacts. This will result in no burden to a minimal burden to LHAs for each case, from the time spent identifying close contacts and the time and, potentially, materials such as drugs needed to comply with the control measures, but it will result in a significant benefit for ADHS, LHAs, and the public because identifying and applying control measures to all individuals who have spent sufficient time with and have been within a sufficient proximity to a case to have sustained significant exposure to an infectious agent will help to prevent transmission of disease. This will also benefit each close contact who would otherwise have become a case.

In the Sections for mumps, pertussis, rubella, and varicella, ADHS requires an administrator of a school or CCE to consult with an LHA to determine exclusions and to comply with the LHA's recommendations for exclusion. This will result in a minimal-to-moderate burden for LHAs, from the time spent consulting with schools or CCEs. Each consultation should only take a few minutes and can be done by telephone. In 2003, Arizona had one reported case of mumps, 128 reported cases of pertussis, and no reported cases of rubella. Total varicella numbers are not yet available for 2003, but Arizona had 606 reported cases in 2002 and 930 reported cases between January 1 and August 31, 2003. This may result in a minimal-to-moderate burden for each affected school or CCE because of the need to exclude non-immune attendees and workers for some diseases, which may result in the need for substitute workers and complaints from the parents of excluded attendees, depending on the duration of exclusion. This may also result in a minimal-to-moderate burden for workers who are excluded or the parents of children who are excluded, from time lost from work or the cost of substitute care. It is important to note, however, that 9 A.A.C. 6, Article 7 requires immunization for mumps, pertussis, and rubella in order to attend school or a CCE unless an exemption is granted for personal, religious, or medical reasons. In addition, there is a licensed vaccine available for varicella, and routine varicella immunization is recommended by the CDC, the American Academy of Pediatrics, and the American Academy of Family Physicians, although it is not required by 9 A.A.C. 6, Article 7. ADHS has found that individuals who are opposed to immunization for religious or personal reasons may submit to immunization when there is a real threat of disease, which may prevent or shorten the duration of any exclusion for mumps, rubella, or varicella if an individual is immunized after exposure. These requirements will result in a significant benefit for ADHS, LHAs, the public, and the individuals excluded because exclusion helps to prevent transmission of disease.

In 12 Sections in Article 3, ADHS expands isolation precaution requirements, generally to make a diagnosing HCP or HCI administrator responsible for effecting isolation and to apply to any case, not just a hospitalized case. The affected Sections are those for *Haemophilus influenzae* invasive disease, measles, meningococcal invasive disease, plague, rubella, congenital rubella syndrome, TB, tularemia, vancomycin-resistant *Enterococcus* spp., vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus*, vancomycin-resistant *Staphylococcus epidermidis*, and varicella. The existing isolation precaution requirements vary somewhat, but generally make hospital administrators responsible for isolating hospitalized cases, without addressing other HCIs or the involvement of diagnosing HCPs. ADHS is aware that HCIs other than hospitals may have patients or residents who will require isolation for infectious disease and that diagnosing HCPs may even need to effect isolation for patients. For each of these diseases, ADHS believes that isolation precautions are consistent with the current standard for infection control in the medical community and, thus, that the change will result in no burden to a minimal burden to HCPs and HCI administrators. ADHS is changing the rules to clarify who is responsible for effecting isolation precautions and that isolation precautions are necessary even for non-hospitalized cases. These changes will result in a significant benefit for ADHS, LHAs, and the public because using isolation precautions with a case helps to prevent transmission of disease.

R9-6-302 adds a requirement for LHAs to disseminate surveillance information to HCPs. This will result in a minimal-to-moderate burden for LHAs, from the time and money spent disseminating surveillance information to HCPs. ADHS intentionally does not prescribe the manner in which this information is to be disseminated to HCPs so that each LHA can choose the most effective and cost-effective method. Some examples of how it could be done include a newsletter or other published information or a regularly updated website. This will result in a significant benefit for HCPs and the public because HCPs will have current surveillance information and thus may be able to make better-informed decisions regarding diagnosis and effective treatment of patients, thereby preventing disease.

R9-6-303 adds a requirement for the person in charge of a food establishment to ensure compliance with all food handler exclusion requirements appearing in Article 3 or ordered by an LHA. This will result in a minimal-to-moderate burden for food establishments because persons in charge will need to be trained and will need to ensure that staff are trained on exclusion requirements, and staffing changes may need to be made to accommodate food handler exclusions. This will result in a significant benefit for ADHS, LHAs, food establishments, and the public because having the person in charge of a food establishment be more knowledgeable about and ensure compliance with exclusion requirements should enhance the safety of food served in food establishments and help to prevent disease.

In R9-6-322, ADHS adopts the control measures for outbreaks of unspecified foodborne or waterborne illness as the control measures for outbreaks of diarrhea, nausea, or vomiting. This may result in a minimal-to-moderate burden to LHAs because of the broadening of the rule. However, ADHS believes that outbreaks of diarrhea, nausea, or vomit-

ing of unknown origin frequently would have been reported and investigated as potential foodborne or waterborne illness outbreaks, at least initially. ADHS estimates that there are 20 to 30 outbreaks of diarrhea, nausea, or vomiting in Arizona annually. This will result in a significant benefit for ADHS, LHAs, and the public because food safety threats and water safety threats have been identified by the CDC as potential bioterrorism agents, and an outbreak of diarrhea, nausea, or vomiting may be the first evidence that a bioterrorism event has occurred. Thus, it is essential that these be identified and investigated.

R9-6-323 expands the quarantine requirement for diphtheria to include close contacts, rather than just household contacts. This will result in a minimal burden to LHAs for each case, from the time spent identifying out-of-household close contacts and effecting their quarantine. This will result in a minimal-to-moderate burden for each close contact who is not in the case's household, from time lost from work or school. ADHS estimates that a quarantine would last approximately two-to-seven days. This will result in a significant benefit for ADHS, LHAs, and the public because quarantining close contacts will help to prevent transmission of disease. It will also result in a minimal-to-moderate benefit for each individual who would otherwise have become infected.

R9-6-325 requires an LHA to consult with ADHS and to isolate a case or suspect case of an emerging or exotic disease as needed to prevent transmission. This will result in a minimal burden for an LHA required to consult with ADHS, from the time spent in consultation, and in a minimal-to-moderate burden for an LHA required to isolate a case or suspect case, from effecting the isolation. This may result in a minimal-to-moderate burden for a case or suspect case placed in isolation, because of the time lost from work, depending on the disease and whether the case or suspect case would have been able to work if not for the isolation. This will result in a significant benefit for ADHS, LHAs, and the public because isolation of cases and suspect cases can prevent transmission of disease, which can save lives. The recent SARS pandemic is an example of a situation that would have been worse in the United States if isolation had not been used appropriately to isolate cases and suspect cases once they were identified.

R9-6-325 also requires an LHA to consult with ADHS and to quarantine an emerging or exotic disease contact as needed to prevent transmission. This will result in a minimal burden for an LHA required to consult with ADHS, from the time spent in consultation, and in a minimal-to-moderate burden for an LHA required to quarantine a contact, from effecting the quarantine. This will also result in a minimal-to-moderate burden for a contact quarantined because of the time lost from work, which will depend on the disease. This will result in a significant benefit for ADHS, LHAs, and the public because quarantine of contacts can prevent transmission of disease, which can save lives.

The rule for encephalitis, R9-6-326, is expanded to include parasitic encephalitis. This will result in no burden to LHAs because A.R.S. § 36-624 already requires an LHA to investigate immediately when it is apprised that infectious or contagious disease exists within its jurisdiction. This will result in a significant benefit to LHAs, ADHS, and the public. In 2003, there were two deaths caused by parasitic encephalitis in Arizona that led to the temporary closure and decontamination of a private community water supply. It is essential that LHAs and ADHS track and investigate cases of parasitic encephalitis to prevent disease and deaths.

At R9-6-327, ADHS replaces the rule for *E. coli* O157:H7, the old R9-6-320, with a rule for EHEC, a broader category. This may result in a minimal burden for LHAs because of the broadening of the rule, but *E. coli* O157:H7 is responsible for most cases of EHEC in the United States, so any additional burden should be minimal. This will result in a significant benefit for ADHS, LHAs, and the public. As a food safety threat, EHEC has been identified by the CDC as a potential bioterrorism agent, so investigation and control of cases is essential. In addition, control of EHEC can help prevent HUS, which is life threatening.

R9-6-329 requires that an LHA conduct an epidemiologic investigation of each reported giardiasis outbreak. This will not burden LHAs because A.R.S. § 36-624 already requires an LHA to investigate immediately when it is apprised that infectious or contagious disease exists within its jurisdiction. This will result in a significant benefit for ADHS, LHAs, and the public because investigating an outbreak may lead to identification of the source of illness and prevention of further transmission of disease. R9-6-329 also eliminates the requirement for an LHA to provide education and consultation regarding prevention and control measures to giardiasis cases and known contacts. ADHS believes that the requirement is somewhat vague and is redundant because LHAs will provide information about preventing transmission to cases during the course of an outbreak investigation. The rule still requires an LHA to counsel contacts about sanitation. ADHS believes that no person will be burdened by this change and that the change may result in a minimal benefit to LHAs because they may provide only the education and consultation that they believe to be necessary and appropriate.

In R9-6-332, the time for which an LHA is required to examine contacts for signs and symptoms of Hansen's disease (leprosy) is extended from three years to five years, and the requirement is expanded to include close contacts (instead of only household contacts). This will result in no burden to a minimal burden for LHAs. ADHS believes that LHAs already follow contacts of a case for at least five years, because that is consistent with the currently accepted public health standard. The longer duration of follow-up is necessary because the incubation period for Hansen's disease is usually three-to-five years. This may result in a significant benefit to ADHS, LHAs, and the public because a close contact who becomes a case will be detected and started on treatment in a timely fashion, thus preventing further transmission of disease.

R9-6-337 requires ADHS to provide education on hepatitis C prevention and disease progression to each reported non-acute hepatitis C case or suspect case. Although the number of individuals identified with chronic hepatitis C in Arizona each year is approximately 10,000, this will result in no additional burden to ADHS or other persons. ADHS has a hepatitis C prevention program that already monitors and provides education to individuals with chronic hepatitis C. This requirement will result in a significant benefit to ADHS, LHAs, and the public because all individuals with hepatitis C infection are at risk for developing cirrhosis of the liver and liver cancer and need to understand how to prevent transmission to others and the progression of the disease.

R9-6-341 requires the owner of a water, cooling, or ventilation system that was determined to have caused a case of *Legionella* infection to disinfect it before resuming its use. The rule previously required disinfection only for a system determined to be the source of an outbreak. This will result in no burden to a minimal burden for an owner of a water, cooling, or ventilation system that was a source of infection, from the expense of disinfecting the system. ADHS believes that, due to liability concerns, an owner would generally already ensure disinfection, even in the absence of a rule. This may result in a significant benefit to ADHS, LHAs, and the public, however, because it may convince a reluctant owner that disinfection needs to be completed.

R9-6-343 requires an LHA to counsel a case about the risks of contracting listeriosis from cold deli meats and unpasteurized dairy products. This will result in a minimal burden for LHAs from the time spent providing the counseling. The counseling should not take more than a few minutes and can be done by telephone. In 2003, Arizona had only 12 reported cases of listeriosis. This will result in a significant benefit for ADHS, LHAs, and the public because it may enable cases or the parents or guardians of minor cases to avoid contracting listeriosis in the future, thereby preventing illness.

R9-6-345 requires an LHA to counsel a case about reducing the risks of becoming reinfected or having others become infected with lymphocytic choriomeningitis virus. This will result in a minimal burden for LHAs from the time spent providing the counseling. The counseling should not take more than a few minutes and can be done by telephone. ADHS estimates that Arizona has one-to-three cases of lymphocytic choriomeningitis each year. This will result in a significant benefit for ADHS, LHAs, and the public because it may enable cases or the parents or guardians of minor cases to avoid contracting lymphocytic choriomeningitis in the future, thereby preventing illness.

R9-6-347 requires a school or CCE administrator to comply with an LHA's recommendations for exclusion for measles. This may result in a minimal-to-moderate burden for schools or CCEs because of the need to exclude non-immune attendees and workers, which may result in the need for substitute workers and complaints from the parents of excluded children. This may result in a minimal-to-moderate burden for workers who are excluded or the parents of children who are excluded, from time lost from work or the cost of substitute care. For measles, one case is an outbreak, and an LHA would generally recommend that non-immune individuals be excluded until an outbreak is over, typically 36 days after last exposure. It is important to note, however, that 9 A.A.C. 6, Article 7 requires immunization for measles in order to attend school or a CCE unless an exemption has been granted for personal, religious, or medical reasons. ADHS has found that individuals who are opposed to immunization for religious or personal reasons may submit to immunization when there is a real threat of disease. Measles immunization after exposure would enable a previously non-immune individual to return before the end of an outbreak. This will result in a significant benefit for ADHS, LHAs, the public, and the individuals excluded because exclusion helps to prevent transmission of disease.

In R9-6-350, ADHS is eliminating the requirements for a school or CCE administrator to report an outbreak of pediculosis (head lice) and to consult with an LHA to determine exclusions during an outbreak of pediculosis. ADHS believes that these changes will not burden any person, but will result in a minimal benefit for LHAs and school and CCE administrators. ADHS is adding a requirement for a shelter administrator to ensure that a case is treated with a pediculocide and that the case's clothing and personal articles are disinfested. This will result in a minimal burden for a shelter administrator for each resident who is a case, from the cost of pediculocide, the cost associated with disinfesting clothing and personal articles, and the time spent on treatment and disinfestation. This will result in a significant benefit for a case and for close contacts of the case who might otherwise become infested. Residents of homeless shelters in particular will benefit because they may not otherwise have the means to obtain treatment and effect disinfestation.

R9-6-351 adds a requirement for an HCP to use droplet precautions with any pertussis case, not just a hospitalized case. This will result in no burden to a minimal burden to HCPs. ADHS believes that the use of droplet precautions is consistent with the current standard for infection control in the medical community. The rule merely clarifies that it is to happen even for a non-hospitalized case. This will result in a significant benefit for ADHS, LHAs, and the public because the use of droplet precautions with a case will help to prevent transmission of disease.

R9-6-356 requires an LHA to evaluate the risk of rabies exposure to contacts and, if indicated, to provide or arrange for prophylaxis. This will result in no burden to a minimal-to-moderate burden to LHAs from the time spent evaluating the risk of exposure and potentially from the cost of prophylaxis. Arizona has not had a case of rabies in a human for at least the past 11 years, but recently had an incident where an infected dog had significant contact with approximately 85 individuals before it was diagnosed. Public health authorities recommended prophylaxis for all of those individuals. This will result in a significant benefit to ADHS, LHAs, and the public because it will help to prevent the transmission of rabies, which is almost invariably fatal once an infected individual becomes ill.

R9-6-363 requires a shelter administrator to ensure that a scabies case receives treatment and that the case's clothing and personal articles are disinfested. This will result in a minimal burden for a shelter administrator, from the cost of disinfestation and, potentially, the cost of treatment. This will result in a significant benefit for a case living at or using a shelter because the case may not otherwise be able to obtain treatment or disinfestation of clothing and personal articles. The rule also requires an HCI administrator (instead of a nursing home administrator) or a shelter administrator to advise a symptomatic contact to obtain examination and, if necessary, treatment. This will result in a minimal burden for an HCI administrator or shelter administrator, from the time spent providing the information. This may result in a significant benefit for a symptomatic contact who may not otherwise obtain information about having been exposed and needing to go for examination and treatment.

The new SARS and smallpox rules, R9-6-364 and R9-6-366, require an LHA, in consultation with ADHS, to isolate a case or suspect case and quarantine a contact as necessary to control transmission. Each of these requirements will result in a minimal burden for an LHA required to consult with ADHS, from the time spent in consultation, and in a minimal-to-moderate burden for an LHA required to isolate a case or suspect case or quarantine a contact, from effecting the isolation or quarantine. This may also result in a minimal-to-moderate burden for a case or suspect case placed in isolation or a contact placed in quarantine, because of the time lost from work. For a case or suspect case, the extent of the burden will depend on whether the case or suspect case's illness renders the case or suspect case unable to work even in the absence of the isolation. These requirements will result in a significant benefit for ADHS, LHAs, and the public because isolation of cases and suspect cases and quarantine of contacts can prevent transmission of disease, which can save lives. The smallpox rule also requires an LHA to monitor a contact's temperature and symptoms each day for 21 days after the last exposure. This will result in a minimal burden for an LHA, from the time spent monitoring a contact, but will result in a significant benefit to each contact who becomes a case, because illness will be detected quickly so that treatment can begin, and to any individuals quarantined with a contact who becomes ill, because the contact who becomes ill will be placed in isolation, and vaccination of unimmunized contacts can be done quickly.

R9-6-373 requires an HCI administrator to notify the LHA at least one working day before discharging a TB case or suspect case. This will result in a minimal burden to HCI administrators and LHAs, from the time spent providing and receiving notice, which can be made by telephone. This will result in a significant benefit for ADHS, LHAs, and the public because having this information will enable LHAs to better follow TB cases and suspect cases to ensure that they are receiving appropriate treatment and thereby to prevent transmission of disease. R9-6-373 also requires an exposed individual to allow an LHA to evaluate the individual's TB status. ADHS believes that LHAs are already evaluating individuals' TB status on a voluntary basis or under A.R.S. § 36-723(A)(3), which authorizes a local health officer to enter and inspect private property and premises to locate and inspect persons who may be afflicted persons. However, this change may result in a significant benefit to ADHS, LHAs, and the public because it may be easier for LHAs to gain cooperation when evaluating an individual for TB. The rule also requires an LHA to question a contact known to have a history of a positive result on an approved test for TB and to provide or arrange for a chest x-ray if the contact is symptomatic. ADHS believes that this will impose no new burden on LHAs. Under A.R.S. § 36-723(A), an LHA already has a duty to investigate when notified that an afflicted person is within the LHA's jurisdiction. In addition, A.R.S. § 36-717 makes LHAs responsible for providing or arranging for medical care and treatment of persons infected with TB. This may result in a significant benefit to ADHS, LHAs, and the public because it clarifies what an LHA is required to do regarding evaluation of a symptomatic contact with a history of a positive TB test. The rule also allows for use of a test for TB other than a Mantoux skin test, if the test is recommended by the CDC or the TB control officer. This will result in no burden on any person, but may result in a significant benefit to ADHS, LHAs, HCPs, HCIs, and the public because it may enable the use of newer and potentially more accurate TB tests as they become available. The rule also establishes that an HCI or CF administrator has primary responsibility, in consultation with the LHA, for identifying and evaluating contacts who were exposed in the HCI or CF. This may result in a moderate-to-substantial burden for HCI and CF administrators, from the time spent consulting with LHAs, the time spent identifying and evaluating contacts, and the testing supplies or chest x-rays used in evaluating contacts. ADHS believes that HCI and CF administrators generally are already doing this as part of their infection control procedures, but this requirement establishes that they are required to do so and requires consultation with the LHA. This will result in a significant benefit for ADHS, LHAs, HCIs, CFs, and the public (particularly patients or residents in HCIs or CFs and their contacts) because it helps to ensure that the persons in the best position to identify and evaluate contacts have that responsibility, which should lead to more effective infection control. ADHS estimates that the total cost of treating one individual with active pulmonary TB averages from $10,000 to $20,000, so each case prevented results in a substantial benefit.

R9-6-373 also clarifies that for each individual with infectious active TB, an LHA is required to identify contacts and provide or arrange for evaluation of each contact's TB status, except when contact exposure has occurred in an HCI or CF, and that an LHA is required to conduct the initial contact investigation interview within three working days after receiving the TB case report. This is really a clarification of an LHA's responsibilities under A.R.S. § 36-723, so it will result in no new burden to LHAs. It will result in a significant benefit to ADHS, LHAs, and the public if it results in LHAs' acting more quickly to investigate TB contacts and thus prevent transmission of disease.

R9-6-384, the new rule for viral hemorrhagic fever, requires a diagnosing HCP or HCI administrator to isolate and implement contact precautions for a case or suspect case. This will result in no burden to a minimal burden to HCI administrators and diagnosing HCPs. ADHS believes that isolation with contact precautions of a case or suspect case

is consistent with the current standard for infection control in the medical community. The rule merely establishes who is responsible for making it happen. This will result in a significant benefit for ADHS, LHAs, and the public because isolation of a case or suspect case will help to prevent transmission of disease. The rule also requires an LHA, in consultation with ADHS, to quarantine a contact as necessary to prevent transmission. This will result in a minimal burden for an LHA required to consult with ADHS, from the time spent in consultation, and in a minimal-to-moderate burden for an LHA required to quarantine a contact, from effecting the quarantine. This will result in a minimal-to-moderate burden for a quarantined contact, or the parent of a child who is a quarantined contact, because of the time lost from work. Depending upon the viral hemorrhagic fever agent, quarantine could last from several days to several weeks. This will result in a significant benefit for ADHS, LHAs, and the public because quarantine of contacts can prevent transmission of disease, which can save lives.

In R9-6-388, ADHS is adding a new rule for isolation and quarantine, which applies to the rules for emerging or exotic diseases, SARS, smallpox, vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus*, and viral hemorrhagic fever. This rule requires an LHA to prepare and issue a written order for isolation or quarantine to each individual or group of individuals whose isolation or quarantine is required under Article 3; to petition for a court order within 10 days after issuing a written order to cooperate, if isolation or quarantine needs to continue; and to notify each individual identified in a petition within 24 hours after filing the petition and according to the Arizona rules of civil procedure. Each of these requirements will result in a minimal-to-moderate burden for an LHA each time the requirement is implemented, from the time spent complying with the requirements. ADHS anticipates that these requirements will rarely be used because the relevant diseases are very rare. The requirements will result in a significant benefit for ADHS, LHAs, and the public because isolation of cases or suspect cases and quarantine of contacts can prevent further transmission of disease. Effective use of these control measures is especially important for emerging or exotic diseases, smallpox, and viral hemorrhagic fever because any of these could be a sign of bioterrorism.

In the Rabies Control Article, Article 5, ADHS is updating R9-6-502 by adding ferrets and clarifying the requirements. This may result in a minimal-to-moderate burden for animal control agencies, which will be required to treat ferrets in the same manner as cats and dogs (rather than automatically euthanizing them if exposed). This will result in a significant benefit for ferret owners because their pet ferrets will be treated in the same manner as cats and dogs and may not be euthanized after exposure to a rabid animal.

In R9-6-504, ADHS is reducing the information that animal control agencies are required to report to ADHS each year. This will result in a minimal-to-moderate benefit for animal control agencies, which will no longer be required to compile information about and report on various animal control agency activities.

ADHS is substantially revising Article 6, for TB control, by removing provisions that are unnecessary because of statutory changes to A.R.S. Title 36, Chapter 6, Article 6 and by adopting control measures for CFs at R9-6-603. R9-6-603 establishes TB screening and testing requirements for inmates, including screening for all inmates, specific control measures for inmates with symptoms suggestive of TB, chest x-rays and medical evaluations for specified inmate groups, and annual testing requirements. In addition, the rule requires that each inmate with active TB receive medical treatment that meets accepted standards of medical practice and be placed in airborne infection isolation until no longer infectious. The rule exempts from the screening, testing, medical evaluation, and treatment requirements inmates who are incarcerated for 13 days or less and CFs that do not house inmates for longer than 13 days. ADHS estimates that the annual cost of the screening, testing, and medical evaluation provisions in the rule will be potentially substantial for CFs, potentially costing the Arizona Department of Corrections approximately $474,969-$644,789, the combined county jails approximately $3,963,224-$5,317,300, and the combined private prisons approximately $59,760-$80,700. ADHS believes, however, that for most CFs, this is not a new burden; most CFs are already spending these funds to screen, test, and evaluate inmates for TB. In addition, a CF will incur a burden of approximately $3,000-$5,000 for each inmate who is transported to an HCI for isolation with airborne precautions, because the inmate would be at the HCI from three days to two weeks, and will incur a moderate-to-substantial burden for each inmate who receives treatment while incarcerated. ADHS believes, however, that CFs with good infection control practices are already incurring these costs. The duration of an inmate's incarceration will determine how much of the treatment cost is borne by the CF. Treatment for TB takes at least six months and includes administration of multiple drugs over that time period. In spite of the substantial cost of the new requirements in R9-6-603, ADHS believes that the benefits of the rule outweigh the burdens. R9-6-603 will result in a substantial benefit for ADHS, LHAs, CFs, and the public because inmates are at an increased risk of being infected with TB or, if not infected when in-processed, of becoming infected with TB while incarcerated. If TB is controlled in the CF setting so that transmission is prevented, transmission to the public upon inmates' release will also be prevented. Each case prevented results in a substantial benefit. Additionally, CFs will be substantially benefited for each case identified during in-processing who thus does not enter the general population while infectious because they will be able to avoid contact investigations, which can be extensive and costly, and contact evaluations and, if any contacts have been infected, treatment of contacts.

R9-6-603 also requires a CF administrator to notify the LHA when a case or suspect case is released and to provide a case, suspect case, or inmate being treated for latent TB infection with the name and address of the LHA before release. These requirements will result in a minimal burden to CFs because of the time spent providing notice and will result in a substantial benefit for ADHS, LHAs, and the public because an LHA's receiving notice of a case's or suspect case's release should enable the LHA to ensure that the case or suspect case receives necessary evaluation and

treatment, thereby preventing transmission of TB to the public upon the inmates' release. Providing inmates with latent TB infection information that enables them to contact the LHA for continuing treatment upon release will also help prevent transmission of TB to the public and will help to prevent drug-resistant TB from developing.

R9-6-604 requires an HCP caring for an afflicted person to comply with the recommendations for treatment of TB in the American Thoracic Society/CDC/Infectious Diseases Society of America publication *Treatment of Tuberculosis* (October 2002) (ATS/CDC/IDSA recommendations), unless the HCP believes, based on the HCP's professional judgment, that deviation from the ATS/CDC/IDSA recommendations is medically necessary. ADHS believes that this requirement will result in no impact to a minimal impact to HCPs because the ATS/CDC/IDSA recommendations reflect the current standard of care in the medical community, and an HCP can deviate from the ATS/CDC/IDSA recommendations when the HCP believes that deviation is medically necessary. R9-6-604 also requires that an HCP caring for an afflicted person explain to ADHS or an LHA, upon request, any deviation from the ATS/CDC/IDSA recommendations. This will result in a minimal burden for an HCP who is requested to explain the HCP's deviation from the ATS/CDC/IDSA recommendations and may result in a substantial benefit for ADHS, LHAs, and the public because it will provide ADHS or LHAs with the information needed to determine whether the treatment being provided for an afflicted person is appropriate and to step in if the treatment is not appropriate. A.R.S. § 36-723(C) authorizes the TB control officer to take charge of the investigation and treatment of a case or suspect case of TB if the officer reasonably believes that the public health and welfare require this action. Ensuring that TB treatment is appropriate will prevent transmission of TB to the public. Each case prevented results in a substantial benefit.

ADHS believes that CFs may hire additional staff or rearrange staff assignments to come into compliance with the new TB control measures. Whether this is necessary or not will depend upon the extent to which TB control measures are currently being used in a CF. For example, ADHS believes that Maricopa County, the Arizona Department of Corrections, and private prisons are already on the verge of complying with the TB control measures in the rules and will not need to add staff. ADHS does not believe that the rules will result in other impacts on private and public employment in businesses, agencies, and political subdivisions.

ADHS believes that the vast majority of HCPs impacted by these rules are in practices that would qualify as small businesses under the definition in the Arizona Administrative Procedure Act. ADHS also believes that a number of clinical laboratories, pharmacies, private schools, and health care institutions and all of the shelters in Arizona would qualify as small businesses. A large percentage of child care establishments are also small businesses. It is also possible that some of the private prisons in Arizona may qualify as small businesses. ADHS believes that it is not possible to reduce the impact of the rules on small businesses. The purpose of this rulemaking is to improve Arizona's system for detecting, reporting, controlling, and preventing communicable diseases and, thereby, to protect and improve the public health. Any kind of exception or exemption granted to a small business could undermine this purpose. ADHS is not aware of any less intrusive or less costly alternative method of achieving the purpose of the rulemaking.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

ADHS made the following changes to the rules from the Notice of Supplemental Proposed Rulemaking, many of them as a result of the suggestions of Governor's Regulatory Review Council staff:

In R9-6-101, ADHS:

a. Added clarifying language at the end of the definition of "approved test for tuberculosis";

b. Eliminated use of "causative agent," made other clarifying changes to accommodate this change, and changed "Vaccinia" to lower case in the definition of "case";

c. Eliminated the word "infectious" from the definitions of "communicable disease" and "communicable period";

d. Corrected the capitalization in the definition of "HBsAg";

e. Moved the definition of "individual with infectious active tuberculosis" from R9-6-601 to R9-6-101 because of changes made in R9-6-373;

f. Added a definition of "local health officer";

g. Added clarifying language at the end of the definition of "quarantine";

h. Revised the definition of "respiratory protection" to make it more understandable;

i. Revised the definition of "suspect case" to make it consistent with the definition of "unexplained death with a history of fever" and to put "Vaccinia" in lower case; and

j. Revised the definition of "viral hemorrhagic fever" to eliminate use of "febrile illness."

In R9-6-102, ADHS corrected the citation and added "upon request."

In R9-6-201, ADHS added a definition of "clinical laboratory" and a definition of "epidemiologic curve."

In R9-6-202(E)(1) and (2), ADHS eliminated "of the illness."

In R9-6-203, ADHS:

a. Replaced "of a disease, infestation, or occurrence" in subsection (A) with "listed in Table 2";

b. Replaced "report a case, suspect case, or outbreak by telephone and shall include the following information in the report" in subsection (B) with "submit a report by telephone that includes";

c. Replaced "each individual with illness" in subsection (B)(5) with "each affected individual"; and

d. Added "child care" before "establishment" in subsection (B)(6).

In R9-6-204(A), ADHS changed "isolates" to "an isolate."

In Table 3, for consistency, ADHS changed a reference to "polymerase chain reactions" and two references to "viral genetic sequence detection" to read "detection of viral nucleic acid."

In the Key for Table 3, ADHS replaced "the described test result" with "a test result specified in Table 3" and replaced "isolates of the organism" with "an isolate of the organism for each positive culture."

In R9-6-206, ADHS:

a. Added "required under Article 3" after "epidemiologic investigation" in subsection (B)(2);

b. Replaced "when" with "if" in subsection (C);

c. Replaced "outcome of the case's course of illness" with "case's outcome" in subsection (C)(4);

d. Added "that resulted in the disease" after "infection" in subsection (C)(5);

e. Added ", including any report of disease in a nonresident of the jurisdiction who is or has been diagnosed or treated in the jurisdiction," in subsection (D) and eliminated subsection (E);

f. Replaced "specific definition of a case" with "specific case definition used" in what is now subsection (E)(6); and

g. Eliminated "of the illness" from what is now subsection (E)(7).

In R9-6-207, ADHS:

a. Revised the language in subsections (A)(7) and (B)(10) to be consistent with the definition of "school" in R9-6-101, and

b. Replaced "operating on federal or tribal land or otherwise within this state and" with "operating within this state, whether on federal or tribal land or otherwise," in subsection (B).

In R9-6-301, ADHS:

a. Added hyphens in the definition of "disinfection,"

b. Replaced "at the time of inspection" with "at the time in question" in the definition of "person in charge,"

c. Added quotation marks around "school district" in the definition of "school district personnel," and

d. Added a definition of "state health officer."

In R9-6-302(1), ADHS replaced "communicable disease report received" with "report received under Article 2."

In R9-6-303, ADHS eliminated "included."

In R9-6-308(B), ADHS twice added "known to be" before "contaminated."

In R9-6-310, ADHS clarified the exclusion requirements by replacing references to symptoms of campylobacteriosis with references to diarrhea because diarrhea is the symptom of concern that can lead to transmission of illness to others. ADHS also added "spp." after each reference to *Campylobacter* to make the rule clearer.

In R9-6-318, ADHS clarified the exclusion requirement by replacing references to symptoms of cryptosporidiosis with references to diarrhea because diarrhea is the symptom of concern that can lead to transmission of illness to others.

In R9-6-323(A)(2)(a), ADHS added "(in use on April 16, 2004)" as the date for the "CDC Diphtheria Worksheet" incorporated by reference.

In R9-6-327, ADHS clarified the exclusion requirements by replacing references to symptoms of enterohemorrhagic *Escherichia coli* with references to diarrhea because diarrhea is the symptom of concern that can lead to transmission of illness to others.

In R9-6-328, ADHS clarified the exclusion requirements by replacing references to symptoms of enterotoxigenic *Escherichia coli* with references to diarrhea because diarrhea is the symptom of concern that can lead to transmission of illness to others.

In R9-6-329, ADHS clarified the exclusion requirements by replacing references to symptoms of giardiasis with references to diarrhea because diarrhea is the symptom of concern that can lead to transmission of illness to others.

In R9-6-330(A)(2), ADHS replaced "Arizona" with "this state."

In R9-6-331, ADHS:

a. Added "(in use on April 16, 2004)" as the date for the "CDC Expanded Case Report Form" incorporated by reference in subsection (A)(2)(b)(i), and

b. Rephrased subsection (B) to make it clearer.

In R9-6-332, ADHS eliminated "or five years after the case becomes noninfectious" from subsection (B) because it was redundant.

In R9-6-333, R9-6-349, and R9-6-351, ADHS added dates to the citations for three CDC forms incorporated by reference. The CDC forms themselves did not change. ADHS merely clarified the citations for them.

In R9-6-334, ADHS clarified the exclusion requirements by replacing references to symptoms of hemolytic uremic syndrome with references to diarrhea because diarrhea is the symptom of concern that can lead to transmission of illness to others. ADHS also added "spp." after the reference to *Shigella* to make the rule clearer.

In R9-6-335, ADHS rephrased subsection (B)(3) to make it clearer.

In R9-6-341(B), ADHS replaced "determined to be a source of *Legionella* infection" with "determined by the Department or a local health agency to have caused a case of *Legionella* infection."

In R9-6-346, ADHS relabeled subsections (a) and (b) as subsections (1) and (2).

In R9-6-347, ADHS:

a. Added "(in use on April 16, 2004)" as the date for the "Measles Surveillance Worksheet" incorporated by reference in subsection (A)(3)(a); and

b. Replaced "by a physician or a state or local health officer" in subsection (B)(3)(b) with "by a physician, state health officer, or local health officer."

In R9-6-348, ADHS rephrased subsection (B) to make it clearer.

In R9-6-356, ADHS rephrased subsection (B) to make it clearer.

In R9-6-360, ADHS:

a. Clarified the isolation requirement in subsection (A)(2) by adding "through the seventh day after the rash appears," thereby making it consistent with the exclusion requirement in subsection (A)(1);

b. Added "(in use on April 16, 2004)" as the date for the "Rubella Surveillance Worksheet" incorporated by reference in subsection (A)(3)(a); and

c. Replaced "by a physician or a state or local health officer" in subsection (B)(1)(b) with "by a physician, state health officer, or local health officer."

In R9-6-362, ADHS clarified the exclusion requirements by replacing references to symptoms of salmonellosis with references to diarrhea because diarrhea is the symptom of concern that can lead to transmission of illness to others. ADHS also added "spp." after the references to *Salmonella* to make the rule clearer.

In R9-6-363, ADHS:

a. Replaced "refer a scabies contact with symptoms of scabies for examination and treatment" in subsection (B) with "advise a scabies contact with symptoms of scabies to obtain examination and, if necessary, treatment"; and

b. Added "to individuals affected by the outbreak" after "scabies" at the end of subsection (C)(2) to clarify the requirement.

In R9-6-365, ADHS clarified the exclusion requirements by replacing references to symptoms of shigellosis with references to diarrhea because diarrhea is the symptom of concern that can lead to transmission of illness to others. ADHS also added "spp." after the references to *Shigella* to make the rule clearer.

In R9-6-370, ADHS added "(in use on April 16, 2004)" as the date for the "Tetanus Surveillance Worksheet" incorporated by reference in subsection (1).

In R9-6-373, ADHS:

a. Replaced "infectious tuberculosis case," "infectious pulmonary tuberculosis case," and "infectious case" with "individual with infectious active tuberculosis," a defined term;

b. Replaced "not to have infectious tuberculosis" with "not to be an individual with infectious active tuberculosis" in subsection (B)(3); and

c. Eliminated an unnecessary closing parenthesis in subsection (A)(4)(a)(i).

In R9-6-374(2), ADHS eliminated "pneumonic."

In R9-6-378(1), (2), and (3), ADHS added "(in use on April 16, 2004)" as the date for the FDA documents incorporated by reference.

In R9-6-382, ADHS added "until the case is no longer infectious" at the end of subsection (A)(2) to clarify the requirement.

In R9-6-388, ADHS:

a. Added "and other control measures" after "isolation or quarantine" and ", except as provided in subsection (A)(3)" at the end of subsection (A);

b. Changed several indefinite articles to definite articles;

c. Changed "an" to "each" in subsection (A)(1)(a);

d. Changed "commence" to "begin" and "commenced" to "began";

e. Eliminated the first sentence of subsection (A)(3);

f. Added "for more than 10 days after the date of the order" after "continue" in subsection (B); and

g. Rephrased subsection (C) to make it clearer.

ADHS revised and renamed Exhibit III-D, the form an LHA is required to complete and submit after investigating a case of mosquito-borne viral encephalitis, to remove information redundant with the case report and concerning laboratory testing (thereby shortening the form to one page and decreasing the burden on LHAs), to clarify information about disease acquisition, to obtain the investigator's name and the date the investigation began, and to reflect the form's applicability to all mosquito-borne viral encephalitis cases rather than just West Nile encephalitis.

ADHS revised Exhibit III-K, the form an LHA is required to complete and submit after investigating a case of Lyme disease, to reflect current understanding of Lyme disease and to condense the form (thereby shortening the form and decreasing the burden on LHAs).

In R9-6-501, ADHS replaced "Arizona" with "this state" in the definition of "approved rabies vaccine."

In R9-6-504, ADHS added "reported as" before "occurring."

In R9-6-603(A)(2)(a)(ii), ADHS replaced "a medical environment" with "an environment where exposure to the general inmate population is minimal and the inmate can be observed at all times to be wearing the mask." ADHS revised subsection (A)(2)(c) to be consistent with this change.

ADHS also made minor formatting and stylistic changes to make the rules more clear, concise, and understandable.

11. A summary of the comments made regarding the rules and the agency response to them:

A. FIRST PUBLIC COMMENT PERIOD	
Rulemaking Process Generally	
Public Comment	**ADHS Response**
The Arizona Hospital and Healthcare Association (AzHHA) thanked ADHS for the openness of its rulemaking process, praised ADHS for its efforts to involve stakeholders early in the rulemaking process, and thanked ADHS for its willingness to address many of AzHHA's concerns (as reflected in the proposed rules). AzHHA stated that ADHS's collaborative approach to formulating rules allows hospitals to better understand and clarify ADHS's intent at an earlier stage, allows ADHS to hear and address unintended concerns and difficulties that rules may pose to hospitals, and increases hospitals' compliance with the revised standards.	ADHS appreciates the support.
An epidemiologist from the Pima County Health Department (PCHD) stated how wonderfully splendid the ADHS personnel involved in the oral proceedings had been.	ADHS appreciates the support.
Preamble, Economic Impact Summary	
Public Comment	**ADHS Response**
An epidemiologist from PCHD asked whether the term "burden," used in the preamble's economic impact summary, is defined.	ADHS explained that because "burden" is not used within the text of the rules, it is not defined. ADHS does not define terms in rule unless they are used in rule text. However, ADHS pointed out that "minimal," "moderate," and "substantial" are quantified in the preamble's economic impact summary and that "burden" is used only in reference to economic impacts. ADHS has not made any changes in response to this comment.
An epidemiologist from PCHD asked whether the rules include any provision for local health authorities regarding funding for the additional burdens arising from the rules.	ADHS explained that the rulemaking does not affect the funding that is provided to local health agencies by the state. Local health agency funding is a budget issue that is not directly impacted by the rulemaking. ADHS has not made any changes in response to this comment.
R9-6-101. Definitions	
Public Comment	**ADHS Response**
The Director of the Maricopa County Department of Public Health Division of Epidemiology and Data Services (MCDPH) stated that the definition of "epidemiologic investigation" should be revised to read "ascertain a diagnosis" instead of "verify a diagnosis."	ADHS changed the definition to read "ascertain a diagnosis."
Section: Article 2 Generally	
Public Comment	**ADHS Response**

An epidemiologist from PCHD asked whether the rules include any requirements for ADHS to provide local health agencies with laboratory reports of hepatitis in time for local health agencies to implement prophylaxis for hepatitis contacts. The epidemiologist stated that, most recently, reports had been received after the time when contacts of a hepatitis A case would benefit from prophylaxis.	ADHS explained that the rules do not require ADHS to report the receipt of laboratory reports to LHAs within a particular time period. ADHS also explained that a LHA that discovers it has not received a report from a diagnosing HCP should educate the HCP about the requirement to report. Laboratory reporting was originally designed to be a backup when a diagnosing HCP fails to report; diagnosing HCPs are intended to be the primary reporting source. In addition, ADHS explained that ADHS is currently developing an electronic disease reporting system that will give LHAs immediate access to laboratory reports. ADHS has not made any changes in response to this comment.
R9-6-202. Reporting Requirements for a Health Care Provider or an Administrator of a Health Care Institution or Correctional Facility	
Public Comment	**ADHS Response**
MCDPH stated that an investigation form should be created for the use of health care institutions (HCIs) and HCI or correctional facility (CF) administrators to help them with reporting unexplained deaths with a history of fever. MCDPH offered to create the form and stated that the form does not need to go into the rules.	ADHS supports MCDPH's creating a form for HCPs and HCI and CF administrators to use when reporting unexplained deaths with a history of fever, provided that the form requires submission of the information described in R9-6-202(D). ADHS has not made any changes in response to this comment.
MCDPH stated that subsection (E)(2) should be amended to read "If possible, a diagnosis of the illness and suspected sources."	ADHS revised subsection (E)(2) to read "If possible, a diagnosis of the illness and identification of suspected sources."
MCDPH stated that subsection (E)(4) should be deleted.	ADHS deleted subsection (E)(4).
MCDPH stated that subsection (E)(5) should be revised to read "A description of the setting of the outbreak."	ADHS revised the subsection to read "A description of the setting of the outbreak."
Table 1. Reporting Requirements for a Health Care Provider or an Administrator of a Health Care Institution or Correctional Facility	
Public Comment	**Public Comment**

AzHHA expressed concern about the requirement to report conditions that may be difficult for reporting staff to easily identify and report, including conditions for which no laboratory test is available or for which the diagnosis must be made through inference rather than by objectively determined symptoms. AzHHA specifically mentioned Kawasaki syndrome, hemolytic uremic syndrome, and unexplained death with a history of fever. AzHHA explained that in each case, hospital staff cannot rely on a clearly identified lab value or other objective identifier to easily determine a reporting obligation, but instead must review the clinical chart, evaluate symptoms and chart notes, and make subjective determinations of whether reporting is required. AzHHA stated that the physician is the most appropriate source for this information, but that the rule imposes this reporting obligation on the hospital as well. AzHHA stated that this is of particular concern for hospitals because significant consequences could potentially be imposed on a facility for missing a report or improperly determining that a report is not necessary. AzHHA stated that failing to report could be seen as a breach of a facility's regulatory obligations, potentially resulting in a risk to the organization's license. For these reasons, hospitals have expressed concern that the obligation to report these three subjective conditions does not establish a clear enough rule to be uniformly and correctly followed. AzHHA acknowledged ADHS's desire to receive early reporting of conditions such as these to identify early outbreaks of potentially dangerous diseases or other concerns. AzHHA also acknowledged that ADHS had been very receptive to this concern and had removed some of the conditions appearing in earlier drafts. AzHHA urged ADHS to create a substantive policy statement, which AzHHA had discussed with ADHS previously, clarifying that the responsibility to provide the appropriate information to a reporting hospital lies with the attending physician. Such a statement could assist in the defense of a hospital that may face a licensure challenge for failure to report a borderline case. While hospitals would prefer to have the reporting obligation rest solely with the physician, AzHHA expressed its appreciation in advance for ADHS's willingness to address its concern through the development of a substantive policy statement.	ADHS intends to create a substantive policy statement explaining that, in the context of an HCI setting, ADHS interprets the requirement for both the diagnosing HCP and the HCI administrator to report a case, suspect case, or occurrence to mean that each HCI needs to have a system in place to ensure that reportable cases, suspect cases, and occurrences diagnosed or detected in the HCI are reported at least once. R9-6-202 allows for HCP and HCI administrator reporting to be done either personally or through a representative, so it is permissible for an HCI administrator to establish a policy and procedure requiring internal reporting by HCPs so that HCI infection control personnel can complete all required reporting on behalf of the HCI administrator and HCPs. Alternatively, an HCI administrator could establish a policy and procedure requiring diagnosing HCPs to report on behalf of the HCI administrator and themselves. ADHS does not expect an HCI administrator to have personal knowledge of every reportable case, suspect case, or occurrence at the HCI, but does expect an HCI administrator to make every effort to ensure that there is an effective system in place to ensure that cases, suspect cases, and occurrences are reported as required and to educate each HCP providing medical services in the HCI of the HCP's responsibilities under the rules and the HCI's policy and procedure. ADHS has not made any changes in response to this comment.

AzHHA stated that hospitals have expressed concern regarding the obligation to report outbreaks of acquired infections, including those that may arise within a treating hospital (nosocomial infections). AzHHA stated that hospital infectious disease programs are specifically designed to address nosocomial infections and act immediately in each instance to eliminate the concern. While some outbreaks can carry high significance not only within a hospital but for the public health at large, others may be localized and minor and addressed quickly and easily in house with no significance outside of the affected facility. In such cases, the spread may be so minor that hospital staff may not even believe that a report is required. The licensure concerns expressed regarding syndromic reporting apply in this situation as well, and hospitals should not be placed at risk for a licensure violation over what may be an inadvertent oversight stemming from a judgment call. AzHHA stated its belief that ADHS previously had suggested a willingness to consider a substantive policy statement acknowledging the appropriate role of a hospital's infectious disease department's judgment in considering whether a localized and quickly addressed outbreak within a hospital would be appropriate for reporting. The goal of such a substantive policy statement would not be to eliminate the hospitals' reporting requirement, but to simply acknowledge that a good faith difference of opinion may exist when determining whether a report of a nosocomial outbreak is necessary.	ADHS is not targeting nosocomial infection outbreaks in Table 1. Rather, ADHS is requiring outbreak reporting for certain illnesses, regardless of the setting. Table 1 requires outbreak reporting for 12 enteric illnesses (including diarrhea, nausea, or vomiting); acute conjunctivitis; and scabies. Table 1 also requires case and suspect case reporting for each of these except diarrhea, nausea, or vomiting; acute conjunctivitis; and scabies, for which only outbreak reporting is required. Thus, for most of these, a HCI will already be reporting each case or suspect case, either within five working days or, if the case or suspect case is a food handler or works in a child care establishment or HCI, within 24 hours. The additional information required to be provided in an outbreak report is very limited. Because of the potential for enteric outbreaks to be foodborne or associated with bioterrorism, it is essential that LHAs receive a report of each enteric outbreak regardless of the setting in which it occurs. The compromised health of the population in HCIs means that an HCI may be the first place where illness is detected, so HCI outbreak reporting is crucial. Any outbreak may have an impact beyond the setting where it is detected, whether that is an HCI or elsewhere. LHAs need to be made aware of the existence of all outbreaks in order to determine whether public health involvement is necessary for each one. In addition, the proposed rules actually reduce the burden to HCI administrators by requiring only outbreak reporting for acute conjunctivitis; scabies; and diarrhea, nausea, or vomiting. The current rules require case reporting for each of these (diarrhea, nausea, or vomiting is a replacement for foodborne or waterborne illness with an unspecified agent). To address AZHHA's concerns, ADHS intends to create a substantive policy statement explaining that ADHS understands that an outbreak occurring in an HCI may not come to the attention of an HCI administrator or may not be recognized as an outbreak until after it has been contained and resolved, but that ADHS still expects an HCI administrator to ensure that each identified outbreak is reported within 24 hours after it is recognized as an outbreak, even if it is reported after it has been resolved. ADHS intends to issue a separate substantive policy statement that will include ADHS's interpretation of the term "outbreak" as applied to each disease or condition for which outbreak reporting is required. ADHS intends to revise this separate substantive policy statement whenever necessary to ensure that it reflects current knowledge about the diseases involved. ADHS has not made any changes in response to this comment.
MCDPH stated that pertussis should be made reportable within 24 hours (instead of one working day).	ADHS revised Table 1 to make pertussis reportable within 24 hours.
R9-6-203. Reporting Requirements for an Administrator of a School, Child Care Establishment, or Shelter	
Public Comment	**ADHS Response**
MCDPH stated that subsection (B)(5)(a) should be amended to read "Name, Date of Birth or age, address and Phone number."	ADHS revised R9-6-203 to require reporting of these fields of information.

Table 2. Reporting Requirements for an Administrator of a School, Child Care Establishment, or Shelter	
Public Comment	**ADHS Response**
MCDPH stated that the following reporting requirements should be added: *E. coli* O157:H7, within 24 hours after detecting a case; Campylobacteriosis, within five working days after detecting a case; and Conjunctivitis, within 24 hours after detecting an outbreak.	ADHS revised Table 2 to require reporting of: Enterohemorrhagic *E. coli*, within 24 hours after detecting a case or suspect case; Campylobacteriosis, within five working days after detecting a case or suspect case; and Acute conjunctivitis outbreaks, within 24 hours after detecting an outbreak.
R9-6-204. Clinical Laboratory Director Reporting Requirements	
Public Comment	**Public Comment**
A representative from a hospital clinical laboratory asked whether faxes will still be accepted as electronic reports, whether a cover sheet is required with those, and whether the fax is secure. The hospital's software sends automatically and does not include a cover sheet with those faxes.	ADHS explained that ADHS will still accept fax reporting under R9-6-204, which does not require use of a cover sheet, and that the fax used is secure. ADHS has not made any changes in response to this comment.
A representative from a hospital clinical laboratory asked whether the ordering physician's phone number is required with a laboratory report. The commenter explained that there are times when the laboratory does not know which physician ordered a test and that, when multiple physicians are involved, it can be difficult to backtrack to discover which physician ordered a test. The commenter also explained that it is difficult for the laboratory to maintain accurate phone numbers for physicians. The commenter suggested that it would be most convenient for the laboratory and most effective for the Department if the hospital switchboard number, the laboratory's direct number, or the infection control personnel's direct number were provided instead. The commenter explained that an ordering physician might not be involved with a patient's care anymore after the patient is discharged, so that physician may not be able or willing to provide additional information related to a report. In these instances, laboratory personnel or infection control personnel are the ones pulling files and providing information related to a report anyway, so it might be easier just to contact them.	ADHS explained that ADHS will consider a clinical laboratory director to be in compliance with the requirement for providing the ordering health care provider's phone number if the clinical laboratory report provides the most recent phone number that the clinical laboratory has for the health care provider, which may be the main number for the hospital in which the clinical laboratory is located if the health care provider has not provided another phone number. ADHS will not consider a clinical laboratory director to be noncompliant if the clinical laboratory director has made a good faith effort to comply. ADHS has not made any changes in response to this comment.
Table 3. Clinical Laboratory Director Reporting Requirements	
Public Comment	**ADHS Response**
A representative from a hospital clinical laboratory asked for a clarification of the term "sterile site" and suggested that ADHS might want to define the term.	ADHS has added a definition for "normally sterile site" in R9-6-201.
A representative from a hospital clinical laboratory asked whether the reporting requirement had changed for non-invasive *Neisseria meningitidis* from a sputum culture.	ADHS explained that the rule clarifies that it is to be from a normally sterile site, which is not actually a change. The rule changes the reporting deadline from weekly reporting to reporting within 24 hours. ADHS has not made any changes in response to this comment.

A representative for a hospital clinical laboratory stated that the commenter would appreciate any reduction in the number of isolates required to be submitted. The commenter stated that the expense involved with the special shipping and packaging requirements for isolates and trying to get those special containers back is an expense that the laboratory cannot always bear.	ADHS is actually increasing the number of isolates required to be submitted by clinical laboratories by adding weekly isolate submission for *Bacillus anthracis*, *Brucella* spp., *E. coli*: *Shiga*-toxin producing, *Francisella tularensis*, *Legionella* spp., *Listeria* spp., *Mycobacterium tuberculosis* complex (only the initial positive, a change in resistance patterns, or a positive at least 12 months after the initial positive), *Shigella* spp., *Streptococcus pneumoniae*, vancomycin-intermediate *Staphylococcus aureus*, vancomycin-resistant *Staphylococcus epidermidis*, *Vibrio* spp., *Yersinia* spp., and *Yersinia pestis*. Although ADHS understands that this will result in a minimal-to-moderate burden for each clinical laboratory, with an estimated aggregate supply and shipping cost to all clinical laboratories of approximately $10,870-28,444, the changes will result in a significant benefit to ADHS, LHAs, and the public. New technologies for strain-typing allow public health laboratories to identify related clones and clusters within the state and to share those patterns with a national database to identify interstate clusters, thus allowing public health to track possible sources of disease or the circumstances of exposure and to intervene and implement control measures to prevent disease. Additionally, for some of these agents, analyzing isolates will enable ADHS and LHAs to monitor the resistance patterns of the agents and thereby assist HCPs in their choice of antibiotic therapy. ADHS has not made any changes in response to this comment.
MCDPH stated that reporting should be required for *Entamoeba histolytica*, without suggesting the reporting deadline, and that reporting of *Neisseria meningitidis* should be required within 24 hours (instead of one working day) after obtaining a positive result.	ADHS added a requirement for reporting of *Entamoeba histolytica* within five working days and changed the reporting deadline for *Neisseria meningitidis* from one working day to 24 hours.
R9-6-206. Local Health Agency Responsibilities Regarding Communicable Disease Reports	
Public Comment	**ADHS Response**
MCDPH stated that the items of information required in subsections (B)(1), (2), (3), (10), and (12) could be provided within seven days, but that the items of information in subsections (B)(6), (7), (8), (9), and (11) likely could not be provided within seven days.	ADHS bifurcated the required reporting in subsection (B) to require local health agencies to report some of the information within one working day and some of the information within 30 days, instead of all of the information within seven days.
MCDPH stated that subsection (G)(2) should be revised to read "The number of known and suspect cases if known."	ADHS revised subsection (G)(2) to read "If known, the number of cases and suspect cases."
MCDPH stated that subsection (G)(5) should be revised to read "The name of the disease suspected or known to be the subject of the outbreak or suspect outbreak if known, and."	ADHS believes that the suggested change would create redundancy and thus did not make any changes in response to this comment.
R9-6-311. Chancroid (*Haemophilus ducreyi*) **R9-6-312. *Chlamydia* Infection** **R9-6-330. Gonorrhea** **R9-6-368. Syphilis**	
Public Comment	**ADHS Response**

The Manager of the Pima County Health Department's Laboratory Program (PCHD) expressed concern that the proposed rules eliminate requirements prescribing a diagnosing HCP's treatment or counseling of a sexually transmitted disease (STD) case. PCHD disagreed with ADHS's statement that HCPs will continue to provide or arrange for this counseling and will continue to prescribe antibiotics where appropriate, even in the absence of the rule requirements, because these practices are consistent with the accepted standard of medical care in the community. PCHD has found that this is not always the case with STD cases and that many times, when treatment is prescribed, the treatment may be inappropriate. PCHD has found that at least 10% of the reports received from HCPs either have no listed treatment or have the wrong treatment listed. PCHD disease investigators spend long hours ensuring that STD cases have been treated and treated appropriately in order to abbreviate case spread. PCHD would not like to see these requirements eliminated in cases of STDs.	ADHS has chosen to eliminate prescriptive requirements for how HCPs treat and counsel their patients except where such prescriptive requirements are required under statute, such as with the standard of medical care for TB patients. ADHS believes that HCPs will continue to provide or arrange for counseling and to prescribe antibiotics where appropriate because these practices are consistent with the current standard of care in the medical community. Without data to support PCHD's assertion, ADHS is not in a position to determine that prescriptive requirements are needed. There are well established national guidelines for the treatment of STD patients. HCPs are subject to disciplinary action by their regulatory boards if they depart from the standard of care and thereby cause harm. ADHS has not made any changes in response to this comment.
PCHD stated that there is currently a syphilis epidemic and that PCHD believes that it would be helpful to mandate the listing of treatment in a communicable disease report for an STD. Requiring the listing of treatment would result in the medical community's needing to be more complete and would benefit the LHA by eliminating many prolonged case investigations and physicians' reluctance to share treatment information because of HIPAA.	In R9-6-202(C), ADHS added a requirement for a HCP or administrator of a HCI or CF to include with a report of chancroid, gonorrhea, syphilis, or genital *Chlamydia* infection information about the treatment prescribed, if the case or suspect case was treated.
R9-6-326. Encephalitis: Viral or Parasitic	
Public Comment	**ADHS Response**
MCDPH stated that completion of the West Nile virus form should be required only for confirmed cases of West Nile virus infection. The form is 10 pages long, and MCDPH suggested that it does not make sense to require completion of the form for each viral encephalitis case.	ADHS clarified that Exhibit III-D only needs to be submitted for mosquito-borne viral encephalitis cases, not all viral encephalitis cases. In addition, ADHS revised Exhibit III-D to make it more concise and less burdensome for LHAs.
R9-6-327. Enterohemorrhagic *Escherichia coli*	
Public Comment	**ADHS Response**
MCDPH stated that subsection (B) should be revised to require exclusion of a contact with symptoms of enterohemorrhagic *Escherichia coli* from working as a food handler "until symptoms are absent."	ADHS initially clarified the contact exclusion requirement by adding "until symptoms are absent" at the end of subsection (B). In the Notice of Final Rulemaking (NFR), ADHS further clarified the exclusion requirements in the rule by replacing references to symptoms of enterohemorrhagic *Escherichia coli* with references to diarrhea because diarrhea is the symptom of concern that can lead to transmission of illness to others.
R9-6-328. Enterotoxigenic *Escherichia coli*	
Public Comment	**ADHS Response**
MCDPH stated that subsection (B) should be revised to require exclusion of a contact with symptoms of enterotoxigenic *Escherichia coli* from working as a food handler "until symptoms are absent."	ADHS initially clarified the contact exclusion requirement by adding "until symptoms are absent" at the end of subsection (B). In the NFR, ADHS further clarified the exclusion requirements in the rule by replacing references to symptoms of enterotoxigenic *Escherichia coli* with references to diarrhea, the symptom of concern for transmission to others.
R9-6-331. *Haemophilus influenzae*: Invasive Disease	

Public Comment	ADHS Response
MCDPH stated that subsection (A)(2)(b) should be revised to require completion and submission of the CDC forms for each "*Haemophilus influenzae* type B invasive disease case younger than 5 years of age" (adding "type B").	ADHS clarified that the CDC form only needs to be completed and submitted for *Haemophilus influenzae* type B invasive disease cases younger than 5 years of age.
R9-6-334. Hemolytic Uremic Syndrome	
Public Comment	**ADHS Response**
MCDPH stated that subsection (B) should be revised to require exclusion of a hemolytic uremic syndrome contact with diarrhea from working as a food handler "until symptoms are absent."	ADHS initially clarified the contact exclusion requirement by adding "until symptoms are absent" at the end of subsection (B). In the NFR, ADHS further clarified the exclusion requirements in the rule by replacing references to symptoms of hemolytic uremic syndrome with references to diarrhea, the symptom of concern for transmission to others.
R9-6-335. Hepatitis A	
Public Comment	**ADHS Response**
MCDPH stated, in relation to subsection (B)(3), that MCDPH is able to arrange for each contact to receive prophylaxis and immunization but does not have the resources to provide immunoglobulin and immunization to all contacts, especially adults.	The rule requires that a LHA "provide or arrange for each contact to receive prophylaxis and immunization," so an LHA that arranges for prophylaxis and immunization is compliant with the rule. ADHS has not made any changes in response to this comment.
R9-6-345. Lymphocytic Choriomeningitis	
Public Comment	**ADHS Response**
MCDPH stated that ADHS needs to provide a case definition for lymphocytic choriomeningitis.	ADHS intends to issue a substantive policy statement including case definitions for the diseases included within the rules. ADHS does not include case definitions for diseases within the rules because this would make it impossible for ADHS to adjust case definitions as necessary to maintain currency with scientific developments and CDC guidance. ADHS has not made any changes in response to this comment.
R9-6-347. Measles (Rubeola)	
Public Comment	**ADHS Response**
MCDPH stated that the word "if" should be inserted after "non-immune measles contact" in subsection (B)(2).	ADHS added "if possible" at the end of subsection (B)(2).
R9-6-350. Pediculosis (Lice Infestation)	
Public Comment	**ADHS Response**
MCDPH stated that the words "and is nit free" should be inserted after "pediculocide" in subsection (1).	The American Academy of Pediatrics states in its *Red Book 2003: Report of the Committee of Infectious Diseases* that "no-nit" policies are not effective in controlling head lice transmission and are not recommended. ADHS has not made any changes in response to this comment.
R9-6-351. Pertussis (Whooping Cough)	
Public Comment	**ADHS Response**
MCDPH stated that the word "antibiotic" should be inserted before "prophylaxis" in subsection (B)(2).	ADHS added the word "antibiotic" before "prophylaxis" in subsection (B)(2).
R9-6-382. Varicella (Chickenpox)	
Public Comment	**ADHS Response**
MCDPH stated that the words "diagnosing health care provider" should be replaced with "hospital" in subsection (A)(2).	ADHS eliminated the requirement for a diagnosing HCP to place a varicella case in airborne infection isolation.

Exhibit III-A. Campylobacter Investigation Form **Exhibit III-F. Giardiasis Investigation Form** **Exhibit III-L. Salmonellosis Investigation Form**	
Public Comment	**ADHS Response**
MCDPH stated that MCDPH is not able at this time to obtain seven-day food histories for all enteric case investigations and that the latest information shows that asking people what they usually eat, rather than what they ate during the last week, is a more exact representation of what they actually ate.	ADHS believes that it is important to elicit information about what was actually eaten by a case, to the extent that the case is able to recall the information. ADHS has not made any changes in response to this comment.
Exhibit III-G. Hepatitis A Case Report	
Public Comment	**ADHS Response**
MCDPH stated that the question regarding number of sex partners for Hepatitis A virus cases is a bit intrusive and may serve to terminate the client's participation in the questionnaire, as might the question about street drug use. MCDPH suggested simply asking sexual preference and whether or not a person has used street drugs in the two-to-six weeks before the onset of symptoms. MCDPH also suggested that it might be helpful to leave these questions for last.	ADHS revised Exhibit III-G to update some of the information requirements and to reorganize some of the questions. Questions regarding sexual partners and use of street drugs are now at the end of page two and are to be asked "if appropriate."
MCDPH stated that the questions regarding transfusions, dialysis, dentists/oral surgeons, other surgery, tattoos, and pierces are more relevant to Hepatitis B and C investigations, because these things are rarely associated with Hepatitis A. MCDPH asked whether these questions could be removed from the Hepatitis A virus form.	ADHS revised Exhibit III-G to update some of the information requirements and to reorganize some of the questions. Although rarely, hepatitis A transmission has been associated with blood and clotting factor transfusion. Also, per Exhibit III-G, these questions are only to be asked "if applicable."
R9-6-604. Standards of Medical Care	
Public Comment	**ADHS Response**

AzHHA stated that by explicitly mandating a specific course of treatment for TB, ADHS has established a clinical practice pattern and standard of care through regulation, which AzHHA believes should be left to licensed professionals and healthcare facilities. AzHHA acknowledged that the need for standardized protocols may be particularly strong in the case of the treatment of TB, but urged against going down the road of dictating practice patterns through regulation. AzHHA stated that if a protocol is established, it should not be done in a way that may hinder progress toward future improvements in care. A future study could suggest a clinical benefit from a different regimen than that ADHS has proposed to require. An Arizona provider would be prohibited from adopting this new standard by the "old research" standard locked into place by regulation. While the proposed rule partially addresses this concern by permitting a physician to modify treatment if the physician believes it to be medically necessary, this still puts the onus on the provider to justify a different treatment and does not allow any flexibility for the improvement of future treatment. AzHHA recommends that if a protocol must be used, it should be accompanied by language that would allow for future changes in the clinical standard of care. This could be accomplished by adding language allowing ADHS to designate in the future, outside of regulation, a new protocol to serve as the designated standard of care. If the proposed rule were adopted, ADHS would have to amend the rule in order to allow for future developments in treatment.	ADHS is required by A.R.S. § 36-721(2) to adopt rules to "[p]rescribe reasonable and necessary measures regarding standards of medical care to be used by health care providers, agencies and institutions caring for afflicted persons." To satisfy this statutory mandate, ADHS is requiring that a HCP caring for an afflicted person comply with the most recent (October 2002) recommendations for treatment of TB issued (jointly) by the American Thoracic Society, the Centers for Disease Control and Prevention, and the Infectious Diseases Society of America, unless the HCP believes, based on the HCP's professional judgment, that deviation from the recommendations is medically necessary. ADHS intends to update the incorporation by reference through rulemaking when the recommendations are updated. ADHS agrees that it is unfortunate that there is not a more expeditious method for updating the incorporation by reference, but believes that the rule would allow a HCP to follow updated guidelines during an interim period if the HCP believes that new developments in the updated guidelines make it medically necessary to do so. ADHS believes that this is preferable to adopting a process, criteria, and time-frames for Director approval of alternate guidelines. ADHS has not made any changes in response to this comment.
B. SECOND PUBLIC COMMENT PERIOD	
Table 3. Clinical Laboratory Director Reporting Requirements	
Public Comment	**ADHS Response**
A representative from a large clinical laboratory company asked whether the requirement to submit a report immediately after receiving one specimen for detection of *Yersinia pestis* would apply when a laboratory receives a specimen with a request to rule out *Yersinia*. The representative asked whether, if the specimen were anything except stool, ADHS would expect the lab to contact the physician and clarify the organism in question before alerting ADHS or to contact ADHS and then follow up with the physician.	ADHS responded that ADHS would not expect a laboratory to report to ADHS receipt of an order requesting that *Yersinia* spp. be ruled out. Nor would ADHS expect a laboratory to contact the ordering HCP for clarification. However, if a laboratory contacted the ordering HCP of its own volition to get clarification for a non-stool specimen and discovered that the ordering HCP wanted the specimen to be tested for *Yersinia pestis*, then ADHS would expect the laboratory to report that. ADHS has not made any changes in response to this comment.
A representative from a large clinical laboratory company expressed concern about the requirement to only report the first methicillin-resistant *Staphylococcus aureus* (MRSA) result for an individual. The representative stated that ADHS would receive more than the first MRSA result. On the laboratory's commercial side, with computerized reporting, there is no mechanism to do selective reporting, and there is no continuous medical record, so there is no means to ensure that patients are the same when subsequent specimens are received. Additionally, on their hospital side, with their volume, it is not feasible to manually weed out duplicates. The representative wanted to make ADHS aware of these limitations.	ADHS responded that it is always permissible for a laboratory to report more than the rules require. ADHS has not made any changes in response to this comment.
R9-6-603. Tuberculosis Control in Correctional Facilities	
Public Comment	**ADHS Response**

A representative from the Navajo County Sheriff's Office Medical Unit asked who will provide the funding for the TB control measures for correctional facilities—the state or the county.	ADHS explained that the counties are expected to fund the TB control measures for county correctional facilities. ADHS has not made any changes in response to this comment.
The representative from the Navajo County Sheriff's Office Medical Unit expressed concern about the cost of the TB control measures for correctional facilities, specifically the cost of testing, x-rays, and treatment for inmates who stay at the jail more than 14 days. The representative explained that Navajo County is an economically stressed county and that, although Navajo County is not against the testing, because it makes it better for everybody to know [that an inmate is infected], the cost is prohibitive.	ADHS explained that, in the long run, if the TB control measures prevent cases from being within the inmate population, they actually result in a cost savings for counties, because of the costs of treatment, investigating contacts, and evaluating contacts. ADHS is cognizant that there are up front and continuing costs, but believes that there is a $10,000 to $20,000 treatment savings every time a case is prevented. A county might not have to pay the entire treatment cost for a case, depending on the circumstances (such as the duration of incarceration), but would have significant costs related to each case identified and thus receives a significant benefit every time a case is prevented. ADHS has not made any changes in response to this comment.
A representative from the Navajo County Sheriff's Office stated that the whole county budget for TB is $20,000. One case would go through that.	ADHS explained that the state may allocate the county $20,000 for TB, but ADHS also expects counties to support their own TB control programs. ADHS is aware that $20,000 does not cover a whole TB control program. The TB testing described in the rules has long been recommended by the CDC and the National Commission on Correctional Health Care, so it is actually standard for correctional facility procedure. ADHS has not made any changes in response to this comment.
The representative from the Navajo County Sheriff's Office stated that their concern is the financial end of it. The control measures are a good thing, but they do not know how they will pay for them. Navajo County houses federal prisoners and borders three reservations. TB is becoming a big thing, especially on the Navajo reservation, and Navajo County is an economically depressed county. The concern is not actually with federal prisoners. The federal government pays for them, and most have already had TB screening when they come. The federal government notifies Navajo County if a federal prisoner has TB and pays for that. The problem is related to individuals coming off of the reservation, most of whom do not even pay taxes. Another border county had expressed similar concerns to the Navajo County Sheriff's Office.	ADHS explained that ADHS is aware of the economic burden and believes that the burden was described thoroughly in the economic impact summary. ADHS believes that there is an overall cost savings resulting from the TB control measures for correctional facilities because of the prevention of cases. ADHS has not made any changes in response to this comment.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

13. Incorporations by reference and their location in the rules:

R9-6-308: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.73, "Guide to Investigation of Infant Botulism" (September 1987)

R9-6-309: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 4.153, "Brucellosis Case Surveillance Report" (November 1980)

R9-6-313: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.79, "Cholera and Other *Vibrio* Illness Surveillance Report" (July 2000)

R9-6-322: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.13, "Investigation of a Foodborne Outbreak" (October 2000)
Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.12, "Waterborne Diseases Outbreak Report" (January 2003)

R9-6-323: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "CDC

Diphtheria Worksheet" (in use on April 16, 2004)

R9-6-324: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 55.1, "Tick-Borne Rickettsial Disease Case Report" (January 2001)

R9-6-331: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.15N, "National Bacterial Meningitis and Bacteremia Case Report" (February 1993)
Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "CDC Expanded Case Report Form: *Haemophilus Influenzae* Type B in Children < 5 Years of Age" (in use on April 16, 2004)

R9-6-332: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.18, "Hansen's Disease Surveillance Form" (March 1996)

R9-6-333: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "Hantavirus Pulmonary Syndrome Case Report Form" (November 2002)
Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "Individual Questionnaire" (January 1996)

R9-6-338: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 53.1, "Viral Hepatitis Case Record for Reporting of Patients with Symptomatic Acute Viral Hepatitis" (June 1993)

R9-6-340: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 55.54, "Kawasaki Syndrome Case Reporting" (January 1991)

R9-6-341: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.56, "Legionellosis Case Report" (August 1999)

R9-6-342: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form 52.26, "Leptospirosis Case Investigation Report" (October 1987)

R9-6-346: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 54.1, "Malaria Case Surveillance Report" (January 2002)

R9-6-347: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "Measles Surveillance Worksheet" (in use on April 16, 2004)

R9-6-349: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "Mumps Surveillance Worksheet" (May 1998)

R9-6-351: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "Pertussis Surveillance Worksheet" (November 1999)

R9-6-352: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 56.37, "Plague Case Investigation Report" (May 1985)

R9-6-353: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "Suspected Polio Case Worksheet" (August 1998)

R9-6-354: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.2, "Psittacosis Case Surveillance Report" (March 1981)

R9-6-355: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 55.1, "Q Fever Case Report" (March 2002)

R9-6-358: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 55.8, "CDC Reye Syndrome Case Investigation Report" (March 1985)

R9-6-360: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "Rubella Surveillance Worksheet" (in use on April 16, 2004)

R9-6-361: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 71.17, "Congenital Rubella Syndrome Case Report" (March 1997)

R9-6-370: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "Tetanus Surveillance Worksheet" (in use on April 16, 2004)

R9-6-371: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.3, "Toxic-Shock Syndrome Case Report" (April 1996)

R9-6-372: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 54.7, "Trichinosis Surveillance Case Report" (February 1990)

R9-6-373: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 72.9A and B, "Report of Verified Case of Tuberculosis" (January 2003)

R9-6-375: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.5, "Typhoid Fever Surveillance Report" (June 1997)

R9-6-378: Food and Drug Administration, U.S. Department of Health and Human Services, Form VAERS-1, "Vaccine Adverse Event Reporting System" (in use on April 16, 2004)
Food and Drug Administration, U.S. Department of Health and Human Services, "Smallpox Vaccine Adverse Event Supplemental Surveillance Worksheet" (in use on April 16, 2004)

Food and Drug Administration, U.S. Department of Health and Human Services, "Smallpox Vaccine VAERS Report Follow-up Worksheet" (in use on April 16, 2004)

R9-6-604: *American Thoracic Society/Centers for Disease Control and Prevention/Infectious Diseases Society of America: Treatment of Tuberculosis* (October 2002), published in 167 *American Journal of Respiratory and Critical Care Medicine* 603-662 (February 15, 2003)

14. Was this rule previously made as an emergency rule?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 6. DEPARTMENT OF HEALTH SERVICES
COMMUNICABLE DISEASES AND INFESTATIONS

ARTICLE 1. ~~DEFINITIONS~~ GENERAL

Section
R9-6-101. Definitions
R9-6-102. Release of Protected Health Information
R9-6-103. Renumbered
R9-6-105. Renumbered
R9-6-106. Renumbered
Exhibit I-A. Case Definitions for Suspected Clinically Significant Adverse Events

ARTICLE 2. COMMUNICABLE DISEASE AND INFESTATION REPORTING

Section
~~R9-6-201.~~ ~~Responsibilities for Reporting~~
~~R9-6-102.~~ R9-6-201. ~~Communicable Disease Reporting~~ Definitions
R9-6-202. ~~Special~~ Reporting Requirements for a Health Care Provider or an Administrator of a Health Care Institution or Correctional Facility
Table 1. Reporting Requirements for a Health Care Provider or an Administrator of a Health Care Institution or Correctional Facility
R9-6-203. Reporting Requirements for an Administrator of a School, Child Care Establishment, or Shelter
Table 2. Reporting Requirements for an Administrator of a School, Child Care Establishment, or Shelter
R9-6-204. Clinical Laboratory Director Reporting Requirements
Table 3. Clinical Laboratory Director Reporting Requirements
R9-6-205. ~~Reserved~~ Reporting Requirements for a Pharmacist or Pharmacy Administrator
~~R9-6-203.~~ R9-6-206. Local Health Agency Responsibilities Regarding Communicable Disease Reports
R9-6-207. Federal or Tribal Entity Reporting

ARTICLE 3. CONTROL MEASURES FOR COMMUNICABLE ~~AND PREVENTABLE~~ DISEASES AND INFESTATIONS

Section
~~R9-6-301.~~ ~~Diseases and Conditions Declared Reportable~~
~~R9-6-103.~~ R9-6-301. ~~Control Measures for Communicable Diseases~~ Definitions
~~R9-6-204.~~ R9-6-302. ~~Other~~ Local Health Agency Control Measures
R9-6-303. Food Establishment Control Measures
~~R9-6-302.~~ R9-6-304. Amebiasis
~~R9-6-303.~~ R9-6-305. Anthrax
~~R9-6-304.~~ R9-6-306. Aseptic Meningitis: Viral
R9-6-307. Basidiobolomycosis
~~R9-6-305.~~ R9-6-308. Botulism
~~R9-6-306.~~ R9-6-309. Brucellosis
~~R9-6-307.~~ R9-6-310. Campylobacteriosis
~~R9-6-308.~~ R9-6-311. Chancroid (*Haemophilus ducreyi*)
~~R9-6-309.~~ R9-6-312. ~~Chlamydia~~ *Chlamydia* Infection, Genital
~~R9-6-310.~~ R9-6-313. Cholera
~~R9-6-311.~~ R9-6-314. Coccidioidomycosis (Valley Fever)
~~R9-6-312.~~ R9-6-315. Colorado Tick Fever
~~R9-6-316.~~ ~~Diarrhea of Newborn~~

~~R9-6-313.~~ R9-6-316. Conjunctivitis: Acute
R9-6-317. Creutzfeldt-Jakob Disease
~~R9-6-314.~~ R9-6-318. Cryptosporidiosis
R9-6-319. *Cyclospora* Infection
~~R9-6-320. *Escherichia coli* O157:H7 Infection~~
R9-6-320. Cysticercosis
~~R9-6-315.~~ R9-6-321. Dengue
~~R9-6-321.~~ R9-6-322. ~~Foodborne/Waterborne Illness: Unspecified Agent~~ Diarrhea, Nausea, or Vomiting
~~R9-6-317.~~ R9-6-323. Diphtheria
~~R9-6-318.~~ R9-6-324. Ehrlichiosis
R9-6-325. Emerging or Exotic Disease
~~R9-6-319.~~ R9-6-326. Encephalitis: Viral or Parasitic
R9-6-327. Enterohemorrhagic *Escherichia coli*
R9-6-328. Enterotoxigenic *Escherichia coli*
~~R9-6-329. Hepatitis Non-A, Non-B~~
~~R9-6-322.~~ R9-6-329. Giardiasis
~~R9-6-330. Herpes Genitalis~~
~~R9-6-323.~~ R9-6-330. Gonorrhea
~~R9-6-324.~~ R9-6-331. *Haemophilus influenzae*: Invasive ~~Diseases~~ Disease
~~R9-6-332. Human T-cell Lymphotropic Virus (HTLV-I/II) Type I and II Infection~~
~~R9-6-334.~~ R9-6-332. ~~Leprosy (~~Hansen's Disease~~)~~ (Leprosy)
~~R9-6-325.~~ R9-6-333. Hantavirus Infection
R9-6-334. Hemolytic Uremic Syndrome
~~R9-6-326.~~ R9-6-335. Hepatitis A
~~R9-6-327.~~ R9-6-336. Hepatitis B and ~~Delta~~ Hepatitis D
~~R9-6-328.~~ R9-6-337. Hepatitis C
R9-6-338. Hepatitis E
~~R9-6-331.~~ R9-6-339. Human Immunodeficiency Virus (HIV) Infection and Related Disease
R9-6-340. Kawasaki Syndrome
~~R9-6-333.~~ R9-6-341. Legionellosis (Legionnaires' Disease)
~~R9-6-335.~~ R9-6-342. Leptospirosis
~~R9-6-336.~~ R9-6-343. Listeriosis
~~R9-6-337.~~ R9-6-344. Lyme Disease
R9-6-345. Lymphocytic Choriomeningitis
~~R9-6-338.~~ R9-6-346. Malaria
~~R9-6-339.~~ R9-6-347. Measles (Rubeola)
~~R9-6-340.~~ R9-6-348. Meningococcal Invasive Disease
~~R9-6-341.~~ R9-6-349. Mumps
~~R9-6-342.~~ R9-6-350. Pediculosis (Lice Infestation)
~~R9-6-343.~~ R9-6-351. Pertussis (Whooping Cough)
~~R9-6-344.~~ R9-6-352. Plague
~~R9-6-345.~~ R9-6-353. Poliomyelitis
~~R9-6-346.~~ R9-6-354. Psittacosis (Ornithosis)
~~R9-6-347.~~ R9-6-355. Q Fever
~~R9-6-348.~~ R9-6-356. Rabies in ~~Humans~~ a Human
~~R9-6-357. Staphylococcal Skin Disease~~
~~R9-6-349.~~ R9-6-357. Relapsing Fever (Borreliosis)
~~R9-6-350.~~ R9-6-358. Reye Syndrome
~~R9-6-359. Streptococcal Group B: Invasive Disease in Infants Less Than 30 Days of Age~~
~~R9-6-351.~~ R9-6-359. Rocky Mountain Spotted Fever
~~R9-6-352.~~ R9-6-360. Rubella (German Measles)
~~R9-6-353.~~ R9-6-361. Rubella Syndrome, Congenital
~~R9-6-354.~~ R9-6-362. Salmonellosis
~~R9-6-355.~~ R9-6-363. Scabies
R9-6-364. Severe Acute Respiratory Syndrome
~~R9-6-356.~~ R9-6-365. Shigellosis
R9-6-366. Smallpox
~~R9-6-358.~~ R9-6-367. ~~Streptococcal Disease and Invasive Group A~~ Streptococcal ~~Disease~~ Group A Infection
~~R9-6-360.~~ R9-6-368. Syphilis

~~R9-6-361.~~ R9-6-369. Taeniasis
~~R9-6-362.~~ R9-6-370. Tetanus
~~R9-6-363.~~ R9-6-371. Toxic Shock Syndrome
~~R9-6-364.~~ R9-6-372. Trichinosis
~~R9-6-365.~~ R9-6-373. Tuberculosis
~~R9-6-366.~~ R9-6-374. Tularemia
~~R9-6-367.~~ R9-6-375. Typhoid Fever
~~R9-6-368.~~ R9-6-376. Typhus Fever~~: Flea-borne~~
R9-6-377. Unexplained Death with a History of Fever
R9-6-378. Vaccinia-Related Adverse Event
~~R9-6-369.~~ R9-6-379. Vancomycin-Resistant ~~*Enterococcus*~~ *Enterococcus* spp.
~~R9-6-370.~~ R9-6-380. Vancomycin-Resistant or Vancomycin-Intermediate *Staphylococcus aureus*
~~R9-6-371.~~ R9-6-381. Vancomycin-Resistant *Staphylococcus epidermidis*
~~R9-6-372.~~ R9-6-382. Varicella (Chickenpox)
~~R9-6-373.~~ R9-6-383. ~~Vibrio~~ *Vibrio* Infection
R9-6-384. Viral Hemorrhagic Fever
R9-6-385. West Nile Virus Fever or West Nile Encephalitis
~~R9-6-374.~~ R9-6-386. Yellow ~~fever~~ Fever
~~R9-6-375.~~ R9-6-387. Yersiniosis
R9-6-388. Isolation and Quarantine
Exhibit III-A. Campylobacter Investigation Form
Exhibit III-B. Cryptosporidiosis Investigation Form
Exhibit III-C. Suspected Viral Gastroenteritis Outbreak Form
Exhibit III-D. Arboviral Case Investigation Form
Exhibit III-E. *E. coli* O157:H7 Investigation Form
Exhibit III-F. Giardiasis Investigation Form
Exhibit III-G. Hepatitis A Case Report
Exhibit III-H. Acute Hepatitis B and D Case Report
Exhibit III-I. Perinatal Hepatitis B Case Management Report
Exhibit III-J. Listeriosis Investigation Form
Exhibit III-K. Lyme Disease Report Form
Exhibit III-L. Salmonellosis Investigation Form
Exhibit III-M. Shigellosis Investigation Form
Exhibit III-N. RVCT Addendum Form for TB Reporting

ARTICLE 5. RABIES CONTROL

Section
~~R9-6-105.~~ R9-6-501. ~~Rabies Control~~ Definitions
~~R9-6-501.~~ R9-6-502. Management of Exposed Animals ~~Exposed to a Known Rabid Animal~~
~~R9-6-502.~~ R9-6-503. Suspect ~~Rabies~~ Cases
~~R9-6-503.~~ R9-6-504. ~~Records Submitted by Enforcement Agents~~ Animal Control Agency Reporting Requirements

ARTICLE 6. TUBERCULOSIS CONTROL

Section
~~R9-6-106.~~ R9-6-601. ~~Tuberculosis Control~~ Definitions
~~R9-6-602. Issuance and Enforcement of an Order for Isolation and Quarantine~~
~~R9-6-601.~~ R9-6-602. ~~Reports of Disease and Infection; Tuberculosis Registry~~ Local Health Agency Reporting Requirements
~~R9-6-603. Removal of Persons to Another State or Country~~
R9-6-603. Tuberculosis Control in Correctional Facilities
R9-6-604. Standards of Medical Care

ARTICLE 1. ~~DEFINITIONS~~ GENERAL

R9-6-101. Definitions
In this Chapter, unless otherwise specified:
1. "Administrator" means the individual who is the senior leader at a child care establishment, health care institution, correctional facility, school, pharmacy, or shelter.
~~1.~~2. "AIDS" means Acquired Immunodeficiency Syndrome.
~~2. "Approved" means acceptable to the Department.~~
~~3. "Authorized Representative" means a person designated by a physician, health care institution administrator, school,~~

~~preschool, child care center, laboratory, or director of local health agency to perform specific tasks for the prevention, investigation, or reporting of a disease.~~

3. "Airborne infection isolation" means, in addition to use of Standard precautions, placement of a case in a private room or a cohort room with negative air-pressure ventilation and use of respiratory protection when in the room.
4. "Approved test for tuberculosis" means a Mantoux skin test or other test for tuberculosis recommended by the Centers for Disease Control and Prevention or the Tuberculosis Control Officer appointed under A.R.S. § 36-714.
5. "Barrier" means a mask, gown, glove, face shield, face mask, or other membrane or filter to prevent the transmission of infectious agents and protect an individual from exposure to body fluids.
~~4.~~6. "Body fluid" means semen, vaginal secretion, tissue, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid, urine, blood, or saliva.
~~5.~~7. "Carrier" means an infected individual ~~with an asymptomatic infection that can be transmitted~~ without symptoms who can spread the infection to a susceptible individual.
~~6.~~8. "Case" means an individual:
   a. ~~with~~ With a clinical syndrome of a communicable disease whose condition is documented:
      ~~a.~~i. By laboratory results that support the presence of the ~~causative~~ agent that causes the disease;
      ~~b.~~ii. By a health care provider's diagnosis based on clinical observation; or
   ~~c.~~ iii. By epidemiologic associations with the communicable disease, the ~~causative~~ agent that causes the disease, or ~~its~~ toxic products of the agent;
   b. Who has experienced diarrhea, nausea, or vomiting as part of an outbreak;
   c. Who has died without apparent cause within 48 hours after experiencing a fever; or
   d. Who has experienced a vaccinia-related adverse event.
9. "Child" means an individual younger than 18 years of age.
10. "Child care establishment" means:
   a. A "child care facility," as defined in A.R.S. § 36-881;
   b. A "child care group home," as defined in A.R.S. § 36-897;
   c. A child care home registered with the Arizona Department of Education under A.R.S. § 46-321; or
   d. A child care home certified by the Arizona Department of Economic Security under A.R.S. Title 46, Chapter 7, Article 1.
11. "Cohort room" means a room housing only individuals infected with the same agent and no other agent.
~~7.~~12. "Communicable disease" means an illness caused by an ~~infectious~~ agent or its toxic products that arises through the transmission of that agent or its products to a susceptible host, either directly or indirectly.
~~8.~~13. "Communicable period" means the time during which an ~~infectious~~ agent may be ~~transferred~~ transmitted directly or indirectly:
   a. ~~from~~ From an infected ~~person~~ individual to another ~~person~~ individual;
   b. ~~from~~ From an infected animal, arthropod, or vehicle to ~~a person~~ an individual; or
   c. ~~from~~ From an infected ~~person~~ individual to an animal.
14. "Contact" means an individual who has been exposed to an infectious agent in a manner that may have allowed transmission of the infectious agent to the individual during the communicable period.
15. "Correctional facility" means any place used for the confinement or control of an individual:
   a. Charged with or convicted of an offense,
   b. Held for extradition, or
   c. Pursuant to a court order for law enforcement purposes.
~~9.~~16. "Dentist" means an individual licensed under A.R.S. Title 32, Chapter 11, Article 2.
~~10.~~17. "Department" means the Arizona Department of Health Services.
18. "Emerging or exotic disease" means:
   a. A new disease resulting from change in an existing organism;
   b. A known disease not usually found in the geographic area or population in which it is found;
   c. A previously unrecognized disease appearing in an area undergoing ecologic transformation; or
   d. A disease reemerging as a result of a situation such as antimicrobial resistance in a known infectious agent, a breakdown in public health measures, or deliberate release.
~~11. "Employee" means any paid or volunteer, full or part-time worker at any facility or establishment.~~
~~12.~~19. "Epidemiologic investigation" means the application of scientific methods to ~~verify~~ ascertain a diagnosis~~,~~ ; identify risk factors for a disease~~,~~ ; determine the potential for ~~spread,~~ spreading a disease; institute control measures~~,~~ ; and complete ~~requisite~~ forms and reports such as communicable disease ~~and~~ , case investigation , and outbreak reports.
20. "Fever" means a temperature of 101° F or higher.
21. "Food establishment" has the same meaning as in the document incorporated by reference in A.A.C. R9-8-107.
~~13.~~22. "Food handler" means:
   a. ~~any employee of~~ A paid or volunteer full- or part-time worker ~~a food service~~ ~~establishment~~ who prepares or serves food or who ~~has direct contact with~~ otherwise touches food in a food establishment; or

b. A paid or volunteer full- or part-time worker who prepares or serves food or who otherwise touches food in a group setting other than a food establishment.

~~14.~~23. "~~Foodborne/waterborne~~ Foodborne" means that food ~~or water~~ serves as a ~~source for the spread of disease or illness~~ mode of transmission of an infectious agent.

24. "Guardian" means an individual who is invested with the authority and charged with the duty of caring for an individual by a court of competent jurisdiction.

~~15.~~25. "~~HbsAG~~ HBsAg" means ~~the~~ hepatitis B surface antigen~~, the outer surface portion of the Hepatitis B Virus which can be detected in the blood of an individual with an active hepatitis B infection or a carrier of hepatitis B~~.

26. "Health care institution" has the same meaning as in A.R.S. § 36-401.

~~16.~~27. "Health care provider" means a physician, physician assistant, registered nurse practitioner, or dentist.

~~17.~~28. "HIV" means Human Immunodeficiency Virus.

~~18.~~29. "HIV-related test" has the same meaning as in A.R.S. § 36-661.

30. "Individual with infectious active tuberculosis" means a pulmonary or laryngeal tuberculosis case who has not:
   a. Had three successive sputum smears, collected at least eight hours apart, at least one of which was taken first thing in the morning, test negative for acid-fast bacilli;
   b. Begun anti-tuberculosis treatment; and
   c. Experienced improvement in clinical signs and symptoms of active tuberculosis.

31. "Infant" means a child younger than 12 months of age.

32. "Isolate" means:
   a. To separate an infected individual or animal from others to limit the transmission of infectious agents, or
   b. A pure strain of an agent obtained from a specimen.

~~19.~~33. "Isolation" means ~~the~~ separation, during the communicable period, of an infected ~~persons~~ individual or ~~animals~~ animal from others~~, so as~~ to limit the transmission of infectious agents.

~~20.~~34. "Local health agency" means a county health department, a public health services district, a tribal health unit, or a ~~United States~~ U.S. Public Health Service Indian Health Service Unit.

35. "Local health officer" means an individual who has daily control and supervision of a local health agency or the individual's designee.

~~21.~~36. "Outbreak" means an unexpected increase in incidence of a disease, infestation, or sign or symptom of illness.

37. "Parent" means a biological or adoptive mother or father.

38. "Pharmacy" has the same meaning as in A.R.S. § 32-1901.

~~22.~~39. "Physician" means an individual licensed as a doctor of:
   a. Allopathic medicine under A.R.S. Title 32, Chapter 13;
   b. Naturopathic medicine under A.R.S. Title 32, Chapter 14;
   c. Osteopathic medicine under A.R.S. Title 32, Chapter 17; or
   d. Homeopathic medicine under A.R.S. Title 32, Chapter 29.

~~23.~~40. "Physician assistant" has the same meaning as in A.R.S. § 32-2501.

~~24.~~41. "Quarantine" means the restriction of activities of ~~persons~~ an individual or ~~animals who have~~ animal that has been exposed to a case or carrier of a communicable disease during ~~its~~ the communicable period, to prevent transmission of the disease if infection occurs.

~~25.~~42. "Registered nurse practitioner" has the same meaning as in A.R.S. § 32-1601.

43. "Respiratory protection" means a fit-tested device, designed to protect the wearer against inhalation of a hazardous atmosphere, that is at least as protective as a National Institute for Occupational Safety and Health-approved N-95 respirator.

44. "School" means:
   a. An "accommodation school," as defined in A.R.S. § 15-101;
   b. A "charter school," as defined in A.R.S. § 15-101;
   c. A "private school," as defined in A.R.S. § 15-101;
   d. A "school," as defined in A.R.S. § 15-101;
   e. A college or university;
   f. An institution that offers a "private vocational program," as defined in A.R.S. § 32-3001; or
   g. An institution that grants a "degree," as defined in A.R.S. § 32-3001, for completion of an educational program of study.

45. "Shelter" means:
   a. A facility or home that provides "shelter care," as defined in A.R.S. § 8-201;
   b. A "homeless shelter," as defined in A.R.S. § 16-121; or
   c. A "shelter for victims of domestic violence," as defined in A.R.S. § 36-3001.

~~26. "Special ventilation" means an air exhaust system which generates negative air pressure within a room and does not recirculate air exiting the room.~~

46. "Standard precautions" means the use of barriers by an individual to prevent parenteral, mucous membrane, and non-

intact skin exposure to body fluids and secretions other than sweat.

~~27.~~47. "Subject" means an individual whose blood or other body fluid has been tested or is to be tested.

~~28.~~48. "Suspect case" means an individual whose medical history, signs, or symptoms indicate that the individual:

a. ~~may~~ May have or is developing a communicable disease;

b. May have experienced diarrhea, nausea, or vomiting as part of an outbreak;

c. May have died without apparent cause within 48 hours after experiencing a fever; or

d. May have experienced a vaccinia-related adverse event.

~~29.~~49. "Syndrome" means a pattern of signs and symptoms characteristic of a specific disease.

50. "Unexplained death with a history of fever" means the demise of an individual who has had a fever within 48 hours before death and whose illness has not been diagnosed at the time of death.

51. "Vaccinia-related adverse event" means any of the reactions described in Exhibit I-A.

52. "Viral hemorrhagic fever" means disease characterized by fever and hemorrhaging and caused by an Arenavirus, a Bunyavirus, a Filovirus, a Flavivirus, or another virus.

53. "Waterborne" means that water serves as a mode of transmission of an infectious agent.

54. "Working day" means the period from 8:00 a.m. to 5:00 p.m. on a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state holiday.

R9-6-102. Release of Protected Health Information

A person in possession of protected health information, as defined in 45 C.F.R. 160.103, shall release the protected health information to the Department or a local health agency upon request if the protected health information is requested for the purpose of detecting, preventing, or controlling disease, injury, or disability.

R9-6-103. Renumbered

R9-6-105. Renumbered

R9-6-106. Renumbered

Exhibit I-A: Case Definitions for Suspected Clinically Significant Adverse Events

Adverse Event	Case Definition
Anaphylaxis	Hypotension, tachycardia, nausea, vomiting, collapse in first hours after smallpox vaccination
Eczema vaccinatum	• Extensive vesicular and pustular eruption anywhere, or • More limited vesicular or pustular eruption occurring in more than one site typically affected by atopic dermatitis (inner elbow folds, back of knees, face) Comments: Usually occurs in a patient with a history of skin disease, especially atopic dermatitis. Usually occurs concurrently or shortly after the local vaccinial lesion in a vaccine or 5-19 days after exposure in a contact. Patients usually have signs of moderate to severe systemic illness, including fever, malaise, prostration.
Fetal vaccinia	Generalized vaccinial type rash (vesicular, pustular, or ulcerative) in newborn of vaccinated mother
Generalized vaccinia (severe)	Disseminated maculopapular or vesicular lesions with either: a. Symptoms of moderate to severe systemic illness, including fever, malaise, prostration; or b. Documented immunodeficiency
Inadvertent inoculation (severe)	Extensive vesicular and pustular lesions at distal sites in a vaccinee or any sites in a contact, which are not generalized but may involve large contiguous areas, including sites of other skin injury. Comments: Sites usually consistent with physical transfer of virus from primary vaccination site and most commonly are the face, eyelids, nose, mouth, lips, genitalia, and anus.
Ocular vaccinia	Inflammation involving peri-ocular soft tissue or the eye itself (blepharitis, conjunctivitis, keratitis, or iritis) in a recent vaccinee or contact of vaccinee
Post-vaccinial encephalitis or encephalomyelitis	Any change in mental status (confusion, delirium, somnolence) or in sensorimotor function (altered sensation, weakness, paresis) occurring 6-15 days after vaccination
Progressive vaccinia	• Progressive expansion of the vaccination site lesion, often with necrosis, or • Failure to heal the vaccinia lesion(s), or • Disseminated vaccinia lesions In association with • Minimal or no inflammatory response to the vaccinia lesion(s) Comments: Either (a) rapid progression of the vaccination site lesion with minimal inflammation at any time, or (b) progression at any rate with minimal inflammation after 15 days should suggest progressive vaccinia.
Rashes (severe)	Generalized rash with mucosal ulceration or symptoms of moderate to severe systemic illness, including fever, malaise, prostration

ARTICLE 2. COMMUNICABLE DISEASE AND INFESTATION REPORTING

~~**R9-6-201. Responsibilities for Reporting**~~
~~Within five business days of diagnosis or treatment, a physician or an administrator of a health care facility or an authorized representative shall submit a communicable disease report to the local health agency unless otherwise specified in this Chapter.~~

~~**R9-6-102**~~ **R9-6-201. ~~Communicable Disease Reporting~~ Definitions**
In this Article ~~2~~, unless otherwise specified:

~~1. "Health care facility" means any hospital, medical clinic, or nursing care facility, whether organized for profit or not.~~
~~2. "Medical information" means case, suspect case, carrier and suspect carrier reports; contact and suspect contact reports; and diagnostic information which is reported to the Department or a local health agency.~~
1. "Clinical laboratory" has the same meaning as in A.R.S. § 36-451.
2. "Drug" has the same meaning as in A.R.S. § 32-1901.
3. "Epidemiologic curve" means a graphic display of the number of cases over time.
4. "Normally sterile site" means an anatomic location, or tissue or body fluid from an anatomic location, in which microorganisms are not found in the absence of disease and includes:
   a. The lower respiratory tract;
   b. Blood;
   c. Bone marrow;
   d. Cerebrospinal fluid;
   e. Pleural fluid;
   f. Peritoneal fluid;
   g. Synovial fluid;
   h. Pericardial fluid;
   i. Urine;
   j. A closed abscess; or
   k. Another anatomic location other than the skin, upper respiratory tract, middle ear, vaginal tract, or gastrointestinal tract.
5. "Pharmacist" has the same meaning as in A.R.S. § 32-1901.
6. "Point of contact" means an individual through whom the Department or a local health agency can obtain information upon request.
7. "Whole blood" means human blood from which plasma, erythrocytes, leukocytes, and thrombocytes have not been separated.

R9-6-202. ~~Special~~ Reporting Requirements for a Health Care Provider or an Administrator of a Health Care Institution or Correctional Facility

~~**A.** A physician or an administrator of a health care facility, or an authorized representative, shall submit a communicable disease report of a case or a suspect case of the following diseases and conditions within 24 hours of diagnosis to the local health agency by telephone or other equally expeditious means:~~
~~1. Botulism,~~
~~2. Cholera,~~
~~3. Diphtheria,~~
~~4. *Haemophilus influenzae* type b: invasive disease,~~
~~5. Measles (rubeola),~~
~~6. Meningococcal invasive disease,~~
~~7. Outbreaks of foodborne/waterborne illness,~~
~~8. Pertussis (whooping cough),~~
~~9. Plague,~~
~~10. Poliomyelitis,~~
~~11. Rabies in humans,~~
~~12. Rubella (German measles),~~
~~13. Tuberculosis diseases; including tuberculosis infection in a child less than 6 years of age,~~
~~14. Vancomycin resistant *Staphylococcus aureus*, and~~
~~15. Yellow fever.~~
~~**B.** A physician or an administrator of a health care facility, or an authorized representative, shall submit a communicable disease report of a case, suspect case or carrier of the following diseases in a food handler, nursing home caregiver or child care worker within 24 hours of diagnosis to the local health agency by telephone or other equally expeditious means:~~
~~1. Amebiasis,~~
~~2. Campylobacteriosis,~~
~~3. *Escherichia coli* O157:H7 infection,~~

4. Giardiasis,
5. Hepatitis A or unspecified,
6. Salmonellosis,
7. Shigellosis, and
8. Typhoid fever.

C. An administrator or authorized representative of a school, child care center or preschool shall report by telephone or equally expeditious means within 24 hours of discovery to the local health agency, an outbreak of:

1. Foodborne or waterborne illness,
2. Giardiasis,
3. *Haemophilus influenzae* type b: invasive disease,
4. Hepatitis A,
5. Measles (rubeola),
6. Meningococcal invasive disease,
7. Mumps,
8. Pertussis (whooping cough),
9. Rubella (German measles),
10. Scabies, and
11. Shigellosis.

D. A clinical laboratory director, either personally or through a representative, shall submit to the Department a weekly written, or electronic report of the following:

1. Positive laboratory findings for the following communicable disease pathogens:
   a. *Bordetella pertussis*;
   b. *Brucella* sp.;
   c. *Campylobacter* sp.;
   d. *Chlamydia trachomatis*;
   e. *Coccidioides immitis*: culture or serologies;
   f. *Cryptosporidium* sp.;
   g. *Escherichia coli* O157:H7;
   h. Group A *Streptococcus*: isolated from normally sterile site, tissue, or body fluid;
   i. Group B *Streptococcus*: isolated from normally sterile site, tissue or body fluid;
   j. *Haemophilus influenzae*: isolated from normally sterile sites;
   k. Hantavirus;
   l. Hepatitis A Virus (anti HAV IgM serologies);
   m. Hepatitis B Virus (anti-Hepatitis B core IgM serologies and Hepatitis B surface antigen serologies);
   n. Hepatitis C Virus (anti-Hepatitis C RIBA, PCR or other confirmatory test);
   o. Hepatitis Delta Virus;
   p. Human Immunodeficiency Virus (HIV) (by culture, antigen, antibodies to the virus, or viral genetic sequence detection);
   q. Human T cell Lymphotropic Virus type I and II;
   r. *Legionella* sp.: culture or DFA;
   s. *Listeriosis* sp.: culture isolated from normally sterile sites only;
   t. *Mycobacterium tuberculosis* and its drug sensitivity pattern;
   u. *Neisseria gonorrhoeae*;
   v. *Neisseria meningitidis*;
   w. *Plasmodium* sp.;
   x. *Streptococcus pneumoniae* and its drug sensitivity pattern: culture isolated from normally sterile sites only;
   y. *Treponema pallidum* (syphilis);
   z. Vancomycin resistant *Enterococcus*;
   aa. Vancomycin resistant *Staphylococcus aureus*;
   bb. Vancomycin resistant *Staphylococcus epidermidis*;
   cc. *Vibrio* sp.; and
   dd. Yersinia sp.; and
2. Each laboratory finding of a CD_4-T-lymphocyte count of fewer than 200 per microliter of whole blood or a CD_4-T-lymphocyte percentage of total lymphocytes of less than 14%.

E. The written or electronic laboratory report shall include:

1. Unless the test result is from anonymous HIV testing as described in R9-6-331, name and, if available, address and telephone number of the patient;
2. Unless the test result is from anonymous HIV testing as described in R9-6-331, date of birth of the patient;
3. Reference number;

~~4. Specimen type;~~
~~5. Date of collection;~~
~~6. Type of test;~~
~~7. Test results; and~~
~~8. Ordering physician's name and telephone number.~~

~~**F.** A clinical laboratory director, or authorized representative, shall submit isolates of the following organisms to the Arizona State Laboratory:~~
~~1. *Bordetella pertussis*,~~
~~2. *Haemophilus influenzae* from sterile sites only,~~
~~3. Group A *Streptococcus* from sterile sites only,~~
~~4. *Neisseria meningitidis*,~~
~~5. *Salmonella* sp., and~~
~~6. Vancomycin resistant *Staphylococcus aureus*.~~

A. A health care provider who diagnoses, treats, or detects a case or suspect case of a communicable disease listed in Table 1 or detects an occurrence listed in Table 1 shall, either personally or through a representative, submit a report to the local health agency within the time limitation in Table 1 and as specified in subsection (C), (D), or (E).

B. An administrator of a health care institution or correctional facility in which a case or suspect case of a communicable disease listed in Table 1 is diagnosed, treated, or detected or an occurrence listed in Table 1 is detected shall, either personally or through a representative, submit a report to the local health agency within the time limitation in Table 1 and as specified in subsection (C), (D), or (E).

C. Except as described in subsections (D) and (E), for each case, suspect case, or occurrence for which a report is required by subsection (A) or (B) and Table 1, a health care provider or an administrator of a health care institution or correctional facility shall submit a report that includes:
1. The following information about the case or suspect case:
   a. Name;
   b. Residential and mailing addresses;
   c. Whether the individual resides on or off an Indian reservation and, if on, the name of the reservation;
   d. Telephone number;
   e. Date of birth;
   f. Race and ethnicity;
   g. If Native American, tribal affiliation, if known;
   h. Gender;
   i. If known, whether the individual is pregnant;
   j. Occupation;
   k. If known, whether the individual is attending a school or a child care establishment and, if so, the name of the school or child care establishment; and
   l. For a case or suspect case who is a child requiring parental consent for treatment, the name, residential address, and telephone number of the child's parent or guardian, if known;
2. The following information about the disease:
   a. The name of the disease;
   b. The date of onset of symptoms;
   c. The date of diagnosis;
   d. The date of specimen collection;
   e. Each type of specimen collected;
   f. Each type of laboratory test completed;
   g. The date of laboratory confirmation; and
   h. A description of the laboratory test results, including quantitative values if available;
3. If reporting a case or suspect case of chancroid, gonorrhea, syphilis, or genital *Chlamydia* infection, a description of the treatment prescribed, if any, including:
   a. The name of each drug prescribed,
   b. The dosage prescribed for each drug, and
   c. The date of prescription for each drug; and
4. The name, address, and telephone number of the individual making the report.

D. For each unexplained death with a history of fever, a health care provider or an administrator of a health care institution or correctional facility shall submit a report that includes:
1. The following information about the deceased individual:
   a. Name;
   b. Residential address;
   c. Telephone number; and

d. If known, medical history;

2. A description of the clinical course of the illness that resulted in death;
3. A list of the laboratory tests completed on the deceased individual and, if available, the laboratory test results, including quantitative values;
4. The suspected cause or causes of death;
5. If known, the status of the autopsy;
6. The name, residential address, and telephone number of a family member of the deceased individual who can serve as a point of contact; and
7. The name, address, and telephone number of the individual making the report.

E. For each outbreak for which a report is required by subsection (A) or (B) and Table 1, a health care provider or an administrator of a health care institution or correctional facility shall submit a report that includes:

1. A description of the signs and symptoms;
2. If possible, a diagnosis and identification of suspected sources;
3. The number of known cases and suspect cases;
4. A description of the setting of the outbreak; and
5. The name, address, and telephone number of the individual making the report.

F. A health care provider who orders an HIV-related test on an infant who was perinatally exposed to HIV to determine whether the infant is infected with HIV or an administrator of a health care institution in which an HIV-related test is ordered on an infant who was perinatally exposed to HIV to determine whether the infant is infected with HIV shall, either personally or through a representative, report the following to the Department within five working days after receiving the results of the HIV-related test:

1. The name of the infant;
2. The name of the infant's mother;
3. The infant's date of birth;
4. The type of HIV-related test ordered;
5. The date of the HIV-related test;
6. The results of the HIV-related test; and
7. The ordering health care provider's name, address, and telephone number.

G. Except as provided in Table 1, a health care provider or an administrator of a health care institution or correctional facility shall, either personally or through a representative, submit a report required under this Section:

1. By telephone;
2. In a document sent by fax, delivery service, or mail; or
3. Through an electronic reporting system authorized by the Department.

Table 1. Reporting Requirements for a Health Care Provider or an Administrator of a Health Care Institution or Correctional Facility

📠*,O	Amebiasis	📠	Hantavirus infection	📠*,O	Salmonellosis
☎	Anthrax	☎	Hemolytic uremic syndrome	O	Scabies
📠	Aseptic meningitis: viral	📠*,O	Hepatitis A	☎	Severe acute respiratory syndrome
📠	Basidiobolomycosis	📠	Hepatitis B and D	📠*,O	Shigellosis
☎	Botulism	📠	Hepatitis C	☎	Smallpox
①	Brucellosis	📠*,O	Hepatitis E	📠	Streptococcal Group A: Invasive disease
📠*,O	Campylobacteriosis	📠	Herpes genitalis	📠	Streptococcal Group B: Invasive disease in infants younger than 90 days of age
📠	Chancroid	📠	HIV infection and related disease	📠	*Streptococcus pneumoniae* (pneumococcal invasive disease)
📠	*Chlamydia* infection, genital	📠	Kawasaki syndrome	📠	Syphilis
①*	Cholera	📠	Legionellosis (Legionnaires' disease)	📠*,O	Taeniasis
📠	Coccidioidomycosis (valley fever)	📠	Leptospirosis	📠	Tetanus
📠	Colorado tick fever	☎	Listeriosis	📠	Toxic shock syndrome
O	Conjunctivitis: acute	📠	Lyme disease	📠	Trichinosis
📠	Creutzfeldt-Jakob disease	📠	Lymphocytic choriomeningitis	①	Tuberculosis
📠*,O	Cryptosporidiosis	📠	Malaria	①	Tuberculosis infection in a child younger than 6 (positive test result)
📠	*Cyclospora* infection	☎	Measles (rubeola)	☎	Tularemia
📠	Cysticercosis	☎	Meningococcal invasive disease	☎	Typhoid fever
📠	Dengue	①	Mumps	①	Typhus fever
O	Diarrhea, nausea, or vomiting	☎	Pertussis (whooping cough)	☎	Unexplained death with a history of fever

☎	Diphtheria	☎	Plague	②	Vaccinia-related adverse event
✉	Ehrlichiosis	☎	Poliomyelitis	✉	Vancomycin-resistant *Enterococcus* spp.
☎	Emerging or exotic disease	✉	Psittacosis (ornithosis)	☎	Vancomycin-resistant or Vancomycin-intermediate *Staphylococcus aureus*
②	Encephalitis, viral or parasitic	②	Q fever	☎	Vancomycin-resistant *Staphylococcus epidermidis*
☎	Enterohemorrhagic *Escherichia coli*	☎	Rabies in a human	✉	Varicella (chickenpox)
☎	Enterotoxigenic *Escherichia coli*	✉	Relapsing fever (borreliosis)	✉*,O	*Vibrio* infection
✉*,O	Giardiasis	✉	Reye syndrome	☎	Viral hemorrhagic fever
✉	Gonorrhea	✉	Rocky Mountain spotted fever	☎	West Nile virus infection
✉	*Haemophilus influenzae*: invasive disease	②*	Rubella (German measles)	☎	Yellow fever
✉	Hansen's disease (Leprosy)	②	Rubella syndrome, congenital	✉*,O	Yersiniosis

Key:

☎ Submit a report by telephone or through an electronic reporting system authorized by the Department within 24 hours after a case or suspect case is diagnosed, treated, or detected or an occurrence is detected.

* If a case or suspect case is a food handler or works in a child care establishment or a health care institution, instead of reporting within the general reporting deadline, submit a report within 24 hours after the case or suspect case is diagnosed, treated, or detected.

② Submit a report within one working day after a case or suspect case is diagnosed, treated, or detected.

✉ Submit a report within five working days after a case or suspect case is diagnosed, treated, or detected.

O Submit a report within 24 hours after detecting an outbreak.

R9-6-203. Reporting Requirements for an Administrator of a School, Child Care Establishment, or Shelter

A. An administrator of a school, child care establishment, or shelter shall, either personally or through a representative, report a case, suspect case, or outbreak listed in Table 2 to the local health agency within the time limitation and as specified in Table 2 and subsection (B).

B. An administrator of a school, child care establishment, or shelter shall submit a report by telephone that includes:

1. The name and address of the school, child care establishment, or shelter;
2. The number of individuals with the disease, infestation, or symptoms;
3. The date and time that the disease or infestation was detected or that the symptoms began;
4. The number of rooms, grades, or classes affected and the name of each;
5. The following information about each affected individual:
   a. Name;
   b. Date of birth or age;
   c. Residential address and telephone number; and
   d. Whether the individual is a staff member, a student, a child in care, or a resident;
6. The number of individuals attending or residing at the school, child care establishment, or shelter; and
7. The name, address, and telephone number of the individual making the report.

Table 2. Reporting Requirements for an Administrator of a School, Child Care Establishment, or Shelter

✉	Campylobacteriosis	☎	Mumps
O	Conjunctivitis: acute	☎	Pertussis (whooping cough)
☎	Cryptosporidiosis	☎	Rubella (German measles)
O	Diarrhea, nausea, or vomiting	☎	Salmonellosis
☎	Enterohemorrhagic *Escherichia coli*	O	Scabies
☎	*Haemophilus influenzae*: invasive disease	☎	Shigellosis
☎	Hepatitis A	O	Streptococcal Group A infection
☎	Measles	✉	Varicella (chicken pox)
☎	Meningococcal invasive disease		

Key:

☎ Submit a report within 24 hours after detecting a case or suspect case.

✉ Submit a report within five working days after detecting a case or suspect case.

O Submit a report within 24 hours after detecting an outbreak.

R9-6-204. Clinical Laboratory Director Reporting Requirements

A. A director of a clinical laboratory that obtains a test result described in Table 3 or that receives a specimen for detection of an infectious agent or toxin listed in Table 3 shall, either personally or through a representative, submit a report and, if applicable, an isolate to the Department within the time limitation and as specified in Table 3 and subsection (B) or (C).

B. Except as provided in Table 3, for each test result for which a report is required by subsection (A) and Table 3, a clinical laboratory director shall submit a report that includes:

1. Unless the test result is from anonymous HIV testing as described in R9-6-339, the name and, if available, the address and telephone number of the subject;
2. Unless the test result is from anonymous HIV testing as described in R9-6-339, the date of birth of the subject;
3. The laboratory identification number;
4. The specimen type;
5. The date of collection of the specimen;
6. The type of test completed on the specimen;
7. The test result, including quantitative values if available; and
8. The ordering health care provider's name and telephone number.

C. For each specimen for which an immediate report is required by subsection (A) and Table 3, a clinical laboratory director shall submit a report that includes:

1. The name and, if available, the address and telephone number of the subject;
2. The date of birth of the subject;
3. The laboratory identification number;
4. The specimen type;
5. The date of collection of the specimen;
6. The type of test ordered on the specimen; and
7. The ordering health care provider's name and telephone number.

D. A clinical laboratory director shall submit a report by telephone; in a document sent by fax, delivery service, or mail; or through an electronic reporting system authorized by the Department. Except as provided in Table 3, each report shall contain the information required under subsection (B) or (C).

Table 3. Clinical Laboratory Director Reporting Requirements

☽	Arboviruses	☎,☮	*Haemophilus influenzae*, type B, isolated from a normally sterile site	▭+	Respiratory syncytial virus
💣,☎,☮	*Bacillus anthracis*	▭,☮	*Haemophilus influenzae*, other, isolated from a normally sterile site	☽,☮	*Salmonella* spp.
☎,☮	*Bordetella pertussis*	▭	Hantavirus	☎	SARS-associated corona virus
☽,☮	*Brucella* spp.	▭	Hepatitis A virus (anti-HAV-IgM serologies)	☽,☮	*Shigella* spp.
▭	*Campylobacter* spp.	▭	Hepatitis B virus (anti-Hepatitis B core-IgM serologies, Hepatitis B surface antigen serologies, and detection of viral nucleic acid)	▭,☮	*Streptococcus* Group A, isolated from a normally sterile site
▭	CD_4-T-lymphocyte count of fewer than 200 per microliter of whole blood or CD_4-T-lymphocyte percentage of total lymphocytes of less than 14%	▭	Hepatitis C virus	▭	*Streptococcus* Group B, isolated from a normally sterile site in an infant younger than 90 days of age

📝	*Chlamydia trachomatis*	📝	Hepatitis D virus	📝,☮	*Streptococcus pneumoniae* and its drug sensitivity pattern, isolated from a normally sterile site
💣,☎	*Clostridium botulinum* toxin (botulism)	📝	Hepatitis E virus	📝	*Treponema pallidum* (syphilis)
📝	*Coccidioides* spp., by culture or serologies	📝	HIV (by culture, antigen, antibodies to the virus, or detection of viral nucleic acid)	📝	Vancomycin-resistant *Enterococcus* spp.
◑	*Coxiella burnetii*	📝	HIV—any test result for an infant (by culture, antigen, antibodies to the virus, or detection of viral nucleic acid)	◑,☮	Vancomycin-resistant or Vancomycin-intermediate *Staphylococcus aureus*
📝	*Cryptosporidium* spp.	📝+	Influenza virus	◑,☮	Vancomycin-resistant *Staphylococcus epidermidis*
◑	*Cyclospora* spp.	📝,☮	*Legionella* spp. (culture or DFA)	💣,☎	Variola virus (smallpox)
💣,☎	Dengue virus	◑,☮	*Listeria* spp., isolated from a normally sterile site	◑,☮	*Vibrio* spp.
💣,☎	Emerging or exotic disease agent	📝[1]	Methicillin-resistant *Staphylococcus aureus*, isolated from a normally sterile site	💣,☎	Viral hemorrhagic fever agent
📝	*Entamoeba histolytica*	📝,☮[2]	*Mycobacterium tuberculosis* complex and its drug sensitivity pattern	◑	West Nile virus
◑	*Escherichia coli* O157:H7	📝	*Neisseria gonorrhoeae*	◑,☮	*Yersinia* spp. (other than *Y. pestis*)
◑,☮	*Escherichia coli*, *Shiga*-toxin producing	☎,☮	*Neisseria meningitidis*, isolated from a normally sterile site	💣,☎,☮	*Yersinia pestis* (plague)
💣,☎,☮	*Francisella tularensis*	📝	*Plasmodium* spp.		

Key:

💣 Submit a report immediately after receiving one specimen for detection of the agent. Report receipt of subsequent specimens within five working days after receipt.

☎ Submit a report within 24 hours after obtaining a positive test result.

◑ Submit a report within one working day after obtaining a positive test result.

📝 Submit a report within five working days after obtaining a positive test result or a test result specified in Table 3.

☮ Submit an isolate of the organism for each positive culture to the Arizona State Laboratory at least once each week, as applicable.

\+ A clinical laboratory director may report aggregate numbers of positive test results every five working days rather than submitting individual reports as required in R9-6-204(B).

1 Submit a report only when an initial positive result is obtained for an individual.

2 Submit an isolate of the organism only when an initial positive result is obtained for an individual, when a change in resistance pattern is detected, or when a positive result is obtained ≥ 12 months after the initial positive result is obtained for an individual.

R9-6-205. ~~Reserved~~ Reporting Requirements for a Pharmacist or an Administrator of a Pharmacy

A. A pharmacist who fills an individual's initial prescription for two or more of the drugs listed in subsection (B) or an administrator of a pharmacy in which an individual's initial prescription for two or more of the drugs listed in subsection (B) is filled shall, either personally or through a representative, submit a report that complies with subsection (C) to the Department within five working days after the prescription is filled.

B. Any combination of two or more of the following drugs when initially prescribed for an individual triggers the reporting

requirement of subsection (A):
1. Isoniazid,
2. Streptomycin,
3. Any rifamycin,
4. Pyrazinamide, or
5. Ethambutol.

C. A pharmacist or an administrator of a pharmacy shall submit a report required under subsection (A) by telephone; in a document sent by fax, delivery service, or mail; or through an electronic reporting system authorized by the Department and shall include in the report:
1. The following information about the individual for whom the drugs are prescribed:
   a. Name,
   b. Address,
   c. Telephone number, and
   d. Date of birth; and
2. The following information about the prescription:
   a. The name of the drugs prescribed,
   b. The date of prescription, and
   c. The name and telephone number of the prescribing health care provider.

~~R9-6-203.~~ R9-6-206. Local Health Agency Responsibilities Regarding Communicable Disease Reports

A. The Department shall supply each local health agency with ~~forms which shall~~ a form to be used ~~for~~ by a health care provider or an administrator of a health care institution or correctional facility when making a written ~~reports of suspected or confirmed disease~~ report required under R9-6-202(A) or (B) and Table 1. The form shall contain space to provide the information required under R9-6-202(C). A local health agency shall distribute copies of the form as needed to health care providers and administrators of health care institutions and correctional facilities. ~~The forms shall include:~~
~~1. Patient's name, address, telephone number, date of birth, race or ethnicity, gender, and occupation;~~
~~2. Disease, date of onset, date of diagnosis, date of laboratory confirmation, and test results; and~~
~~3. Name, address, and telephone number of the person or agency making the report.~~

B. For each reported case or suspect case of unexplained death with a history of fever, the local health agency for the jurisdiction in which the death occurred shall:
1. Within one working day after receiving a report, submit to the Department:
   a. The following information about the deceased individual:
      i. Name;
      ii. Residential address;
      iii. Date of birth;
      iv. Race and ethnicity;
      v. Whether the individual resided on or off a reservation and, if on, the name of the reservation;
      vi. Gender;
      vii. Whether the individual was pregnant and, if so, the outcome of the pregnancy; and
      viii. Occupation;
   b. The approximate date and time of death;
   c. A description of the setting where the death occurred and of the circumstances leading up to the time of death;
   d. The name, residential address, and telephone number of a family member of the deceased individual who can serve as a point of contact; and
   e. The name, address, and telephone number of the individual making the report; and
2. Within 30 days after receiving the report, submit to the Department a written report of the epidemiologic investigation required under Article 3, including:
   a. The name and date of birth of the deceased individual;
   b. The date of any specimen collection;
   c. Identification of each type of specimen collected;
   d. Identification of each type of laboratory test completed;
   e. A description of the laboratory test results, including quantitative results if available;
   f. If an autopsy was completed, the autopsy results;
   g. A hypothesis or conclusion as to the cause of death; and
   h. Specific recommendations for preventing future deaths, if applicable.

C. Within 10 working days after completing an epidemiologic investigation of a case as required under Article 3, if Article 3 does not require a local health agency to complete a disease-specific form, a local health agency shall submit to the Department a written report of the epidemiologic investigation, including:
1. A communicable disease report containing the information described in R9-6-202(C),
2. A description of all laboratory test results contributing to the diagnosis,

3. A classification of the case according to the case definition,
4. A description of the case's outcome,
5. A description of the case's specific risk factors for the disease or a hypothesis of how the case acquired the infection that resulted in the disease, and
6. A description of how the local health agency provided or arranged for the case to receive education about the nature of the disease and how to prevent transmission or limit disease progression.

B.D. ~~The~~ A local health agency shall forward to the Department ~~the~~ each original ~~copy of the reports to the Department each week~~ report received by the local health agency, including any report of disease in a nonresident of the jurisdiction who is or has been diagnosed or treated in the jurisdiction, within five working days after receipt~~, specifying~~ and shall specify the current status for each report ~~what action, if any, was initiated~~, as follows:

1. Case confirmed and epidemiologic investigation not required,
2. Case confirmed and report from epidemiologic investigation attached,
3. Case under investigation, or
4. No action taken.

~~The local health agency shall forward to the Department reports of disease in a nonresident of that jurisdiction who is or has been treated in that jurisdiction.~~

C.E. Within 30 days ~~of the completion of any~~ after completing an epidemiologic investigation of an outbreak ~~investigation conducted pursuant to~~ as required under this ~~Article~~ Chapter, ~~the~~ a local health agency shall submit to the Department a written summary of the ~~outbreak~~ investigation ~~to include~~, including:

1. ~~a~~ A description of the outbreak location~~,~~ ;
2. ~~the~~ The date and time ~~of notification~~ that the local health agency was notified of the outbreak~~,~~ ;
3. A description of how the local health agency verified the outbreak ~~was verified,~~ ;
4. ~~the~~ The number of ~~persons~~ individuals reported to be ill during the outbreak~~,~~ ;
5. ~~the~~ The number of ~~persons~~ individuals estimated to be at risk for illness as a result of the outbreak~~,~~ ;
6. ~~the~~ The specific case definition ~~of a case,~~ used;
7. A summary profile of the signs and symptoms;
8. An epidemiologic curve;
9. A copy of the laboratory evidence collected, including ~~and~~ all laboratory test results~~,~~ ;
10. ~~hypotheses as to~~ Hypotheses of how the outbreak occurred~~,~~ ;
11. A description of the control measures ~~that~~ used and the dates they were implemented~~,~~ ;
12. The conclusions drawn based upon the results of the investigation~~,~~ ; ~~and~~
13. ~~the~~ Specific recommendations ~~to prevent~~ for preventing future ~~occurrences~~ outbreaks; and
14. The name, address, and telephone number of the individual making the report.

F. A local health agency shall immediately notify the Department when the local health agency receives a report or reports indicating an outbreak or suspect outbreak. The notification shall include:

1. The location of the outbreak or suspect outbreak;
2. If known, the number of cases and suspect cases;
3. The date that the outbreak was reported or dates that cases suggestive of an outbreak were reported;
4. The setting of the outbreak or suspect outbreak;
5. The name of the disease suspected or known to be the subject of the outbreak or suspect outbreak; and
6. The name and telephone number of an individual at the local health agency who can serve as a point of contact regarding the outbreak or suspect outbreak.

R9-6-207. Federal or Tribal Entity Reporting

A. To the extent permitted by law, a federal or tribal entity shall comply with the reporting requirements in this Article as follows:

1. If the federal or tribal entity is participating in the diagnosis or treatment of an individual, the federal or tribal entity shall comply with the reporting requirements for a health care provider;
2. If the federal or tribal entity is operating a facility that provides health care services, the federal or tribal entity shall comply with the reporting requirements for an administrator of a health care institution;
3. If the federal or tribal entity is operating a correctional facility, the federal or tribal entity shall comply with the reporting requirements for an administrator of a correctional facility;
4. If the federal or tribal entity is operating a clinical laboratory, the federal or tribal entity shall comply with the reporting requirements for a clinical laboratory director;
5. If the federal or tribal entity is operating a facility that provides pharmacy services, the federal or tribal entity shall comply with the reporting requirements for an administrator of a pharmacy;
6. If the federal or tribal entity is operating a facility that provides child care services, the federal or tribal entity shall comply with the reporting requirements for an administrator of a child care establishment; and
7. If the federal or tribal entity is operating a facility that offers instruction to students in a grade level from kindergarten through grade 12, a college or university, a "private vocational program" as defined in A.R.S. § 32-3001, or an insti-

tution that grants a "degree" as defined in A.R.S. § 32-3001, the federal or tribal entity shall comply with the reporting requirements for an administrator of a school.

B. For the purposes of this Section, "federal or tribal entity" means a person operating within this state, whether on federal or tribal land or otherwise, under the authority of an agency or other administrative subdivision of the federal government or a tribal nation and who is:

1. Licensed as a doctor of allopathic, naturopathic, osteopathic, or homeopathic medicine under the laws of this or another state;
2. Licensed as a physician assistant under the laws of this or another state;
3. Licensed as a registered nurse practitioner under the laws of this or another state;
4. Licensed as a dentist under the laws of this or another state;
5. Operating a facility that provides health care services;
6. Operating a correctional facility;
7. Operating a clinical laboratory;
8. Operating a facility that provides pharmacy services;
9. Operating a facility that provides child care services; or
10. Operating a facility that offers instruction to students in a grade level from kindergarten through grade 12, a college or university, a "private vocational program" as defined in A.R.S. § 32-3001, or an institution that grants a "degree" as defined in A.R.S. § 32-3001.

ARTICLE 3. CONTROL MEASURES FOR COMMUNICABLE ~~AND PREVENTABLE~~ DISEASES AND INFESTATIONS

~~**R9-6-301. Diseases and Conditions Declared Reportable**~~

~~The following diseases listed below are reportable. The diseases and corresponding Sections of this Article which designate the case control, contact control, environmental control, special control and outbreak control measures, if any for each such reportable disease, are listed below:~~

~~R9-6-302. Amebiasis~~
~~R9-6-303. Anthrax~~
~~R9-6-304. Aseptic meningitis: viral~~
~~R9-6-305. Botulism~~
~~R9-6-306. Brucellosis~~
~~R9-6-307. Campylobacteriosis~~
~~R9-6-308. Chancroid (*Haemophilus ducreyi*)~~
~~R9-6-309. Chlamydia~~
~~R9-6-310. Cholera~~
~~R9-6-311. Coccidioidomycosis (valley fever)~~
~~R9-6-312. Colorado tick fever~~
~~R9-6-313. Conjunctivitis: acute~~
~~R9-6-314. Cryptosporidosis~~
~~R9-6-315. Dengue~~
~~R9-6-317. Diphtheria~~
~~R9-6-318. Ehrlichiosis~~
~~R9-6-319. Encephalitis: viral~~
~~R9-6-320. *Escherichia coli* O57: H7 infection~~
~~R9-6-321. Foodborne/Waterborne illness: unspecified agent~~
~~R9-6-322. Giardiasis~~
~~R9-6-323. Gonorrhea~~
~~R9-6-324. *Haemophilus influenzae*: Invasive Disease~~
~~R9-6-325. Hantavirus Infection~~
~~R9-6-326. Hepatitis A~~
~~R9-6-327. Hepatitis B and delta virus~~
~~R9-6-328. Hepatitis C~~
~~R9-6-329. Hepatitis Non-A, Non-B~~
~~R9-6-330. Herpes genitalis~~
~~R9-6-331. Human Immunodeficiency Virus (HIV) infection and related disease~~
~~R9-6-332. Human T-cell Lymphotropic Virus (HTLV-I/II) type I and II infection~~
~~R9-6-333. Legionellosis (Legionnaires' disease)~~
~~R9-6-334. Leprosy~~
~~R9-6-335. Leptospirosis~~
~~R9-6-336. Listeriosis~~

~~R9-6-337. Lyme disease~~
~~R9-6-338. Malaria~~
~~R9-6-339. Measles (rubeola)~~
~~R9-6-340. Meningococcal invasive disease~~
~~R9-6-341. Mumps~~
~~R9-6-343. Pertussis (whooping cough)~~
~~R9-6-344. Plague~~
~~R9-6-345. Poliomyelitis~~
~~R9-6-346. Psittacosis~~
~~R9-6-347. Q fever~~
~~R9-6-348. Rabies in humans~~
~~R9-6-349. Relapsing fever (borreliosis)~~
~~R9-6-350. Reye syndrome~~
~~R9-6-351. Rocky Mountain spotted fever~~
~~R9-6-352. Rubella (German measles)~~
~~R9-6-353. Rubella syndrome, congenital~~
~~R9-6-354. Salmonellosis~~
~~R9-6-355. Scabies~~
~~R9-6-356. Shigellosis~~
~~R9-6-358. Streptococcal Group A: Invasive Disease~~
~~R9-6-359. Streptococcal Group B: Invasive Disease in Infants Less Than 30 Days of Age~~
~~R9-6-360. Syphilis~~
~~R9-6-361. Taeniasis~~
~~R9-6-362. Tetanus~~
~~R9-6-363. Toxic shock syndrome~~
~~R9-6-364. Trichinosis~~
~~R9-6-365. Tuberculosis~~
~~R9-6-366. Tularemia~~
~~R9-6-367. Typhoid fever~~
~~R9-6-368. Typhus fever: flea-borne~~
~~R9-6-369. Vancomycin resistant *Enterococcus* sp.~~
~~R9-6-370. Vancomycin resistant *Staphylococcus aureus*~~
~~R9-6-371. Vancomycin resistant *Staphylococcus epidermidis*~~
~~R9-6-372. Varicella (chickenpox)~~
~~R9-6-373. Vibrio infection~~
~~R9-6-374. Yellow fever~~
~~R9-6-375. Yersiniosis~~

~~R9-6-103.~~ R9-6-301. ~~Control Measures for Communicable Diseases~~ Definitions

In this Article ~~3~~, unless otherwise specified:

~~1. "Airborne precautions" means, in addition to Standard precautions, the use of respiratory protection by susceptible individuals and placement of the case in a negative pressure room.~~
~~2. "Barrier" means masks, gowns, gloves, face shields, face masks, or other membranes or filters to prevent the transmission of infectious agents and protect individuals from exposure to blood and body fluids.~~
~~3.~~1. "Blood bank" means a facility where human whole blood or a blood component is collected, prepared, tested, processed, or stored, or from which human whole blood or a blood component is distributed.
~~4.~~2. "Blood center" means a mobile or stationary facility that procures human whole blood or a blood component that is transported to a blood bank.
~~5. "Blood component" means any part of a single donor unit of blood separated by physical or mechanical means.~~
3. "Close contact" means an individual who has spent a sufficient amount of time with and who has been within a sufficient proximity to a case to have sustained significant exposure to an infectious agent.
~~6.~~4. "Concurrent disinfection" means the application of ~~disinfective~~ measures to disinfect inanimate objects or surfaces after the discharge of ~~blood or~~ body fluids from the body of an infected individual or after the contamination of articles with ~~blood or~~ body fluids.
5. "Contact precautions" means, in addition to Standard precautions, placement of a case in a private room or a cohort room and use of a gown and gloves when in the proximity of the case.
~~7.~~6. "Contaminated" means to have come in contact with a disease-causing agent or toxin.
~~8.~~7. "Counseling and testing site" means a health facility offering clients HIV counseling and HIV-related testing that meets the standards established in Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Revised Guidelines for HIV Counseling, Testing, and Referral (November 2001), published in Cen-

ters for Disease Control and Prevention, U.S. Department of Health and Human Services, Pub. No. RR-19, 50 Morbidity and Mortality Weekly Report (November 9, 2001), incorporated by reference, on file with the Department and the Office of the Secretary of State, and available at http://www.cdc.gov/mmwr/ or ftp://ftp.cdc.gov/pub/Publications/mmwr/ or from Centers for Disease Control and Prevention, 1600 Clifton Road, N.E., Atlanta, GA 30333. This incorporation by reference contains no future editions or amendments.

~~9.~~8. "Disinfection" means killing or inactivating communicable-disease-causing agents on inanimate objects by directly applied chemical or physical means.

~~10.~~9. "Disinfestation" means any physical, biological, or chemical process to reduce or eliminate undesired arthropod or rodent populations.

~~11.~~10. "Droplet precautions" means, in addition to Standard precautions, placement of a case in a private room or cohort room ~~the use of~~ and use of a mask when working within ~~3~~ three feet of the case.

~~12. "Drug" means a chemical substance licensed by the United States Food and Drug Administration.~~

~~13.~~11. "Follow-up" means the practice of investigating and monitoring cases, carriers, contacts, or suspect cases to detect, treat, or prevent disease.

~~14. "Guardian" means an individual who is invested with the authority and charged with the duty of caring for a minor by a court of competent jurisdiction.~~

~~15.~~12. "Identified individual" means an individual named by a case as an individual who may have been exposed through sexual contact with the case and for whom a case provides information that enables the local health agency to locate the individual.

13. "Incapacitated adult" means an individual older than 18 years of age for whom a guardian has been appointed by a court of competent jurisdiction.

~~16.~~14. "Midwife" has the same meaning as in A.R.S. § 36-751.

~~17. "Milk bank" means a facility that procures, processes, stores, or distributes human breast milk.~~

~~18. "Organ bank" means a facility that procures, processes, stores, or distributes human kidneys, livers, hearts, lungs, or pancreases.~~

~~19. "Parent" means a natural or adoptive mother or father.~~

15. "Pediculocide" means a shampoo or cream rinse manufactured and labeled for controlling head lice.

16. "Person in charge" means the individual present at a food establishment who is responsible for the food establishment's operation at the time in question.

~~20.~~17. "Plasma center" means a facility where the process of plasmapheresis or another form of apheresis is conducted.

~~21.~~18. "Pupil" means a student attending a school, as defined in A.R.S. § 15-101.

~~22.~~19. "School district personnel" means individuals who work for a "school district," as defined by A.R.S. § 15-101, whether within a classroom or other setting and whether as employees, contractors, or volunteers.

~~23.~~20. "Sexual contact" means vaginal intercourse, anal intercourse, fellatio, or cunnilingus.

21. "State health officer" means the Director of the Department or the Director's designee.

~~24. "Standard precautions" means the use of barriers to prevent contact with blood, mucous membranes, nonintact skin, all body fluids, and secretions (except sweat).~~

~~25. "Tissue bank" means a facility that procures, processes, stores, or distributes corneas, bones, semen, or other specialized human cells for the purpose of injecting, transfusing, or transplanting the cells into a human body.~~

~~26. "Whole blood" means human blood from which plasma, erythrocytes, leukocytes, and thrombocytes have not been separated.~~

~~R9-6-204.~~ R9-6-302. ~~Other~~ Local Health Agency Control Measures

~~The~~ A local health agency shall:

1. ~~review~~ Review each ~~communicable disease reports~~ report received under Article 2 for completeness and accuracy~~,~~ ;
2. ~~confirm diagnoses~~ Confirm each diagnosis~~,~~ ;
3. ~~conduct~~ Conduct epidemiologic and other investigations required by this Chapter~~,~~ ;
4. ~~facilitate~~ Facilitate notification of known contacts~~,~~ ;
5. ~~conduct~~ Conduct surveillance~~,~~ ;
6. ~~determine~~ Determine trends~~,~~ ; ~~and~~
7. ~~implement~~ Implement control measures, quarantines, isolations, and exclusions as required by the Arizona Revised Statutes and this Chapter; and
8. Disseminate surveillance information to health care providers.

R9-6-303. Food Establishment Control Measures

The person in charge of a food establishment shall ensure compliance with all food handler exclusion requirements in this Article or ordered by a local health agency.

~~R9-6-302.~~ R9-6-304. Amebiasis

A. Case control measures:

1. ~~The~~ A local health agency shall exclude ~~a~~ an amebiasis case from working as a food ~~handling~~ handler, caring for chil-

dren in or attending a child care establishment, or caring for patients or residents in a health care institution until treatment with an amebicide is completed and two successive ~~negative~~ fecal examinations negative for amoebae are obtained from specimens collected at least 24 hours ~~or more~~ apart.

2. A local health agency shall conduct an epidemiologic investigation of each reported amebiasis case or suspect case.

B. Contact control measures: ~~The~~ A local health agency shall exclude ~~contacts~~ each amebiasis contact with symptoms of amebiasis from working as a food handler until two successive ~~negative~~ fecal examinations negative for ~~the presence of amoeba~~ amoebae are obtained from specimens collected at least 24 hours ~~or more~~ apart.

~~**C.** Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case regarding handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, the health care provider shall counsel the person responsible for care.~~

~~**D.** Outbreak control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported outbreak.~~

~~R9-6-303.~~ R9-6-305. Anthrax

A. Case control measures: A local health agency shall conduct an epidemiologic investigation of each reported anthrax case or suspect case.

~~**A.**~~**B.** Environmental control measures: ~~The~~ A local health agency shall provide or arrange for ~~incineration or~~ sterilization by dry heating or incineration of objects contaminated ~~products, products which have been in direct contact with contaminated products, and articles soiled with discharges from lesions~~ by *Bacillus anthracis*.

~~**B.** Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.~~

~~R9-6-304.~~ R9-6-306. Aseptic Meningitis: Viral

Outbreak control measures: ~~The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported outbreak of viral aseptic meningitis.

R9-6-307. Basidiobolomycosis

Case control measures: A local health agency shall conduct an epidemiologic investigation of each reported basidiobolomycosis case or suspect case.

~~R9-6-305.~~ R9-6-308. Botulism

A. Case control measures: A local health agency shall conduct an epidemiologic investigation of each reported botulism case or suspect case. For each botulism case who is an infant, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:

1. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.73, "Guide to Investigation of Infant Botulism" (September 1987), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Bacterial and Mycotic Diseases, 1600 Clifton Rd., NE, Mailstop C-09, Atlanta, GA 30333, including no future editions or amendments; or
2. An electronic equivalent to Form CDC 52.73 provided by the Department.

~~**A.**~~**B.** Environmental control measures: ~~The person in possession~~ An individual in possession of food known to be contaminated by *Clostridium botulinum* shall ~~discard~~ boil the contaminated food ~~after boiling it~~ for ~~ten~~ 10 minutes and then discard it. ~~The person in possession~~ An individual in possession of utensils known to be contaminated by *Clostridium botulinum* shall boil the contaminated utensils for ~~ten~~ 10 minutes ~~prior to~~ before reuse or disposal.

~~**B.** Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.~~

~~R9-6-306.~~ R9-6-309. Brucellosis

~~Special~~ Case control measures: ~~The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported brucellosis case or suspect case. For each brucellosis case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:

1. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 4.153, "Brucellosis Case Surveillance Report" (November 1980), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Bacterial and Mycotic Diseases, 1600 Clifton Rd., NE, Mailstop C-09, Atlanta, GA 30333, including no future editions or amendments; or
2. An electronic equivalent to Form CDC 4.153 provided by the Department.

~~R9-6-307.~~ R9-6-310. Campylobacteriosis

A. Case control measures:

1. ~~The~~ A local health agency shall exclude a campylobacteriosis case from ~~handling~~ working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until:
   a. One of the following occurs:

i. ~~a~~ A ~~negative stool~~ culture negative for *Campylobacter* spp. is obtained from a stool specimen, or
ii. ~~until treatment~~ Treatment is maintained for 24 hours; and

b. ~~symptoms of campylobacteriosis are absent~~ Diarrhea has resolved.

2. A local health agency shall conduct an epidemiologic investigation of each reported campylobacteriosis case or suspect case. For each campylobacteriosis case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation Exhibit III-A or an electronic equivalent to Exhibit III-A provided by the Department.

B. Contact control measures: ~~The~~ A local health agency shall exclude ~~contacts~~ each campylobacteriosis contact with ~~symptoms of campylobacteriosis~~ diarrhea from working as a food handler until a ~~negative stool~~ culture negative for *Campylobacter* spp. is obtained from a stool specimen or ~~symptoms are absent~~ diarrhea has resolved.

~~**C.** Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, the health care provider shall counsel the person responsible for care.~~

~~**D.** Outbreak control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported outbreak.~~

~~R9-6-308.~~ R9-6-311. Chancroid (*Haemophilus ducreyi*)

A. Case control measures:

~~1. A diagnosing health care provider shall prescribe drugs to render a case noninfectious and counsel or arrange for the case to be counseled:~~
~~a. To abstain from sexual contact during drug treatment and for at least seven days after drug treatment is completed; and~~
~~b. About the following:~~
~~i. The characteristics of chancroid,~~
~~ii. The syndrome caused by chancroid,~~
~~iii. Measures to reduce the likelihood of transmitting chancroid to another, and~~
~~iv. The need to notify individuals with whom the case has had sexual contact within a time period determined based upon the stage of the disease; and~~

~~2.~~ ~~The~~ A local health agency shall conduct an epidemiologic investigation of each reported chancroid case or suspect case, confirming the stage of the disease.

B. Contact control measures: ~~The~~ When a chancroid case has named an identified individual, a local health agency shall:

1. Notify ~~each~~ the identified individual of chancroid exposure;
2. Offer or arrange for the identified individual to receive treatment ~~of each identified individual~~ for chancroid; and
3. Counsel ~~each~~ the identified individual about the following:
   a. The characteristics of chancroid,
   b. The syndrome caused by chancroid,
   c. Measures to reduce the likelihood of transmitting chancroid to another, and
   d. The need to notify individuals with whom the identified individual has had sexual contact within a time period determined based upon the stage of the disease.

~~R9-6-309.~~ R9-6-312. ~~Chlamydia~~ *Chlamydia* Infection, Genital

A. Case control measures:

~~1. A diagnosing health care provider shall:~~
~~a. Prescribe drugs to render a case noninfectious,~~
~~b. Counsel or arrange for the case to be counseled to abstain from sexual contact during drug treatment and for at least seven days after drug treatment is completed, and~~
~~c. Counsel or arrange for the case to be counseled about the importance of notifying individuals who may have been exposed through sexual contact of exposure and of the need to seek medical treatment.~~

~~2.~~ The Department shall review each *Chlamydia* infection case report for completeness, accuracy, and need for follow-up.

B. Contact control measures: If an individual who may have been exposed to *Chlamydia* through sexual contact with a *Chlamydia* infection case seeks treatment for *Chlamydia* infection from ~~the~~ a local health agency, the local health agency shall offer or arrange for treatment.

~~R9-6-310.~~ R9-6-313. Cholera

A. Case control measures:

1. ~~The~~ A local health agency shall exclude a cholera case from ~~handling~~ working as a food handler, caring for patients or residents in a health care institution, or ~~working~~ caring for children in or attending a child care ~~center or preschool~~ establishment until ~~2 negative~~ two successive ~~fecal examinations have been~~ cultures negative for *Vibrio cholerae* are obtained from fecal specimens collected at least 24 hours ~~or more~~ apart and at least 48 hours after discontinuing antibiotics.

2. A local health agency shall conduct an epidemiologic investigation of each reported cholera case or suspect case. For each cholera case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:
   a. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.79, "Cholera and Other *Vibrio* Illness Surveillance Report" (July 2000), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Bacterial and Mycotic Diseases, 1600 Clifton Rd., NE, Mailstop C-09, Atlanta, GA 30333, including no future editions or amendments; or
   b. An electronic equivalent to Form CDC 52.79 provided by the Department.

B. Contact control measures: ~~The~~ A local health agency shall:
1. ~~provide~~ Provide follow-up for ~~5~~ each cholera contact for five days after exposure~~.~~ ; and
2. ~~The local health agency shall exclude~~ Exclude ~~a~~ each cholera contact with symptoms of cholera from ~~handling~~ working as a food handler, caring for patients or residents in a health care institution, or ~~working~~ caring for children in or attending a child care ~~center or preschool~~ establishment until ~~2~~ two successive ~~negative fecal examinations~~ cultures negative for *Vibrio cholerae* are ~~have been~~ obtained from fecal specimens collected at least 24 hours ~~or more~~ apart.

~~**C.** Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.~~

~~**D.** Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.~~

~~R9-6-311.~~ R9-6-314. Coccidioidomycosis (Valley Fever)

~~Reports~~ Outbreak control measures: ~~The~~ A local health agency shall ~~epidemiologically describe~~ conduct an epidemiologic investigation of each reported outbreak of coccidioidomycosis.

~~R9-6-312.~~ R9-6-315. Colorado Tick Fever

~~Special~~ Case control measures: ~~The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported Colorado tick fever case or suspect case.

~~**R9-6-316. Diarrhea of Newborn**~~

~~**A.** Case control measures: An administrator of a hospital or an authorized representative shall isolate or group cases or suspect cases in a separate area. A health care provider shall use enteric precautions for a hospitalized case.~~

~~**B.** Contact control measures. An administrator of a hospital, or an authorized representative, shall provide follow-up of newborn contacts for a period of two weeks following the date the last case is discharged from the nursery.~~

~~**C.** Environmental control measures: The diagnosing health care provider or authorized representative shall counsel the person responsible for care.~~

~~**D.** Special control measures: An administrator of a hospital or an authorized representative shall not admit additional infants to the contaminated area until all exposed infants have been discharged and the nursery has been cleaned and disinfected.~~

~~R9-6-313.~~ R9-6-316. Conjunctivitis: Acute

~~**A.**~~ Case control measures: An administrator ~~or authorized representative~~ of a ~~public or private~~ school~~,~~ or child care ~~center, or preschool~~ establishment, either personally or through a representative, shall exclude ~~a~~ an acute conjunctivitis case from attending the school or child care establishment until the symptoms of acute conjunctivitis subside or treatment for acute conjunctivitis is initiated and maintained for 24 hours.

~~**B.** Special control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, the health care provider shall counsel the person responsible for care.~~

R9-6-317. Creutzfeldt-Jakob Disease

Case control measures: A local health agency shall complete an epidemiologic investigation of each reported Creutzfeldt-Jakob disease case or suspect case.

~~R9-6-314.~~ R9-6-318. Cryptosporidiosis

~~Environmental~~ Case control measures:

1. A local health agency shall exclude a cryptosporidiosis case with diarrhea from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until diarrhea has resolved. ~~The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, the health care provider shall counsel the person responsible for care.~~
2. A local health agency shall conduct an epidemiologic investigation of each reported cryptosporidiosis case or suspect case. For each cryptosporidiosis case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation Exhibit III-B or an electronic equivalent to Exhibit III-

B provided by the Department.

R9-6-319. *Cyclospora* Infection
Case control measures: A local health agency shall conduct an epidemiologic investigation of each reported *Cyclospora* infection case or suspect case.

~~**R9-6-320. *Escherichia coli* O157:H7 Infection**~~
~~**A.** Case control measures: The local health agency shall exclude a case with symptoms of *Escherichia coli* O157:H7 from handling food or attending child care until either of the following occurs:~~
~~1. Two successive stool cultures obtained from specimens collected 24 hours or more apart are negative, or~~
~~2. Symptoms are absent.~~
~~**B.** Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.~~
~~**C.** Outbreak control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported outbreak.~~

R9-6-320. Cysticercosis
Case control measures: A local health agency shall conduct an epidemiologic investigation of each reported cysticercosis case or suspect case.

~~**R9-6-315.**~~ **R9-6-321. Dengue**
~~Special~~ Case control measures: ~~The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported dengue case or suspect case.

~~**R9-6-321.**~~ **R9-6-322.** ~~**Foodborne/Waterborne Illness: Unspecified Agent**~~ **Diarrhea, Nausea, or Vomiting**
A. Environmental control measures: ~~The~~ A local health agency shall conduct a sanitary inspection or ~~assure~~ ensure that a sanitary inspection is conducted of ~~the~~ each water, sewage, or food preparation ~~facilities~~ facility associated with an outbreak of ~~foodborne/waterborne illness~~ diarrhea, nausea, or vomiting.
B. Outbreak control measures: ~~The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported outbreak of diarrhea, nausea, or vomiting.
1. For each suspected foodborne illness outbreak, a local health agency shall complete and submit to the Department within 30 days after completing an epidemiologic investigation:
   a. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.13, "Investigation of a Foodborne Outbreak" (October 2000), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Bacterial and Mycotic Diseases, 1600 Clifton Rd., NE, Mailstop C-09, Atlanta, GA 30333, including no future editions or amendments; or
   b. An electronic equivalent to Form CDC 52.13 provided by the Department.
2. For each suspected waterborne illness outbreak, a local health agency shall complete and submit to the Department within 30 days after completing an epidemiologic investigation:
   a. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.12, "Waterborne Diseases Outbreak Report" (January 2003), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Parasitic Diseases, 1600 Clifton Rd., NE, Mailstop F-22, Atlanta, GA 30333, including no future editions or amendments; or
   b. An electronic equivalent to Form CDC 52.12 provided by the Department.
3. For each outbreak of viral gastroenteritis, a local health agency shall complete and submit to the Department within 30 days after completing an epidemiologic investigation Exhibit III-C or an electronic equivalent to Exhibit III-C provided by the Department.

~~**R9-6-317.**~~ **R9-6-323. Diphtheria**
A. Case control measures:
1. ~~The~~ A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate a ~~hospitalized~~ diphtheria case until ~~either of the following occurs~~:
   ~~1.~~a. One of the following:
      i. If the case has pharyngeal diphtheria, ~~Two~~ two successive ~~negative~~ sets of cultures negative for *Cornyebacterium diphtheriae* ~~each from the nose and throat or skin~~ are obtained from nose and throat specimens collected from the case at least 24 hours ~~or more~~ apart and at least 24 hours ~~or more~~ after cessation of treatment~~.~~; or
      ii. If the case has cutaneous diphtheria, two successive cultures negative for *Cornyebacterium diphtheriae* are obtained from skin specimens collected from the case at least 24 hours apart and at least 24 hours after cessation of treatment; or

~~2.~~b. Fourteen days after initiation of treatment.

2. A local health agency shall conduct an epidemiologic investigation of each reported diphtheria case or suspect case. For each diphtheria case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:
   a. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "CDC Diphtheria Worksheet" (in use on April 16, 2004), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Bacterial and Mycotic Diseases, 1600 Clifton Rd., NE, Mailstop C-09, Atlanta, GA 30333, including no future editions or amendments; or
   b. An electronic equivalent to the "CDC Diphtheria Worksheet" provided by the Department.

B. Contact control measures: ~~The~~ A local health agency shall:
1. Exclude ~~contacts~~ each diphtheria contact from ~~handling~~ working as a food handler until a ~~negative culture~~ set of cultures negative for *Cornyebacterium diphtheriae* is obtained from the contact's ~~of the~~ nose and throat ~~or skin~~ specimens ~~is obtained.~~ ;
2. Quarantine ~~household contacts~~ each close contact of a diphtheria case until two successive sets of ~~negative~~ cultures negative for *Cornyebacterium diphtheriae* are obtained ~~each~~ from ~~the~~ nose and throat ~~or skin have been obtained~~ specimens collected from the close contact at least 24 hours ~~or more~~ apart~~.~~ ;
3. Offer each previously immunized ~~contacts~~ diphtheria contact a vaccine containing diphtheria toxoid~~.~~ ; and
4. Offer each unimmunized ~~contacts~~ diphtheria contact the primary vaccine series and treatment.

~~**C.** Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.~~

~~**D.** Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.~~

~~R9-6-318.~~ R9-6-324. Ehrlichiosis

~~Special~~ Case control measures: ~~The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported ehrlichiosis case or suspect case. For each ehrlichiosis case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:
1. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 55.1, "Tick-Borne Rickettsial Disease Case Report" (January 2001), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Viral and Rickettsial Diseases, 1600 Clifton Rd., NE, Mailstop A-30, Atlanta, GA 30333, including no future editions or amendments; or
2. An electronic equivalent to Form CDC 55.1 provided by the Department.

R9-6-325. Emerging or Exotic Disease

A. Case control measures:
1. A local health agency, in consultation with the Department, shall isolate an emerging or exotic disease case or suspect case as necessary to prevent transmission.
2. A local health agency shall conduct an epidemiologic investigation of each reported emerging or exotic disease case or suspect case.

B. Contact control measures: A local health agency, in consultation with the Department, shall quarantine an emerging or exotic disease contact as necessary to prevent transmission.

~~R9-6-319.~~ R9-6-326. Encephalitis: Viral or Parasitic

~~Special~~ Case control measures: ~~The~~ A local health ~~agencies~~ agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported viral or parasitic encephalitis case or suspect case. For each mosquito-borne viral encephalitis case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation Exhibit III-D or an electronic equivalent to Exhibit III-D provided by the Department.

R9-6-327. Enterohemorrhagic *Escherichia coli*

A. Case control measures:
1. A local health agency shall exclude an enterohemorrhagic *Escherichia coli* case with diarrhea from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
   a. Two successive cultures negative for enterohemorrhagic *Escherichia coli* are obtained from stool specimens collected from the case at least 24 hours apart and at least 48 hours after discontinuing antibiotics, or
   b. Diarrhea has resolved.
2. A local health agency shall conduct an epidemiologic investigation of each reported enterohemorrhagic *Escherichia coli* case or suspect case. For each enterohemorrhagic *Escherichia coli* case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation Exhibit III-E or an electronic equivalent to Exhibit III-E provided by the Department.

B. Contact control measures: A local health agency shall exclude an enterohemorrhagic *Escherichia coli* contact with diarrhea from working as a food handler until diarrhea has resolved.

R9-6-328. Enterotoxigenic *Escherichia coli*

A. Case control measures:
1. A local health agency shall exclude an enterotoxigenic *Escherichia coli* case with diarrhea from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
   a. Two successive cultures negative for enterotoxigenic *Escherichia coli* are obtained from stool specimens collected from the case at least 24 hours apart and at least 48 hours after discontinuing antibiotics, or
   b. Diarrhea has resolved.
2. A local health agency shall conduct an epidemiologic investigation of each reported enterotoxigenic *Escherichia coli* case or suspect case.

B. Contact control measures: A local health agency shall exclude an enterotoxigenic *Escherichia coli* contact with diarrhea from working as a food handler until diarrhea has resolved.

~~**R9-6-329. Hepatitis Non-A, Non-B**~~

~~**A.** Case control measures: A health care provider or operator of a blood or plasma center shall not utilize donated blood, plasma, body organs, sperm, or other tissue from a case, suspect case, or carrier for transfusion or transplantation.~~

~~**B.** Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, the health care provider shall counsel the person responsible for care.~~

~~**C.** Special control measures: Any person operating a blood or plasma center who interprets, as positive, a test for HCV or antibodies to HCV shall, within 30 days of verifying the final results of the test, notify the person on whom the test was performed.~~

~~**R9-6-322.**~~ **R9-6-329. Giardiasis**

A. Case control measures: ~~The~~ A local health agency shall exclude a giardiasis case from ~~handling~~ working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care ~~center or a preschool,~~ establishment until ~~either of the following occurs~~:
1. Two ~~negative~~ successive fecal examinations negative for *Giardia lamblia* ~~have been~~ are obtained from specimens collected from the case at least 24 hours ~~or more~~ apart, or
2. Treatment for giardiasis is initiated and ~~the case no longer has symptoms~~ diarrhea has resolved.

B. Contact control measures:
1. ~~The~~ A local health agency shall exclude a giardiasis contact with ~~symptoms of giardiasis~~ diarrhea from ~~handling~~ working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care ~~centers or preschools~~ establishment until ~~the contact no longer has symptoms~~ diarrhea has resolved.
2. A local health agency shall counsel or arrange for a giardiasis contact or, if the contact is a child or incapacitated adult, the parent or guardian of the contact to be counseled about handwashing and concurrent disinfection of contaminated objects.

~~**C.** Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.~~

~~**D.**~~**C.** Outbreak control measures: ~~The~~ A local health agency shall ~~provide education and consultation regarding prevention and control measures to cases and known contacts~~ conduct an epidemiologic investigation of each reported giardiasis outbreak. For each giardiasis case involved in an outbreak, a local health agency shall complete and submit to the Department within 30 days after completing an epidemiologic investigation Exhibit III-F or an electronic equivalent to Exhibit III-F provided by the Department.

~~**R9-6-330. Herpes Genitalis**~~

~~Case control measures: A diagnosing health care provider shall counsel or arrange for a case to be counseled:~~
~~1. To abstain from sexual contact until lesions are healed,~~
~~2. About available treatment, and~~
~~3. About chemoprophylaxis and other measures to prevent transmission.~~

~~**R9-6-323.**~~ **R9-6-330. Gonorrhea**

A. Case control measures:
~~1. A diagnosing health care provider shall:~~
   ~~a. Prescribe drugs to render a case noninfectious,~~
   ~~b. Counsel or arrange for the case to be counseled to abstain from sexual contact during drug treatment and for at least seven days after drug treatment is completed, and~~

~~c. Counsel or arrange for the case to be counseled about the importance of notifying individuals who may have been exposed through sexual contact of exposure and of the need to seek medical treatment.~~

~~2.~~1. The Department shall review each gonorrhea case report for completeness, accuracy, and need for follow-up.

~~3.~~2. For the prevention of gonorrheal ophthalmia, a health care provider or midwife attending the birth of an infant in ~~Arizona~~ this state shall treat the eyes of the infant immediately after the birth with one of the following, unless treatment is refused by the parent or guardian:

a. Erythromycin ophthalmic ointment 0.5%, or

b. Tetracycline ophthalmic ointment 1%.

B. Contact control measures: If an individual who may have been exposed to gonorrhea through sexual contact with a gonorrhea case seeks treatment for gonorrhea from ~~the~~ a local health agency, the local health agency shall offer or arrange for treatment.

~~R9-6-324.~~ R9-6-331. *Haemophilus ~~Influenzae~~ influenzae*: Invasive ~~Diseases~~ Disease

~~**A.** Reports: A health care provider shall report invasive diseases including meningitis, epiglottitis, bacteremia, pneumonia, septic arthritis, and cellulitis.~~

~~**B.**~~**A.** Case control measures:

1. ~~The~~ A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate a ~~hospitalized~~ *Haemophilus influenzae* invasive disease case for 24 hours ~~following~~ after the initiation of treatment.

2. A local health agency shall conduct an epidemiologic investigation of each reported *Haemophilus influenzae* invasive disease case or suspect case.

   a. For each *Haemophilus influenzae* invasive disease case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:

      i. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.15N, "National Bacterial Meningitis and Bacteremia Case Report" (February 1993), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Bacterial and Mycotic Diseases, 1600 Clifton Rd., NE, Mailstop C-09, Atlanta, GA 30333, including no future editions or amendments; or

      ii. An electronic equivalent to Form CDC 52.15N provided by the Department.

   b. For each *Haemophilus influenzae* type B invasive disease case younger than 5 years of age, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:

      i. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "CDC Expanded Case Report Form: *Haemophilus Influenzae* Type B in Children < 5 Years of Age" (in use on April 16, 2004), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Bacterial and Mycotic Diseases, 1600 Clifton Rd., NE, Mailstop C-09, Atlanta, GA 30333, including no future editions or amendments; or

      ii. An electronic equivalent to the "CDC Expanded Case Report Form: *Haemophilus Influenzae* Type B in Children < 5 Years of Age" provided by the Department.

~~**C.**~~**B.** Contact control measures: ~~The~~ A local health agency shall evaluate the level of risk of transmission from each contact's exposure to a *Haemophilus influenzae* invasive disease ~~contacts~~ case and, if indicated, shall provide or arrange for each contact to receive immunization or treatment.

~~**D.** Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.~~

~~R9-6-332. Human T-cell Lymphotropic Virus (HTLV-I/II) Type I and II Infection~~

~~**A.** Case control measures: A health care provider or operator of a blood or plasma center shall not utilize donated blood, plasma, milk, body organs, sperm, or other tissue from a case or carrier for transfusion or transplantation.~~

~~**B.** Special control measures: Any person operating a blood or plasma center who interprets as positive a test for the HTLV-I/II shall, in addition to meeting the reporting requirements specified, notify the person on whom the test was performed within 30 days of receiving the final test results.~~

~~R9-6-334.~~ R9-6-332. ~~Leprosy (~~Hansen's Disease~~)~~ (Leprosy)

A. Case control measures: A local health agency shall conduct an epidemiologic investigation of each reported Hansen's disease case or suspect case. For each Hansen's disease case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:

1. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.18, "Hansen's Disease Surveillance Form" (March 1996), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Bacterial and Mycotic Diseases, 1600 Clifton Rd., NE, Mailstop C-09, Atlanta, GA 30333, including no future editions or amendments; or

2. An electronic equivalent to Form CDC 52.18 provided by the Department.

~~A.~~**B.** Contact control measures: ~~The~~ A local health agency shall examine ~~household~~ close contacts of a Hansen's disease case for signs and symptoms of leprosy at ~~6-12~~ six-to-twelve month intervals for ~~3~~ five years after the last ~~contact with~~ exposure to an infectious case~~, or 3 years after the case becomes noninfectious~~.

~~**B.** Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.~~

~~R9-6-325.~~ R9-6-333. Hantavirus Infection

~~Environmental~~ Case control measures:

1. A local health agency shall ~~provide~~ counsel or arrange for ~~the provision of education on~~ a Hantavirus infection case or, if the case is a child or incapacitated adult, the parent or guardian of the case to be counseled about reducing the risks of becoming reinfected with or of having others become infected with hantavirus ~~infection to the patient~~.
2. A local health agency shall conduct an epidemiologic investigation of each reported hantavirus infection case or suspect case. For each hantavirus infection case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:
   a. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "Hantavirus Pulmonary Syndrome Case Report Form" (November 2002) and a Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "Individual Questionnaire" (January 1996), which are incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Viral and Rickettsial Diseases, 1600 Clifton Rd., NE, Mailstop A-30, Atlanta, GA 30333, including no future editions or amendments; or
   b. Electronic equivalents to the "Hantavirus Pulmonary Syndrome Case Report Form" and "Individual Questionnaire" provided by the Department.

R9-6-334. Hemolytic Uremic Syndrome

A. Case control measures:

1. A local health agency shall exclude a hemolytic uremic syndrome case from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
   a. Two successive cultures negative for enterohemorrhagic *Escherichia coli* and *Shigella* spp. are obtained from stool specimens collected from the case at least 24 hours apart and at least 48 hours after discontinuing antibiotics, or
   b. Diarrhea has resolved.
2. A local health agency shall conduct an epidemiologic investigation of each reported hemolytic uremic syndrome case or suspect case.

B. Contact control measures: A local health agency shall exclude a hemolytic uremic syndrome contact with diarrhea from working as a food handler until diarrhea has resolved.

~~R9-6-326.~~ R9-6-335. Hepatitis A

A. Case control measures:

1. A local health agency shall exclude a hepatitis A case from working as a food handler or attending a child care establishment during the first 14 days of illness or for seven days after onset of jaundice.
2. A local health agency shall conduct an epidemiologic investigation of each reported hepatitis A case or suspect case. For each hepatitis A case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation Exhibit III-G or an electronic equivalent to Exhibit III-G provided by the Department.

~~**A.** Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.~~

B. Contact control measures: A local health agency shall:

1. Exclude a hepatitis A contact with symptoms of hepatitis A from working as a food handler during the first 14 days of illness or for seven days after onset of jaundice;
2. For 45 days after exposure, provide follow-up to a food handler who is a contact of a hepatitis A case during the infectious period; and
3. Evaluate the level of risk of transmission from each contact's exposure to a hepatitis A case and, if indicated, provide or arrange for each contact to receive prophylaxis and immunization.

~~**B.** Outbreak control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported outbreak. The local health agency shall evaluate the risk of exposure and, if indicated, provide or arrange for prophylaxis.~~

~~**C.** Special control measures: The local health agency shall:~~

~~1. Exclude a case from handling food during the 1st 14 days of illness or for 7 days after the onset of jaundice.~~
~~2. Provide follow-up of food handlers who are household contacts with a case or who consumed food prepared by a case during the infectious period for 45 days following the exposure.~~

~~R9-6-327.~~ R9-6-336. Hepatitis B and ~~Delta~~ Hepatitis D

A. Case control measures: ~~A health care provider or operator of a blood or plasma center shall not utilize donated blood, plasma, body organs, sperm, or other tissue from a case, suspect case, or carrier for transfusion or transplantation.~~
1. A local health agency shall evaluate a health care provider identified as the source of hepatitis B virus transmission in the work place and, if indicated, ensure reassignment of the health care provider to a position where the occupational risk of transmission is eliminated.
2. A local health agency shall conduct an epidemiologic investigation of each reported hepatitis B case or suspect case.
   a. For each acute hepatitis B case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation Exhibit III-H or an electronic equivalent to Exhibit III-H provided by the Department.
   b. For each perinatal hepatitis B case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation Exhibit III-I or an electronic equivalent to Exhibit III-I provided by the Department.
3. The operator of a blood bank, blood center, or plasma center shall notify a donor of a test result with significant evidence suggestive of hepatitis B, as required under A.R.S. § 32-1483 and 21 CFR 630.6.

B. Contact control measures: ~~The~~ A local health agency shall refer each ~~exposed~~ non-immune ~~persons~~ hepatitis B contact to a ~~physician~~ health care provider for prophylaxis and initiation of the hepatitis B vaccine series.

~~C.~~ ~~Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, the health care provider shall counsel the person responsible for care.~~

~~D.~~ ~~Special control measures:~~
1. ~~Control of donors: A health care provider or operator of a blood or plasma center shall exclude:~~
   a. ~~Anyone who has, or has had, hepatitis B or delta hepatitis or demonstrates serologic evidence of having the hepatitis B surface antigen (HBsAg) from donating blood, plasma, sperm, organ, or tissue.~~
   b. ~~Anyone who has received a transfusion of blood or blood product from donating blood for 6 months following the transfusion.~~
2. ~~Control of an infectious health care provider: The local health agency shall evaluate a health care provider who is identified as the source of Hepatitis B Virus transmission in the work place and, if indicated, shall ensure reassignment of the health care provider to a position where the occupational risk of transmission is eliminated.~~
3. ~~The local health agency shall conduct or direct an epidemiological investigation of each reported case of hepatitis B or delta hepatitis.~~
4. ~~Any person operating a blood or plasma center who interprets, as positive, a test for the hepatitis B surface antigen (HbsAg) or hepatitis B core IgM antibodies (HBcAb IgM), in addition to meeting the reporting requirements specified in R9-6-202 shall, within 30 days of performing the test, notify the person on whom the test was performed.~~

~~R9-6-328.~~ R9-6-337. Hepatitis C

~~A.~~ Case control measures: ~~A health care provider or operator of a blood or plasma center shall not utilize donated blood, plasma, body organs, sperm, or other tissue from a case, suspect case, or suspect carrier for transfusion or transplantation.~~
1. A local health agency shall conduct an epidemiologic investigation of each reported acute hepatitis C case or suspect case.
2. The Department shall provide education related to the progression of hepatitis C disease and the prevention of transmission of hepatitis C infection to each reported non-acute hepatitis C case or suspect case.

~~B.~~ ~~Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the persons responsible for their care.~~

~~C.~~ ~~Special control measures: Any person operating a blood or plasma center who interprets, as positive, a test for HCV or antibodies to HCV, shall within 30 days of verifying the final results of the test, notify the person on whom the test was performed.~~

R9-6-338. Hepatitis E

Case control measures: A local health agency shall conduct an epidemiologic investigation of each reported hepatitis E case or suspect case. For each case of symptomatic acute viral hepatitis, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:
1. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 53.1, "Viral Hepatitis Case Record for Reporting of Patients with Symptomatic Acute Viral Hepatitis" (June 1993), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Viral Hepatitis, 1600 Clifton Rd., NE, Mailstop G-37, Atlanta, GA 30333, including no future editions or amendments; or
2. An electronic equivalent to Form CDC 53.1 provided by the Department.

~~R9-6-331.~~ R9-6-339. Human Immunodeficiency Virus (HIV) Infection and Related Disease

A. Case control measures:

~~1. A health care provider or operator of a blood bank, blood center, plasma center, tissue bank, organ bank, or milk bank shall not use donated blood or blood components, plasma, milk, organs, semen, or other tissue from a case or carrier for transfusion, transplantation, or consumption.~~

~~2. A health care provider or operator of a blood bank, blood center, plasma center, tissue bank, organ bank, or milk bank who orders or administers a test for HIV or HIV antibodies and receives a test result that the health care provider or operator interprets as positive for HIV or HIV antibodies shall notify the subject or arrange for the subject to be notified of the test result within 30 days after receiving the test result.~~

~~3. A health care provider or operator of a blood bank, blood center, plasma center, tissue bank, organ bank, or milk bank shall provide or arrange for subject counseling at the time of notification that includes the following information:~~

~~a. The characteristics of HIV;~~

~~b. The syndrome caused by HIV and its symptoms;~~

~~c. The measures that are effective in reducing the likelihood of transmitting HIV to another;~~

~~d. The need to notify individuals, including a spouse, with whom the subject has had sexual contact or has shared needles of exposure to HIV; and~~

~~e. The availability of assistance from local health agencies in notifying those individuals described in subsection (A)(3)(d).~~

~~4.~~1. ~~The~~ A local health agency shall conduct an epidemiologic investigation of each reported HIV case, suspect case, or carrier within 30 days after receiving a report. Upon completion of ~~the~~ an epidemiologic investigation, ~~the~~ a local health agency shall not retain any personal identifying information about the case, suspect case, or carrier.

2. The operator of a blood bank, blood center, or plasma center shall notify a donor of a test result with significant evidence suggestive of HIV infection, as required under A.R.S. § 32-1483 and 21 CFR 630.6.

~~5.~~3. A counseling and testing site supervised by the Department or by a local health agency shall offer anonymous testing. The Department or local health agency shall collect the following epidemiologic information about each individual opting for anonymous testing:

a. Age,
b. Race and ethnicity,
c. ~~Sex~~ Gender,
d. County of residence, and
e. HIV-associated risk behaviors.

~~6.~~4. The Department shall confidentially notify an identifiable third party reported to be at risk of HIV infection under A.R.S. § 36-664(K) if all of the following conditions are met:

a. The Department receives the report of risk in a document that includes the following:
   i. The name and address of the identifiable third party,
   ii. The name and address of the individual placing the identifiable third party at risk,
   iii. The name and address of the individual making the report, and
   iv. The type of exposure placing the identifiable third party at risk;
b. The individual making the report is in possession of confidential HIV-related information; and
c. The Department determines that the information provided in the report is accurate and sufficient to warrant notification of the identifiable third party.

~~7.~~5. As authorized under A.R.S. § 36-136(L), a local health agency shall notify the superintendent of a school district, as defined in A.R.S. § 15-101, in a confidential document that a pupil of the school district is a case or carrier of HIV if the following criteria are met:

a. The local health agency determines by consulting with the Department that the pupil places others in the school setting at risk for HIV infection; and
b. The school district has an HIV policy that includes the following provisions:
   i. That a school shall not exclude an infected pupil from attending school or school functions or from participating in school activities solely due to HIV infection;
   ii. That the school district shall establish a group to determine on a case-by-case basis whether an infected pupil should be permitted to attend school by considering the risks and benefits to the pupil and to others if the pupil attends school;
   iii. That the group described in subsection ~~(A)(7)(b)(ii)~~ (A)(5)(b)(ii) shall include the superintendent of the school district, the parents or guardians of a minor pupil, the pupil if the pupil is not a minor or is emancipated, the pupil's physician, and the local health officer, and may include ~~a~~ an administrator of a school ~~administrator~~, a school nurse, and a teacher or counselor of the pupil;
   iv. That school district personnel who are informed of the pupil's HIV infection shall keep that information confidential;
   v. That the school district shall provide HIV education programs to pupils, parents or guardians of pupils, and school district personnel through age-appropriate curricula, workshops, or in-service training sessions; and

vi. That school district personnel who handle blood or body fluids shall comply with Elizabeth A. Bolyard et al., Guideline for Infection Control in Health Care Personnel, 1998 (1998), incorporated by reference~~,~~ ; on file with the Department and the Office of the Secretary of State~~,~~ ; ~~and~~ available from National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161~~. This incorporation by reference includes~~ ; and including no future editions or amendments.

B. Environmental control measures: An employer, as defined under A.R.S. § 23-401, or health care provider shall comply with 29 CFR 1910.1030 (~~1999~~ as of November 7, 2002), as required by A.R.S. § 23-403 and A.A.C. R20-5-602.

R9-6-340. Kawasaki Syndrome

A local health agency shall conduct an epidemiologic investigation of each reported Kawasaki syndrome case or suspect case. For each Kawasaki syndrome case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:

1. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 55.54, "Kawasaki Syndrome Case Reporting" (January 1991), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Viral and Rickettsial Diseases, 1600 Clifton Rd., NE, Mailstop A-30, Atlanta, GA 30333, including no future editions or amendments; or
2. An electronic equivalent to Form CDC 55.54 provided by the Department.

~~**R9-6-333.**~~ **R9-6-341. Legionellosis (Legionnaires' Disease)**

A. ~~Outbreak~~ Case control measures: ~~The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported ~~outbreak~~ legionellosis case or suspect case. For each legionellosis case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:

1. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.56, "Legionellosis Case Report" (August 1999), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Bacterial and Mycotic Diseases, 1600 Clifton Rd., NE, Mailstop C-09, Atlanta, GA 30333, including no future editions or amendments; or
2. An electronic equivalent to Form CDC 52.56 provided by the Department.

B. Environmental control measures: The owner of a water, cooling, or ventilation system ~~which~~ that is determined by the Department or a local health agency to ~~be a source in an outbreak~~ have caused a case of *Legionella* infection shall disinfect the system before ~~reusing it~~ resuming its use.

~~**R9-6-335.**~~ **R9-6-342. Leptospirosis**

~~Special~~ Case control measures: ~~The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported leptospirosis case or suspect case. For each leptospirosis case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:

1. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.26, "Leptospiroris Case Investigation Report" (October 1987), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Bacterial and Mycotic Diseases, 1600 Clifton Rd., NE, Mailstop C-09, Atlanta, GA 30333, including no future editions or amendments; or
2. An electronic equivalent to Form CDC 52.26 provided by the Department.

~~**R9-6-336.**~~ **R9-6-343. Listeriosis**

~~Outbreak~~ Case control measures:

1. ~~The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported ~~outbreak~~ listeriosis case or suspect case. For each listeriosis case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation Exhibit III-J or an electronic equivalent to Exhibit III-J provided by the Department.
2. A local health agency shall counsel a listeriosis case or, if the case is a child or an incapacitated adult, the parent or guardian of the case about the risks of contracting listeriosis from cold deli meats and unpasteurized dairy products.

~~**R9-6-337.**~~ **R9-6-344. Lyme Disease**

~~Special~~ Case control measures: ~~The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported Lyme disease case or suspect case. For each Lyme disease case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation Exhibit III-K or an electronic equivalent to Exhibit III-K provided by the Department.

R9-6-345. Lymphocytic Choriomeningitis

Case control measures:

1. A local health agency shall conduct an epidemiologic investigation of each reported lymphocytic choriomeningitis case or suspect case.
2. A local health agency shall counsel or arrange for a lymphocytic choriomeningitis case or, if the case is a child or incapacitated adult, the parent or guardian of the case to be counseled about reducing the risks of becoming reinfected

with or of having others become infected with lymphocytic choriomeningitis virus.

~~R9-6-338.~~ R9-6-346. Malaria

~~**A.**~~ Case control measures: ~~A health care provider shall exclude a case from donating blood or plasma for transfusion.~~

~~**B.**~~ ~~Special control measures:~~

~~1. Control of a blood donor - The medical director of a blood collection center shall obtain from a prospective blood donor the following information concerning whether the person:~~

~~a. Has or had malaria; or~~

~~b. Has traveled in, visited, or immigrated from an area endemic for malaria; or~~

~~c. Has taken antimalarial drugs.~~

~~The blood collection center shall not draw blood from any person who affirmatively responds to any of the questions or refuses to supply this information.~~

~~2.~~ ~~The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported malaria case or suspect case. For each malaria case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:

1. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 54.1, "Malaria Case Surveillance Report" (January 2002), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Parasitic Diseases, 1600 Clifton Rd., NE, Mailstop F-22, Atlanta, GA 30333, including no future editions or amendments; or
2. An electronic equivalent to Form CDC 54.1 provided by the Department.

~~R9-6-339.~~ R9-6-347. Measles (Rubeola)

A. Case control measures:

1. An administrator ~~or authorized representative~~ of a school~~,~~ or child care ~~center, or preschool~~ establishment, either personally or through a representative, shall:
   a. ~~exclude~~ Exclude a measles case from the school~~,~~ or child care ~~center, or preschool~~ establishment and ~~school-sponsored~~ from school- or child-care-establishment-sponsored events from the onset of illness through the ~~4th~~ fourth day after the rash appears, and
   b. Exclude a measles suspect case from the school or child care establishment and from school- or child-care-establishment-sponsored events until evaluated and determined to be noninfectious by a physician, physician assistant, or registered nurse practitioner.
2. ~~An~~ A diagnosing health care provider or an administrator of a ~~hospital~~ health care institution, ~~or authorized~~ either personally or through a representative, shall isolate a ~~hospitalized~~ measles case from onset of illness through the ~~4th~~ fourth day after the rash appears.
3. A local health agency shall conduct an epidemiologic investigation of each reported measles case or suspect case. For each measles case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:
   a. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "Measles Surveillance Worksheet" (in use on April 16, 2004), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Parasitic Diseases, 1600 Clifton Rd., NE, Mailstop F-22, Atlanta, GA 30333, including no future editions or amendments; or
   b. An electronic equivalent to the "Measles Surveillance Worksheet" provided by the Department.

B. Contact control measures:

1. ~~Unless able to provide evidence of immunity to measles in accordance with R9-6-703, an~~ When a measles case has been at a school or child care establishment, the administrator ~~or authorized representative~~ of ~~a~~ the school~~,~~ or child care ~~center, or preschool~~ establishment, either personally or through a representative, shall:
   a. ~~consult~~ Consult with the local health agency to determine who shall be excluded and ~~the~~ how long ~~they~~ each individual shall be excluded from the school or child care establishment, and
   b. Comply with the local health agency's recommendations for exclusion.
2. ~~The~~ A local health agency shall provide or arrange for immunization of each non-immune ~~individuals~~ measles contact within 72 hours ~~of~~ after last exposure, if possible.
3. A paid or volunteer full- or part-time worker at a health care institution shall not participate in the direct care of a measles case or suspect case unless the worker is able to provide evidence of immunity to measles through one of the following:
   a. A record of immunization against measles with two doses of live virus vaccine given on or after the first birthday and at least one month apart;
   b. A statement signed by a physician, state health officer, or local health officer affirming serologic evidence of immunity to measles; or
   c. Documentary evidence of birth before January 1, 1957.

~~**C.**~~ ~~Outbreak control measures: An administrator or authorized representative of a school, child care center, or preschool shall~~

~~consult with the local health agency to determine who shall be excluded and how long they shall be excluded during an outbreak.~~

~~**D.** Special control measures:~~

~~1. No employee of any health care facility shall have direct contact with any measles patient, including suspect cases, unless able to provide evidence of immunity to measles.~~

~~a. Evidence of immunity to measles shall consist of:~~

~~i. A record of immunization against measles with 2 doses of live virus vaccine given on or after the 1st birthday and 1 month or more apart; or~~

~~ii. A statement signed by a licensed physician, or a state or local health officer which affirms serologic evidence of having had measles.~~

~~b. Anyone born prior to January 1, 1957 shall be considered to be immune to measles.~~

~~2. The local health agency shall conduct or direct an epidemiologic investigation of each reported case.~~

~~R9-6-340.~~ R9-6-348. Meningococcal Invasive Disease

~~**A.** Reports: A report of invasive disease includes meningitis, bacteremia, and septic arthritis.~~

~~**B.**~~**A.** Case control measures:

1. ~~The~~ A diagnosing health care provider~~,~~ or an administrator of a ~~hospital~~ health care institution, ~~or authorized~~ either personally or through a representative, shall isolate a ~~hospitalized~~ meningococcal invasive disease case for 24 hours after the initiation of treatment.
2. A local health agency shall conduct an epidemiologic investigation of each reported meningococcal invasive disease case or suspect case. For each meningococcal invasive disease case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:
   a. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.15N, "National Bacterial Meningitis and Bacteremia Case Report" (February 1993), which is incorporated by reference in R9-6-331; or
   b. An electronic equivalent to Form CDC 52.15N provided by the Department.

~~**C.** Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.~~

~~**D.**~~**B.** Contact control measures: ~~The~~ A local health agency shall evaluate the level of risk of transmission from each contact's exposure to a meningococcal invasive disease case and, if indicated, provide or arrange for each contact to receive prophylaxis ~~of contacts~~.

~~**E.** Special control measures: The local health agency shall conduct or direct as epidemiologic investigation of each reported case.~~

~~R9-6-341.~~ R9-6-349. Mumps

A. Case control measures:

1. An administrator ~~or authorized representative~~ of a school~~,~~ or child care ~~center, or preschool~~ establishment, either personally or through a representative, shall exclude a mumps case from the school~~, day care center,~~ or ~~preschool~~ child care establishment for ~~9~~ nine days ~~following~~ after the onset of glandular swelling.
2. A health care provider shall use droplet precautions with a mumps case for ~~9~~ nine days ~~following~~ after the onset of glandular swelling.
3. A local health agency shall conduct an epidemiologic investigation of each reported mumps case or suspect case. For each mumps case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:
   a. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "Mumps Surveillance Worksheet" (May 1998), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Viral and Rickettsial Diseases, 1600 Clifton Rd., NE, Mailstop A-30, Atlanta, GA 30333, including no future editions or amendments; or
   b. An electronic equivalent to the "Mumps Surveillance Worksheet" provided by the Department.

~~**B.** Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.~~

B. Contact control measures: When a mumps case has been at a school or child care establishment, the administrator of the school or child care establishment, either personally or through a representative, shall:

1. Consult with the local health agency to determine who shall be excluded and how long each individual shall be excluded from the school or child care establishment, and
2. Comply with the local health agency's recommendations for exclusion.

~~R9-6-342.~~ R9-6-350. Pediculosis (Lice Infestation)

~~**A.** Reports: An administrator or authorized representative of a public or private school, child care center, or preschool shall~~

~~report an outbreak of pediculosis.~~

~~**B.**~~ Case control measures:

1. An administrator ~~or authorized~~ of a school or child care establishment, either personally or through a representative ~~of a school, child care center, or preschool~~ , shall exclude a pediculosis case from the school~~,~~ or child care ~~center, or preschool~~ establishment until ~~treatment for pediculosis is initiated~~ the case is treated with a pediculocide.
2. An administrator of a shelter shall ensure that a pediculosis case is treated with a pediculocide and that the case's clothing and personal articles are disinfested.

~~**C.** Outbreak control measures: An administrator or authorized representative of a school, child care center, or preschool shall consult with the local health agency to determine who shall be excluded and how long they shall be excluded during an outbreak.~~

~~**D.** Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfestation of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.~~

~~R9-6-343.~~ R9-6-351. Pertussis (Whooping Cough)

A. Case control measures:

1. An administrator ~~or authorized representative~~ of a school~~,~~ or child care ~~center, or preschool~~ establishment, either personally or through a representative, shall:
   a. ~~exclude~~ Exclude a pertussis case from the school~~,~~ or child care ~~center, or preschool~~ establishment for 21 days after the date of onset of ~~the illness,~~ cough or for ~~5~~ five days ~~following~~ after the date of initiation of antibiotic treatment for pertussis; and
   b. Exclude a pertussis suspect case from the school or child care establishment until evaluated and determined to be noninfectious by a physician, physician assistant, or registered nurse practitioner.
2. An administrator of a health care institution, either personally or through a representative, shall:
   a. Exclude a pertussis case from working at the health care institution for 21 days after the date of onset of cough or for five days after the date of initiation of antibiotic treatment for pertussis; and
   b. Exclude a pertussis suspect case from working at the health care institution until evaluated and determined to be noninfectious by a physician, physician assistant, or registered nurse practitioner.
3. A health care provider shall use droplet precautions for a ~~hospitalized~~ pertussis case for ~~5~~ five days ~~following~~ after the date of initiation of antibiotic treatment for pertussis.
4. A local health agency shall conduct an epidemiologic investigation of each reported pertussis case or suspect case. For each pertussis case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:
   a. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "Pertussis Surveillance Worksheet" (November 1999), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Bacterial and Mycotic Diseases, 1600 Clifton Rd., NE, Mailstop C-09, Atlanta, GA 30333, including no future editions or amendments; or
   b. An electronic equivalent to the "Pertussis Surveillance Worksheet" provided by the Department.

B. Contact control measures:

1. When a pertussis case has been at a school or child care establishment, the administrator of the school or child care establishment, either personally or through a representative, shall:
   a. Consult with the local health agency to determine who shall be excluded and how long each individual shall be excluded from the school or child care establishment, and
   b. Comply with the local health agency's recommendations for exclusion.
2. ~~The~~ A local health agency shall ~~evaluate household~~ identify close contacts ~~for exposure~~ of a pertussis case and, if indicated, shall provide or arrange for each close contact to receive antibiotic prophylaxis.

~~**C.** Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.~~

~~**D.** Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.~~

~~R9-6-344.~~ R9-6-352. Plague

A. Case control measures:

1. ~~A hospital~~ A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall ~~use~~ isolate a pneumonic plague case with droplet precautions ~~for a case of pneumonic plague~~ until ~~3 full days~~ 72 hours of ~~clinically effective~~ antibiotic therapy have been completed with favorable clinical response.
2. ~~Clothing and personal articles shall be disinfested of fleas with an insecticide approved and labeled for use against fleas.~~

2. An individual handling the body of a deceased plague case shall use droplet precautions.
3. A local health agency shall conduct an epidemiologic investigation of each reported plague case or suspect case. For each plague case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:
   a. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 56.37, "Plague Case Investigation Report" (May 1985), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Vector-Borne Infectious Diseases, P.O. Box 2087 (Foothills Campus), Fort Collins, CO 80522, including no future editions or amendments; or
   b. An electronic equivalent to Form CDC 56.37 provided by the Department.

B. Contact control measures: ~~The~~ A local health agency shall provide follow-up ~~of~~ to pneumonic plague contacts ~~of cases of pneumonic plague~~ for ~~7~~ seven days after last exposure to a pneumonic plague case.

~~**C.** Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.~~

~~**D.** Special control measures:~~
~~1. Persons handling bodies of deceased cases shall observe universal and respiratory precautions.~~
~~2. The local health agency shall conduct or direct an epidemiologic investigation of each reported case.~~

~~R9-6-345.~~ R9-6-353. Poliomyelitis

Case control measures: A local health agency shall conduct an epidemiologic investigation of each reported poliomyelitis case or suspect case. For each poliomyelitis case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:

1. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "Suspected Polio Case Worksheet" (August 1998), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Viral and Rickettsial Diseases, 1600 Clifton Rd., NE, Mailstop A-30, Atlanta, GA 30333, including no future editions or amendments; or
2. An electronic equivalent to the "Suspected Polio Case Worksheet" provided by the Department.

~~**A.** Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.~~

~~**B.** Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.~~

~~R9-6-346.~~ R9-6-354. Psittacosis (Ornithosis)

A. Case control measures: A local health agency shall conduct an epidemiologic investigation of each reported psittacosis case or suspect case. For each psittacosis case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:

1. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.2, "Psittacosis Case Surveillance Report" (March 1981), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Bacterial and Mycotic Diseases, 1600 Clifton Rd., NE, Mailstop C-09, Atlanta, GA 30333, including no future editions or amendments; or
2. An electronic equivalent to Form CDC 52.2 provided by the Department.

~~**A.**~~**B.** Environmental control measures:

~~1.~~ ~~The~~ A local health agency shall ~~cause~~ ensure that ~~infected~~ bird populations infected with *Chlamydia psittaci* or *Chlamydophila psittaci* ~~to be~~ are treated or destroyed and that any contaminated structures are disinfected.

~~2. The health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.~~

~~**B.** Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.~~

~~R9-6-347.~~ R9-6-355. Q Fever

~~Special~~ Case control measures: ~~The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported Q fever case or suspect case. For each Q fever case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:

1. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 55.1, "Q Fever Case Report" (March 2002), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Viral and Rickettsial Diseases, 1600 Clifton Rd., NE, Mailstop A-30, Atlanta, GA 30333, including no future editions or amendments; or
2. An electronic equivalent to Form CDC 55.1 provided by the Department.

~~R9-6-348.~~ R9-6-356. Rabies in ~~Humans~~ a Human

A. Case control measures: ~~A health care provider or operator of a blood or plasma center shall not utilize donated blood, plasma, body organs, sperm or other tissue from a case, suspect case or suspect carrier for transfusion or transplantation.~~

~~**B.** Special control measures: The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported human rabies case or suspect case.

B. Contact control measures: A local health agency shall evaluate the level of risk of transmission from each contact's exposure to a human rabies case and, if indicated, provide or arrange for each contact to receive prophylaxis.

~~**R9-6-357. Staphylococcal Skin Disease**~~

~~**A.** Case control measures: A hospital shall exclude a case with staphylococcal lesion from providing direct patient care in health care facilities and food handling. A hospital nursery shall isolate a case.~~

~~**B.** Contact control measures: An administrator of a hospital or health care facility, or an authorized representative, shall isolate a case or, during an outbreak, may group cases colonized with the same organism together.~~

~~**C.** Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.~~

~~**D.** Special control measures: In a hospital nursery outbreak, a hospital administrator or authorized representative shall exclude a health care provider from the nursery until the health care provider is examined and found not to carry the epidemic strain or the cases are discharged.~~

~~R9-6-349.~~ R9-6-357. Relapsing Fever (Borreliosis)

~~Special~~ Case control measures: ~~The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported borreliosis case or suspect case.

~~R9-6-350.~~ R9-6-358. Reye Syndrome

~~Special~~ Case control measures: ~~The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported Reye syndrome case or suspect case. For each Reye syndrome case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:

1. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 55.8, "CDC Reye Syndrome Case Investigation Report" (March 1985), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Bacterial and Mycotic Diseases, 1600 Clifton Rd., NE, Mailstop C-09, Atlanta, GA 30333, including no future editions or amendments; or
2. An electronic equivalent to Form CDC 55.8 provided by the Department.

~~**R9-6-359. Streptococcal Group B Invasive Disease in Infants Less Than 30 Days of Age**~~

~~Special control measures: The local health agency shall complete an investigation of each case of invasive group B streptococcal disease using a form provided by the Department.~~

~~R9-6-351.~~ R9-6-359. Rocky Mountain Spotted Fever

~~Special~~ Case control measures: ~~The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported Rocky Mountain spotted fever case or suspect case. For each Rocky Mountain spotted fever case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:

1. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 55.1, "Tick-Borne Rickettsial Disease Case Report" (January 2001), which is incorporated by reference in R9-6-324; or
2. An electronic equivalent to Form CDC 55.1 provided by the Department.

~~R9-6-352.~~ R9-6-360. Rubella (German Measles)

A. Case control measures:

1. An administrator ~~or authorized representative~~ of a school or child care establishment, either personally or through a representative, shall exclude a rubella case from the school~~,~~ or child care ~~center, or preschool~~ establishment from the onset of illness through the ~~4th~~ seventh day after the rash appears.
2. ~~An~~ A diagnosing health care provider or an administrator of a ~~hospital or authorized representative~~ health care institution, either personally or through a representative, shall isolate a ~~hospitalized~~ rubella case through the seventh day after the rash appears.
3. A local health agency shall conduct an epidemiologic investigation of each reported rubella case or suspect case. For each rubella case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:
   a. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "Rubella Surveillance Worksheet" (in use on April 16, 2004), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Viral and Rickettsial Diseases, 1600 Clifton Rd., NE, Mailstop A-30, Atlanta, GA 30333, including no future editions or amendments; or
   b. An electronic equivalent to the "Rubella Surveillance Worksheet" provided by the Department.

B. Contact control measures:
1. A paid or volunteer full- or part-time worker at a health care institution shall not participate in the direct care of a rubella case or suspect case or of a patient who is or may be pregnant unless the worker first provides evidence of immunity to rubella consisting of:
   a. A record of immunization against rubella given on or after the first birthday, or
   b. A statement signed by a physician, state health officer, or local health officer affirming serologic evidence of immunity to rubella.
2. When a rubella case has been at a school or child care establishment, the administrator of the school or child care establishment, either personally or through a representative, shall:
   a. Consult with the local health agency to determine who shall be excluded and how long each individual shall be excluded from the school or child care establishment, and
   b. Comply with the local health agency's recommendations for exclusion.

~~**B.** Outbreak control measures: An administrator or authorized representative of a school, child care center, or preschool shall exclude non-immune persons from the school, child care center, or preschool during an outbreak.~~

~~**C.** Special control measures:~~
~~1. No employee of any health care facility shall have direct contact with any rubella patient, including suspect cases, or with any patient who is or may be pregnant unless able to provide evidence of immunity to rubella. Evidence of immunity to rubella shall consist of:~~
~~a. A record of immunization against rubella given on or after the 1st birthday; or~~
~~b. A statement signed by a licensed physician, or a state or local health officer which affirms serologic evidence of having had rubella.~~
~~2. The local health agency shall conduct or direct an epidemiologic investigation of each reported case.~~

~~R9-6-353.~~ R9-6-361. Rubella Syndrome, Congenital

A. Case control measures:
1. ~~An~~ A diagnosing health care provider or an administrator of a ~~hospital~~ health care institution ~~or its authorized representative~~ , either personally or through a representative, shall isolate and implement contact precautions for an infant congenital rubella syndrome ~~a~~ case ~~under 1 year of age~~ until a negative virus culture is obtained.
2. A local health agency shall conduct an epidemiologic investigation of each reported congenital rubella syndrome case or suspect case. For each congenital rubella syndrome case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:
   a. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 71.17, "Congenital Rubella Syndrome Case Report" (March 1997), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Viral and Rickettsial Diseases, 1600 Clifton Rd., NE, Mailstop A-30, Atlanta, GA 30333, including no future editions or amendments; or
   b. An electronic equivalent to Form CDC 71.17 provided by the Department.

B. ~~Special~~ Contact control measures:
1. ~~No employee of any~~ A paid or volunteer full- or part-time worker at a health care ~~facility~~ institution who is known to be pregnant shall not ~~have direct contact with any~~ participate in the direct care of a ~~congenital rubella syndrome patient, including~~ congenital rubella syndrome case or suspect ~~cases,~~ case unless ~~able to provide~~ the worker first provides evidence of immunity to rubella ~~in accordance~~ that complies with ~~R9-6-349(C)~~ R9-6-360(B)(1).
2. ~~The local health agency shall conduct or direct an epidemiologic investigation of each reported case.~~

~~R9-6-354.~~ R9-6-362. Salmonellosis

A. Case control measures:
1. ~~The~~ A local health agency shall exclude a salmonellosis case with diarrhea ~~symptoms of salmonellosis~~ from ~~handling~~ working as a food handler, ~~attending child care,~~ caring for children in or attending a child care ~~or preschools~~ establishment, or caring for patients or residents in ~~nursing homes~~ a health care institution until either of the following occurs:
   ~~1.~~a. Two successive ~~negative stool~~ cultures negative for *Salmonella* spp. are obtained from stool specimens collected at least 24 hours ~~or more~~ apart, or
   ~~2.~~b. ~~Symptoms are absent~~ Diarrhea has resolved.
2. A local health agency shall conduct an epidemiologic investigation of each reported salmonellosis case or suspect case. For each salmonellosis case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation Exhibit III-L or an electronic equivalent to Exhibit III-L provided by the Department.

B. Contact control measures: ~~The~~ A local health agency shall exclude ~~contacts~~ a salmonellosis contact with ~~symptoms of salmonellosis~~ diarrhea from working as a food ~~handlers~~ handler until either of the following occurs:
1. Two successive ~~negative stool~~ cultures negative for *Salmonella* spp. are obtained from stool specimens collected at

least 24 hours ~~or more~~ apart, or

2. ~~Symptoms are absent~~ Diarrhea has resolved.

~~**C.** Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.~~

~~**D.** Outbreak control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported outbreak.~~

~~R9-6-355.~~ R9-6-363. Scabies

~~**A.** Reports: An administrator or authorized representative of a public or private school, child care center, preschool, or nursing home shall report an outbreak of scabies.~~

~~**B.**~~**A.** Case control measures:

1. An administrator ~~or authorized representative~~ of a ~~public or private~~ school~~,~~ or child care ~~center, preschool, or nursing home~~ establishment, either personally or through a representative, shall exclude a scabies case from the school~~,~~ or child care ~~center, or preschool or from having direct patient contact~~ establishment until treatment for scabies is ~~initiated~~ completed.
2. An administrator of a health care institution or shelter, either personally or through a representative, shall exclude a scabies case from participating in the direct care of a patient or resident until treatment for scabies is completed.
3. An administrator of a shelter, either personally or through a representative, shall ensure that a scabies case receives treatment for scabies and that the case's clothing and personal articles are disinfested.

~~**C.**~~**B.** Contact control measures: An administrator ~~or authorized representative~~ of a school, child care ~~center, preschool, or nursing home~~ establishment, health care institution, or shelter, either personally or through a representative, shall ~~refer~~ advise a ~~household~~ scabies contact with symptoms of scabies ~~for~~ to obtain examination and, if necessary, treatment.

~~**D.** Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about concurrent sanitary disposal or disinfestation of the clothing and bedding. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.~~

~~**E.**~~**C.** Outbreak control measures: ~~The~~ A local health agency shall:

1. ~~conduct or direct~~ Conduct an epidemiologic investigation of each reported scabies outbreak~~,~~ ;
2. ~~shall provide~~ Provide education and consultation regarding prevention, control, and treatment ~~pursuant to subsections (A), (B), and (C),~~ of scabies to individuals affected by the outbreak; and~~,~~
3. ~~when~~ When a scabies outbreak occurs in a health care ~~facility~~ institution, ~~shall~~ notify the licensing agency of the outbreak.

R9-6-364. Severe Acute Respiratory Syndrome

A. Case control measures:

1. A local health agency, in consultation with the Department, shall isolate a severe acute respiratory syndrome case or suspect case as necessary to prevent transmission.
2. A local health agency shall conduct an epidemiologic investigation of each reported severe acute respiratory syndrome case or suspect case.

B. Contact control measures: A local health agency, in consultation with the Department, shall quarantine a severe acute respiratory syndrome contact as necessary to prevent transmission.

~~R9-6-356.~~ R9-6-365. Shigellosis

A. Case control measures:

1. ~~The~~ A local health agency shall exclude a shigellosis case with diarrhea ~~symptoms of shigellosis~~ from ~~handling~~ working as a food handler, caring for children in or attending a child care ~~centers or preschools~~ establishment, or caring for patients or residents in ~~nursing homes~~ a health care institution until either of the following occurs:
   a. Two successive ~~negative stool~~ cultures negative for *Shigella* spp. are obtained from stool specimens collected at least 24 hours ~~or more~~ apart~~,~~ and at least 48 hours ~~or more~~ after discontinuing antibiotics~~;~~ , or
   b. Treatment is maintained for 24 hours and ~~symptoms are absent~~ diarrhea has resolved.

~~2. The diagnosing health care provider or authorized representative shall counsel a case regarding the importance of proper handwashing to prevent transmission.~~

2. A local health agency shall conduct an epidemiologic investigation of each reported shigellosis case or suspect case. For each shigellosis case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation Exhibit III-M or an electronic equivalent to Exhibit III-M provided by the Department.

B. Contact control measures: ~~The~~ A local health agency shall exclude a shigellosis contact with ~~symptoms of shigellosis~~ diarrhea from ~~handling~~ working as a food handler, caring for children in or attending a child care ~~centers~~ establishment ~~or preschools~~, ~~and~~ or caring for patients or residents in ~~nursing homes~~ a health care institution until ~~2~~ two successive ~~negative stool~~ cultures negative for *Shigella* spp. are obtained from stool specimens collected at least 24 hours ~~or more~~ apart. If ~~either~~ a culture is positive for *Shigella* spp., ~~the~~ a local health agency shall reclassify a contact ~~shall be considered~~ as a

case ~~or carrier~~.

~~**C.** Environmental control measures: The health care provider or authorized representative shall counsel a case about hand-washing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.~~

~~**D.** Outbreak control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported outbreak.~~

R9-6-366. Smallpox

A. Case control measures:
1. A local health agency, in consultation with the Department, shall isolate a smallpox case or suspect case as necessary to prevent transmission.
2. A local health agency, in consultation with the Department, shall conduct an epidemiologic investigation of each reported smallpox case or suspect case.

B. Contact control measures: A local health agency, in consultation with the Department, shall quarantine a smallpox contact as necessary to prevent transmission and shall monitor the contact for smallpox symptoms, including fever, each day for 21 days after last exposure.

~~R9-6-358.~~ R9-6-367. ~~Streptococcal Disease and Invasive Group A~~ Streptococcal ~~Disease~~ Group A Infection

A. Non-invasive streptococcal group A infection:
Case control measures: ~~The local health agency~~ An administrator of a school, child care establishment, or health care institution or a person in charge of a food establishment, either personally or through a representative, shall exclude a streptococcal group A infection case with streptococcal lesions or streptococcal sore throat from ~~food handling or~~ working as a food handler, attending school, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution for 24 hours after the initiation of treatment for streptococcal ~~disease~~ infection.

B. Invasive streptococcal group A infection:
Outbreak control measures: ~~The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported outbreak of streptococcal group A invasive infection.

~~**C.** Special control measures: The local health agency shall complete an investigation of each case of invasive group A streptococcal disease using a form provided by the Department.~~

~~R9-6-360.~~ R9-6-368. Syphilis

A. Case control measures:
~~1. A diagnosing health care provider shall prescribe drugs to render a case noninfectious and counsel or arrange for the case to be counseled:~~
~~a. To abstain from sexual contact during drug treatment and for at least seven days after drug treatment is completed; and~~
~~b. About the following:~~
~~i. The characteristics of syphilis,~~
~~ii. The syndromes caused by syphilis,~~
~~iii. Measures to reduce the likelihood of transmitting syphilis to another, and~~
~~iv. The need to notify individuals with whom the case has had sexual contact within a time period determined based upon the stage of the disease.~~
~~2.~~1. A syphilis case shall obtain serologic testing for syphilis three months and six months after initiating ~~drug~~ treatment.
~~3. A health care provider or operator of a blood bank, blood center, plasma center, tissue bank, or organ bank shall not use blood, blood components, sperm, organs, or tissue from a case for injection, transfusion, or transplantation.~~
~~4. An operator of a blood bank, blood center, plasma center, tissue bank, or organ bank who interprets as positive a test for the syphilis antigen or antibody shall notify the subject of the test within 30 days after interpreting the test.~~
~~5.~~2. ~~The~~ A local health agency shall conduct an epidemiologic investigation of each reported syphilis case or suspect case, confirming the stage of the disease.
3. The operator of a blood bank, blood center, or plasma center shall notify a donor of a test result with significant evidence suggestive of syphilis, as required under A.R.S. § 32-1483 and 21 CFR 630.6.

B. Contact control measures: ~~The~~ When a syphilis case has named an identified individual, a local health agency shall:
1. Notify ~~each~~ the identified individual of syphilis exposure;
2. Offer or arrange for the identified individual to receive serologic testing and treatment for syphilis ~~of each identified individual~~; and
3. Counsel ~~each~~ the identified individual about the following:
   a. The characteristics of syphilis,
   b. The syndromes caused by syphilis,
   c. Measures to reduce the likelihood of transmitting syphilis to another, and
   d. The need to notify individuals with whom the identified individual has had sexual contact within a time period determined based upon the stage of the disease.

~~R9-6-361.~~ R9-6-369. Taeniasis

~~A.~~ Case control measures: ~~The~~ A local health agency shall exclude a ~~food handler or a student~~ taeniasis case with *Taenia solium* from ~~handling~~ working as a food handler, caring for children in or attending a child care ~~center~~ establishment, or caring for patients or residents in a health care institution until free of infestation.

~~B. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.~~

~~R9-6-362.~~ R9-6-370. Tetanus

~~Special~~ Case control measures: ~~The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported tetanus case or suspect case. For each tetanus case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:

1. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "Tetanus Surveillance Worksheet" (in use on April 16, 2004), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Bacterial and Mycotic Diseases, 1600 Clifton Rd., NE, Mailstop C-09, Atlanta, GA 30333, including no future editions or amendments; or
2. An electronic equivalent to the "Tetanus Surveillance Worksheet" provided by the Department.

~~R9-6-363.~~ R9-6-371. Toxic Shock Syndrome

~~Special~~ Case control measures: ~~The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported toxic shock syndrome case or suspect case. For each toxic shock syndrome case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:

1. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.3, "Toxic-Shock Syndrome Case Report" (April 1996), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Bacterial and Mycotic Diseases, 1600 Clifton Rd., NE, Mailstop C-09, Atlanta, GA 30333, including no future editions or amendments; or
2. An electronic equivalent to Form CDC 52.3 provided by the Department.

~~R9-6-364.~~ R9-6-372. Trichinosis

~~Special~~ Case control measures: ~~The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported trichinosis case or suspect case. For each trichinosis case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:

1. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 54.7, "Trichinosis Surveillance Case Report" (February 1990), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Parasitic Diseases, 1600 Clifton Rd., NE, Mailstop F-22, Atlanta, GA 30333, including no future editions or amendments; or
2. An electronic equivalent to Form CDC 54.7 provided by the Department.

~~R9-6-365.~~ R9-6-373. Tuberculosis

A. Case control measures: ~~A hospital shall isolate a pulmonary or laryngeal case in a room with special ventilation until 3 sputum smears are negative for acid fast bacilli, treatment for tuberculosis is initiated, and the case is no longer coughing.~~

1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall place an individual with infectious active tuberculosis or a suspect case in airborne infection isolation until:
   a. At least three successive sputum smears collected at least eight hours apart, at least one of which is taken first thing in the morning, are negative for acid-fast bacilli;
   b. Anti-tuberculosis treatment is initiated; and
   c. Clinical signs and symptoms of active tuberculosis are improved.
2. An administrator of a health care institution, either personally or through a representative, shall notify a local health agency at least one working day before discharging a tuberculosis case or suspect case.
3. A local health agency shall exclude an individual with infectious active tuberculosis or a suspect case from working until:
   a. At least three successive sputum smears collected at least eight hours apart, at least one of which is taken first thing in the morning, are negative for acid-fast bacilli;
   b. Anti-tuberculosis treatment is initiated; and
   c. Clinical signs and symptoms of active tuberculosis are improved.
4. A local health agency shall conduct an epidemiologic investigation of each reported tuberculosis case or suspect case. For each tuberculosis case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:
   a. One of the following:
      i. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC

72.9A and B, "Report of Verified Case of Tuberculosis" (January 2003), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of TB Elimination, 1600 Clifton Rd., NE, Mailstop E-10, Atlanta, GA 30333, including no future editions or amendments; or

ii. An electronic equivalent to Form CDC 72.9A and B provided by the Department; and

b. Exhibit III-N or an electronic equivalent to Exhibit III-N provided by the Department.

B. Contact control measures: ~~Contacts shall be subject to Mantoux tuberculin testing with purified protein derivative (PPD)~~

1. Except as provided in subsection (B)(7), for each individual with infectious active tuberculosis, a local health agency shall identify contacts and provide or arrange for evaluation of each contact's tuberculosis status. A local health agency shall conduct the initial contact investigation interview within three working days after receiving a tuberculosis case report.
2. An individual who has been exposed to an individual with infectious active tuberculosis shall allow a local health agency to evaluate the individual's tuberculosis status.
3. A local health agency shall exclude a tuberculosis contact with symptoms suggestive of tuberculosis from working until the contact has been evaluated by a physician, physician assistant, or registered nurse practitioner and determined by the physician, physician assistant, or registered nurse practitioner not to be an individual with infectious active tuberculosis.
4. ~~The~~ Except as provided in subsection (B)(5), a local health agency shall arrange for ~~tuberculin skin testing~~ a tuberculosis contact to have an approved test for tuberculosis ~~of a contact not known to have tuberculosis infection~~.
5. If a tuberculosis contact is known to have had a prior positive result on an approved test for tuberculosis, post-exposure testing is not required. A local health agency shall question the contact about symptoms of active tuberculosis and, if the contact has symptoms of active tuberculosis, provide or arrange for the contact to receive a chest x-ray.
6. If a tuberculosis contact tests negative for tuberculosis, ~~the~~ a local health agency shall arrange for ~~a retest 3~~ reevaluation three months after the ~~1st skin test~~ contact's last exposure to an individual with infectious active tuberculosis.
7. For exposures to an individual with infectious active tuberculosis occurring in a health care institution or correctional facility, the administrator of the health care institution or correctional facility, in consultation with a local health agency, shall have the primary responsibility for identifying and evaluating tuberculosis contacts.
8. A health care provider or an administrator of a health care institution or correctional facility that has identified and evaluated tuberculosis contacts shall release information gathered regarding the contacts, including personal identifying information, to a local health agency or to the Department upon request.

C. An individual is not a tuberculosis case if the individual has a positive result from an approved test for tuberculosis but does not have clinical signs or symptoms of disease.

~~**C.** Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.~~

~~**D.** Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.~~

~~R9-6-366.~~ R9-6-374. Tularemia

~~**A.**~~ Case control measures:

1. ~~A hospital~~ A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate a pneumonic tularemia case ~~of pneumonic tularemia~~ with droplet precautions ~~for~~ until 48 hours ~~after the initiation of treatment~~ of antibiotic therapy have been completed with favorable clinical response.
2. A local health agency shall conduct an epidemiologic investigation of each reported tularemia case or suspect case.

~~**B.** Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.~~

~~**C.** Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.~~

~~R9-6-367.~~ R9-6-375. Typhoid Fever

A. Case control measures:

1. ~~The~~ A local health agency shall exclude a typhoid fever case from ~~handling~~ working as a food handler, ~~and~~ caring for children in or attending a child care ~~centers or preschools~~ establishment, or caring for patients or residents in a health care institution until at least ~~1~~ one month ~~or more~~ after the date of onset of ~~the~~ illness and ~~3~~ three successive ~~negative stool~~ cultures negative for *Salmonella typhi* have been obtained from stool specimens collected at least 24 hours ~~or more~~ apart and at least 48 hours ~~or more~~ after cessation of antibiotic therapy. If ~~1~~ a culture is positive for *Salmonella typhi*, ~~the exclusions~~ a local health agency shall ~~be enforced~~ enforce the exclusions until ~~3~~ three successive ~~negative stool~~ cultures negative for *Salmonella typhi* are obtained from stool specimens collected at least ~~1~~ one month ~~or more~~

apart~~,~~ and 12 or fewer months ~~or less~~ after the date of onset of ~~the~~ illness. If a positive ~~stool~~ culture is obtained on a stool specimen collected at least 12 months ~~or more~~ after onset, ~~the~~ a local health agency shall redesignate a case ~~shall be designated~~ as a carrier.

2. A local health agency shall exclude a typhoid fever carrier from working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until three successive cultures negative for *Salmonella typhi* have been obtained from stool specimens collected at least one month apart, at least one by purging.
3. A local health agency shall conduct an epidemiologic investigation of each reported typhoid fever case or suspect case. For each typhoid fever case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:
   a. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.5, "Typhoid Fever Surveillance Report" (June 1997), which is incorporated by reference, on file with the Department, and available from the Centers for Disease Control and Prevention, Division of Bacterial and Mycotic Diseases, 1600 Clifton Rd., NE, Mailstop C-09, Atlanta, GA 30333, including no future editions or amendments; or
   b. An electronic equivalent to Form CDC 52.5 provided by the Department.

B. Contact control measures: ~~The~~ A local health agency shall exclude a typhoid fever contact from ~~handling~~ working as a food handler ~~and~~ or caring for children in a child care ~~centers or preschools~~ establishment until ~~2~~ two successive ~~negative stool~~ cultures negative for *Salmonella typhi* are obtained from stool specimens collected at least 24 hours ~~or more~~ apart. If ~~either~~ a culture is positive for *Salmonella typhi*, ~~the~~ a local health agency shall redesignate a contact ~~shall be considered to be~~ as a case.

~~**C.** Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.~~

~~**D.** Special control measures:~~

~~1. A local health officer shall not exclude a carrier from food handling when 3 negative stool cultures are obtained from specimens collected 1 month or more apart and no contact is symptomatic during this time. One of the 3 specimens shall be obtained by purging.~~
~~2. Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.~~

~~R9-6-368.~~ R9-6-376. Typhus Fever~~: Flea-borne~~

~~Special~~ Case control measures: ~~The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each reported typhus fever case or suspect case.

R9-6-377. Unexplained Death with a History of Fever

Case control measures: A local health agency shall conduct an epidemiologic investigation of each reported case or suspect case of unexplained death with a history of fever.

R9-6-378. Vaccinia-Related Adverse Event

Case control measures: A local health agency shall conduct an epidemiologic investigation of each reported case or suspect case of a vaccinia-related adverse event. For each vaccinia-related adverse event case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:

1. One of the following:
   a. A Food and Drug Administration, U.S. Department of Health and Human Services, Form VAERS-1, "Vaccine Adverse Event Reporting System" (in use on April 16, 2004), which is incorporated by reference, on file with the Department, and available from the Vaccine Adverse Event Reporting System, P.O. Box 1100, Rockville, MD 20849-1100, including no future editions or amendments; or
   b. An electronic equivalent to Form VAERS-1 provided by the Department;
2. One of the following:
   a. A Food and Drug Administration, U.S. Department of Health and Human Services, "Smallpox Vaccine Adverse Event Supplemental Surveillance Worksheet" (in use on April 16, 2004), which is incorporated by reference, on file with the Department, and available from the Vaccine Adverse Event Reporting System, P.O. Box 1100, Rockville, MD 20849-1100, including no future editions or amendments; or
   b. An electronic equivalent to the "Smallpox Vaccine Adverse Event Supplemental Surveillance Worksheet" provided by the Department; and
3. One of the following:
   a. A Food and Drug Administration, U.S. Department of Health and Human Services, "Smallpox Vaccine VAERS Report Follow-up Worksheet" (in use on April 16, 2004), which is incorporated by reference, on file with the Department, and available from the Vaccine Adverse Event Reporting System, P.O. Box 1100, Rockville, MD 20849-1100; or
   b. An electronic equivalent to the "Smallpox Vaccine VAERS Report Follow-up Worksheet" provided by the

Department.

~~R9-6-369.~~ R9-6-379. Vancomycin-Resistant ~~*Enterococcus* sp.~~ *Enterococcus* spp.
Case control measures: ~~An~~ A diagnosing health care provider or an administrator ~~or authorized representative~~ of a ~~hospital or~~ health care ~~facility~~ institution, either personally or through a representative, shall ~~implement contact isolation for patients~~ isolate and implement contact precautions for a case of ~~with suspected~~ vancomycin-resistant *Enterococcus* ~~sp.~~ spp.

~~R9-6-370.~~ R9-6-380. Vancomycin-Resistant or Vancomycin-Intermediate *Staphylococcus aureus*
Case control measures:
1. ~~An~~ A diagnosing health care provider or an administrator ~~or authorized representative~~ of a ~~hospital or~~ health care ~~facility~~ institution, either personally or through a representative, shall ~~implement contact isolation for patients with suspected~~ isolate and implement contact precautions for a case or suspect case of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus*.
2. A local health agency, in consultation with the Department, shall isolate a case or suspect case of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus* as necessary to prevent transmission.

~~R9-6-371.~~ R9-6-381. Vancomycin-Resistant *Staphylococcus epidermidis*
Case control measures: ~~An~~ A diagnosing health care provider or an administrator ~~or authorized representative~~ of a ~~hospital or~~ health care ~~facility~~ institution, either personally or through a representative, shall ~~implement contact isolation for patients with suspected~~ isolate and implement contact precautions for a case or suspect case of vancomycin-resistant *Staphylococcus epidermidis*.

~~R9-6-372.~~ R9-6-382. Varicella (Chickenpox)
A. Case control measures:
1. An administrator ~~or authorized representative~~ of a school~~,~~ or child care ~~center, or preschool~~ establishment, either personally or through a representative, shall exclude a varicella case from the school~~,~~ or child care ~~center, or preschool~~ establishment until lesions are dry and crusted.
2. ~~A hospital~~ An administrator of a health care institution, either personally or through a representative, shall ~~use~~ place a varicella case in airborne infection isolation ~~precautions for a case~~ until the case is no longer infectious.

B. Contact control measures: When a varicella case has been at a school or child care establishment, the administrator of the school or child care establishment, either personally or through a representative, shall:
1. Consult with a local health agency to determine who shall be excluded and how long each individual shall be excluded from the school or child care establishment, and
2. Comply with the local health agency's recommendations for exclusion.

~~R9-6-373.~~ R9-6-383. ~~Vibrio~~ *Vibrio* Infection
~~Special~~ Case control measures: ~~The~~ A local health agency shall ~~complete~~ conduct an epidemiologic investigation of each reported *Vibrio* infection case or suspect case ~~of *Vibrio* infection using a form provided by the Department~~. For each case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation:
1. A Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 52.79, "Cholera and Other *Vibrio* Illness Surveillance Report" (July 2000), which is incorporated by reference in R9-6-313; or
2. An electronic equivalent to Form CDC 52.79 provided by the Department.

R9-6-384. Viral Hemorrhagic Fever
A. Case control measures:
1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and implement contact precautions for a viral hemorrhagic fever case or suspect case for the duration of the illness.
2. A local health agency shall conduct an epidemiologic investigation of each reported viral hemorrhagic fever case or suspect case.

B. Contact control measures: A local health agency, in consultation with the Department, shall quarantine a viral hemorrhagic fever contact as necessary to prevent transmission.

R9-6-385. West Nile Virus Fever or West Nile Encephalitis
Case control measures: A local health agency shall conduct an epidemiologic investigation of each reported West Nile virus fever or West Nile encephalitis case or suspect case. For each West Nile encephalitis case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation Exhibit III-D or an electronic equivalent to Exhibit III-D provided by the Department.

~~R9-6-374.~~ R9-6-386. Yellow Fever
~~Special~~ Case control measures: ~~The~~ A local health agency shall conduct ~~or direct~~ an epidemiologic investigation of each

reported yellow fever case or suspect case.

~~R9-6-375.~~ R9-6-387. Yersiniosis

~~Special~~ Case control measures: ~~The~~ A local health agency shall ~~complete~~ conduct an epidemiologic investigation of each reported yersiniosis case or suspect case ~~of yersinosis using a form provided by the Department~~. For each yersiniosis case, a local health agency shall complete and submit to the Department within 10 working days after completing an epidemiologic investigation Exhibit III-L or an electronic equivalent to Exhibit III-L provided by the Department.

R9-6-388. Isolation and Quarantine

A. When a local health agency is required by this Article to isolate or quarantine an individual or group of individuals, the local health agency shall issue a written order for isolation or quarantine and other control measures to each individual or group of individuals and, for each individual who is a minor or incapacitated adult, the individual's parent or guardian, except as provided in subsection (A)(3).

1. The written order shall specify:
   a. The isolation or quarantine and other control measure requirements being imposed, which may include requirements for physical examinations and medical testing to ascertain and monitor each individual's health status;
   b. The identity of each individual or group of individuals subject to the order;
   c. The premises at which each individual or group of individuals is to be isolated or quarantined;
   d. The date and time at which isolation or quarantine and other control measure requirements begin; and
   e. The justification for isolation or quarantine and other control measure requirements, including, if known, the disease for which the individual or individuals are believed to be cases, suspect cases, or contacts.
2. The written order may provide information about existing medical treatment, if available and necessary to render an individual less infectious, and the consequences of an individual's failure to obtain the medical treatment.
3. If an order applies to a group of individuals, and it would be impractical to provide a copy to each individual, the local health agency may post the order in a conspicuous place at the premises at which the individuals are to be isolated or quarantined.

B. Within 10 days after issuing a written order described in subsection (A), if a local health agency determines that isolation or quarantine and other control measure requirements need to continue for more than 10 days after the date of the order, the local health agency shall file a petition for a court order authorizing the continuation of isolation or quarantine and other control measure requirements pertaining to an individual or group of individuals. The petition shall:

1. Include the following:
   a. The isolation or quarantine and other control measure requirements being imposed, which may include requirements for physical examinations and medical testing to ascertain and monitor an individual's health status;
   b. The identity of each individual or group of individuals subject to isolation or quarantine and other control measure requirements;
   c. The premises at which each individual or group of individuals is isolated or quarantined;
   d. The date and time at which isolation or quarantine and other control measure requirements began; and
   e. The justification for isolation or quarantine and other control measure requirements, including, if known, the disease for which the individual or individuals are believed to be cases, suspect cases, or contacts; and
2. Be accompanied by the sworn affidavit of a representative of the local health agency or the Department attesting to the facts asserted in the petition, together with any further information that may be relevant and material to the court's consideration.

C. A local health agency that files a petition for a court order under subsection (B) shall provide notice to each individual or group of individuals identified in the petition according to the Arizona Rules of Civil Procedure, except that notice shall be provided within 24 hours after the petition is filed.

D. In the event of noncompliance with a written order issued under subsection (A), a local health agency may contact law enforcement to request assistance in enforcing the order.

EXHIBIT III-A

Patient Name: _____ County: _____

Campylobacter Investigation Form
Arizona Department of Health Services

Symptomatology

1. Which of the following symptoms did you have?

>3 loose stools	□Yes	□No	Fever	□Yes	□No
# days (>3 loose stools) _____			highest temperature _____ date _____		
# episodes in 24 hours _____			Chills	□Yes	□No
Blood in stools	□Yes	□No	Headache	□Yes	□No
Abdominal cramps	□Yes	□No	Muscle aches	□Yes	□No
Nausea	□Yes	□No	Fatigue	□Yes	□No
Vomiting	□Yes	□No	Other: _____		

2. When did your symptoms start? Date_____ Time _____ a.m. p.m.
3. What date did the diarrhea start? Date_____ Time_____ a.m. p.m.
4. Were you hospitalized? □ Yes □ No Adm Date _____ # days _____
5. How long did your illness last? _____# of days to full recovery

Occupation

6. Work at or attend child care? □ Yes □ No
7. Food handler (work or volunteer)? □ Yes □ No
   Household member is a food handler? □ Yes □ No
8. Provide patient care? □ Yes □ No

Food Habits

9. Are you a vegetarian? □ Yes □ No

Type _____

Medical History

10. Have existing chronic medical problem(s) or any medical condition(s)? □Yes □No

Describe _____

_____

Within the last month:

11. Antibiotics □Yes □No

Name	dosage, # of days
_____	_____
_____	_____
_____	_____

12. Antacids (Tums, Mylanta, Tagamet, Prilosec, Pepcid, Zantac, Pepto bismol)? □Yes □ No

Risk factors:

In the 7 days prior to your illness, were you exposed to any of the following:

13. Contact with :

Farm animals □ Yes □No
Petting zoo animal □ Yes □No
Pets □ Yes □No
What kind of animal(s) _____
When?_____Where? _____
Were any ill? □ Yes □No

14. Any travel? □ Yes □No
Where?
_____
From? __/__/__ to __/__/__
Airline?_____ Flight No. _____
Foods eaten on:
outbound flight _____
return flight _____

15. Contact to someone with diarrhea?
□ Yes □ No
Name & relationship? _____
When? _____

16. Attend any gatherings (wedding, reception, festival, fair, convention, etc.)? □ Yes □No
When? __/__/__ Where?
_____
When? __/__/__ Where?
_____

17. Get your face wet in the ocean, a lake, pool or river? □ Yes □No
Where?_____

Patient Name: _____ County: _____

ADHS Campylobacter Investigation Form Page two

Food History

During the 7 days prior to your illness give the day and date to orient the patient :

18. Where and what did you eat? List below. Attach additional paperwork as necessary.

Date	Foods & Drinks Consumed	Where? if restaurant, list location
	Breakfast Lunch Dinner Snacks	
	B L D S	
	B L D S	
	B L D S	
	B L D S	
	B L D S	
	B L D S	

In the 7 days prior to your illness, did you consume any of the following:

19. Fresh (not pasteurized) eggs? □Yes □No
Runny yolk? □Yes □No
Where? _____

20. Poultry (chicken, turkey, etc)? □Yes □No
Brand/Where bought? _____

21. Raw (unpasteurized) milk or dairy product?
□ Yes □ No
Brand/Where bought? _____

22. Untreated or raw water? □ Yes □ No
Where? _____

That completes the questionnaire, thank you very much for your help. The information you have provided will be a great assistance to our investigation. Thank you again, we appreciate your assistance.

Interviewer: _____ Date:_____

Send or Fax to: ADHS Infectious Disease Epidemiology
150 North 18th Ave, Suite 140
Phoenix, Arizona 85007-3237
(602) 364-3676
(602) 364-3199 Fax

EXHIBIT III-B

Arizona Department of Health Services **State ID:**
Fax completed form to:
Infectious Disease Epidemiology Section
(602) 364-3199
CRYPTOSPORIDIOSIS INVESTIGATION FORM

Patient's Name _____ _____
Last **First**

Length of symptoms: ____ days

RISK INFORMATION

In the last 12 days before onset of symptoms, has the patient...

Y N Unk Attended or worked in a day care
Location: _____

Y N Unk Contact to a cyptosporidiosis case

Y N Unk Contact to farm animals

Y N Unk Drank unpasteurized milk/dairy products

Y N Unk Drank unpasteurized fruit cider/juice

Y N Unk Drank unpotable water: Source: _____

Y N Unk Swimming, wading, or other recreational water contact
Location: _____ Date: ____/____/____

Y N Unk Food handler;
Location: _____

Y N Unk Immunosuppressed;

2. Are there other symptomatic contacts?

Y N Unk in the Household: Number ____

Y N Unk in the Day care; Number ____

Y N Unk at Work Number ____

symptomatic contacts:	O & P taken
1. _____	Y N Unk
2. _____	Y N Unk
3. _____	Y N Unk
4. _____	Y N Unk
5. _____	Y N Unk
6. _____	Y N Unk

Arizona Department of Health Services

EXHIBIT III-C

[For State Use Only]
ID _____
EFORS _____

SUSPECTED VIRAL GASTROENTERITIS OUTBREAK FORM

Infectious Disease Epidemiology Section
Arizona Department of Health Services
150 N 18th Ave, Suite 140
Phoenix, AZ 85007-3237

Telephone (602) 364-3676
Facsimile (602) 364-3199

General Information

Date ____/____/____ (mm dd yy)

Primary contact person for epidemiologic investigation _____

Address _____ Telephone _____

_____ Facsimile _____

_____ Email _____

Outbreak Information

Date of first case ____/____/____ (mm dd yy)

Date health department notified ____/____/____ (mm dd yy)

Date of last case ____/____/____ (mm dd yy)

Outbreak ongoing? Yes No

Location(s) of outbreak City _____ County _____

City _____ County _____

Institution or event (if applicable) _____
[e.g., nursing home, restaurant, bus tour, wedding, catered meal]

Date of event ____/____/____ (mm dd yy)

Institution or event contact person _____ Telephone _____

Illness Characteristics

Number of persons ill _____

Duration of illness (mean/median/range) _____

Number of persons susceptible _____

Incubation of illness (mean/median/range) _____

Predominant symptoms (frequencies if available)

_____

_____

_____

Number of persons who sought medical care _____
(e.g., emergency room, doctor=s office, medical clinic)

Number of persons admitted to a hospital _____

Suspected source(s) of exposure _____
e.g., water, specific food(s), ice, person, object]

Specimen Collection

Contact person for specimen collection and handling _____

Telephone _____ Facsimile _____

Number of **stool** specimens collected _____ Number of **vomitus** specimens collected _____

Tested for bacteria? Yes No Results (if known) _____

Tested for ova and parasites? Yes No Results (if known) _____

Stool and vomitus specimens collected from ill persons should be stored in watertight containers (e.g., urine specimen cups) and refrigerated (not frozen), and shipped on ice, accompanied by CDC form 50.34.

Date specimens shipped to CDC ____/____/____ (mm dd yy) Specimen type _____

Date specimens shipped to CDC ____/____/____ (mm dd yy) Specimen type _____

Date specimens shipped to CDC ____/____/____ (mm dd yy) Specimen type _____

Comments:

THANK YOU

Revised 8/03

MMWR, Vol. 50, No. RR-9, Page 11

RECOMMENDATIONS REGARDING SPECIMEN COLLECTION FOR DIAGNOSIS OF NLVs*

Clinical Specimens

Stool

Timing. Specimen collection for viral testing should begin on day 1 of the epidemiologic investigation. Any delays to await testing results for bacterial or parasitic agents could preclude establishing a viral diagnosis. Ideally, specimens should be obtained during the acute phase of illness (i.e., within 48--72 hours after onset) while the stools are still liquid or semisolid because the level of viral excretion is greatest then. With the development of sensitive molecular assays, the ability to detect viruses in specimens collected later in the illness has been improved. In specific cases, specimens might be collected later during the illness (i.e., 7--10 days after onset), if the testing is necessary for either determining the etiology of the outbreak or for epidemiologic purposes (e.g., a specimen obtained from an ill foodhandler who might be the source of infection). If specimens are collected late in the illness, the utility of viral diagnosis and interpretation of the results should be discussed with laboratory personnel before tests are conducted.

Number and Quantity. Ideally, specimens from ≥10 ill persons should be obtained during the acute phase of illness. Bulk samples (i.e., 10--50 ml of stool placed in a stool cup or urine container) are preferred, as are acute diarrhea specimens that are loose enough to assume the shape of their containers. Serial specimens from persons with acute, frequent, high-volume diarrhea are useful as reference material for the development of assays. The smaller the specimen and the more formed the stool, the lower the diagnostic yield. Rectal swabs are of limited or no value because they contain insufficient quantity of nucleic acid for amplification.

Storage and Transport. Because freezing can destroy the characteristic viral morphology that permits a diagnosis by EM, specimens should be kept refrigerated at 4 C. At this temperature, specimens can be stored without compromising diagnostic yield for 2--3 weeks, during which time testing for other pathogens can be completed. If the specimens have to be transported to a laboratory for testing, they should be bagged and sealed and kept on ice or frozen refrigerant packs in an insulated, waterproof container. If facilities for testing specimens within 2--3 weeks are not available, specimens can be frozen for antigen or PCR testing.

Vomitus

Vomiting is the predominant symptom among children, and specimens of vomitus can be collected to supplement the diagnostic yield from stool specimens during an investigation. Recommendations for collection, storage, and shipment of vomitus specimens are the same as those for stool specimens.

Serum

Timing. If feasible, acute- and convalescent-phase serum specimens should be obtained to test for a diagnostic ≥4-fold rise in IgG titer to NLVs. Acute-phase specimens should be obtained during the first 5 days of symptoms, and the convalescent-phase specimen should be collected from the third to sixth week after resolution of symptoms.

Number and Quantity. Ideally, 10 pairs of specimens from ill persons (i.e., the same persons submitting stool specimens) and 10 pairs from well persons (controls) should be obtained. Adults should provide 5--7 ml of blood, and children should provide 3--4 ml.

Storage. Specimens should be collected in tubes containing no anticoagulant, and the sera should be spun off and frozen. If a centrifuge is not available, a clot should be allowed to form, and the serum should be decanted and frozen. If this step cannot be accomplished, the whole blood should be refrigerated but not frozen.

Environmental Specimens

NLVs cannot be detected routinely in water, food, or environmental specimens. Nevertheless, during recent outbreaks (*33--36*), NLVs have been detected successfully in vehicles epidemiologically implicated as the source of infection. If a food or water item is strongly suspected as the source of an outbreak, then a sample should be obtained as early as possible and stored at 4 C. If the epidemiologic investigation confirms the link, a laboratory with the capacity to test these specimens should be contacted for further testing. If drinking water is suspected, special filtration (*45*) of large volumes (i.e., 5--100 liters) of water can concentrate virus to facilitate its detection.

EXHIBIT III-D

Arboviral Case Investigation Form

County/IHS ID number:

State ID Number

Patient's name (Last) (First) (Middle Initial)

Diagnosis at presentation:

- ☐ Uncomplicated Fever
- ☐ Meningitis
- ☐ Encephalitis
- ☐ Asymptomatic
- ☐ Viremic Blood Donor
- ☐ Other:_____

Patient hospitalized?

- ☐ Yes, Admit date: ___/___/____
- ☐ No

Is patient breastfeeding a child?

- ☐ Yes
- ☐ No

Is patient a breastfed child?

- ☐ Yes
- ☐ No

Past medical history:

- ☐ Cancer
- ☐ Diabetes: type: _____
- ☐ Viral Hepatitis
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Immunosuppressive Condition
- ☐ Pulmonary Disease
- ☐ Mosquito-borne illness: Dengue, Yellow fever, Japanese encephalitis, WNV, SLE, flavivirus

Symptoms (Check all that apply – circle primary symptom):

- ☐ Headache
- ☐ Fever (> 38ºC or 100ºF)

Max. temp. :_____

- ☐ Neck pain/stiffness
- ☐ Arthralgia or Myalgia
- ☐ Photophobia
- ☐ Rash
- ☐ Seizure
- ☐ Lymphadenopathy
- ☐ Tremors
- ☐ Extreme fatigue
- ☐ Nausea/vomiting/diarrhea
- ☐ Shortness of breath
- ☐ Flaccid paralysis
- ☐ Spastic paralysis
- ☐ Profound muscle weakness
- ☐ Altered mental status
- ☐ Unconsciousness
- ☐ Other – *specify*: _____

_____

_____

Risk factor assessment:

Within 14 days of onset of symptoms, did the patient…

1) have known mosquito exposure? ☐ Yes ☐ No

Date: ____/____/_____ Location:_____

Date: ____/____/_____ Location:_____

2) travel outside county of residence? ☐ Yes ☐ No

Dates From:____/____/_____ To: ____/____/_____

Location: _____

Dates From:____/____/_____ To: ____/____/_____

Location: _____

3) travel outside Arizona? ☐ Yes ☐ No

Dates From:____/____/_____ To: ____/____/_____

Location: _____

Dates From:____/____/_____ To: ____/____/_____

Location: _____

4) travel outside US ? ☐ Yes ☐ No

Dates From:____/____/_____ To: ____/____/_____

Location: _____

Dates From:____/____/_____ To: ____/____/_____

Location: _____

5) donate blood? ☐ Yes ☐ No

Date: ____/____/_____

6) donate an organ or tissue? ☐ Yes ☐ No

Date: ____/____/_____

In the 30 days prior to onset of symptoms:

7) did the patient receive blood or blood product? ☐ Yes ☐ No

8) did the patient receive an organ or tissue transplant? ☐ Yes ☐ No

Vaccination history:

- ☐ Yellow fever Date: ____/____/____
- ☐ Japanese encephalitis Date: ____/____/____
- ☐ Tick-borne encephalitis Date: ____/____/____

Contact or person providing patient information, if other than patient:

Name:_____ **Telephone:**_____ **Relationship:**_____

Please FAX above information as soon as completed to: ADHS VBZD Section – 602-364-3199 or 602-364-3198

Acquired:

in utero? ☐ Yes ☐ No

in a laboratory? ☐ Yes ☐ No

occupationally (non lab)? ☐ Yes ☐ No

Length of Illness: _____ days Date of discharge , if hospitalized: ____/____/_____

Outcome:

- ☐ Died Date: ____/___/_____
- ☐ Full Recovery
- ☐ Recovery with sequelae (describe):_____

_____

Treatment (check all that apply):

- ☐ Immunoglobulin
- ☐ Antiviral
- ☐ Interferon
- ☐ Supportive care only
- ☐ None

Case Classification:

- ☐ Confirmed case
- ☐ Probable case
- ☐ Suspect
- ☐ Ruled out/ Non case

Case acquisition:

- ☐ Out of county
- ☐ Out of state
- ☐ Out of US
- ☐ Unknown

Investigator: _____ **Date initiated** ____/____/_____ **Date completed:** ____/____/_____

ADHS ARBOCIF 4/2004

EXHIBIT III-E

***E. coli* O157:H7 Investigation Form**
Arizona Department of Health Services

State I.D. Number:_____

****Please attach Communicable Disease Report (CDR) to this form****

Reporting State: _____ County:_____

I. DEMOGRAPHIC INFORMATION

1. Name-Last First

2. Date of Birth: ____/____/____ or Age: _____ years _____ months
mo day yr

II. ISOLATE INFORMATION

3. Source of Specimen: □1 Stool (whole, stool swab, rectal swab)
□2 Other (specify): _____
□3 Not Isolated
□4 Unknown

4. Date of Specimen Collection: _____/_____/_____
mo day yr

5. Was identification of the O157 serogroup confirmed, either at the State Public Health Laboratory or at the Centers for Disease Control?
□Yes 1 □No 2 □Unknown 3

6. Was identification of the H7 serotype confirmed, either at the State Public Health Laboratory or at the Centers for Disease Control?
□Yes 1 □No 2 □Unknown 3

7. Was Shiga-like toxin production confirmed, either at the State Public Health Laboratory or at the Centers for Disease Control?
□Yes 1 □No 2 □Unknown 3

8. This case reported by:
□1 Hospital lab □6 State Lab
□2 Other lab □7 Other (specify): _____
□3 Physician
□4 Infection Control Practitioner
□5 School

Reporting laboratorian's name: _____

Telephone: ( ) _____ - _____

Physician's name: _____

Telephone: ( ) _____ - _____

III. CLINICAL INFORMATION

9. Date of Illness Onset: _____/_____/_____ □Unknown
mo day yr

10. Did the patient have: (please check one answer for each question)

	Yes 1	No 2	Unknown 3
Diarrhea	□	□	□
Vomiting	□	□	□
Visible blood in stools	□	□	□
Fever (or felt feverish)	□	□	□
Abdominal cramps	□	□	□

11. Was the patient admitted overnight to a hospital for this illness?
□Yes 1 □No 2 □Unknown 3
if yes, name of hospital:

12. Was the patient treated with antibiotics?
□Yes 1 □No 2 □Unknown 3
if yes, name and dose: _____

13. Did the patient: (please check one answer for each question)

	Yes 1	No 2	Unknown 3
have Hemolytic Uremic Syndrome? (i.e. hemolytic anemia, low platelet count, kidney impairment):	□	□	□
have Thrombotic Thrombocytopenic Purpura? (i.e. hemolytic anemia, low platelet count, kidney impairment, central nervous system involvement, fever):	□	□	□
undergo dialysis?	□	□	□
have surgery?	□	□	□
die?	□	□	□

IV. PUBLIC HEALTH INFORMATION

14. Does the patient attend or work in:

	Yes 1	No 2	Unknown 3
a child day care center?	□	□	□
an institution?	□	□	□

if yes, where: _____

15. Is the patient usually employed as:

	Yes 1	No 2	Unknown 3
a health care worker?	□	□	□
a food handler?	□	□	□

if yes, where: _____

V. DATA COLLECTOR INFORMATION

Person Completing This Form: Agency: Phone Number: ( ) _____ - _____ Date: _____/_____/_____
mo day yr

***Note: If patient was hospitalized, please attach copy of discharge summary if possible.**

Page 1 of 2
(1/01)

VI. EPIDEMIOLOGIC INFORMATION

16. In the 7 days before the illness began, did the patient eat at:

	Yes 1	No 2	Unknown 3
a fast food restaurant?	☐	☐	☐
another restaurant?	☐	☐	☐

if yes, name and location of restaurant(s)

_____
_____
_____
_____
_____
_____
_____

17. In the 7 days before the illness began, did the patient eat or drink any of the following items at home, in a restaurant, or in any other place?

	Yes 1	No 2	Unknown 3
raw (unpasteurized) milk	☐	☐	☐
other dairy products made from raw (unpasteurized) milk	☐	☐	☐
well water	☐	☐	☐
other unchlorinated water	☐	☐	☐
apple cider	☐	☐	☐
any ground beef or hamburger	☐	☐	☐
pink or red ground beef or hamburger	☐	☐	☐
any steak or roast beef	☐	☐	☐
pink or red steak or roast beef	☐☐	☐	

if yes, please list brand names and location where purchased:

_____
_____
_____
_____

22. In the 7 days before the illness began, did the patient:

	Yes 1	No 2	Unknown 3
visit or live on a farm?	☐	☐	☐
have contact with any cows or cattle?	☐	☐	☐
touch any cow manure?	☐	☐	☐
have contact with any children who attend a day care center?	☐	☐	☐
change any diapers?	☐	☐	☐
have contact with any children who use diapers?	☐	☐	☐
go swimming?	☐	☐	☐

if yes, where? _____

travel to another state? ☐ ☐ ☐

if yes, where? _____

travel to another country? ☐ ☐ ☐

if yes, where? _____

From? ____/____/____ to ____/____/____

23. Did anyone else in the patient's home have diarrhea in the 7 days before or after this patient's illness began?

☐Yes (1) ☐No (2) ☐Unknown (3)

if yes, please obtain the following information on these people:

Name	Age	Sex	Bloody Stools? Yes 1	No 2	Unknown 3
_____	_____	_____	☐	☐	☐
_____	_____	_____	☐	☐	☐
_____	_____	_____	☐	☐	☐
_____	_____	_____	☐	☐	☐

24. Does the patient know anyone else who has had a similar illness in the past 3 weeks? ☐ Yes 1 ☐ No 2 ☐ Unknown 3

if yes, please obtain names and telephone numbers of persons with similar illnesses: _____
_____
_____

25. Did this case occur as part of an outbreak (two or more cases of *coli* O157:H7 infection associated by time and place?

☐ Yes 1 ☐ No 2 ☐ Unknown 3

if yes, please describe: _____
_____
_____

VII. COMMENTS

Page 2 of 2

EXHIBIT III-F

Patient Name: _____ County: _____

Giardiasis Investigation Form
Arizona Department of Health Services

Symptomatology
1. Which of the following symptoms did you have?

>3 loose stools	□Yes	□No	Fever	□Yes	□No
# days (>3 loose stools) _____			highest temperature _____ date _____		
# episodes in 24 hours _____			Chills	□Yes	□No
Blood in stools	□Yes	□No	Headache	□Yes	□No
Pale/Greasy	□Yes	□No	Backache	□Yes	□No
Abdominal cramps	□Yes	□No	Muscle aches	□Yes	□No
Nausea	□Yes	□No	Fatigue	□Yes	□No
Vomiting	□Yes	□No	Other: _____		

2. When did your symptoms start? Date_____ Time _____ a.m. p.m.
3. What date did the diarrhea start? Date_____ Time_____ a.m. p.m.
4. Were you hospitalized? □ Yes □ No Adm Date _____ # days _____
5. How long did your illness last? _____# of days to full recovery

Occupation
6. Work at or attend child care? □ Yes □ No
7. Food handler (work or volunteer)? □ Yes □ No
   Household member is a food handler? □ Yes □ No
8. Provide patient care? □ Yes □ No

Food Habits
9. Are you a vegetarian? □ Yes □ No
Type _____

Medical History
10. Have existing chronic medical problem(s) or any medical condition(s)? □Yes □No
Describe _____
_____

Within the last month:
11. Antibiotics □Yes □No
Name dosage, # of days
_____ _____
_____ _____
_____ _____
12. Antacids (Tums, Mylanta, Tagamet, Prilosec, Pepcid, Zantac, Pepto bismol)? □Yes □ No

Risk factors:
In the 7 days prior to your illness, were you exposed to any of the following:
13. Contact with :
Farm animals □ Yes □No
Petting zoo animal □ Yes □No
Pets (including hedgehogs) □ Yes □No
What kind of animal(s) _____
When?_____Where?_____
If the pet is a dog was it exposed to untreated water?
□ Yes □ No
Were any pets ill with diarhea? □ Yes □ No

14. Any travel? □ Yes □No
Where?
_____
From? __/__/__ to __/__/__
Airline?_____ Flight No. _____
Foods eaten on:
Outbound Flight_____
Return Flight_____

15. Contact to someone with diarrhea?
□ Yes □No
Name & relationship? _____
When? _____

16. Attend any gatherings (wedding, reception, festival, fair, convention, etc.)? □ Yes □ No
When? __/__/__ Where? _____
When?__/__/__ Where? _____

17. Get your face wet in the a lake, river, pool or spa? □ Yes □No
Where?_____

Patient Name: _____ County: _____

ADHS Giardiasis Investigation Form Page two

Food History

During the 7 days prior to your illness give the day and date to orient the patient :

18. Where and what did you eat? List below. Attach additional paperwork as necessary.

Date	Foods & Drinks Consumed	Where? if restaurant, list location
	Breakfast Lunch Dinner Snacks	
	B L D S	
	B L D S	
	B L D S	
	B L D S	
	B L D S	
	B L D S	

In the 7 days prior to your illness, did you consume any of the following:

19. Raw sprouts (alfalfa, clover)? □Yes □No
Brand/Where bought? _____

20. Raw (unpasteurized) milk or dairy product? □ Yes □No
Brand/Where bought? _____

21. Untreated or raw water? □ Yes □No
Where? _____

22. Use water from a well? □ Yes □ No

23. Is your water filtered? □ Yes □ No

24. Who supplies your water?_____

That completes the questionnaire, thank you very much for your help. The information you have provided will be a great assistance to our investigation. Thank you again, we appreciate your assistance.

Interviewer: _____ Date:_____

Send or Fax to: ADHS Infectious Disease Epidemiology
150 North 18th Ave, Suite 140
Phoenix, Arizona 85007-3237
(602) 364-3676
(602) 364-3199 Fax

EXHIBIT III-G **Arizona Department of Health Services** **State ID _____**
Bureau of Epidemiology and Disease Control

HEPATITIS A CASE REPORT

The following questions should be asked for every case of Hepatitis A

Last: _____ First: _____ Middle: _____

Street Address: _____

City: _____ Phone: ( ) - Zip Code: _____

SSN # (optional) _____-_____-_____

State: _____ County: _____ Date Reported to Health Department _____/_____ / _____

DEMOGRAPHIC INFORMATION

RACE (check all that apply):
☐ Amer Indian or Alaska Native ☐ Asian
☐ Black or African American ☐ Native Hawaiian or Pacific Islander
☐ White ☐ Other Race, specify _____

ETHNICITY:
☐ Hispanic .....
☐ Non-hispanic ..
☐.....Other/Unknown

SEX: ☐ Male ☐ Female ☐ Unk

PLACE OF BIRTH: ☐ USA ☐ Other: _____

DATE OF BIRTH: _____/_____ / _____
AGE: _____ (years) (00= <1yr, 99= Unk)

CLINICAL & DIAGNOSTIC DATA

REASON FOR TESTING: (Check all that apply)
☐ Symptoms of acute hepatitis
☐ Screening of asymptomatic patient with reported risk factors
☐ Screening of asymptomatic patient with no risk factors (e.g., patient requested)
☐ Follow-up testing for previous marker of viral hepatitis
☐ Other: specify: _____
☐ Prenatal screening
☐ Blood / organ donor screening
☐ Evaluation of elevated liver enzymes
☐ Unknown

CLINICAL DATA:

Diagnosis Date: _____/_____ / _____

Is patient symptomatic? ☐ Yes ☐ No ☐ Unk
If yes, onset date: _____/_____ / _____

Did the patient have
Jaundice: ☐ Yes ☐ No ☐ Unk
Diarrhea: ☐ Yes ☐ No ☐ Unk

Hospitalized for Hepatitis? ☐ Yes ☐ No ☐ Unk

Did the patient die from Hepatitis?
☐ Yes ☐ No ☐ Unk
Date of death: : _____/_____ / _____

DIAGNOSTIC TESTS: CHECK ALL THAT APPLY

	Pos	Neg	Unk	Date
Total antibody to Hepatitis A (total anti-HAV)	☐	☐	☐	_____
IgM antibody to Hepatitis A virus (IgM anti-HAV)	☐	☐	☐	_____
Hepatitis B surface antigen (HBsAg)	☐	☐	☐	_____
IgM antibody to hepatitis B core antigen (IgM anti HBc)	☐	☐	☐	_____
Antibody to hepatitis E virus (anti-HEV)	☐	☐	☐	_____

VACCINATION HISTORY

Has the patient ever received the
hepatitis A vaccine? **Yes**☐ **No**☐ **Unk**☐
If yes, how many doses? ☐1 ☐2
In what year was the last dose received? _____

Has the patient ever received
immune globulin? **Yes**☐ **No**☐ **Unk**☐
If yes, when was the last dose received? _____/_____/_____

LIVER ENZYME LEVELS AT TIME OF DIAGNOSIS

ALT (SGPT) Result _____ Upper limit normal _____
Date of ALT Result_____

AST (SGOT) Result _____ Upper limit normal _____
Date of AST Result _____

If this case has a diagnosis of hepatitis A that has not been serologically confirmed, is there an **epidemiologic link** between this patient and a laboratory-confirmed hepatitis A case?
☐ Yes ☐ No ☐ Unk

Arizona Department of Health Services **State ID _____**
Bureau of Epidemiology and Disease Control

PATIENT HISTORY-ACUTE HEPATITIS A

Patient history: Contacts

In the **2-6 weeks** before symptom onset	Yes	No	Unk
Was the patient a contact of a person with confirmed or suspected hepatitis A virus infection?	☐	☐	☐
If yes, was the contact (check one)			
household member (non-sexual)?	☐	☐	☐
sexual partner?	☐	☐	☐
child cared for by this patient?	☐	☐	☐
babysitter of this patient?	☐	☐	☐
playmate?	☐	☐	☐
other _____			
Was the patient			
a child or employee in a day care center, nursery, or preschool?	☐	☐	☐
a household contact of a child or employee in a day care center, nursery or preschool?	☐	☐	☐
If yes for either of these, was there an identified hepatitis A case in the childcare facility?	☐	☐	☐

Patient history: Travel

In the **2- 6 weeks** before symptom onset	Yes	No	Unk
Did the patient travel **outside** of the U.S.A. or Canada?	☐	☐	☐
If yes, where? 1) _____ 2) _____ (Country) 3) _____			
In the **3 months** before symptom onset			
Did anyone in the patient's household travel outside of the U.S.A. or Canada?	☐	☐	☐
If yes, where? 1) _____ 2) _____ (Country) 3) _____			

Patient history: Food/Water

Is the patient suspected of being part of a common-source outbreak?	Yes	No	Unk
If yes, was the outbreak			
Foodborne - associated with an infected food handler?	☐	☐	☐
Foodborne - NOT associated with an infected food handler?	☐	☐	☐
Specify food item _____			
Waterborne	☐	☐	☐
Source not identified	☐	☐	☐
Was the patient employed as a food handler during the **TWO WEEKS** prior to onset of symptoms or while ill?	☐	☐	☐

Patient history: Sexual partners/Drug use (if appropriate)

Please ask both of the following questions regardless of the patient's gender. In the **2- 6 weeks** before symptom onset how many	0	1	2-5	>5	Unk	N/A
Male sex partners did the patient have?	☐	☐	☐	☐	☐	☐
Female sex partners did the patient have?	☐	☐	☐	☐	☐	☐
Unprotected sex?	Yes ☐		No ☐		Unk ☐	

In the **2- 6 weeks** before symptom onset	Yes	No	Unk	N/A
Did the patient inject drugs not prescribed by a doctor?	☐	☐	☐	☐
Did the patient use street drugs but not inject?	☐	☐	☐	☐

Arizona Department of Health Services **State ID _____**
Bureau of Epidemiology and Disease Control

SUPPLEMENTARY INFORMATION

FOR USE BY LOCAL HEALTH DEPARTMENTS TO DETERMINE THE PATIENT'S MOST PROBABLE SOURCE OF INFECTION

Patient's Name _____ Home phone _____ Employed by _____ Work phone _____
Report physician's name, address, and phone # _____
_____
If patient was hospitalized for hepatitis, give name of hospital _____

FURTHER INFORMATION FOR ADMITTED RISK FACTORS AND SOURCES LISTED ON PREVIOUS PAGES

IF APPLICABLE:
1. Name, address and phone # of child care center _____
2. Name and address of school, grade, classroom attended _____
3. Name, address and phone # of restaurant where food handler worked _____
_____
4. Food history of patient for the 2-6 weeks prior to onset:
   a. name and location of restaurants _____
   b. name and location of food stores _____
   c. name and location of bakery _____
   d. group meals attended (e.g., reception, church, meeting, etc) _____
   e. location raw shellfish purchased _____
5. Name, address, and phone # of known hepatitis A contacts _____
_____ Relationship _____
6.

CONTACTS REQUIRING PROPHYLAXIS FOR HEPATITIS A

Name	Date of Birth	Relationship to Case	IG	Vaccine

7. If transfused, **NOTIFY BLOOD CENTER!** Name of Blood Center _____
   a. number of units of whole blood, packed RBC or frozen RBC received _____
   b. specify type of blood product (e.g., albumin, fibrinogen, factor VIII, etc) _____
8. **IF DONOR**, name, address, and phone # of donor or plasmapheresis center _____
_____ Date _____
9. Name, address, and phone # of dialysis center _____
10. Name, address, and phone # of dentist or oral surgeon _____
11. If other surgery performed, name, address, and phone # of location _____
_____
12. Name, address, and phone of acupuncturist or tattoo parlor _____
13. Is patient currently pregnant? _____ If yes, give obstetrician's name, address and phone # _____
_____
   a. estimated date and location of delivery _____

COMMENTS _____
_____
_____

INVESTIGATOR'S NAME AND TITLE _____
DATE OF INTERVIEW _____

EXHIBIT III-H

Arizona Department of Health Services **State ID** _____
Bureau of Epidemiology and Disease Control

ACUTE HEPATITIS B and D CASE REPORT

The following questions should be asked for every case of Acute Hepatitis B and D

Last: _____ First: _____ Middle: _____

Preferred Name (nickname): _____ Maiden: _____

Address: Street: _____

City: _____ Phone: ( ) - Zip Code: _____

SSN # (optional) _____ - _____ - _____

State: _____ County: _____ Date Reported to Health Department ____/____ / _____

DEMOGRAPHIC INFORMATION

RACE (check all that apply):
- ☐ Amer Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other Race, specify _____

ETHNICITY:
- ☐ Hispanic .....
- ☐ Non-hispanic ..
- ☐ .....Other/Unknown

SEX: ☐ Male ☐ Female ☐ Unk

PLACE OF BIRTH: ☐ USA ☐ Other: _____

DATE OF BIRTH: ____/____ / _____
AGE: _____ (years) (00= <1yr, 99= Unk)

CLINICAL & DIAGNOSTIC DATA

REASON FOR TESTING: (Check all that apply)
- ☐ Symptoms of acute hepatitis
- ☐ Screening of asymptomatic patient with reported risk factors
- ☐ Screening of asymptomatic patient with no risk factors (e.g., patient requested)
- ☐ Follow-up testing for previous marker of viral hepatitis
- ☐ Other: specify: _____
- ☐ Prenatal screening
- ☐ Blood / organ donor screening
- ☐ Evaluation of elevated liver enzymes
- ☐ Unknown

CLINICAL DATA:

Diagnosis Date: ____/____ / _____

Is patient symptomatic? ☐ Yes ☐ No ☐ Unk
If yes, onset date: ____/____ / _____

Was the patient
Jaundiced: ☐ Yes ☐ No ☐ Unk
Hospitalized for Hepatitis ☐ Yes ☐ No ☐ Unk

Was the patient pregnant? ☐ Yes ☐ No ☐ Unk
Due date: ____/____ / _____

Did the patient die from Hepatitis?
☐ Yes ☐ No ☐ Unk
Date of death: : ____/____ / _____

LIVER ENZYME LEVELS AT TIME OF DIAGNOSIS

ALT (SGPT) Result _____ Upper limit normal _____
Date of ALT Result ____/____ / _____
AST (SGOT) Result _____ Upper limit normal _____
Date of AST Result ____/____ / _____
Bilirubin Result _____
Date of Bilirubin Result ____/____ / _____

DIAGNOSTIC TESTS: CHECK ALL THAT APPLY

	Pos	Neg	Unk
Total antibody to Hepatitis A (total anti-HAV) Test Result Date _____	☐	☐	☐
IgM antibody to Hepatitis A virus (IgM anti-HAV) Test Result Date _____	☐	☐	☐
Hepatitis B surface antigen (HBsAg) First Test Result Date _____	☐	☐	☐
Total antibody to hepatitis B core antigen (total anti-HBC) Test Result Date _____	☐	☐	☐
IgM antibody to hepatitis B core antigen (IgM anti HBc) Test Result Date _____	☐	☐	☐

If IgM anti-HBc is negative, STOP. Do not use this form.
Use the Chronic Hepatitis B Case Report

Antibody to hepatitis C virus (anti-HCV) Test Result Date _____	☐	☐	☐
Anti-HCV signal to cut-off ratio _____			
Supplemental anti-HCV assay (e.g., RIBA)	☐	☐	☐
HCV RNA (e.g., PCR) Test Result Date _____	☐	☐	☐
Antibody to hepatitis D virus (anti-HDV) Test Result Date _____	☐	☐	☐
Antibody to hepatitis E virus (anti-HEV) Test Result Date _____	☐	☐	☐

Arizona Department of Health Services **State ID _____**
Bureau of Epidemiology and Disease Control

PATIENT HISTORY-ACUTE HEPATITIS B and D

During the **6 weeks- 6 months** prior to onset of symptoms was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis B virus infection?

If yes, type of contact	**Yes**	**No**	**Unk**
Sexual	☐	☐	☐
Household [Non-sexual]	☐	☐	☐
Other: _____	☐	☐	☐

Ask both of the following questions regardless of the patient's gender.

In the 6 **months** before symptom onset how many

	0	**1**	**2-5**	**>5**	**Unk**
male sex partners did the patient have?	☐	☐	☐	☐	☐
female sex partners did the patient have?	☐	☐	☐	☐	☐

	Yes	**No**	**Unk**
unprotected sex?	☐	☐	☐
Was the patient EVER ***treated*** for a sexually-transmitted disease?	☐	☐	☐

If yes, what is the date of the most recent treatment ? _____

During the **6 weeks- 6 months** prior to onset of symptoms did patient

	Yes	**No**	**Unk**
inject drugs not prescribed by a doctor?	☐	☐	☐
use street drugs but not inject?	☐	☐	☐

During the **6 weeks- 6 months** prior to onset of symptoms,

Did the patient-	**Yes**	**No**	**Unk**
undergo hemodialysis?	☐	☐	☐
have an accidental stick or puncture with a needle or other object contaminated with blood?	☐	☐	☐
receive blood or blood products [transfusion]?	☐	☐	☐
if yes, when? ____/____/_____			
have other exposure to someone else's blood?	☐	☐	☐
specify: _____			

During the **6 weeks - 6 months** prior to onset of symptoms

Was the patient employed in a medical or dental field involving direct contact with human blood?	**Yes** ☐	**No** ☐	**Unk** ☐

If yes, frequency of direct blood contact?
☐ Frequent (several times weekly) ☐ Infrequent

Was the patient employed as a public safety worker (fire fighter, law enforcement or correctional officer) having direct contact with human blood?	**Yes** ☐	**No** ☐	**Unk** ☐

If yes, frequency of direct blood contact?
☐ Frequent (several times weekly) ☐ Infrequent

Did the patient receive a tattoo?	**Yes** ☐	**No** ☐	**Unk** ☐

where was the tattooing performed? (select all that apply)
☐ commercial parlor / shop
☐ correctional facility
☐ other _____

During the **6 weeks- 6 months** prior to onset of symptoms

Did the patient have any part of their body pierced (other than ear)?	**Yes** ☐	**No** ☐	**Unk** ☐

if yes, where was the piercing performed? (select all that apply)
☐ commercial parlor / shop
☐ correctional facility
☐ other _____

	Yes	**No**	**Unk**
Did the patient have dental work or oral surgery?	☐	☐	☐
Did the patient have surgery? (other than oral surgery) ?	☐	☐	☐

Was the patient- ***Check all that apply***

hospitalized?	☐	☐	☐
a resident of a long term care facility ?	☐	☐	☐
incarcerated for longer than 24 hours ?	☐	☐	☐

if yes, what type of facility (check all that apply)
☐ prison . ☐ jail ..... ☐ juvenile facility

During his/her lifetime, was the patient ***EVER*** incarcerated for longer than 6 months?	**Yes** ☐	**No** ☐	**Unk** ☐

If yes, what year was the most recent incarceration ? _____
for how long ? _____ months

VACCINATION HISTORY

	Yes	**No**	**Unk**
Did the patient ever receive hepatitis B vaccine?	☐	☐	☐
	1	**2**	**3+**
If yes, how many shots?	☐	☐	☐

When was the last shot received? ____/____/_____

	Yes	**No**	**Unk**
Was the patient tested for antibody to HBsAg (anti-HBs) within 1-2 months after the last dose?	☐	☐	☐
If yes, was the serum anti-HBs = 10mIU/ml? (answer 'yes' if the laboratory result was reported as 'positive' or 'reactive')	☐	☐	☐

Arizona Department of Health Services **State ID** _____
Bureau of Epidemiology and Disease Control

SUPPLEMENTARY INFORMATION

FOR USE BY LOCAL HEALTH DEPARTMENTS TO DETERMINE THE PATIENT'S MOST PROBABLE SOURCE OF INFECTION

Patient's Name _____ Home phone _____ Employed by _____ Work phone _____

Report physician's name, address, and phone # _____

_____

If patient was hospitalized for hepatitis, give name of hospital _____

FURTHER INFORMATION FOR ADMITTED RISK FACTORS AND SOURCES LISTED ON PREVIOUS PAGES

IF APPLICABLE:

1. Name, address and phone # of child care center _____
2. Name and address of school, grade, classroom attended _____
3. Name, address, and phone # of known hepatitis B contacts _____

_____ Relationship _____

4.

CONTACTS REQUIRING PROPHYLAXIS FOR HEPATITIS B

Name	Date of Birth	Relationship to Case	HBIG	Vaccine

5. If transfused, **NOTIFY BLOOD CENTER!** Name of Blood Center _____
   a. number of units of whole blood, packed RBC or frozen RBC received _____
   b. specify type of blood product (e.g., albumin, fibrinogen, factor VIII, etc) _____
6. **IF DONOR**, name, address, and phone # of donor or plasmapheresis center _____

_____ Date _____

7. Name, address, and phone # of dialysis center _____
8. Name, address, and phone # of dentist or oral surgeon _____
9. If other surgery performed, name, address, and phone # of location _____

_____

10. Name, address, and phone of acupuncturist or tattoo parlor _____
11. Is patient currently pregnant? _____ If yes, give obstetrician's name, address and phone # _____

_____

   a. estimated date and location of delivery _____

COMMENTS _____

_____

_____

INVESTIGATOR'S NAME AND TITLE _____

DATE OF INTERVIEW _____

EXHIBIT III-I

ARIZONA DEPARTMENT OF HEALTH SERVICES
Division of Public Health Services
Arizona Immunization Program Office
Perinatal Hepatitis B Program
(602) 364-3630

CONFIDENTIAL

Case Identification #:_____
(ADHS use only)
Date Initiated: _____

Perinatal Hepatitis B Case Management Report

Client Name: _____ ___ _____ Birthdate: _____
(First) (MI) (Last)

Address: _____

City: _____ State: _____ Zip: _____

Street address (if different from mailing address): _____

Phone: (_____) _____-_____ County: _____

Mother's language: _____ Country of birth: _____

Refugee program: _____ Yes _____ No

Race/Ethnicity: American Indian/Alaskan Native _____ White _____ Black _____

Hispanic Group _____ Asian/Pacific Island Group _____ Other _____ Unknown _____

Name of facility/provider filing report:_____

Date of HBsAg test #1: _____ Results: ____ Pos ____ Neg _____ Lab

Date of HBsAg test #2: _____ Results: ____ Pos ____ Neg _____ Lab

Diagnosed: _____ Acute _____ Carrier _____ Unknown

Obstetrical care provider: _____ Provider's phone #: _____

Planned delivery hospital: _____ EDC: _____

When complete please mail or fax to:
Arizona Department of Health Services
Perinatal Hepatitis B Program
150 N. 18th Avenue, Suite 120
Phoenix, AZ 85007-3233
Fax Number - (602)364-3274

Infant Information

Name: _____ _____ _____ Birthdate: _____
(First) (MI) (Last)

Sex: _____ Male _____ Female Actual delivery hospital: _____

Guardian name (if different than parent): _____ Relationship:_____

Pediatrician/ well child provider: _____ Phone #: _____
(Report within 15 days of birth)

Infant Immunization Record

HBIG given: _____ (Date) Hep B #2 given: _____ (Date)

Hep B #1 given: _____ (Date) Hep B #3 given: _____ (Date)

Post-vaccination Follow-up Serology

HBsAg test date: _____ Results: _____ Pos _____ Neg

Anti-HBs test date: _____ Results: _____ Pos _____ Neg

Additional doses of Hep B needed:_____ If yes, dates received: _____

Comments/notes:

Household/sexual contacts:
(Use *Household Contacts Form* to list contacts)

Date Identified: _____

Comments/Notes:

Case worker/PHN signature: _____ Date: _____

EXHIBIT III-J

Listeriosis Investigation Form
Arizona Department of Health Services State ID:_____

****Please attach Communicable Disease Report (CDR) to this form****

County:_____ Interviewer:_____ Interview Date:____/____/____

I. Patient Information

Name: Last First | Date of Birth: _____/_____/_____

II. Isolate Information

Source of Specimen:
☐ Blood ☐ Tissue
☐ CSF ☐ Other
☐ Vaginal Specify:_____

Type of Infection:
☐ Bacteremia ☐ Meningitis
☐ Neonatal Sepsis ☐ Other
☐ Encephalitis Specify:_____

Date of first positive culture: ____/____/_____

Lab test type:
☐ Culture ☐ Other (specify): _____

III. Clinical Information

Date of symptom onset: ____/____/_____

Was the case hospitalized? ☐ Yes ☐No ☐Unk.
Hospital: _____
Admit Date: ____/____/_____
Total days hospitalized: _____

Health Care Provider Information:
Provider Name: _____
Provider Address: _____
Provider Phone: (____) _____
Chart #: _____ Record #: _____

Outcome: *(check all that apply)* ☐ Died ☐ Survived ☐Miscarriage ☐ Still birth ☐ Unknown

Was the case diagnosed while pregnant or within 2 weeks of delivery or miscarriage? ☐Yes ☐No ☐ Unknown
If yes, please indicate the outcome of the pregnancy:

☐ Normal Date of delivery: ____/____/_____
☐ Still birth Date of stillbirth: ____/____/_____
☐ Miscarriage Date of miscarriage: ____/____/_____
☐ On-going Expected delivery date: ____/____/_____
☐ Other (please specify): _____

Was the case a newborn? ☐ Yes ☐No ☐Unknown

If yes: Was the mother tested for listeriosis? ☐ Yes ☐ No ☐Unknown
Date of mother's positive test result (if applicable) ____/____/_____ ☐ Unknown
Mother's Name: Last Name First Name
_____

IV. Exposure History

Did the case (or mother of a newborn case) consume any of the following food items within 3 weeks prior to symptom onset. *If asymptomatic, use the date of specimen collection (or the delivery date, if a newborn case) as the date of onset.*

Hot Dogs: ☐ Yes ☐ No ☐ Unknown Specify types/brands: _____
Pre-packaged or sliced deli meats: ☐ Yes ☐ No ☐ Unknown Specify types/brands: _____
Soft/Mexican cheese: ☐ Yes ☐ No ☐ Unknown Specify types/brands: _____
Unpasteurized milk (or products made from unpasteurized milk): ☐ Yes ☐ No ☐ Unknown Specify types/brands: _____
Any other high risk foods? ☐ Yes ☐ No ☐ Unknown
If yes, please specify: _____

G:\Groups\Epi\Forms\Listeria.doc Page 1 of 1

EXHIBIT III-K

Lyme Disease Case Report Form

• Complete Communicable Disease Report form and this two-page form for each case.

Case's name: _____ **Date of Birth:**____/____/_____

Symptoms and Signs of Current Episode (Please mark each question):

DERMATOLOGIC manifestation and date of onset ___/____/_____:

☐yes ☐no ☐unknown Erythema migrans (physician diagnosed EM at least 5cm. in diameter)?

RHEUMATOLOGIC manifestation and date of onset ___/____/_____:

☐yes ☐no ☐unknown Arthritis characterized by brief attacks of joint swelling?

NEUROLOGIC manifestation(s) and first date of onset ___/____/_____:

☐yes ☐no ☐unknown Bell's palsy or other cranial neuritis?

☐yes ☐no ☐unknown Radiculoneuropathy?

☐yes ☐no ☐unknown Lymphocytic meningitis?

☐yes ☐no ☐unknown Encephalitis/Encephalomyelitis?

☐yes ☐no ☐unknown CSF tested for antibodies to *B. burgdorferi*?

☐yes ☐no ☐unknown Antibody to *B. burgdorferi* higher in CSF than serum?

CARDIOLOGIC manifestation and date of onset ___/____/_____:

☐yes ☐no ☐unknown 2nd or 3rd degree atrioventricular block?

Hospitalization:

☐yes ☐no ☐unknown Was the patient hospitalized?

If yes, where (hospital name and city): _____

Treatment:

Antibiotic(s) used:_____ Duration: _____

Exposure Information

☐yes ☐no ☐unknown History of tick bite in month prior to illness?

If Yes, date: ____/____/_____ and location: _____

☐yes ☐no ☐unknown Was the tick found? If yes, date ____/____/_____

Tick identification (Genus and species): _____

If No, please ask the following questions

☐yes ☐no ☐unknown Was there potential exposure to a tick endemic area?

If Yes, date: ____/____/_____ and location: _____

☐yes ☐no ☐unknown History of travel out-of-state or country in month preceding onset?

If Yes, date: ____/____/_____ and location: _____

Lyme Disease Case Report Form
page two

Laboratory Information

Specimen Type	Date Collected	Specific Test Type	Test Results/Values	Laboratory name/ telephone number
☐blood ☐CSF ☐other: _____				
☐blood ☐CSF ☐other: _____				
☐blood ☐CSF ☐other: _____				
☐blood ☐CSF ☐other: _____				**State Laboratory confirmation**

Form completed by: _____ Date:____/____/_____

Fax or send completed form to:

Vector Borne and Zoonotic Disease Section
150 N. 18th Avenue, Suite 140
Phoenix, AZ 85007
FAX: (602) 364-3198

ADHS Lyme Disease Case Report Form 06/2004

EXHIBIT III-L

Patient Name: _____ County: _____

Salmonellosis Investigation Form
Arizona Department of Health Services

Symptomatology
1. Which of the following symptoms did you have?

>3 loose stools	□Yes	□No	Fever	□Yes	□No
# days (>3 loose stools) _____			highest temperature _____ date _____		
# episodes in 24 hours _____			Chills	□Yes	□No
Blood in stools	□Yes	□No	Headache	□Yes	□No
Constipation	□Yes	□No	Backache	□Yes	□No
Abdominal cramps	□Yes	□No	Muscle aches	□Yes	□No
Nausea	□Yes	□No	Fatigue	□Yes	□No
Vomiting	□Yes	□No	Other: _____		

2. When did your symptoms start? Date_____ Time _____ a.m. p.m.
3. What date did the diarrhea start? Date_____ Time_____ a.m. p.m.
4. Were you hospitalized? □ Yes □ No Adm Date _____ # days _____
5. How long did your illness last? _____# of days to full recovery

Occupation
6. Work at or attend child care? □ Yes □ No
7. Food handler (work or volunteer)? □ Yes □ No
8. Household member is a food handler? □ Yes □ No
9. Provide patient care? □ Yes □ No

Food Habits
10. Are you a vegetarian? □ Yes □ No
Type _____

Medical History
11. Have existing chronic medical problem(s) or any medical condition(s)? □Yes □No
Describe_____
_____

Within the last month:
12. Antibiotics □Yes □No

Name	dosage, # of days
_____	_____
_____	_____
_____	_____

13. Antacids (Tums, Mylanta, Tagamet, Prilosec, Pepcid, Zantac, Pepto bismol)? □Yes □ No

Risk factors:
In the 7 days prior to your illness, were you exposed to any of the following:
14. Contact with :

Reptiles (turtles, iguanas, snakes)	□ Yes	□No
Amphibians (frogs, salamanders)	□ Yes	□No
Farm animals	□ Yes	□No
Petting zoo animal	□ Yes	□No
Pets (including hedgehogs)	□ Yes	□No

What kind of animal(s) _____
When?_____Where? _____

15. Any travel? □ Yes □No
Where?
_____
From? __/__/__ to __/__/__
Airline?_____ Flight No._____
Foods eaten on:
outbound flight
_____
return flight
_____

16. Contact to someone with diarrhea?
□ Yes □No
Name & relationship? _____
When? _____

17. Attend any gatherings (wedding, reception, festival, fair, convention, etc.)? □ Yes □ No
When?__/__/__ Where? _____
When?__/__/__ Where? _____

18. Get your face wet in the ocean, a lake, river, pool or spa? □ Yes □ No

Where?_____

Patient Name: _____ County: _____

ADHS Salmonella Investigation Form Page two

Food History

During the 7 days prior to your illness (give the day and date to orient the patient):

19. Where and what did you eat? List below. Attach additional paperwork as necessary.

Date	Foods & Drinks Consumed	Where? (if restaurant list location)
	Breakfast Lunch Dinner Snacks	
	B L D S	
	B L D S	
	B L D S	
	B L D S	
	B L D S	
	B L D S	

In the 7 days prior to your illness, did you consume any of the following:

20. Fresh (not pasteurized) eggs? □Yes □No
Runny yolk? □Yes □No
Where? _____

21. Poultry (chicken, turkey, etc)? □Yes □No
Brand/Where bought? _____

22. Raw sprouts (alfalfa, clover)? □Yes □No
Brand/Where bought? _____

23. Beverage containing unpasteurized/fresh juice? □Yes □No
Brand/Where bought? _____

24. Raw (unpasteurized) milk or dairy product? □ Yes □ No
Brand/Where bought? _____

25. Untreated or raw water? □ Yes □ No
Where? _____

That completes the questionnaire, thank you very much for your help. The information you have provided will be a great assistance to our investigation. Thank you again, we appreciate your assistance.

Interviewer: _____ Date:_____

Send or Fax to: ADHS Infectious Disease Epidemiology
150 North 18th Ave, Suite 140
Phoenix, Arizona 85007-3237
(602) 364-3676
(602) 364-3199 Fax

EXHIBIT III-M

Patient Name: _____ County: _____

Shigellosis Investigation Form
Arizona Department of Health Services

Symptomatology

1. Which of the following symptoms did you have?

Diarrhea	☐Yes	☐No	Fever	☐Yes	☐No
# days (>3 loose stools) _____			highest temperature _____ date _____		
# episodes in 24 hours _____			Chills	☐Yes	☐No
Blood in stools	☐Yes	☐No	Headache	☐Yes	☐No
Mucous in stools	☐Yes	☐No	Backache	☐Yes	☐No
Watery stools	☐Yes	☐No	Muscle aches	☐Yes	☐No
Constipation	☐Yes	☐No	Fatigue	☐Yes	☐No
Abdominal cramps	☐Yes	☐No	Joint Pain	☐Yes	☐No
Nausea	☐Yes	☐No	Anorexia/weight loss	☐Yes	☐No
Vomiting	☐Yes	☐No	Other: _____		

2. When did your symptoms start? Date_____ Time _____ a.m. p.m.
3. What date did the diarrhea start? Date_____ Time _____ a.m. p.m.
4. Were you hospitalized? ☐ Yes ☐ No Adm Date _____ # days _____
5. How long did your illness last? _____# of days to full recovery

Occupation

6. Work at or attend child care? ☐ Yes ☐ No
7. Food handler (work or volunteer)? ☐ Yes ☐ No
8. Household member is a food handler? ☐ Yes ☐ No
9. Provide patient care? ☐ Yes ☐ No

Medical History

10. Have existing chronic medical problem(s) or any medical condition(s)? ☐Yes ☐No
Describe_____
_____

Within the last month:

11. Antibiotics ☐Yes ☐No
Name dosage, # of days
_____ _____
_____ _____
_____ _____

12. Antacids (Tums, Mylanta, Tagamet, Prilosec, Pepcid, Zantac, Pepto bismol)? ☐Yes ☐ No
13. Did the patient survive? ☐Yes ☐ No Date of Death: ___/___/___

Risk factors:
In the 7 days prior to your illness, were you exposed to any of the following:

14. Any travel? ☐ Yes ☐No
Where?
_____
From? __/__/__ to __/__/__
Airline?_____ Flight No._____
Foods eaten on:
outbound flight
_____
return flight
_____

15. Contact with someone with similar symptoms ? ☐ Yes ☐No
Name & relationship? _____
When? _____Phone #_____

16. Attend any gatherings (wedding, reception, festival, fair, convention, etc.)? ☐ Yes ☐No
When?__/__/__ Where? _____
When?__/__/__ Where? _____

17. Get your face wet in the ocean, a lake, river, pool, or spa? ☐ Yes ☐No
Where?_____

15. Change any diapers? ☐ Yes ☐No

16. Contact with human or primate feces? ☐ Yes ☐No

Patient Name: _____ County: _____

ADHS Shigella Investigation Form Page two

Food History

During the 7 days prior to your illness (give the day and date to orient the patient):

18. Where and what did you eat? List below. Attach additional paperwork as necessary.

Date	Foods & Drinks Consumed	Where? (if restaurant list location)
	Breakfast Lunch Dinner Snacks	
	B L D S	
	B L D S	
	B L D S	
	B L D S	
	B L D S	
	B L D S	

In the 7 days prior to your illness, did you consume any of the following:

19. What type of water did you drink?
☐Public ☐Well ☐Bottled ☐Other

20. Raw or untreated water? ☐Yes ☐No
Where? _____

21. Raw (unpasteurized) milk or dairy products?
☐ Yes ☐ No
Brand/Where bought? _____

That completes the questionnaire, thank you very much for your help. The information you have provided will be a great assistance to our investigation. Thank you again, we appreciate your assistance.

Interviewer: _____ Date:_____

Send or Fax to: ADHS Infectious Disease Epidemiology
150 North 18th Ave, Suite 140
Phoenix, Arizona 85007-3237
(602) 364-3676
(602) 364-3199 Fax

EXHIBIT III-N

Arizona Department of Health Services
RVCT Addendum Form for TB Reporting

Pt Name_____ **County** _____	2. Name of Case Manager: _____
5. Alien number for Class B and INS detainees: A _ _ - _ _ _ - _ _ _	6. Is the county providing housing or funds for housing assistance? YES NO UNKNOWN
7. Name of tribe if Native American: _____	8. Name of Indian Health Service site where counted: _____
The following four questions pertain to persons diagnosed with TB while residing in a correctional facility:	
9. Name of correctional facility: _____	10. Date most recently admitted to prison system: _ _ / _ _ / _ _ _ _
11. Prisoner number state or federal prisoners (BOP): _____	12. Is inmate an INS detainee? YES NO UNKNOWN
13. Is this patient on directly-observed therapy (DOT)? YES NO UNKNOWN	14. If not on DOT, please select one of the following reasons: A. Patient refused B. Site of disease is extrapulmonary C. Inadequate staff to provide DOT for this pt. D. Medication given by family member E. Other _____
15. Is this patient diabetic? YES NO UNKNOWN	16. Is the patient a student? A. Not a student B. Primary (grade K – 6) C. Middle (grade 7 - 8) D. High School E. College / University F. Unknown
17. Has the patient ever received treatment for latent tuberculosis infection (LTBI)? A. No B. Complete C. Partial D. Unknown	18. Year of treatment for latent tuberculosis infection: _ _ _ _
19. Name of source case (if known) and relationship to patient: _____	
Is the physician who performed diagnostic TB evaluation (choose one) 20. acting as a public health physician name _____ 21. a private medical provider name_____	Is the physician providing current TB treatment and monitoring (choose one) 22. acting as a public health physician name _____ 23. a private medical provider name_____
24. Stop reason other than "completed" A. deportation B. voluntarily moved to foreign country C. other_____	25. Extended treatment (>1 year) rationale: A. Lost during treatment while on DOT B. Clinical indication _____ C. Cannot tolerate first line drugs D. Physician preference E. Patient non-compliant on self-administered meds F. Other_____
26. Binational status due to (circle one only): A. Diagnostic / clinical / treatment information exchange with Mexico B. Contacts only (this case has contacts living in Mexico or this case was a contact to a Mexico case) C. Both A and B D. Binational case ONLY due to laboratory / radiologic testing E. Not a binational case F. Unknown	

Revised 11/04/2003

ARTICLE 5. RABIES CONTROL

~~R9-6-105.~~ R9-6-501. ~~Rabies Control~~ Definitions

In this Article ~~5~~, unless otherwise specified:

1. "Animal control agency" means a ~~governmental agency or its designated representative with local~~ board, commission, department, office, or other administrative unit of federal or state government or of a political subdivision of the state that has the responsibility for controlling ~~dogs and cats~~ rabies in animals in a particular geographic area.
2. "Approved rabies vaccine" means a rabies vaccine authorized for use in this state by the state veterinarian under A.A.C. R3-2-409.

~~2.~~3. "Cat" means an animal of the genus species *Felis domesticus*.

4. "Currently vaccinated" means that an animal was last immunized against rabies with an approved rabies vaccine:
   a. At least 28 days and no longer than one year before being exposed, if the animal has only received an initial dose of approved rabies vaccine;
   b. No longer than one year before being exposed, if the approved rabies vaccine is approved for annual use under A.A.C. R3-2-409; or
   c. No longer than three years before being exposed, if the approved rabies vaccine is approved for triennial use under A.A.C. R3-2-409.

~~3.~~5. "Dog" means an animal of the genus species *Canis familiaris*.

~~4.~~6. "Euthanize" means to ~~put~~ kill an animal ~~to death~~ painlessly.

~~5.~~7. "Exposed" means bitten by or having ~~direct contact with~~ touched a ~~rabies susceptible~~ rabid animal or an animal suspected of being rabid.

8. "Ferret" means an animal of the genus species *Mustela putorius*.
9. "Not currently vaccinated" means that an animal does not meet the definition of "currently vaccinated."
10. "Rabid" means infected with rabies virus, a rhabdovirus of the genus *Lyssavirus*.
11. "Suspect case" means an animal whose signs or symptoms indicate that the animal may be rabid.

~~R9-6-501.~~ R9-6-502. Management of Exposed Animals ~~Exposed to a Known Rabid Animal~~

A. An animal control agency shall manage ~~a~~ an exposed dog, ~~or~~ cat, or ferret ~~that has direct contact with a known or suspected rabid animal according to 1 of the following procedures~~ as follows:

~~1. Euthanize;~~

~~2. Confine in isolation for 180 days under the supervision and control of the county or municipal animal control agency and vaccinate 30 days before release:~~
   ~~a. If the exposed animal was never vaccinated,~~
   ~~b. If the exposed animal was vaccinated with a triennial vaccine more than 3 years before being exposed, or~~
   ~~c. If the exposed animal was vaccinated with any other vaccine more than a year before being exposed;~~

~~3. Revaccinate and confine in isolation for 90 days under the supervision and control of the county or municipal animal control agency, if the animal was vaccinated less than 30 days before being exposed; or~~

~~4. Revaccinate within 7 days, confine and observe by the owner for 45 days with the approval and supervision of the county or municipal animal control agency under the following circumstances:~~
   ~~a. If the animal was vaccinated with a triennial vaccine more than 30 days and less than 3 years before being exposed, or~~
   ~~b. If the animal was vaccinated with any other vaccine more than 30 days and less than 1 year before being exposed.~~

1. If the exposed dog, cat, or ferret is currently vaccinated, the animal control agency shall:
   a. Revaccinate the animal with an approved rabies vaccine within seven days after the date that the animal is exposed; and
   b. Confine and observe the animal in the owner's home or, at the owner's expense, in a veterinary hospital or the animal control agency's facility, as determined by the animal control agency, for 45 days after the animal is exposed; or
2. If the exposed dog, cat, or ferret is not currently vaccinated, the animal control agency shall:
   a. Euthanize the animal; or
   b. At the owner's request, confine the animal for 180 days, at the owner's expense, in a veterinary hospital or the animal control agency's facility, as determined by the animal control agency, and vaccinate the animal with an approved rabies vaccine 28 days before it is released from confinement.

B. ~~The~~ An animal control agency that is aware of an exposed animal, other than a cat, dog, ferret, or livestock, shall:

1. ~~immediately euthanize, an~~ Make every effort to capture the exposed animal~~, except a cat, dog, or livestock, exposed to a known rabid animal~~ as soon as it is identified, and
2. Euthanize the animal as soon as it is captured.

C. ~~The~~ An animal control agency shall ~~handle~~ release from confinement a dog, ~~or~~ cat, or ferret exposed to ~~a suspected rabid animal~~ a suspect case ~~in the same manner as 1 exposed to a known rabid animal, except that confinement shall be termi-~~

~~nated at such time as it is determined that the biting animal is not rabid. Such determination shall be~~ when the animal control agency receives a negative rabies report on the suspect case from the Department ~~laboratory, or a certificate signed by a veterinarian stating that the suspected animal is no longer showing symptoms of rabies~~.

D. Livestock shall be handled according to ~~Department of Agriculture rule~~ A.A.C. R3-2-408.

~~R9-6-502.~~ R9-6-503. Suspect ~~Rabies~~ Cases

A. ~~The~~ An animal control agency shall ~~confine, supervise, and control an animal, other than livestock, that shows symptoms of rabies when captured~~ ensure confinement of a dog, cat, or ferret that is a suspect case until:

1. ~~it~~ The animal dies,
2. The animal is euthanized, or
3. ~~a~~ A veterinarian determines ~~it is no longer showing symptoms of rabies~~ that the animal is not rabid.

B. ~~Whenever the~~ When an animal control agency euthanizes a ~~suspected rabid animal~~ suspect case, ~~it shall be done in such a way as to~~ the animal control agency shall avoid damaging the brain, so that rabies testing can be performed.

~~R9-6-503.~~ R9-6-504. ~~Records Submitted by Enforcement Agents~~ Animal Control Agency Reporting Requirements

By April 30 of each year, ~~municipal, county and other animal control agents~~ an animal control agency shall ~~file with~~ submit a report to the Department ~~a report of activities~~ that contains the number of animal bites to humans reported as occurring in the animal control agency's jurisdiction during the preceding calendar year~~. The report shall consist of animal control agent activities which include the number of dogs licensed, the number of stray dogs and cats impounded and method of disposition, the number and species of wild animals disposed of, and the number of animal bites reported by species of animal~~ and a breakdown of the bites by:

1. Species of animal,
2. Age of victim, and
3. Month of occurrence.

ARTICLE 6. TUBERCULOSIS CONTROL

~~R9-6-106.~~ R9-6-601. ~~Tuberculosis Control~~ Definitions

In addition to the definitions in A.R.S. § 36-711, the following definitions apply in this Article ~~6~~, unless ~~the context~~ otherwise ~~requires~~ specified:

~~1. "Approved institution" means a health care facility with a current license to operate pursuant to 9 A.A.C. 10, which has a private room with special ventilation.~~

~~2. "State Tuberculosis Control Officer" means a physician, appointed by the Director, with the authority to issue or revoke an Order of Isolation and Quarantine and to deputize a qualified employee of the Department and other governmental agency as a Deputy Tuberculosis Control Officer.~~

1. "Inmate" means an individual who is incarcerated in a correctional facility.

~~3.~~2. "~~Tuberculosis~~ Latent tuberculosis infection" means the presence of ~~bacteria in *Mycobacteria*~~ *Mycobacterium tuberculosis*, as evidenced by a positive result from an approved test for tuberculosis, in an individual who:

a. Has no symptoms of active tuberculosis,
b. Has no clinical signs of tuberculosis other than the positive result from the approved test for tuberculosis, and
c. ~~complex has spread through the body of a person but is~~ Is not ~~contagious~~ infectious to others.

~~4. "Tuberculosis disease" means the bacteria in *Mycobacteria tuberculosis* complex is causing clinical signs and symptoms and is contagious, unless the bacteria cannot exit the body.~~

3. "Symptoms suggestive of tuberculosis" means any of the following that cannot be attributed to a disease or condition other than tuberculosis:

a. A productive cough that has lasted for at least three weeks;
b. Coughing up blood; or
c. A combination of at least three of the following:
   i. Fever,
   ii. Chills,
   iii. Night sweats,
   iv. Fatigue,
   v. Chest pain, and
   vi. Weight loss.

~~R9-6-602. Issuance and Enforcement of an Order for Isolation and Quarantine~~

~~**A.** The State Tuberculosis Control Officer, or a deputized qualified employee of the Department or other governmental health agency, may issue or revoke an Order of Isolation and Quarantine.~~

~~**B.** Orders of Isolation and Quarantine pursuant to A.R.S. § 36-714 shall be issued for a period not to exceed 30 days.~~

~~**C.** All persons deputized to issue an Order of Isolation and Quarantine shall send written notice to the State Tuberculosis Control Officer of the issuance of an Order of Isolation and Quarantine within five working days of such issuance. The notice shall include the description of the person quarantined, the basis upon which it is believed or suspected that such~~

~~person is afflicted with contagious tuberculosis disease and shall include a copy of the issued Order of Isolation and Quarantine.~~

~~**D.** The local health agency shall be responsible for serving Orders of Isolation and Quarantine.~~

~~**R9-6-601.** **R9-6-602. Reports of Disease and Infection; Tuberculosis Registry**~~ **Local Health Agency Reporting Requirements**

~~**A.** A person shall report a case of tuberculosis or a tuberculosis infection in a child under age six in accordance with R9-6-202.~~

~~**B.** The local health agency shall provide the following information to the Department:~~

~~1. Medical information regarding all individuals with diagnosed tuberculosis disease in its jurisdiction, regardless of the supervising agency.~~

~~2. Medical information regarding individuals suspected of having tuberculosis disease, those exposed to communicable tuberculosis disease, those with tuberculosis infection, and other individuals receiving tuberculosis treatment or services through the local health agency.~~

~~**C.** A register of persons having tuberculosis shall be maintained by the State Tuberculosis Control Officer.~~

A. Within 30 days after receiving information, a local health agency shall report to the Department regarding:

1. Each individual in its jurisdiction who has been diagnosed with active tuberculosis,
2. Each individual in its jurisdiction who is suspected of having active tuberculosis, and
3. Each individual in its jurisdiction who is believed to have been exposed to an individual with infectious active tuberculosis.

B. Each report made under subsection (A) shall consist of completed Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 72.9A and B, "Report of Verified Case of Tuberculosis" (January 2003), which is incorporated by reference in R9-6-373, or a completed electronic equivalent to Form CDC 72.9A and B provided by the Department.

~~**R9-6-603. Removal of Persons to Another State or Country**~~

~~**A.** When a case of communicable tuberculosis disease has financial support from out-of-state, the State Tuberculosis Control Officer, with written assurance of such support, shall furnish the patient with travel expenses and subsistence sufficient for the case to reach such support. The State Tuberculosis Control Officer shall ensure this transfer promotes the welfare of both the care and the state.~~

~~**B.** The State Tuberculosis Control Officer shall designate the method of transportation that best assures the safety of the patient and the public.~~

R9-6-603. Tuberculosis Control in Correctional Facilities

A. An administrator of a correctional facility shall ensure that:

1. Each new inmate in the correctional facility undergoes a symptom screening for tuberculosis while processing into the correctional facility;
2. An inmate in whom symptoms suggestive of tuberculosis are detected during screening:
   a. Is immediately:
      i. Placed in airborne infection isolation, or
      ii. Required to wear a surgical mask and retained in an environment where exposure to the general inmate population is minimal and the inmate can be observed at all times to be wearing the mask;
   b. If not immediately placed in airborne infection isolation, is within 24 hours after screening:
      i. Given a medical evaluation for active tuberculosis, or
      ii. Transported to a health care institution to be placed in airborne infection isolation; and
   c. Is given a medical evaluation for active tuberculosis before being released from airborne infection isolation or permitted to stop wearing a surgical mask and released from the environment described in subsection (A)(2)(a)(ii).
3. Except as provided in subsection (A)(6), each new inmate who does not have a documented history of a positive result from an approved test for tuberculosis or who has not received an approved test for tuberculosis within the previous 12 months is given an approved test for tuberculosis within seven days after processing into the correctional facility;
4. Except as provided in subsection (A)(5), each new inmate who has a positive result from an approved test for tuberculosis or who has a documented history of a positive result from an approved test for tuberculosis is given a chest x-ray and a medical evaluation, within 14 days after processing into the correctional facility, to determine whether the inmate has active tuberculosis;
5. If an inmate has had a documented negative chest x-ray after a positive result from an approved test for tuberculosis, the inmate is not required to have another chest x-ray unless the inmate has signs or symptoms of active tuberculosis;
6. Each new inmate who is HIV-positive, in addition to receiving an approved test for tuberculosis, is given a chest x-ray and a medical evaluation within seven days after processing into the correctional facility, to determine whether the inmate has active tuberculosis;

7. Each inmate who has a negative result from an approved test for tuberculosis when tested during processing has a repeat approved test for tuberculosis after 12 months of incarceration and every 12 months thereafter during the inmate's term of incarceration;
8. Each inmate with active tuberculosis is:
   a. Provided medical treatment that meets accepted standards of medical practice, and
   b. Placed in airborne infection isolation until no longer infectious; and
9. All applicable requirements in 9 A.A.C. 6, Articles 2 and 3 are complied with.

B. The requirements of subsection (A) apply to each correctional facility that houses inmates for 14 days or longer and to each inmate who will be incarcerated for 14 days or longer.

C. An administrator of a correctional facility, either personally or through a representative, shall:
1. Unless unable to provide prior notification because of security concerns, notify the local health agency at least one working day before releasing a tuberculosis case or suspect case;
2. If unable to provide prior notification because of security concerns, notify the local health agency within 24 hours after releasing a tuberculosis case or suspect case; and
3. Provide a tuberculosis case or suspect case or an inmate being treated for latent tuberculosis infection the name and address of the local health agency before the case, suspect case, or inmate is released.

R9-6-604. ~~Repealed~~ Standards of Medical Care

A health care provider caring for an afflicted person shall comply with the recommendations for treatment of tuberculosis in *American Thoracic Society/Centers for Disease Control and Prevention/Infectious Diseases Society of America: Treatment of Tuberculosis* (October 2002), published in 167 *American Journal of Respiratory and Critical Care Medicine* 603-662 (February 15, 2003), which is incorporated by reference, on file with the Department, and available from the American Thoracic Society, 61 Broadway, New York, NY 10006-2747 or at www.atsjournals.org, unless the health care provider believes, based on the health care provider's professional judgment, that deviation from the recommendations is medically necessary. If a health care provider caring for an afflicted person deviates from the recommendations for treatment of tuberculosis in *American Thoracic Society/Centers for Disease Control and Prevention/Infectious Diseases Society of America: Treatment of Tuberculosis* (October 2002), the health care provider shall, upon request, explain to the Department or a local health agency the rationale for the deviation. If the tuberculosis control officer determines that deviation from the recommendations for treatment of tuberculosis in *American Thoracic Society/Centers for Disease Control and Prevention/Infectious Diseases Society of America: Treatment of Tuberculosis* (October 2002), is inappropriate and that the public health and welfare require intervention, the tuberculosis control officer may take charge of the afflicted person's treatment as authorized under A.R.S. § 36-723(C).