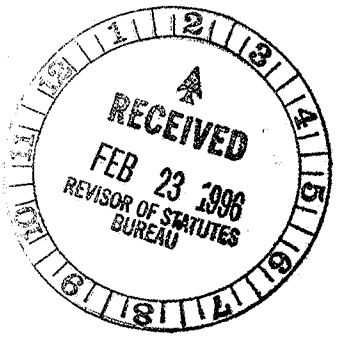
CERTIFICATE

STATE OF WISCONSIN
DEPARTMENT OF REGULATION AND LICENSING

TO ALL WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, Patrick D. Braatz, Director, Bureau of Health Professions in the Wisconsin Department of Regulation and Licensing and custodian of the official records of the Medical Examining Board, do hereby certify that the annexed rules were duly approved and adopted by the Medical Examining Board on the 22nd day of February, 1996.

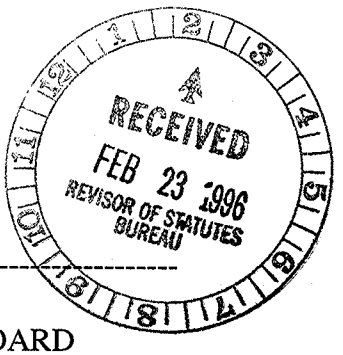
I further certify that said copy has been compared by me with the original on file in this office and that the same is a true copy thereof, and of the whole of such original.



IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the board at 1400 East Washington Avenue, Madison, Wisconsin this 22nd day of February, 1996.

Patrick D. Braatz, Director, Bureau of Health Professions, Department of Regulation and Licensing

5-1-96



STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

IN THE MATTER OF RULE-MAKING PROCEEDINGS BEFORE THE MEDICAL EXAMINING BOARD	:	ORDER OF THE MEDICAL EXAMINING BOARD ADOPTING RULES (CLEARINGHOUSE RULE 95-049)

ORDER

An order of the Medical Examining Board to create Med 10.02 (2) (za) and chapter Med 21 relating to requirements for patient health care records.

Analysis prepared by the Department of Regulation and Licensing.

ANALYSIS

Statutes authorizing promulgation: ss. 15.08 (5) (b), 227.11 (2) and 448.40 (1), Stats.

Statutes interpreted: s. 448.40 (1), Stats.

In this proposed rule-making order the Medical Examining Board creates rules relating to the requirements for maintaining patient health care records by physicians, podiatrists and physician assistants.

Section Med 10.02 (2) (za) is created to outline that the failure to maintain patient health care records as outlined in chapter Med 21 is a part of the unprofessional conduct chapter of the board.

Section Med 21.01 is created to outline the purpose and authority of the board in promulgating this chapter.

Section Med 21.02 sets forth the definitions that will be used in this chapter.

Section Med 21.03 is created to outline the minimum standards for maintaining patient health care records. This section outlines the length that patient health care records must be maintained and the type of clinical information pertaining to the patient that must be included as well as a way to identify the practitioner who created the record.

TEXT OF RULE

SECTION 1. Med 10.02 (2) (za) is created to read:

Med 10.02 (2) (za) Failure by a physician, podiatrist or physician assistant to maintain patient health care records consistent with the requirements of ch. Med 21.

SECTION 2. Chapter Med 21 is created to read:

Chapter Med 21

PATIENT HEALTH CARE RECORDS

Med 21.01 AUTHORITY AND PURPOSE. The rules in this chapter are adopted by the board under the authority of ss. 15.08 (5) (b), 227.11 (2) and 448.40 (1), Stats., to govern the practice of physicians, podiatrists and physician assistants in the preparation and retention of patient health care records.

Med 21.02 DEFINITIONS. As used in this chapter:

(1) "Board" means the medical examining board.

(2) "Patient" means a person who receives health care services from a physician, podiatrist or physician assistant.

(3) "Patient health care record" has the meaning given in s. 146.81 (4), Stats.

Med 21.03 MINIMUM STANDARDS FOR PATIENT HEALTH CARE RECORDS. (1) A physician, podiatrist or physician assistant shall maintain patient health care records on every patient administered to for a period of not less than 5 years after the date of the last entry, or for such longer period as may be otherwise required by law.

(2) A patient health care record prepared by a physician, podiatrist or physician assistant shall contain the following clinical health care information which apply to the patient's medical condition:

(a) Pertinent patient history.

(b) Pertinent objective findings related to examination and test results.

(c) Assessment or diagnosis.

(d) Plan of treatment for the patient.

(3) Each patient health care record entry shall be dated, shall identify the practitioner, and shall be sufficiently legible to allow interpretation by other practitioners for the benefit of the patient.

(END OF TEXT OF RULE)

The rules adopted in this order shall take effect on the first day of the month following publication in the Wisconsin administrative register pursuant to s. 227.22 (2) (intro.), Stats.

Dated February 22, 1996 B. Jim Nevraser
Chairperson
Medical Examining Board

g:\rules\med21
12/19/95

CORRESPONDENCE/MEMORANDUM **STATE OF WISCONSIN**

DATE: February 23, 1996

TO: Gary Poulson
Assistant Revisor of Statutes

FROM: Pamela A. Haack, Rules Center Coordinator
Department of Regulation and Licensing
Office of Administrative Rules

SUBJECT: Final Order Adopting Rules

Agency: MEDICAL EXAMINING BOARD
(Clearinghouse Rule 95-049)

Attached is a copy and a certified copy of a final order adopting rules. Would you please publish these rules in the register.

Please stamp or sign a copy of this letter to acknowledge receipt.

Thank you.