Department of State
Division of Publications
312 Rosa L. Parks, 8th Floor Snodgrass/TN Tower
Nashville, TN 37243
Phone: 615.741.2650
Fax: 615.741.5133
Email: register.information@tn.gov

For Department of State Use Only

Sequence Number: 03-08-12
Notice ID(s): 1747-1761
File Date: 03/09/2012

Notice of Rulemaking Hearing

Hearings will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204. For questions and copies of the notice, contact the person listed below.

Agency/Board/Commission:	Department of Health
Division:	Bureau of Health Licensure and Regulation Division of Health Care Facilities
Contact Person:	Diona E. Layden, Assistant General Counsel
Address:	Plaza One, Suite 210, 220 Athens Way, Nashville, Tennessee 37243
Phone:	(615) 741-1611
Email:	Diona.Layden@tn.gov

Any Individuals with disabilities who wish to participate in these proceedings (to review these filings) and may require aid to facilitate such participation should contact the following at least 10 days prior to the hearing:

ADA Contact:	ADA Coordinator at the Division of Health Related Boards
Address:	227 French Landing, Heritage Place, Nashville, Tennessee 37243
Phone:	(615) 532-4397
Email:	

Hearing Location(s) (for additional locations, copy and paste table)

Address 1:	Iris Conference Room		
Address 2:	227 French Landing, Heritage Place, Nashville, Tennessee 37243		
City:	Nashville, Tennessee		
Zip:	37243		
Hearing Date :	May 2, 2012		
Hearing Time:	9:00 a.m.	X CST/CDT ___ EST/EDT	

Additional Hearing Information:

Revision Type (check all that apply):
X Amendment
X New
___ Repeal

Rule(s) (**ALL** chapters and rules contained in filing must be listed. If needed, copy and paste additional tables to accommodate more than one chapter. Please enter only **ONE** Rule Number/Rule Title per row.)

Chapter Number	**Chapter Title**
1200-08-01	Standards for Hospitals
Rule Number	**Rule Title**
1200-08-01-.15	Appendix I

Chapter Number	Chapter Title
1200-08-02	Standards for Prescribed Child Care Centers
Rule Number	**Rule Title**
1200-08-02-.14	Appendix

Chapter Number	Chapter Title
1200-08-06	Standards for Nursing Homes
Rule Number	**Rule Title**
1200-08-06-.16	Appendix I

Chapter Number	Chapter Title
1200-08-10	Standards for Ambulatory Surgical Treatment Centers
Rule Number	**Rule Title**
1200-08-10-.15	Appendix I

Chapter Number	Chapter Title
1200-08-11	Standards for Homes for the Aged
Rule Number	**Rule Title**
1200-08-11-.14	Appendix I

Chapter Number	Chapter Title
1200-08-15	Standards for Residential Hospices
Rule Number	**Rule Title**
1200-08-15-.15	Appendix I

Chapter Number	Chapter Title
1200-08-24	Standards for Birthing Centers
Rule Number	**Rule Title**
1200-08-24-.01	Definitions
1200-08-24-.14	Appendix I

Chapter Number	Chapter Title
1200-08-25	Standards for Assisted Care Living Facilities
Rule Number	**Rule Title**
1200-08-25-.17	Appendix

Chapter Number	Chapter Title
1200-08-26	Standards for Home Care Organizations Providing Home Health Services
Rule Number	**Rule Title**
1200-08-26-.15	Appendix I

Chapter Number	Chapter Title
1200-08-27	Standards for Home Care Organizations Providing Hospice Services
Rule Number	**Rule Title**
1200-08-27-.15	Appendix I

Chapter Number	Chapter Title
1200-08-28	Standards for HIV Supportive Living Facilities
Rule Number	**Rule Title**
1200-08-28-.15	Appendix I

Chapter Number	Chapter Title
1200-08-32	Standards for End Stage Renal Dialysis Clinics
Rule Number	**Rule Title**
1200-08-32-.15	Appendix I

Chapter Number	Chapter Title
1200-08-34	Standards for Home Care Organizations Providing Professional Support Services
Rule Number	**Rule Title**
1200-08-34-.15	Appendix I

Chapter Number	Chapter Title
1200-08-35	Standards for Outpatient Diagnostic Centers
Rule Number	**Rule Title**
1200-08-35-.15	Appendix I

Chapter Number	Chapter Title
1200-08-36	Standards for Adult Care Homes – Level II
Rule Number	**Rule Title**
1200-08-36-.18	Appendix I

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to http://state.tn.us/sos/rules/1360/1360.htm)

Amendments

Rules 1200-08-01-.15 Appendix I, 1200-08-02-.14 Appendix, 1200-08-6-.16 Appendix I, 1200-08-10-.15 Appendix I, 1200-08-11-.14 Appendix I, 1200-08-15-.15 Appendix I, 1200-08-24-.14 Appendix I, 1200-08-25-.17 Appendix, 1200-08-26-.15 Appendix I, 1200-08-27-.15 Appendix I, 1200-08-28-.15 Appendix I, 1200-08-32-.15 Appendix I, 1200-08-34-.15 Appendix I, 1200-08-36-.18 Appendix I are amended by deleting the rules in their entirety and substituting the following forms, so that as amended, the new rules shall read as follows:

Appendix I

(1) Physician Orders for Scope of Treatment (POST) Form

(This space intentionally left blank)

A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

Physician Orders for Scope of Treatment (POST)

This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.

Patient's Last Name
First Name/Middle Initial
Date of Birth

Section A *Check One Box Only*

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and/or is not breathing.

☐ **Resuscitate (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/ no CPR) (Allow Natural Death)**

When not in cardiopulmonary arrest, follow orders in **B, C,** and **D.**

Section B *Check One Box Only*

MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing.

☐ **Comfort Measures.** Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.**

☐ **Limited Additional Interventions.** Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation.
Transfer to hospital if indicated. Avoid intensive care.

☐ **Full Treatment.** Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. **Transfer to hospital if indicated. Include intensive care.**

*Other Instructions:*_____

Section C *Check One Box Only*

ANTIBIOTICS – Treatment for new medical conditions:

☐ **No Antibiotics**
☐ **Antibiotics** *Other Instructions:*_____

Section D *Check One Box Only in Each Column*

MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Oral fluids & nutrition must be offered if medically feasible.

☐ **No IV fluids** (provide other measures to assure comfort)
☐ **IV fluids for a defined trial period**
☐ **IV fluids long-term if indicated**
☐ **No feeding tube**
☐ **Feeding tube for a defined trial period**
☐ **Feeding tube long-term**

*Other Instructions:*_____

Section E *Must be Completed*

Discussed with:
☐ Patient/Resident
☐ Health care agent
☐ Court-appointed guardian
☐ Health care surrogate
☐ Parent of minor
☐ Other: _____(Specify)

The Basis for These Orders is: (Must be completed)
☐ Patient's preferences
☐ Patient's best interest (patient lacks capacity or preferences unknown)
☐ Medical indications
☐ (Other) _____

Physician Name (Print)	**Physician Signature** (Mandatory)	Date	**Physician Phone Number**

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician /or health care professional. It can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self" if patient)	
Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Directions for Health Care Professionals

Completing POST

Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.

POST must be signed by a physician to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Photocopies/faxes of signed POST forms are legal and valid.

Using POST

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation".

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".

A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.

Reviewing POST

This POST should be reviewed if:

(1) The patient is transferred from one care setting or care level to another, or
(2) There is a substantial change in the patient's health status, or
(3) The patient's treatment preferences change.

Draw line through sections A through E and write "VOID" in large letters if POST is replaced or becomes invalid.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

(2) Advance Care Plan Form

ADVANCE CARE PLAN
(Tennessee)

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: _____ Relation:_____
Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: _____ Relation: _____
Address: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes	☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes	☐ No	**Permanent Confusion:** I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
☐ Yes	☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes	☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ Yes	☐ No	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ Yes	☐ No	**Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
☐ Yes	☐ No	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ Yes	☐ No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Please sign on page 2

Other instructions, such as burial arrangements, hospice care, etc.: _____

_____

_____

_____

_____

(Attach additional pages if necessary)

Organ donation: Upon my death, I wish to make the following anatomical gift (mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

_____

☐ No organ/tissue donation.

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Signature: _____ Date: _____
(Patient)

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

_____
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____

_____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

New Rule

Chapter 1200-08-35
Standards for Outpatient Diagnostic Centers

Chapter 1200-08-35 is amended by adding new rule 1200-08-35-.15 Appendix I to read as follows:

(1) Physician Orders for Scope of Treatment (POST) Form

(This space intentionally left blank)

A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

Physician Orders for Scope of Treatment (POST)

This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.

Patient's Last Name

First Name/Middle Initial

Date of Birth

Section A *Check One Box Only*

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and/or is not breathing.

☐ **Resuscitate (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/ no CPR) (Allow Natural Death)**

When not in cardiopulmonary arrest, follow orders in **B, C,** and **D.**

Section B *Check One Box Only*

MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing.

☐ **Comfort Measures.** Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.**

☐ **Limited Additional Interventions.** Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Full Treatment.** Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. **Transfer to hospital if indicated. Include intensive care.**

*Other Instructions:*_____

Section C *Check One Box Only*

ANTIBIOTICS – Treatment for new medical conditions:

☐ **No Antibiotics**

☐ **Antibiotics** *Other Instructions:*_____

Section D *Check One Box Only in Each Column*

MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Oral fluids & nutrition must be offered if medically feasible.

☐ **No IV fluids** (provide other measures to assure comfort)
☐ **IV fluids for a defined trial period**
☐ **IV fluids long-term if indicated**
☐ **No feeding tube**
☐ **Feeding tube for a defined trial period**
☐ **Feeding tube long-term**

*Other Instructions:*_____

Section E *Must be Completed*

Discussed with:
☐ Patient/Resident
☐ Health care agent
☐ Court-appointed guardian
☐ Health care surrogate
☐ Parent of minor
☐ Other: _____

The Basis for These Orders Is: (Must be completed)
☐ Patient's preferences
☐ Patient's best interest (patient lacks capacity or preferences unknown)
☐ Medical indications
☐ (Other) _____

Physician Name (Print)	**Physician Signature** (Mandatory) Date	**Physician Phone Number**

ture of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician /or health care professional. It can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self" if patient)	
Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Directions for Health Care Professionals

Completing POST

Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.

POST must be signed by a physician to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Photocopies/faxes of signed POST forms are legal and valid.

Using POST

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation".

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".

A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.

Reviewing POST

This POST should be reviewed if:

(1) The patient is transferred from one care setting or care level to another, or
(2) There is a substantial change in the patient's health status, or
(3) The patient's treatment preferences change.

Draw line through sections A through E and write "VOID" in large letters if POST is replaced or becomes invalid.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

(2) Advance Care Plan Form

ADVANCE CARE PLAN
(Tennessee)

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: _____ Relation: _____
Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: _____ Relation: _____
Address: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes	☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes	☐ No	**Permanent Confusion:** I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
☐ Yes	☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes	☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ Yes	☐ No	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ Yes	☐ No	**Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
☐ Yes	☐ No	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ Yes	☐ No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Please sign on page 2

Other instructions, such as burial arrangements, hospice care, etc.: _____

_____

_____

_____

_____

(Attach additional pages if necessary)

Organ donation: Upon my death, I wish to make the following anatomical gift (mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

_____

☐ No organ/tissue donation.

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Signature: _____ Date: _____
(Patient)

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

_____
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____

_____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

I certify that the information included in this filing is an accurate and complete representation of the intent and scope of rulemaking proposed by the agency.

Date: March 9, 2012

Signature: DEL

Name of Officer: Diona E. Layden

Title of Officer: Assistant General Counsel, Department of Health

Subscribed and sworn to before me on: 3/9/12

Notary Public Signature: Theodora P. Wilkins

My commission expires on: 11/3/15

THEODORA P. WILKINS NOTARY PUBLIC STATE OF TENNESSEE DAVIDSON COUNTY

Department of State Use Only

Filed with the Department of State on: 03/09/2012

Tre Hargett

Secretary of State

RECEIVED
2012 MAR -9 PM 3:07
SECRETARY OF STATE
PUBLICATIONS