Section I
Notices of Development of Proposed Rules and Negotiated Rulemaking

DEPARTMENT OF BANKING AND FINANCE

Division of Securities and Finance

RULE TITLE: RULE NO.:
Definitions 3E-200.001

PURPOSE AND EFFECT: The rule is being amended to change the reference date to a federal statute to July 1, 2003.

SUBJECT AREA TO BE ADDRESSED: Reference date.

SPECIFIC AUTHORITY: 517.03(1) FS.

LAW IMPLEMENTED: 517.07, 517.12, 517.021, 517.051, 517.061, 517.081, 517.161 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

The procedure for requesting a hearing is governed by subsection 28-103.004(2), F.A.C., as follows: a request for a public hearing must be in writing and filed with the Agency Clerk during normal business hours, at the address below, within 21 days of publication of this notice. The request must specify how the requestor would be affected by the proposed rule. Any affected person who fails to timely file a request for hearing waives the right to request a hearing on the proposed rule.

Although Rule Development Workshops may be recorded, affected persons are advised that it may be necessary for them to ensure that a verbatim record of the proceeding is made, including the testimony and evidence upon which any appeal is to be based.

Persons with disabilities or handicaps who need assistance may contact: Mary Howell, Agency Clerk, (850)410-9896, at least two business days in advance to make appropriate arrangements.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Bill Reilly, Financial Administrator, Division of Securities, 200 East Gaines Street, Fletcher #604, Tallahassee, Florida 32399-0350, (850)410-9805

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

3E-200.001 Definitions.

As used in the Rules and Regulations of the Division of Securities and Investor Protection, pursuant to Chapter 517, F.S., unless the context otherwise specifically requires:

(1) through (6) No change.

(7)(a) "Associated person" as defined in Section 517.021(2), F.S., shall include any person who for compensation refers, solicits, offers, or negotiates for the purchase or sale of securities and/or of investment advisory services. A person whose activities fall within this definition is required to register with the Department as an associated person pursuant to Sections 517.12(1) or (4), F.S.

(b) Notwithstanding the provisions of paragraph (a), an associated person registered with the Department and operating in compliance with subsection 3E-600.003(2), F.A.C., shall not be deemed an associated person of any investment adviser other than the investment adviser or dually registered dealer/investment adviser with which such associated person is registered.

(c) Any person acting in compliance with SEC Rule 206(4)-3 (17 CFR 275.206(4)-(3), as it existed on July 1, 2003 ~~March 1, 1999~~, shall not be deemed an associated person of an investment adviser.

(8) through (33) No change.

Specific Authority 517.03(1) FS. Law Implemented 517.07, 517.12, 517.021(11), 517.051, 517.061, 517.081 FS. History–New 12-5-79, Amended 9-20-82, Formerly 3E-200.01, Amended 12-8-87, 10-14-90, 7-31-91, 6-16-92, 1-11-93, 5-5-94, 10-20-97, 8-9-98, 8-19-99, _____.

DEPARTMENT OF BANKING AND FINANCE

Division of Securities and Finance

RULE TITLE: RULE NO.:
Financial Statements and Reports 3E-300.002

PURPOSE AND EFFECT: The rule is being amended to change the reference date of a federal statute to July 1, 2003.

SUBJECT AREA TO BE ADDRESSED: Reference date.

SPECIFIC AUTHORITY: 517.03 FS.

LAW IMPLEMENTED: 517.081, 517.12 FS.

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THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

3E-300.002 Financial Statements and Reports.

(1) through (3)(c) No change.

(d) The Department shall deem those financial statements and reports, prepared and filed in accordance with the provisions of SEC Rule 17a-5 (17 CFR 240.17a-5) and SEC Rule 17a-10 (17 CFR 240.17a-10) (as such provisions existed on July 1, 2003 ~~March 1, 1999~~), to be in compliance with, and fulfill the requirements of, this Rule as applicable to a dealer.

(e) No change.

(4) through (7) No change.

Specific Authority 517.03 FS. Law Implemented 517.081, 517.12 FS. History–New 12-5-79, Amended 9-20-82, Formerly 3E-300.02, Amended 6-28-93, 11-22-93, 12-24-95, 9-19-00, _____.

DEPARTMENT OF BANKING AND FINANCE

Division of Securities and Finance

RULE TITLE: RULE NO.:
Examinations/Qualifications 3E-600.005

PURPOSE AND EFFECT: Change the reference to Certified Financial Planner and the initials CFP to denote their special status as trademarks.

SUBJECT AREA TO BE ADDRESSED: Examination requirements for investment advisers and investment adviser representatives.

SPECIFIC AUTHORITY: 517.03(1) FS.

LAW IMPLEMENTED: 517.12(8) FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

The procedure for requesting a hearing is governed by subsection 28-103.004(2), F.A.C., as follows: a request for a public hearing must be in writing and filed with the Agency Clerk during normal business hours, at the address below, within 21 days of publication of this notice. The request must specify how the requestor would be affected by the proposed rule. Any affected person who fails to timely file a request for hearing waives the right to request a hearing on the proposed rule.

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THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

3E-600.005 Examinations/Qualifications.

(1) through (4) No change.

(5) The examination requirement for investment adviser principals, investment adviser representatives, and associated persons of issuer dealers shall not apply to an individual who currently holds one of the following professional designations: 1. CERTIFIED FINANCIAL PLANNER™ or CFP® ~~Certified Financial Planner (CFP)~~ awarded by the Certified Financial Planner Board of Standards, Inc.; 2. Chartered Financial Consultant (ChFC) awarded by the American College, Bryn Mawr, PA; 3. Personal Financial Specialist (PFS) awarded by the American Institute of Certified Public Accountants; 4. Chartered Financial Analyst (CFA) awarded by the Institute of Chartered Financial Analysts; 5. Chartered Investment Counselor (CIC) awarded by the Investment Counsel Association of America, Inc.

Specific Authority 517.03(1) FS. Law Implemented 517.12(8) FS. History–New 12-5-79, Amended 9-20-82, Formerly 3E-600.05, Amended 8-1-91, 1-11-93, 4-18-96, 4-2-00, _____.

DEPARTMENT OF BANKING AND FINANCE

Division of Securities and Finance

RULE TITLE: RULE NO.:
Rules of Conduct 3E-600.012

PURPOSE AND EFFECT: The rule is being amended to change the reference dates of federal statutes and self regulatory association rules to July 1, 2003.

SUBJECT AREA TO BE ADDRESSED: Reference date.

SPECIFIC AUTHORITY: 517.03(1) FS.

LAW IMPLEMENTED: 517.121, 517.301(1) FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

The procedure for requesting a hearing is governed by subsection 28-103.004(2), F.A.C., as follows: a request for a public hearing must be in writing and filed with the Agency Clerk during normal business hours, at the address below, within 21 days of publication of this notice. The request must specify how the requestor would be affected by the proposed rule. Any affected person who fails to timely file a request for hearing waives the right to request a hearing on the proposed rule.

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THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

3E-600.012 Rules of Conduct.

(1) Confirmation of Transactions: Every dealer registered in this state, including those defined as issuer/dealers under Rule 3E-200.001, F.A.C., shall give or send to the customer a written confirmation at or before completion of each transaction. Such confirmation shall set forth at least the following:

(a) through (c) No change.

(d) Compliance with Rule 10b-10 (17 CFR 240.10b-10) and the confirmation, preparation and disclosure requirements of SEC Rule 17a-3 (17 CFR 240.17a-3) or MSRB Rules G-8 and G-15, as those rules existed on July 1, 2003 ~~March 1, 1999,~~ shall be deemed compliance with this Rule.

(2) through (4) No change.

(5) It shall be unlawful and a violation of Section 517.301(1), F.S., for any dealer or associated person to engage in any "device, scheme, or artifice to defraud" which shall include selling or effecting the purchase of any security into, in, or from offices in this state in violation of Sections 9, 10, 11A, or 15(c) of the Securities Exchange Act of 1934 or of S.E.C. Rules 9b-1, 10b-1 et seq., 11Aa3-1, 15c1-1 et seq., or 15c2-1 et seq. (17 CFR 240.9b-1; 17 CFR 240.10b-1 et seq.; 17 CFR 240.11Aa3-1; 17 CFR 240.15c1-1 et seq.; or 17 CFR 240.15c2-1 et seq., respectively), as such provisions existed on July 1, 2003 ~~March 1, 1999~~; or Section 15(g) of the Securities Exchange Act of 1934 or of SEC Rules 15g-1, et seq. (17 CFR 240.15g-1 et seq.) as such provisions existed on July 1, 2003 ~~August 11, 1993~~; or Regulation M (17 CFR 242.100-.105) as such provisions existed on July 1, 2003 ~~March 4, 1997~~.

Specific Authority 517.03(1) FS. Law Implemented 517.121, 517.301(1) FS. History–New 12-5-79, Amended 9-20-82, Formerly 3E-600.12, Amended 12-25-89, 10-14-90, 8-1-91, 6-16-92, 1-11-93, 4-11-94, 1-3-99, _____.

DEPARTMENT OF BANKING AND FINANCE

Division of Securities and Finance

RULE TITLE: RULE NO.:

Prohibited Business Practices for Dealers and Their Associated Persons 3E-600.013

PURPOSE AND EFFECT: The reference date for federal and self-regulatory organization rules is being changed to July 1, 2003.

SUBJECT AREA TO BE ADDRESSED: Reference dates.

SPECIFIC AUTHORITY: 517.03(1) FS.

LAW IMPLEMENTED: 517.161(1), 517.081 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

The procedure for requesting a hearing is governed by subsection 28-103.004(2), F.A.C., as follows: a request for a public hearing must be in writing and filed with the Agency Clerk during normal business hours, at the address below, within 21 days of publication of this notice. The request must specify how the requestor would be affected by the proposed rule. Any affected person who fails to timely file a request for hearing waives the right to request a hearing on the proposed rule.

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THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

3E-600.013 Prohibited Business Practices for Dealers and Their Associated Persons.

(1) The following are deemed demonstrations of unworthiness by a dealer under Section 517.161(1)(h), F.S., without limiting that term to the practices specified herein:

(a) through (e) No change.

(f) Extending, arranging for, or participating in arranging for credit to a customer in violation of the provisions of Regulation T (12 CFR 220.1-220.131, inclusive) promulgated by the Federal Reserve Board, as such provisions existed on July 1, 2003 ~~March 1, 1999~~;

(g) through (h) No change.

(i) Hypothecating a customer's securities in violation of SEC Rule 8c-1 (17 CFR 240.8c-1), as such rule existed on July 1, 2003 ~~March 1, 1999~~;

(j) through (o) No change.

(p) With respect to any customer, transaction or business in this state, violating:

1. Any by-law, schedule thereto, rule or appendix thereto, of the National Association of Securities Dealers ("NASD"), interpreted in accordance with the guidelines, policies, and interpretations of the NASD or SEC, including: the Conduct Rules; the Marketplace Rules; and the Uniform Practice Code, as published in the NASD Manual as of July 1998 and any amendments as existed on July 1, 2003 ~~March 1, 1999~~;

2. For members of the New York Stock Exchange, Rules 405, 412 or 435 of the New York Stock Exchange, as such rules existed on July 1, 2003 ~~March 1, 1999~~, interpreted in accordance with the guidelines, policies, and interpretations of the NYSE or SEC;

3. Sections 2, 4, 5, or 6 of the Securities Act of 1933 or SEC Rules 134 (17 CFR 230.134); 134a (17 CFR 230.134a); 135a (17 CFR 230.135a); 144 (17 CFR 230.144); 144A (17 CFR 230.144A); 156 (17 CFR 230.156); 419 (17 CFR 230.419); 481 (17 CFR 230.481); or 482 (17 CFR 230.482) promulgated pursuant thereto, as such provisions existed on July 1, 2003 ~~March 1, 1999~~, interpreted in accordance with the guidelines, policies, and interpretations of the NASD or SEC;

4. Section 15(b)(4)(E) of the Securities Exchange Act of 1934 as it existed on July 1,2003 ~~March 1, 1999~~; or

5. Any rule of the Municipal Securities Rulemaking Board ("MSRB") including the Definitional Rules (Rules D-1 through D-11, inclusive), and the General Rules with the exception of Rule G-35 (Rules G-1 through G-34, inclusive), promulgated pursuant to Section 15B of the Securities Exchange Act of 1934, as such rules existed on July 1, 2003 ~~March 1, 1999~~, interpreted in accordance with the guidelines, policies, and interpretations of the MSRB, NASD, or SEC.

6. To the extent that any of the rules described in subparagraphs 1. through 5. of this section or their interpretation by the NASD, NYSE, MSRB, or SEC, as appropriate, conflict or are inconsistent with other provisions of the Florida Securities and Investor Protection Act or rules promulgated pursuant thereto, this paragraph of this rule shall not be deemed controlling.

(q) through (t) No change.

(u) Selling or offering for sale any security in a transaction exempt from registration pursuant to Section 517.061(17)(a)1., F.S., where the issuer of such securities has not filed with the SEC within the specified period of time all reports required by Sections 13 or 15(d) of the Securities Exchange Act of 1934, as such sections existed on July 1, 2003 ~~March 1, 1999~~.

(v) No change.

(2) The following are deemed demonstrations of unworthiness by an associated person of a dealer under Section 517.161(1)(h), F.S., without limiting that term to the practices specified herein:

(a) through (g) No change.

(h) Engaging in any of the practices specified in paragraphs (1)(b), (c), (d), (e), (f), (g), (m), (n), (o), (p), (q), (s), (t), (u), or (v).

Specific Authority 517.03(1) FS. Law Implemented 517.161(1), 517.081 FS. History–New 12-5-79, Amended 9-20-82, Formerly 3E-600.13, Amended 8-1-91, 6-16-92, 1-11-93, 11-7-93, 5-5-94, 9-9-96, 10-20-97, 1-25-00, _____.

DEPARTMENT OF BANKING AND FINANCE

Division of Securities and Finance

RULE TITLE: RULE NO.:

Prohibited Business Practices for Investment Advisers and Their Associated Persons 3E-600.0131

PURPOSE AND EFFECT: The reference date for federal rules is being changed to July 1, 2003.

SUBJECT AREA TO BE ADDRESSED: Reference dates.

SPECIFIC AUTHORITY: 517.03(1) FS.

LAW IMPLEMENTED: 517.161(1), 517.081 FS.

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The procedure for requesting a hearing is governed by subsection 28-103.004(2), F.A.C., as follows: a request for a public hearing must be in writing and filed with the Agency Clerk during normal business hours, at the address below, within 21 days of publication of this notice. The request must specify how the requestor would be affected by the proposed rule. Any affected person who fails to timely file a request for hearing waives the right to request a hearing on the proposed rule.

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THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

3E-600.0131 Prohibited Business Practices for Investment Advisers and Their Associated Persons.

(1) The following are deemed demonstrations of unworthiness by an investment adviser or an associated person of an investment adviser under Section 517.161(1)(h), F.S., without limiting that term to the practices specified herein:

(a) With respect to any customer, transaction or business in, to or from this state, engaging in any conduct prohibited by, or failing to comply with the requirements of, the following:

1. Sections 204, 204A, 205, 206, 207, 208 of the Investment Advisers Act of 1940 or SEC Rules 204-3 (17 CFR 275.204-3); 205-1 (17 CFR 275.205-1); 205-2 (17 CFR 275.205-2); 205-3 (17 CFR 275.205-3), 206(3)-1 (17 CFR 275.206(3)-1); 206(3)-2 (17 CFR 275.206(3)-2); 206(4)-1 (17 CFR 275.206(4)-1); 206(4)-2 (17 CFR 275.206(4)-2); 206(4)-3 (17 CFR 275.206(4)-3); and 206(4)-4 (17 CFR 275.206(4)-4) promulgated pursuant thereto, as such provisions existed on July 1, 2003 ~~March 1, 1999~~, interpreted with the guidelines, policies, no-action letters, and interpretations of the SEC;

(b) through (r) No change.

(2) The federal statutory and regulatory provisions referenced herein shall apply to investment advisers and federal covered advisers, to the extent permitted by the National Securities Markets Improvement Act of 1996.

Specific Authority 517.03(1) FS. Law Implemented 517.12, 517.161(1) FS. History–New 1-25-00, Amended _____.

DEPARTMENT OF BANKING AND FINANCE

Division of Securities and Finance

RULE TITLE: RULE NO.:
Books and Records Requirements 3E-600.014

PURPOSE AND EFFECT: The rule is being amended to update the reference date for federal and regulatory agency rules to July 1, 2003.

SUBJECT AREA TO BE ADDRESSED: Dealer, investment adviser, branch office, and associated person books and records requirements.

SPECIFIC AUTHORITY: 517.03(1) FS.

LAW IMPLEMENTED: 517.12, 517.161(1) FS.

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THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

3E-600.014 Books and Records Requirements.

Except as otherwise provided herein, every dealer, investment adviser, branch office, and associated person conducting business in this state shall prepare and maintain on a current basis, and preserve for the periods of time specified, such records, prescribed hereinafter, as are appropriate for said dealer's, investment adviser's, branch office's, or associated person's course of business, and are sufficient to provide an audit trail of all business transactions by said dealer, investment adviser, associated person, or branch office. Associated persons who conduct business from a registered branch office in this state shall be exempt from the provisions of this rule.

(1) All dealers are required to prepare and maintain appropriate books and records relating to their business as described in either SEC Rules 17a-3 (17 CFR 240.17a-3) and

17a-4 (17 CFR 240.17a-4) or MSRB Rules G-7 and G-8, as such rules existed on May 2, 2003 ~~March 1, 1999~~; and records evidencing compliance with NASD Conduct Rule 3000, as published in the NASD Manual as of July 2002 ~~1998~~, and any amendments as existed on May 2, 2003.

(2) All issuer/dealers are required to maintain at least the following records:

(a) Ledgers, journals (or other records) reflecting all assets, liabilities, income and expenses, and capital accounts properly maintained in accordance with generally accepted accounting principles;

(b) Copies of all promotional sales materials and correspondence used in connection with the sales of all securities as distributed;

(c) A record of all sales of securities made by, or on behalf of, said issuer, including but not necessarily limited to name and address of purchaser, date of transaction, money amount involved, and name of agent or principal executing such transaction;

(d) Securities certificate and securities holder records reflecting names and addresses of all holders of record, certificates issued to such holders, number of shares or bonds issued, and full details as to transfers or cancellations;

(e) In lieu of the issuer/dealer preparing and maintaining such records as detailed in paragraph (d) above, a qualified transfer agent/registrar may be appointed, provided such information is accessible to the issuer/dealer.

(3) All investment advisers, notwithstanding the fact that the investment adviser is not registered or required to be registered under the Investment Advisers Act of 1940, shall prepare and maintain true, accurate and current records relating to their business as described in SEC Rule 204-2 (17 CFR 275.204-2) as it existed on July 1, 2003 ~~March 1, 1999~~, and general rules and regulations promulgated by the Securities and Exchange Commission; and have available for the Department at least the following records:

(a) All trial balances, financial statements prepared in accordance with generally accepted accounting principles, and internal audit working papers relating to the investment adviser's business as an investment adviser. For purposes of this paragraph, "financial statements" means balance sheets, income statements, cash flow statements and net worth computations as required by Rule 3E-300.002, F.A.C.

(b) A list or other record of all accounts with respect to the funds, securities, or transactions of any client.

(c) A copy in writing of each agreement entered into by the investment adviser with any client.

(d) A file containing a copy of each record required by SEC Rule 204-2(11) (17 CFR 275.204-2(11)) as it existed on July 1, 2003 ~~March 1, 1999~~ including any communication by electronic media that the investment adviser circulates or distributes, directly or indirectly, to two or more persons, other than persons connected with the investment adviser.

(e) A copy of each written statement and each amendment or revision given or sent to any client or prospective client of the investment adviser in accordance with the provisions of SEC Rule 204-3 (17 CFR 275.204-3) as it existed July 1, 2003 ~~March 1, 1999~~ and a record of the dates that each written statement, and each amendment or revision was given or offered to be given to any client or prospective client who subsequently becomes a client.

(f) For each client that was obtained by the adviser by means of a solicitor to whom a cash fee was paid by the adviser, records required by SEC Rule 206(4)-3 (17 CFR 275206(4)-3) as it existed on July 1, 2003 ~~March 1, 1999~~.

(g) All records required by SEC Rule 204-2(16) (17 CFR 275.204-2(16)) as it existed on July 1, 2003 ~~March 1, 1999~~, including but not limited to electronic media that the investment adviser circulates or distributes, directly or indirectly, to two or more persons, other than persons connected with the investment adviser.

(h) A file containing a copy of all communications received or sent regarding any litigation involving the investment adviser or any investment adviser representative or employee, and regarding any customer or client complaint.

(i) Written information about each investment advisory client that is the basis for making any recommendation or providing any investment advice to such client.

(j) Written procedures to supervise the activities of employees and investment adviser representatives that are reasonably designed to achieve compliance with applicable securities laws and regulations.

(k) A file containing a copy of each document, other than any notices of general dissemination, that was filed with or received from any state or federal agency or self regulatory organization and that pertains to the registrant or its investment adviser representatives. Such file should contain, but is not limited to, all applications, amendments, renewal filings, and correspondence.

(4) No provisions of this Rule, unless specifically designated as a required form, shall be deemed to require the preparation, maintenance, or preservation of a dealer's or investment adviser's books and records in a particular form or system, provided that whatever form or system utilized by such dealer's or investment adviser's course of business is sufficient to provide an audit trail of all business transactions.

(5) Every investment adviser that has its principal place of business in a state other than this state shall be exempt from the requirements of this rule, provided the investment adviser is licensed in such state and is in compliance with that state's record keeping requirements.

(6) All books and records described in this Rule shall be preserved in accordance with the following:

(a) Those records required under subsection (1) of this Rule shall be preserved for such periods of time as specified in either SEC Rule 17a-4 (17 CFR 240.17a-4), or MSRB Rule G-9, as such rules existed on July 1, 2003 ~~March 1, 1999~~.

(b) Those records required under subsection (2) of this rule shall be preserved for a period of not less than five (5) years while effectively registered with the Department, nor for less than five (5) years after withdrawal or expiration of registration in this State.

(c) Books and records required to be prepared under the provisions of subsection (3) shall be maintained and preserved in an easily accessible place for a period of not less than five years from the end of the fiscal year during which the last entry was made on such record, the first two years in the principal office of the investment adviser.

(d) Books and records required to be made under the provisions of subsection (3), shall be maintained and preserved for a period of not less than five years from the end of the fiscal year during which the last entry was made on such record or for the time period during which the investment adviser was registered or required to be registered in the state, if registered less than five years.

(e) Each investment adviser registered or required to be registered in this state and which has a business location in this state shall maintain at such business location:

1. The records or copies required under the provisions of paragraphs (a)(3), (a)(7)-(10), (a)(14)-(15), (b) and (c) of SEC Rule 204-2 (17 CFR 275.204-2); and

2. The records or copies required under the provisions of paragraphs (3)(a)-(j) above related to customers or clients for whom the investment adviser representative provides or has provided investment advisory services; and

3. The records or copies required under the provisions of paragraphs (a)(11) and (a)(16) of SEC Rule 204-2 (17 CFR 275.204-2) which records or related records identify the name of the investment adviser representative or which identify the business locations' physical address, mailing address, electronic mailing address, or telephone number. The records will be maintained for the period described in subsections (d) and (e) of SEC Rule 204-2 (17 CFR 275.204-2). The investment adviser shall be responsible for ensuring compliance with the provisions of this subsection.

(7) To the extent that the U.S. Securities and Exchange Commission promulgates changes to the above-referenced rules of the Investment Advisers Act of 1940, investment advisers in compliance with such rules as amended shall not be subject to enforcement action by the Department for violation of this rule to the extent that the violation results solely from the investment adviser's compliance with the amended rule.

Specific Authority 517.03(1), 517.121(1) FS. Law Implemented 517.121(1) FS. History–New 12-5-79, Amended 9-20-82, Formerly 3E-600.14, Amended 10-14-90, 8-1-91, 6-16-92, 1-11-93, 9-9-96, 6-22-98, 1-25-00, _____.

DEPARTMENT OF BANKING AND FINANCE

Division of Securities and Finance

RULE TITLE: RULE NO.:

Financial Reporting Requirements – Statement of Financial Condition – Dealers and Investment Advisers 3E-600.015

PURPOSE AND EFFECT: The reference date for federal rules is being changed to July 1, 2003.

SUBJECT AREA TO BE ADDRESSED: Reference date.

SPECIFIC AUTHORITY: 517.03(1), 517.12(9), 517.121(2) FS.

LAW IMPLEMENTED: 517.12(9), 517.121(2) FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

The procedure for requesting a hearing is governed by subsection 28-103.004(2), F.A.C., as follows: a request for a public hearing must be in writing and filed with the Agency Clerk during normal business hours, at the address below, within 21 days of publication of this notice. The request must specify how the requestor would be affected by the proposed rule. Any affected person who fails to timely file a request for hearing waives the right to request a hearing on the proposed rule.

Although Rule Development Workshops may be recorded, affected persons are advised that it may be necessary for them to ensure that a verbatim record of the proceeding is made, including the testimony and evidence upon which any appeal is to be based.

Persons with disabilities or handicaps who need assistance may contact: Mary Howell, Agency Clerk, (850)410-9896, at least two business days in advance to make appropriate arrangements.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Bill Reilly, Financial Administrator, Division of Securities, 200 East Gaines Street, Fletcher #604, Tallahassee, Florida 32399-0350, (850)410-9805

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

3E-600.015 Financial Reporting Requirements – Statement of Financial Condition – Dealers and Investment Advisers.

(1) Except as otherwise specifically noted in this rule, an applicant filing an application for registration as a dealer or investment adviser shall file a balance sheet in accordance with Rule 3E-300.002, F.A.C.

(2) Every dealer registered pursuant to Section 517.12, F.S., and Rules thereunder shall file annually with the Department, within ninety (90) days after the conclusion of said registrant's fiscal year, audited financial statements as prepared by an independent outside auditor, unless exempted under Rule 3E-300.002, F.A.C.

(a) The Department may allow up to a thirty (30) day extension of the filing requirement as set forth in this subparagraph provided written request is made prior to the date such audited report is due to be filed, and provided further that good cause for such delay is shown.

(b) Every dealer defined as a broker/dealer under Rule 3E-300.002, F.A.C., shall be required to include in such audited financial statements filed verification of said broker/dealer's compliance with the provisions of Rules 3E-600.016 and 3E-600.017, F.A.C.

(c) In lieu of the provisions of paragraph (b) above, the Department will accept those statements prepared and filed by a dealer in accordance with the provisions of S.E.C. Rule 17a-5 (17 CFR 240.17a-5) and S.E.C. Rule 17a-10 (17 CFR 240.17a-10), as such rules existed on July 1, 2003 ~~February 28, 1992~~.

(3) Every investment adviser registered pursuant to Section 517.12, F.S., and Rules thereunder shall file annually with the Department, within ninety (90) days after the conclusion of said registrant's fiscal year, financial statements as of fiscal year end, such statements prepared in accordance with the provisions of Rule 3E-300.002, F.A.C.

(4) The provisions of paragraph (2)(a) of this Rule apply to the filing requirements set forth in subsection (3).

Specific Authority 517.03(1), 517.12(9), 517.121(2) FS. Law Implemented 517.12(9), 517.121(2) FS. History–New 12-5-79, Amended 9-20-82, Formerly 3E-600.15, Amended 6-16-92, _____.

DEPARTMENT OF BANKING AND FINANCE

Division of Securities and Finance

RULE TITLE: RULE NO.:
Continuing Education Requirements 3E-600.020

PURPOSE AND EFFECT: The reference date for self-regulatory organizations is being changed to July 1, 2003.

SUBJECT AREA TO BE ADDRESSED: Reference dates.

SPECIFIC AUTHORITY: 517.03(1) FS.

LAW IMPLEMENTED: 517.12, 517.161(1) FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

The procedure for requesting a hearing is governed by subsection 28-103.004(2), F.A.C., as follows: a request for a public hearing must be in writing and filed with the Agency Clerk during normal business hours, at the address below, within 21 days of publication of this notice. The request must specify how the requestor would be affected by the proposed rule. Any affected person who fails to timely file a request for hearing waives the right to request a hearing on the proposed rule.

Although Rule Development Workshops may be recorded, affected persons are advised that it may be necessary for them to ensure that a verbatim record of the proceeding is made, including the testimony and evidence upon which any appeal is to be based.

Persons with disabilities or handicaps who need assistance may contact: Mary Howell, Agency Clerk, (850)410-9896, at least two business days in advance to make appropriate arrangements.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Bill Reilly, Financial Administrator, Division of Securities, 200 East Gaines Street, Fletcher #604, Tallahassee, Florida 32399-0350, (850)410-9805

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

3E-600.020 Continuing Education Requirements.

Failure to comply with any of the applicable continuing education requirements set forth in any one of the following shall be deemed a demonstration of unworthiness by a dealer or associated person under Section 517.161(1)(h), F.S.:

(1) Membership and Registration Rule 1120 of the National Association of Securities Dealers, as such provisions existed on July 1, 2003 ~~March 1, 1999~~;

(2) Rule 345 A of the New York Stock Exchange, as such provisions existed on July 1, 2003 ~~March 1, 1999~~;

(3) Rule G-3(h) of the Municipal Securities Rulemaking Board, as such provisions existed on July 1, 2003 ~~March 1, 1999~~;

(4) Rule 341 A of the American Stock Exchange, as such provisions existed on July 1, 2003 ~~March 1, 1999~~;

(5) Rule 9.3A of the Chicago Board of Options Exchange, as such provisions existed on July 1, 2003 ~~March 1, 1999~~;

(6) Article VI, Rule 9 of the Chicago Stock Exchange, as such provisions existed on July 1, 2003 ~~March 1, 1999~~;

(7) Rule 9.27(c) of the Pacific Stock Exchange, as such provisions existed on July 1, 2003 ~~March 1, 1999~~; or

(8) Rule 640 of the Philadelphia Stock Exchange, as such provisions existed on July 1, 2003 ~~March 1, 1999~~.

Specific Authority 517.03(1) FS. Law Implemented 517.12(18), 517.161(1) FS. History–New 12-21-95, Amended 8-19-99, _____.

DEPARTMENT OF INSURANCE

RULE TITLES: RULE NOS.:
Universal Life Valuation and Nonforfeiture 4-164.010
Valuation of Life Insurance Policies 4-164.020

PURPOSE, EFFECT AND SUBJECT AREA TO BE ADDRESSED: Section 625.121(5)(j), F.S., gave the Financial Services Commission authority to adopt a rule to adopt the valuation of life insurance policies model regulation including tables of select mortality factors, and allowed the regulation to be made effective as of January 1, 2000. The rule adopts NAIC guidelines as is provided in Section 625.121(5)(j), F.S. The purpose of the retroactive date is based upon the fact that other states had adopted the NAIC model with an effective date of January 1, 2000. The objective is to have uniformity with the other states; i.e., uniform adoption dates. The effect will not be retroactive in the sense reserves reported prior to adoption are not affected. The rule does not abrogate any contracts.

SPECIFIC AUTHORITY: 624.308(1), 625.121(5)(j),(12)(b), 627.476(10)(c) FS.

LAW IMPLEMENTED: 624.307(1), 625.121(5)(j), 627.476 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW:

TIME AND DATE: 9:00 a.m., August 6, 2003

PLACE: Room 143, Larson Building, 200 East Gaines Street, Tallahassee, Florida.

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this program, please advise the Department at least 5 calendar days before the program by contacting the person listed above.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Kerry Krantz, Bureau of Life and Health Insurer Solvency, Office of Insurance Regulation, 200 East Gaines Street, Tallahassee, Florida 32399-0327, (850)413-5038

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

4-164.010 Universal Life Valuation and Nonforfeiture.

(1) through (2) No change.

(3) Valuation.

(a) Requirements. The minimum valuation standard for universal life insurance policies shall be the Commissioners' Reserve Valuation Method, as described below, for such policies, and the tables and interest rates specified below.

1. No change.

2. Interest and mortality rates. ~~a.~~ All present values shall be determined using:

a.~~i.~~ A~~a~~n interest rate (or rates) specified in subsections 625.121(5) and 625.121(6), Florida Statutes, for policies issued in the same year;

b.~~ii.~~ T~~t~~he mortality rates specified in subsection 625.121(5), Florida Statutes, for policies issued in the same year; and

c.~~iii.~~ A~~a~~ny other tables needed to value supplementary benefits provided by a rider which is being valued together with the policy.

~~b. In no event, however, shall the present values be less than those determined using the guarantees of interest and mortality contained in the policy.~~

(b) No change.

(4) No change.

Specific Authority 624.308(1), 625.121(12)(b), 627.476(10)(c) FS. Law Implemented 624.307(1), 625.121, 627.476 FS. History–New 6-30-94, Amended 3-9-95, _____.

4-164.020 Valuation of Life Insurance Policies.

(1) Purpose.

(a) The purpose of this rule is to provide:

1. Tables of select mortality factors and rules for their use;

2. Rules concerning a minimum standard for the valuation of plans with nonlevel premiums or benefits; and

3. Rules concerning a minimum standard for the valuation of plans with secondary guarantees.

(b) The method for calculating basic reserves defined in this rule will constitute the Commissioners' Reserve Valuation Method for policies to which this rule is applicable.

(2)(a) This rule is consistent with Appendix A-830 of the NAIC Accounting Practices and Procedures Manual as adopted in Rule 4-137.001, F.A.C.

(b) This rule applies to policies issued during calendar year 2000 in addition to those issued on or after January 1, 2001.

(3) Applicability. This rule shall apply to all life insurance policies, with or without nonforfeiture values, issued on or after January 1, 2000, subject to the following exceptions and conditions:

(a) Exceptions.

1. This rule shall not apply to any individual life insurance policy issued on or after the effective date of this rule if the policy is issued in accordance with and as a result of the exercise of a reentry provision contained in the original life insurance policy of the same or greater face amount, issued before January 1, 2000, that guarantees the premium rates of the new policy. This rule also shall not apply to subsequent policies issued as a result of the exercise of such a provision, or a derivation of the provision, in the new policy.

2. This rule shall not apply to any universal life policy that meets all the following requirements:

a. Secondary guarantee period, if any, is 5 years or less;

b. Specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the CSO valuation tables as defined in paragraph (4)(f) and the applicable valuation interest rate; and

c. The initial surrender charge is not less than 100 percent of the first year annualized specified premium for the secondary guarantee period.

3. This rule shall not apply to any variable life insurance policy that provides for life insurance the amount or duration of which varies according to the investment experience of any separate account or accounts.

4. This rule shall not apply to any variable universal life insurance policy that provides for life insurance the amount or duration of which varies according to the investment experience of any separate account or accounts.

5. This rule shall not apply to a group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.

(b) Conditions.

1. Calculation of the minimum valuation standard for policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits (other than universal life policies), or both, shall be in accordance with the provisions of subsection (6).

2. Calculation of the minimum valuation standard for flexible premium and fixed premium universal life insurance policies that contain provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period shall be in accordance with the provisions of subsection (7).

(4) Definitions. For purposes of this rule:

(a) "Basic reserves" means reserves calculated in accordance with Section 625.121(7), Florida Statutes.

(b)1. "Contract segmentation method" means the method of dividing the period from issue to mandatory expiration of a policy into successive segments, with the length of each segment being defined as the period from the end of the prior segment (from policy inception for the first segment) to the end of the latest policy year as determined below. All calculations are made using the 1980 CSO valuation tables, as defined in paragraph (f), and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in paragraph (5)(b) of this rule.

2. The length of a particular contract segment shall be set equal to the minimum of the value t for which G_t is greater than R_t (if G_t never exceeds R_t the segment length is deemed to be the number of years from the beginning of the segment to the mandatory expiration date of the policy), where G_t and R_t are defined as follows:

$$G_t = \frac{GP_{x+k+t}}{GP_{x+k+t-1}}$$

where:

x = original issue age;

k = the number of years from the date of issue to the beginning of the segment;

t = 1, 2, ...; t is reset to 1 at the beginning of each segment;

GPx+k+t-1 = Guaranteed gross premium per thousand of face amount for year t of the segment, ignoring policy fees only if level for the premium paying period of the policy.

$$R_t = \frac{q_{x+k+t}}{q_{x+k+t-1}}$$, However, R_t may be increased or decreased by one

$q_{x+k+t-1}$ percent in any policy year, at the company's option,

but R_t shall not be less than one;

where:

x, k and t are as defined above, and

$q_{x+k+t-1}$ = valuation mortality rate for deficiency reserves in policy year k+t but using the mortality of Section 5B(2) if Section 5B(3) is elected for deficiency reserves.

However, if GP_{x+k+t} is greater than 0 and GPx+k+t-1 is equal to 0, G_t shall be deemed to be 1000. If GP_{x+k+t} and $GP_{x+k+t-1}$ are both equal to 0, G_t shall be deemed to be 0.

(c) "Deficiency reserves" means the excess, if greater than zero, of

1. Minimum reserves calculated in accordance with Section 625.121(11), Florida Statutes, over

2. Basic reserves.

(d) "Guaranteed gross premiums" means the premiums under a policy of life insurance that are guaranteed and determined at issue.

(e) "Maximum valuation interest rates" means the interest rates defined in Section 625.121(6), Florida Statutes, (Computation of Minimum Standard by Calendar Year of Issue) that are to be used in determining the minimum standard for the valuation of life insurance policies.

(f) "1980 CSO valuation tables" means the Commissioners' 1980 Standard Ordinary Mortality Table (1980 CSO Table) without ten-year selection factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law, and variations of the 1980 CSO Table approved by the NAIC, such as the smoker and nonsmoker versions approved in December 1983.

(g) "Scheduled gross premium" means the smallest illustrated gross premium at issue for other than universal life insurance policies. For universal life insurance policies,

scheduled gross premium means the smallest specified premium described in subparagraph (7)(a)3., if any, or else the minimum premium described in subparagraph (7)(a)4.

(h)1. "Segmented reserves" means reserves, calculated using segments produced by the contract segmentation method, equal to the present value of all future guaranteed benefits less the present value of all future net premiums to the mandatory expiration of a policy, where the net premiums within each segment are a uniform percentage of the respective guaranteed gross premiums within the segment. The uniform percentage for each segment is such that, at the beginning of the segment, the present value of the net premiums within the segment equals:

a. The present value of the death benefits within the segment, plus

b. The present value of any unusual guaranteed cash value (see paragraph (6)(d)) occurring at the end of the segment, less

c. Any unusual guaranteed cash value occurring at the start of the segment, plus

d. For the first segment only, the excess of the Item (I) over Item (II), as follows:

(I) A net level annual premium equal to the present value at the date of issue of the benefits provided for in the first segment after the first policy year; divided by the present value at the date of issue of an annuity of 1 per year payable on the first and each subsequent anniversary within the first segment on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the 19 year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.

(II) A net 1 year term premium for the benefits provided for in the first policy year.

2. The length of each segment is determined by the "contract segmentation method," as defined in this rule.

3. The interest rates used in the present value calculations for any policy shall not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the sum of the lengths of all segments of the policy.

4. For both basic reserves and deficiency reserves computed by the segmented method, present values shall include future benefits and net premiums in the current segment and in all subsequent segments.

a. The segmentation requirement shall not be limited to plans with no cash surrender values; otherwise companies could avoid segmentation entirely by designing policies with minimal (positive) cash values.

b. Segmentation for plans with cash surrender values shall be based solely upon gross premium levels.

c. Basing segmentation upon the level of cash surrender values introduces complications because of the inter-relationship between minimum cash surrender values and gross premium patterns.

d. The requirements of this rule relating to reserves for plans with unusual cash values and to reserves if cash values exceed calculated reserves serve to link required reserves and cash surrender values.

e. The calculation of segmented reserves shall not be linked to the occurrence of a positive unitary terminal reserve at the end of a segment.

f. The requirement of this rule to hold the greater of the segmented reserve or the unitary reserve eliminates the need for any linkage.

(i) "Tabular cost of insurance" means the net single premium at the beginning of a policy year for 1 year term insurance in the amount of the guaranteed death benefit in that policy year.

(j) "Ten-year select factors" means the select factors adopted with the 1980 amendments to the NAIC Standard Valuation Law.

(k)1. "Unitary reserves" means the present value of all future guaranteed benefits less the present value of all future modified net premiums, where:

a. Guaranteed benefits and modified net premiums are considered to the mandatory expiration of the policy; and

b. Modified net premiums are a uniform percentage of the respective guaranteed gross premiums, where the uniform percentage is such that at issue the present value of the net premiums equals the present value of all death benefits and pure endowments, plus the excess of Item (I) over Item (II), as follows:

(I) A net level annual premium equal to the present value at the date of issue of the benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the 19 year premium whole life plan of insurance of the same renewal year equivalent level amount at an age 1 year higher than the age at issue of the policy.

(II) A net 1 year term premium for the benefits provided for in the first policy year.

2. The interest rates used in the present value calculations for any policy shall not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the length from issue to the mandatory expiration of the policy.

(l) "Universal life insurance policy" means any individual life insurance policy under the provisions of which separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts) and mortality or expense charges are made to the policy.

(5) General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves.

(a) At the election of the company for any one or more specified plans of life insurance, the minimum mortality standard for basic reserves may be calculated using the 1980 CSO valuation tables with select mortality factors. If select mortality factors are elected, they may be:

1. The 10 year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law; or

2. The select mortality factors in the Appendix.

(b) Deficiency reserves, if any, are calculated for each policy as the excess, if greater than zero, of the quantity A over the basic reserve.

1. The quantity A is obtained by recalculating the basic reserve for the policy using guaranteed gross premiums instead of net premiums when the guaranteed gross premiums are less than the corresponding net premiums.

2. At the election of the company for any one or more specified plans of insurance, the quantity A and the corresponding net premiums used in the determination of quantity A may be based upon the 1980 CSO valuation tables with select mortality factors**.** If select mortality factors are elected, they may be:

1. The 10 year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;

2. The select mortality factors in the Appendix of this rule;

3. For durations in the first segment, X percent of the select mortality factors in the Appendix, subject to the following:

a. X may vary by policy year, policy form, underwriting classification, issue age, or any other policy factor expected to affect mortality experience;

b. X shall not be less than 20 percent;

c. X shall not decrease in any successive policy years;

d. X is such that, when using the valuation interest rate used for basic reserves, Item (I) is greater than or equal to Item (II);

(I) The actuarial present value of future death benefits, calculated using the mortality rates resulting from the application of X;

(II) The actuarial present value of future death benefits calculated using anticipated mortality experience without recognition of mortality improvement beyond the valuation date;

e. X is such that the mortality rates resulting from the application of X are at least as great as the anticipated mortality experience, without recognition of mortality improvement beyond the valuation date, in each of the first 5 years after the valuation date;

f. The appointed actuary shall increase X at any valuation date where it is necessary to continue to meet all the requirements of subparagraph **(**b)3.;

g. The appointed actuary may decrease X at any valuation date as long as X does not decrease in any successive policy years and as long as it continues to meet all the requirements of subparagraph (b)3.; and

h. The appointed actuary shall specifically take into account the adverse effect on expected mortality and lapsation of any anticipated or actual increase in gross premiums.

i. If X is less than 100 percent at any duration for any policy, the following requirements shall be met:

(I) The appointed actuary shall annually prepare an actuarial opinion and memorandum for the company in conformance with the requirements of Rule Chapter 4-138, F.A.C.; and

(II) The appointed actuary shall annually opine for all policies subject to this rule as to whether the mortality rates resulting from the application of X meet the requirements of subparagraph (b)3.

(A) The opinion shall be supported by an actuarial report, subject to appropriate Actuarial Standards of Practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries.

(B) The X factors shall reflect anticipated future mortality without recognition of mortality improvement beyond the valuation date, taking into account relevant emerging experience.

(c) This subsection applies to both basic reserves and deficiency reserves. Any set of select mortality factors may be used only for the first segment. However, if the first segment is less than 10 years, the appropriate 10 year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law may be used thereafter through the tenth policy year from the date of issue.

(d) In determining basic reserves or deficiency reserves, guaranteed gross premiums without policy fees may be used where the calculation involves the guaranteed gross premium, but only if the policy fee is a level dollar amount after the first policy year. In determining deficiency reserves, policy fees may be included in guaranteed gross premiums even if not included in the actual calculation of basic reserves.

(e) Reserves for policies that have changes to guaranteed gross premiums, guaranteed benefits, guaranteed charges, or guaranteed credits that are unilaterally made by the insurer after issue and that are effective for more than 1 year after the date of the change shall be the greatest of the following:

1. Reserves calculated ignoring the guarantee;

2. Reserves assuming the guarantee was made at issue; and

3. Reserves assuming that the policy was issued on the date of the guarantee.

(f) The company shall document the extent of the adequacy of reserves for material blocks, including policies issued prior to the effective date of this rule. The documentation shall include:

1. A demonstration of the extent to which aggregation with immaterial blocks of business is relied upon in the formation of the appointed actuary opinion pursuant to and consistent with the requirements of Chapter 4-138, F.A.C.; and

2. A definition of material.

(6) Calculation of Minimum Valuation Standard for Policies with Guaranteed Nonlevel Gross Premiums or Guaranteed Nonlevel Benefits (Other than Universal Life Policies).

(a) Basic Reserves. Basic reserves shall be calculated as the greater of the segmented reserves and the unitary reserves. Both the segmented reserves and the unitary reserves for any policy shall use the same valuation mortality table and selection factors. At the option of the insurer in calculating segmented reserves and net premiums either of the adjustments described in subparagraph 1. or 2. below may be made:

1. Treat the unitary reserve, if greater than zero, applicable at the end of each segment as a pure endowment and subtract the unitary reserve, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

2. Treat the guaranteed cash surrender value, if greater than zero, applicable at the end of each segment as a pure endowment; and subtract the guaranteed cash surrender value, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

(b) Deficiency Reserves.

1. The deficiency reserve at any duration shall be calculated:

a. On a unitary basis if the corresponding basic reserve determined by paragraph (a) is unitary;

b. On a segmented basis if the corresponding basic reserve determined by paragraph (a) is segmented; or

c. On the segmented basis if the corresponding basic reserve determined by paragraph (a) is equal to both the segmented reserve and the unitary reserve.

2. This subsection shall apply to any policy for which the guaranteed gross premium at any duration is less than the corresponding modified net premium calculated by the method used in determining the basic reserves, but using the minimum valuation standards of in paragraph (5)(b) and rate of interest.

3. Deficiency reserves, if any, shall be calculated for each policy as the excess if greater than zero, for the current and all remaining periods, of the quantity A over the basic reserve, where A is obtained as indicated in paragraph (5)(b).

4. For deficiency reserves determined on a segmented basis, the quantity A is determined using segment lengths equal to those determined for segmented basic reserves.

(c) Minimum Value.

1, Basic reserves shall not be less than the tabular cost of insurance for the balance of the policy year if mean reserves are used.

2. Basic reserves shall not be less than the tabular cost of insurance for the balance of the current modal period or to the paid-to-date, if later, but not beyond the next policy anniversary, if mid-terminal reserves are used.

3. The tabular cost of insurance shall use the same valuation mortality table and interest rates as that used for the calculation of the segmented reserves.

4. However, if select mortality factors are used, they shall be the 10 year select factors incorporated into the 1980 amendments of the NAIC Standard Valuation Law.

5. In no case may total reserves (including basic reserves, deficiency reserves and any reserves held for supplemental benefits that would expire upon contract termination) be less than the amount that the policyowner would receive (including the cash surrender value of the supplemental benefits, if any, referred to above), exclusive of any deduction for policy loans, upon termination of the policy.

(d) Unusual Pattern of Guaranteed Cash Surrender Values.

1. For any policy with an unusual pattern of guaranteed cash surrender values, the reserves actually held prior to the first unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the first unusual guaranteed cash surrender value as a pure endowment and treating the policy as an n year policy providing term insurance plus a pure endowment equal to the unusual cash surrender value, where n is the number of years from the date of issue to the date the unusual cash surrender value is scheduled.

2. The reserves actually held subsequent to any unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the policy as an n year policy providing term insurance plus a pure endowment equal to the next unusual guaranteed cash surrender value, and treating any unusual guaranteed cash surrender value at the end of the prior segment as a net single premium, where:

a. n is the number of years from the date of the last unusual guaranteed cash surrender value prior to the valuation date to the earlier of:

(I) The date of the next unusual guaranteed cash surrender value, if any, that is scheduled after the valuation date; or

(II) The mandatory expiration date of the policy; and

b. The net premium for a given year during the n year period is equal to the product of the net to gross ratio and the respective gross premium; and

c. The net to gross ratio is equal to Item I divided by Item II as follows:

(I)(A) The present value at the beginning of the n year period of death benefits payable during the n year period, plus

(B) The present value at the beginning of the n year period of the next unusual guaranteed cash surrender value, if any, minus.

(C) The amount of the last unusual guaranteed cash surrender value, if any, scheduled at the beginning of the n year period.

(II) The present value at the beginning of the n year period of the scheduled gross premiums payable during the n year period.

3. For purposes of this subsection, a policy is considered to have an unusual pattern of guaranteed cash surrender values if any future guaranteed cash surrender value exceeds the prior year's guaranteed cash surrender value by more than the sum of:

a. 110 percent of the scheduled gross premium for that year;

b. 110 percent of one year's accrued interest on the sum of the prior year's guaranteed cash surrender value and the scheduled gross premium using the nonforfeiture interest rate used for calculating policy guaranteed cash surrender values; and

c. 5 percent of the first policy year surrender charge, if any.

(e) Optional Exemption for Yearly Renewable Term Reinsurance. At the option of the company, the following approach for reserves on YRT reinsurance may be used:

1. Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

2. Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in paragraph (c).

3. Deficiency reserves.

a. For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

b. Deficiency reserves shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with paragraph (a) above.

4. For purposes of this subsection, the calculations use the maximum valuation interest rate and the 1980 CSO mortality tables with or without 10 year select mortality factors.

5. A reinsurance agreement shall be considered YRT reinsurance for purposes of this subsection if only the mortality risk is reinsured.

6. If the assuming company chooses this optional exemption, the ceding company's reinsurance reserve credit shall be limited to the amount of reserve held by the assuming company for the affected policies.

(f) Optional Exemption for Attained-Age-Based Yearly Renewable Term Life Insurance Policies. At the option of the company, the following approach for reserves for attained-age-based YRT life insurance policies may be used:

1. Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

2. Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in paragraph (6)(c).

3. Deficiency reserves.

a. For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

b. Deficiency reserves shall never be less than the sum of the present values at the date of valuation of the excesses determined in accordance with sub-subparagraph a. above.

4. For purposes of this subsection, the calculations use the maximum valuation interest rate and the 1980 CSO valuation tables with or without 10 year select mortality factors.

5. A policy shall be considered an attained-age-based YRT life insurance policy for purposes of this subsection if:

a. The premium rates on both the initial current premium scale and the guaranteed maximum premium scale are based upon the attained age of the insured such that the rate for any given policy at a given attained age of the insured is independent of the year the policy was issued; and

b. The premium rates on both the initial current premium scale and the guaranteed maximum premium scale are the same as the premium rates for policies covering all insureds of the same sex, risk class, plan of insurance, and attained age.

6. For policies that become attained-age-based YRT policies after an initial period of coverage, the approach of this subsection may be used after the initial period if:

a. The initial period is constant for all insureds of the same sex, risk class, and plan of insurance; or

b. The initial period runs to a common attained age for all insureds of the same sex, risk class, and plan of insurance; and

c. After the initial period of coverage, the policy meets the conditions of subparagraph 5. above.

7. If this election is made, this approach shall be applied in determining reserves for all attained-age-based YRT life insurance policies issued on or after the effective date of this rule.

(g) Exemption from Unitary Reserves for Certain n-Year Renewable Term Life Insurance Polices. Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met:

1. The policy consists of a series of n-year periods including the first period and all renewal periods where n is the same for each period, except that for the final renewal period, n may be truncated or extended to reach the expiry age; provided that:

a. This final renewal period is less than 10 years and less than twice the size of the earlier n-year periods, and

b. For each period, the premium rates on both the initial current premium scale and the guaranteed maximum premium scale are level;

2. The guaranteed gross premiums in all n-year periods are not less than the corresponding net premiums based upon the 1980 CSO Table with or without the 10 year select mortality factors; and

3. There are no cash surrender values in any policy year.

(h) Exemption from Unitary Reserves for Certain Juvenile Policies. Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met, based upon the initial current premium scale at issue:

1. At issue, the insured is age 24 or younger;

2. Until the insured reaches the end of the juvenile period, which shall occur at or before age 25, the gross premiums and death benefits are level, and there are no cash surrender values; and

3. After the end of the juvenile period, gross premiums are level for the remainder of the premium paying period, and death benefits are level for the remainder of the life of the policy.

(7) Calculation of Minimum Valuation Standard for Flexible Premium and Fixed Premium Universal Life Insurance Policies that Contain Provisions Resulting in the Ability of a Policyowner to Keep a Policy in Force Over a Secondary Guarantee Period.

(a) General.

1. Policies with a secondary guarantee include:

a. A policy with a guarantee that the policy will remain in force at the original schedule of benefits, subject only to the payment of specified premiums;

b. A policy in which the minimum premium at any duration is less than the corresponding 1 year valuation premium, calculated using the maximum valuation interest rate and the 1980 CSO valuation tables with or without 10 year select mortality factors; or

c. A policy with any combination of subparagraph a. and b.

2. A secondary guarantee period is the period for which the policy is guaranteed to remain in force subject only to a secondary guarantee.

a. When a policy contains more than one secondary guarantee, the minimum reserve shall be the greatest of the respective minimum reserves at that valuation date of each unexpired secondary guarantee, ignoring all other secondary guarantees.

b. Secondary guarantees that are unilaterally changed by the insurer after issue shall be considered to have been made at issue.

c. Reserves described in paragraphs (b) and (c) below shall be recalculated from issue to reflect these changes.

3. Specified premiums mean the premiums specified in the policy, the payment of which guarantees that the policy will remain in force at the original schedule of benefits but which otherwise would be insufficient to keep the policy in force in the absence of the guarantee if maximum mortality and expense charges and minimum interest credits were made and any applicable surrender charges were assessed.

4.a. For purposes of this section, the minimum premium for any policy year is the premium that, when paid into a policy with a zero account value at the beginning of the policy year, produces a zero account value at the end of the policy year.

b. The minimum premium calculation shall use the policy cost factors (including mortality charges, loads, and expense charges) and the interest crediting rate which are all guaranteed at issue.

5.a. The 1 year valuation premium means the net 1 year premium based upon the original schedule of benefits for a given policy year.

b. The 1 year valuation premiums for all policy years are calculated at issue.

c. The select mortality factors defined in subparagraphs (5)(b)2., 3., and 4. shall not be used to calculate the 1 year valuation premiums.

6. The 1 year valuation premium shall reflect the frequency of fund processing, as well as the distribution of deaths assumption employed in the calculation of the monthly mortality charges to the fund.

(b) Basic Reserves for the Secondary Guarantees.

1. Basic reserves for the secondary guarantees shall be the segmented reserves for the secondary guarantee period.

2. In calculating the segments and the segmented reserves, the gross premiums shall be set equal to the specified premiums, if any, or otherwise to the minimum premiums that keep the policy in force.

3. The segments will be determined according to the contract segmentation method as defined in paragraph (4)(b).

(c) Deficiency Reserves for the Secondary Guarantees. Deficiency reserves, if any, for the secondary guarantees shall be calculated for the secondary guarantee period in the same manner as described in paragraph (6)(b) with gross premiums set equal to the specified premiums, if any, or otherwise to the minimum premiums that keep the policy in force.

(d) Minimum Reserves. The minimum reserves during the secondary guarantee period are the greater of:

1. The basic reserves for the secondary guarantee plus the deficiency reserve, if any, for the secondary guarantees; or

2. The minimum reserves required by Rule 4-164.010, F.A.C., governing universal life plans.

(9) Effective Date.

(a) This rule shall be effective for policies issued on or after January 1, 2000 for valuation dates on or after the date this rule is adopted.

(b) For valuation dates prior to the effective date of this rule, at the option of the company, the company may report reserves for policies issues in calendar year 2000 based upon this rule.

Specific Authority 624.308(1), 625.121(5)(j) FS. Law Implemented 624.307(1), 625.121(5)(j) FS. History–New _____.

DEPARTMENT OF TRANSPORTATION

RULE CHAPTER TITLE: RULE CHAPTER NO.:
Highway Traffic Safety Program 14-98
RULE TITLES: RULE NOS.:
Application and Award Procedures 14-98.005
Forms 14-98.008

PURPOSE AND EFFECT: Subsections 14-98.005(7),(10) and 14-98.008(6), F.A.C., are amended because of a revision to the Subgrant Application for Highway Safety Funds, FDOT Form 500-065-01. Part V. Acceptance and Agreement of that form has been extensively revised.

SUBJECT AREA TO BE ADDRESSED: Subsection 14-98.008(6), F.A.C., is amended to incorporate by reference a revised version of the Subgrant Application for Highway Safety Funds, FDOT Form 500-065-01. Subsections 14-98.005(7) and (10), F.A.C., also are being amended to update the revision date references to the same form.

SPECIFIC AUTHORITY: 334.044(2),(25) FS.

LAW IMPLEMENTED: 334.044(25) FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: James C. Myers, Clerk of Agency Proceedings, Florida Department of Transportation, Office of the General Counsel, 605 Suwannee Street, Mail Station 58, Tallahassee, Florida 32399-0458

THE PRELIMINARY TEXT OF THE PROPOSED RULES DEVELOPMENT IS:

14-98.005 Application and Award Procedures.

(1) through (6) No change.

(7) Two copies of the application form, Subgrant Application for Highway Safety Funds, FDOT Form 500-065-01, Rev. 06/03 ~~05/02~~, will be sent to those applicants whose concept papers are selected for funding. Applicants whose concept papers were not selected for funding will be notified by the Office.

(8) through (9) No change.

(10) The Office shall review all applications and will reject any applications not meeting the requirements of these rules and applicable Federal and State laws, within ten working days of receipt of said applications. In the event that an applicant submits a Subgrant Application for Highway Safety Funds, FDOT Form 500-065-01, Rev. 06/03 ~~05/02~~, for an activity that is not included in the Highway Safety Plan, the application shall be rejected. Failure to reject any application within ten days shall not result in the automatic award of a subgrant. All subgrants are subject to funds availability.

(11) No change.

Specific Authority 334.044(2) FS. Law Implemented 334.044(25) FS. History–New 12-30-84, Amended 6-10-85, Formerly 9B-32.05, 9B-32.005, 11-19-89, Formerly 9G-15.005, Amended 12-7-93, 11-29-94, 1-17-99, 4-16-02, 8-6-02, _____.

14-98.008 Forms.

The following forms used in the Highway Traffic Safety Program are hereby incorporated by reference:

(1) through (5) No change.

(6) Subgrant Application for Highway Safety Funds – FDOT Form 500-065-01, Rev. 06/03 ~~05/02~~.

(7) through (8) No change.

Copies of these forms may be obtained by writing or calling the Florida Department of Transportation, State Safety Office, 605 Suwannee Street, MS-17, Tallahassee, Florida 32399-0450; Telephone (850)488-5455.

Specific Authority 334.044(2),(25) FS. Law Implemented 334.044(25) FS. History–New 6-10-85, Formerly 9B-32.08, 9B-32.008, Amended 11-19-89, Formerly 9G-15.008, Amended 12-7-93, 6-14-94, 11-29-94, 4-16-02, 8-6-02, _____.

BOARD OF TRUSTEES OF THE INTERNAL IMPROVEMENT TRUST FUND

Pursuant to Chapter 2003-145, Laws of Florida, all notices for the Board of Trustees of the Internal Improvement Trust Fund are published on the Internet at the Department of Environmental Protection's home page at http://www.dep.state.fl.us/ under the link or button titled "Official Notices."

DEPARTMENT OF CORRECTIONS

RULE TITLE: RULE NO.:
Control of Contraband 33-602.203

PURPOSE AND EFFECT: The purpose of the proposed rule is to delete obsolete language from the rule. The effect is to remove reference to the Inmate Welfare Trust Fund and replace it with the General Revenue Fund which pursuant to Senate Bill 954 (2003).

SUBJECT AREA TO BE ADDRESSED: Contraband.

SPECIFIC AUTHORITY: 944.09, 945.215 FS.

LAW IMPLEMENTED: 944.47, 945.215 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Perri King Dale, 2601 Blair Stone Road, Tallahassee, Florida 32399-2500

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

33-602.203 Control of Contraband.

(1) through (4) No change.

(5)(a) No money shall be given directly to or received by an inmate assigned to a work release center unless authorized by the chief of security or his designated representative. On a case by case basis, each chief of security may authorize a draw of funds from the inmate's account that has not been drawn from the inmate's bank fund or that exceeds the approved amount authorized under subsection 33-203.201(3), F.A.C., if a specific request is made and a review determines it is warranted. Any money found in the possession of an inmate in excess of $75 in work release centers shall be considered contraband and shall be confiscated and deposited in the general revenue ~~inmate welfare trust~~ fund.

(b) In any facility in which inmate identification cards are used to authorize and initiate canteen transactions, any cash found in the possession of an inmate shall be considered contraband and deposited in the general revenue ~~inmate welfare trust~~ fund. An inmate identification card is contraband in the possession of anyone other than the inmate it identifies.

(6) through (8) No change.

Specific Authority 944.09, 945.215 FS. Law Implemented 944.47, 945.215 FS. History–New 10-8-76, Amended 2-24-81, 4-18-82, 8-13-84, 2-13-85, 6-2-85, Formerly 33-3.06, Amended 2-9-87, 11-3-87, 8-14-90, 11-22-91, 1-6-94, 5-28-96, 10-26-97, Formerly 33-3.006, Amended 3-2-00, 7-8-03, _____.

WATER MANAGEMENT DISTRICTS

Southwest Florida Water Management District

RULE TITLE:	RULE NO.:
Forms and Instructions	40D-1.659

PURPOSE AND EFFECT: Forms that the District uses in its dealings with the public must be formally adopted by rule pursuant to Section 120.55(1)(a),(4), Florida Statutes. Section J of the Joint Application for Environmental Resource Permit/Authorization to use State Owned Submerged Lands/Federal Dredge and Fill Permit FORM 547.27/ERP (__/__) has not previously been incorporated into the District's rules. The purpose and effect of this rulemaking is to incorporate this form into the District's rules in compliance with the requirements of the above-referenced statutory provision.

SUBJECT AREA TO BE ADDRESSED: The incorporation into the District's rules of a new Section J of the Environmental Resource Permit Application.

SPECIFIC AUTHORITY: 373.044, 373.113, 373.149, 373.171 FS.

LAW IMPLEMENTED: 373.116, 373.206, 373.207, 373.209, 373.216, 373.219, 373.229, 373.239, 373.306, 373.308, 373.309, 373.313, 373.323, 373.324, 373.339, 373.413, 373.414, 373.416, 373.419, 373.421 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Jack R. Pepper, Senior Attorney, Office of General Counsel, Southwest Florida Water Management District, 2379 Broad Street, Brooksville, FL 34604-6899, (352)796-7211, Extension 4651

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

40D-1.659 Forms and Instructions.

The following forms and instructions have been approved by the Governing Board and are incorporated by reference into this Chapter. Copies of these forms may be obtained from the District.

GROUND WATER

(1) through (20) No change.

SURFACE WATER

Application for Permit – Used for Docks or Piers and Bulkheads

(1) JOINT APPLICATION FOR: ENVIRONMENTAL RESOURCE PERMIT/AUTHORIZATION TO USE STATE OWNED SUBMERGED LANDS/FEDERAL DREDGE AND FILL PERMIT FORM 547.27/ERP (__/__)

(2) through (14) No change.

Specific Authority 373.044, 373.113, 373.149, 373.171 FS. Law Implemented 373.116, 373.206, 373.207, 373.209, 373.216, 373.219, 373.229, 373.239, 373.306, 373.308, 373.309, 373.313, 373.323, 373.324, 373.339, 373.413, 373.414, 373.416, 373.419, 373.421 FS. History–New 12-31-74, Amended 10-24-76, Formerly 16J-0.40, 40D-1.1.901, 40D-1.901, Amended 12-22-94, 5-10-95, 10-19-95, 5-26-95, 7-23-96, 2-16-99, 7-12-99, 7-15-99, 12-2-99, 5-31-00, 10-26-00, 6-26-01, 11-4-01, 6-12-02, 8-25-02, 2-26-03, _____.

AGENCY FOR HEALTH CARE ADMINISTRATION

State Center for Health Statistics

RULE TITLES:	RULE NOS.:
Purpose of Ambulatory Patient Data Reporting	59B-9.010
Definitions	59B-9.013
Schedule for Submission of Ambulatory Patient Data and Extensions	59B-9.014
Reporting Instructions	59B-9.015
Ambulatory Patient Data Format – Data Elements, Codes and Standards	59B-9.018
Ambulatory Patient Data Format – Record Layout	59B-9.019
Data Standards	59B-9.020

PURPOSE AND EFFECT: The proposed rule amendments require emergency department patient data reporting beginning January 1, 2005. The rule amendments add ambulatory data elements, modify ambulatory data elements and codes, modify

ambulatory data formats, and eliminate data elements. The rule amendments require reporting by Internet transmission starting January 1, 2006 for emergency department patient data and ambulatory surgery patient data.

SUBJECT AREA TO BE ADDRESSED: The agency is proposing amendments to Rules 59B-9.010, 59B-9.013, 59B-9.015, 59B-9.018, 59B-9.019, and 59B-9.020, F.A.C., that require the reporting of emergency department data and modify ambulatory surgery reporting requirements.

SPECIFIC AUTHORITY: 408.15(8) FS.

LAW IMPLEMENTED: 408.061, 408.15(11) FS.

A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW:

TIME AND DATE: 10:00 a.m., August 25, 2003

PLACE: Agency for Health Care Administration, First Floor Conference Room, Building 3, 2727 Mahan Drive, Tallahassee, Florida 32308

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Beth C. Dye, Bureau Chief, State Center for Health Statistics, Agency for Health Care Administration, Building 3, 2727 Mahan Drive, Tallahassee, Florida 32308

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

59B-9.010 Purpose of Ambulatory Patient Data Reporting.

The reporting of ambulatory patient data will provide a statewide integrated database that includes ~~of~~ ambulatory surgery ~~surgical procedures~~ and hospital emergency department services for the ~~permit~~ assessment of variations in utilization, disease surveillance ~~practice parameters~~, access to ~~ambulatory~~ care and ~~estimates of~~ cost trends ~~for ambulatory procedures~~. The amendments appearing herein are effective with the reporting period starting January 1, 2005 ~~2003~~.

Specific Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History–New 9-6-93, Formerly 59B-7.010, Amended 6-29-95, 12-28-98, 2-25-02, _____.

59B-9.013 Definitions.

(1) through (4) No change.

(5) "Visit" means a face to face encounter between a health care provider and a patient who is not formally admitted as an inpatient in an acute care hospital setting ~~and who is not treated in the emergency room~~. Visits which require the patient to appear in an ambulatory setting prior to the actual procedure (even if this occurs one or more days before the procedure) shall be counted as one visit.

(6) No change.

(7) "Attending Physician" means a licensed physician, dentist, podiatrist or chiropractor who has primary responsibility for the patient's medical care and treatment or who certifies as to the medical necessity of the services rendered. The attending physician may be the ~~referring physician or the~~ operating or performing physician.

(8) "Other ~~Operating or Performing~~ Physician" means a licensed physician, dentist, podiatrist, or chiropractor other than the attending physician who rendered care to the patient ~~has primary responsibility for the surgery or procedure performed~~.

(9) No change.

Specific Authority 408.15(8) FS. Law Implemented ~~395.002,~~ 408.061, 408.062, 408.063 FS. History–New 9-6-93, Formerly 59B-7.013, Amended 6-29-95, 12-28-98, 7-11-01, 2-25-02, _____.

59B-9.014 Schedule for Submission of Ambulatory Patient Data and Extensions.

(1) Ambulatory ~~All ambulatory~~ centers ~~reporting their ambulatory patient data~~ shall report ambulatory patient data, as described in subsection 59B-9.015(2) and ~~in the format set forth in~~ Rule 59B-9.018 ~~59B-9.019~~, F.A.C., according to the following schedule:

(a) Each report covering patient visits ending ~~occurring~~ between January 1 and March 31, inclusive of each year, shall be submitted no later than June 10 of the calendar year during which the visit occurred.

(b) Each report covering patient visits ending ~~occurring~~ between April 1 and June 30, inclusive of each year, shall be submitted no later than September 10 of the calendar year during which the visit occurred.

(c) Each report covering patient visits ending ~~occurring~~ between July 1 and September 30, inclusive of each year, shall be submitted no later than December 10 of the calendar year during which the visit occurred.

(d) Each report covering patient visits ending ~~occurring~~ between October 1 and December 31, inclusive of each year, shall be submitted no later than March 10 of the calendar year following the year in which the visit occurred.

(2) No change.

Specific Authority 408.15(8) FS. Law Implemented 408.006(5), 408.061 FS. History–New 9-6-93, Formerly 59B-7.014, Amended 6-29-95, _____.

59B-9.015 Reporting Instructions.

(1) Ambulatory centers shall submit ambulatory patient data according to Rule~~s~~ 59B-9.018 ~~59B-9.018, 59B-9.019, and 59B-9.020~~, F.A.C.

(2) Ambulatory centers shall report data for:

(a) All ~~for all~~ non-emergency ~~room ambulatory or outpatient~~ visits in which surgery services were performed and the services provided correspond to a Current Procedural Terminology (CPT) code ~~codes~~ 10000 through 69999 or ~~and~~ 93500 through 93599. Codes must be valid in the current or the immediately preceding year's code book to be accepted.

(b) All emergency department visits in which emergency department registration occurs and the patient is not admitted for inpatient care at the reporting entity. Include all visits for which a billing record is created.

(3) Ambulatory centers shall exclude ~~report one record for each patient per visit, excluding~~ records of any patient visit in which the outpatient and inpatient billing record is combined because the patient was ~~transferred from ambulatory care and~~ admitted to inpatient care within a facility at the same location per Rule 59A-3.203, F.A.C. ~~If more than one visit for the same patient occurs on the same date, report one record which includes all required data for all visits of that patient to the ambulatory center occurring on that date. If more than one visit occurs on different dates by the same patient,~~ Report ~~report~~ one record for each ~~date of~~ visit, except pre-operation visits may be combined with the record of the associated ambulatory surgery visit ~~unless the dates of visits are directly associated to the service~~. See subsection 59B-9.013(5), F.A.C.

(4) For each patient visit, ambulatory centers shall report all services provided using procedural codes specified in subsection 59B-9.018(2), F.A.C. ~~CPT or the Health Care Financing Administration Common Procedure Coding System (HCPCS) codes.~~

(5) Ambulatory ~~Beginning with the report of patient visits occurring between January 1 and March 31, 2002, inclusive, and thereafter, ambulatory~~ centers shall submit ambulatory patient data reports to the agency using one of the following methods described in (a) or in (b) below except that for patient visits ending on or after January 1, 2006, ~~January 1, 2002,~~ the methods described in (b) ~~data tapes~~ must not be used except that an alternative method may be used if an exception is requested by the ambulatory center due to extraordinary or hardship circumstances and the exception is approved by the agency.

(a) Internet Transmission. The Internet address established for receipt of ambulatory patient data is www.fdhc.state.fl.us. Reports sent to the Internet address shall be electronically transmitted with the ambulatory data in a text (XML) ~~(ASCII)~~ file using the XML schema corresponding to the report period at www.fdhc.state.fl.us. ~~The file shall contain a complete set of ambulatory patient data for the calendar quarter. Each record of the text file must be terminated with a carriage return (hex '0D') and line feed mark (hex '0A').~~ The data in the text file shall contain the ~~same~~ data elements, ~~elements and~~ codes, ~~the same record layout~~ and ~~meet the same data~~ standards required ~~for tapes or diskettes mailed to the agency as described~~ in Rules ~~59B-9.018, 59B-9.019 and 59B-9.020~~, F.A.C.

(b) ~~Tapes,~~ CD-ROM or diskettes shall be sent to the agency's mailing address: Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, Florida 32308. Attention: State Center for Health Statistics. Electronic media specifications are:

~~1. Tape:~~

~~a. Density – 1600 or 6250 BPI, 9 track~~

~~b. Collating Sequence – EBCDIC or ASCII~~

~~c. Record Length – 400 Characters, Fixed~~

~~d. Blocking – Unblocked~~

~~e. Labeling – No Label~~

~~2. Diskette and CD-ROM:~~

1.~~a.~~ MS-DOS formatted

2.~~b.~~ PC Text File (XML) with the schema corresponding to the report period described at www.fdhc.state.fl.us ~~(ASCII)~~

~~c. Record Length: – Header Record – 400 Characters, Ambulatory Data Record – 400 Characters, Trailer Record – 400 Characters. Carriage return and line feed are not included in the stated record length.~~

3.~~d~~. Type: 3.5" diskette, 1.4MB, hd; or CD-ROM.

4.~~e.~~ FILENAME: (e.g., AS10QYY.XML ~~AS10QYY.TXT~~) The 5th position shall should contain the quarter (1-4) and the 6th and 7th position shall contain the year. XML ~~TXT~~ indicates an XML ~~a~~ text file.

~~f. Each record must be terminated with a carriage return of hex '0D' and line feed mark of hex '0OA'~~.

5.~~g.~~ Only one (1) file per diskette set or CD-ROM is allowable. Data requiring more than one diskette shall have the same internal file name. Data requiring more than one (1) diskette shall be externally labeled 1 of x, 2 of x, etc. (x = total number of diskettes).

(6) Ambulatory centers submitting diskettes ~~tapes or diskettes,~~ shall affix the following external identification, or for CD-ROM, use a standard CD-ROM external label with the following information:

(a) Ambulatory center name

(b) AHCA center identification in the AHCA format

(c) Reporting period

(d) Number of records excluding the header record and the trailer record

~~(e) Tape Density: 1600/6250 BPI~~

~~(f) Tape Collating Sequence~~

(e)~~(g)~~ Diskette or CD-ROM Filename as in Rule 59B-9.015, F.A.C., above.

(f)~~(h)~~ The description: "AMBULATORY PATIENT DATA"

Specific Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History–New 9-6-93, Formerly 59B-7.015, Amended 6-29-95, 12-28-98, 1-4-00, 7-11-01, 2-25-02, _____.

59B-9.018 Ambulatory Patient Data Format – Data Elements, Codes, and Standards ~~Data Elements Codes~~.

(1) Header Record: The first record in the data file shall be a header record ~~with a logical record length of 400 characters,~~ containing the ~~following~~ information described below ~~in the prescribed format~~. ~~This record must precede any documentation submitted for ambulatory patient data records.~~ If diskettes are submitted, the header record must be placed as

the first record on the first diskette of the data set. ~~A header record must accompany each data set and must be placed as the first record on the first diskette of the data set.~~

~~DATA ELEMENT DESCRIPTION~~

(a) Transaction Code – Enter Q for a calendar quarter report or S for a report period other than a calendar quarter where the special report is requested or authorized by the agency to receive data corrections ~~"H" for header record in the first position.~~

(b) Report ~~Reporting~~ Year – Enter ~~A 4 digit field specifying~~ the year of the data in the format YYYY.

(c) Report ~~Reporting~~ Quarter – Enter ~~A 1 digit field specifying~~ the quarter of the data, 1,2,3 or 4, where 1 corresponds to the first quarter of the calendar year, 2 corresponds to the second quarter of the calendar year, 3 corresponds to the third quarter of the calendar year, and 4 corresponds to the fourth quarter of the calendar year. ~~that the data pertains to:~~

~~1 = Jan. 1 through Mar. 31~~

~~2 = Apr. 1 through Jun. 30~~

~~3 = Jul. 1 through Sept. 30~~

~~4 = Oct. 1 through Dec. 31~~

(d) Data Type – Enter ~~A required four character alphanumeric code. Use~~ AS10 for Ambulatory Data.

(e) Submission Type –Enter I, R, or C ~~A 1 character field for submission~~ where I indicates an initial submission of data or resubmission of previously rejected data, R indicates a replacement submission of previously processed and accepted ambulatory patient data, and C indicates an individual record correction or set of individual record corrections where submission of a correction or corrections is requested or authorized by the agency. ~~type: I = Initial. This is the first submisson for the time period. All submissions which are not "I" will be "R" R = re-submission. This code is used to replace previously submitted records for the specified time period. All existing data for the time period will be deleted and replaced with the new data set.~~

(f) Processing Date – Enter ~~MMDDYYYY,~~ the date that the data file was created ~~by the submitter~~ in the format YYYY-MM-DD where MM represents numbered months of the year from 1 to 12, DD represents numbered days of the month from 1 to 31, and YYYY represents the year in four digits.

(g) AHCA Ambulatory Center Number – Enter the eight ~~A 10~~ digit identification number of the ambulatory center as assigned by AHCA for reporting purposes. ~~A numeric field, right justify.~~

~~(h) Florida License Number Zero fill for this header record only.~~

~~(i) Provider Medicaid Number A 10 digit number provided for Medicaid providers. If not a Medicaid provider, zero fill.~~

~~(j) Provider Medicare Number A 10 digit number provided for Medicare providers. If not a Medicare provider, zero fill.~~

(h)~~(k)~~ ~~Provider~~ Organization Name – Enter the name of the ambulatory center that performed the ambulatory services represented by the data, and which is responsible for reporting the data. All questions regarding data accuracy and integrity will be referred to this entity. Up to a forty character field. ~~The name of the health care entity reporting the patient data records.~~

(i)~~(l) Provider~~ Contact Person Name – Enter the name of the contact person at the ambulatory center. Submit name in the Last, First format. Up to a twenty-five character field. ~~The name of the contact person at the health care entity providing the patient data records.~~

(j)~~(m) Provider~~ Contact Person Telephone Number – The area code, business telephone number, and if applicable ~~required~~, extension for the contact person ~~at the health care entity providing the patient data records~~. Enter the contact person telephone number in the format (AAA)XXX-XXXX-EEEE where AAA is the area code, and EEEE is the extension. Zero fill if no extension.

(k) Contact Person E-Mail Address – The e-mail address of the contact person.

(l) Contact Person Address – Enter the mailing address of the contact person. Up to a forty character field.

(m) Mailing Address City – Enter the city of the address of the contact person. Up to a twenty-five character field.

(n) Mailing Address State – Enter the state of the address of the contact person using the U.S. Postal Service state abbreviation in the format XX. Use the abbreviation FL for Florida.

(o) Mailing Address Zip Code – Enter the zip code of the address of the contact person in the format XXXXX-XXXX. Zero fill if no extension.

~~(n) Submitter Organization Name The name of the organization that produced the data file that is being submitted.~~

~~(o) Submitter Contact Person Name The name of the person at the submitting organization responsible for submitting the data file.~~

~~(p) Submitter Contact Person Telephone Number The area code, telephone number, and if required, extension for the contact person at the organization submitting the data file.~~

~~(q) Filler A field of 183 spaces, to be left blank.~~

(2) Individual Data Records: All data elements and data element codes listed below shall be reported consistent with the records of the reporting entity. Data elements and codes are listed with a description of the data to be reported and data standards.

~~DATA ELEMENT~~ ~~DESCRIPTION~~

(a) AHCA Ambulatory Center ~~ID~~ Number – An eight ~~8~~ digit ~~ambulatory center~~ identification number assigned by ~~for~~ AHCA for reporting purposes. The number must match the ambulatory center number recorded on the CD-ROM or diskette external label and header record. A required entry.

(b) Record Identification Number – An alpha-numeric code containing standard letters or numbers assigned by the facility ~~at the time of reporting~~ as a unique identifier for each record submitted in the reporting period ~~for each reporting period,~~ to facilitate storage and retrieval of individual case records. Up to seventeen ~~twelve~~ characters. A required entry. Duplicate record identification numbers are not permitted.

(c) Patient Social Security Number – The social security number (SSN) of the patient ~~who received treatment/services~~. A nine ~~9~~ digit field to facilitate retrieval of individual case records, to be used to track multiple patient visits ~~readmissions~~, and for medical ~~epidemiological~~ research. Reporting 000000000 is acceptable for newborns and infants up to 2 years of age who do not have a SSN. For patients not from the United States, use 555555555 if a SSN is not assigned. For those patients where efforts to obtain the SSN have been unsuccessful or where one is unavailable, and the patient is 2 years of age or older and not known to be from a country other than the United States, use 777777777. A required entry.

(d) Patient Race or Ethnicity ~~Racial Background~~ – Self-designated by the patient or patient's parent or guardian except code 8 indicating no response may be reported where efforts to obtain the information have been unsuccessful. A required entry. Must be a ~~A~~ one digit code as follows:

1. 1 – American Indian or Alaska Native ~~1 – American Indian/Eskimo/Aleut.~~

2. 2 – Asian or Pacific Islander.

3. 3 – Black or African American.

4. 4 – White.

5. 5 – White Hispanic.

6. 6 – Black Hispanic.

7. 7 – Other. Use ~~7 – Other (Use~~ if the patient's self-designated race or ethnicity ~~patient~~ is not described by the above categories. ~~categories.)~~

8. 8 – No response. Use ~~8 – No response (Use~~ if the patient refuses or fails to disclose.~~)~~

(e) Patient Birth Date – The date of birth of the patient. ~~MMDDYYYY~~ ~~An~~ A ten character ~~8 digit~~ field in the format YYYY-MM-DD where MM represents the numbered months of the year from 1 to 12, DD represents numbered days of the month from 1 to 31, and YYYY represents the year in four digits ~~field~~. Use 9999-99-99 where efforts to obtain the patient's birth date have been unsuccessful. Age greater than 120 years is not permitted unless verified by the reporting entity. A birth date after the patient visit ending date is not permitted. A required entry.

(f) Patient Sex – The gender of the patient. A required entry. Must be a ~~A~~ one digit code as follows:

1. 1 – Male.

2. 2 – Female.

3. 3 – Unknown shall be reported where efforts to obtain the information have been unsuccessful or where the patient's sex cannot be determined due to a medical condition. ~~(Use if unknown due to medical condition.)~~

(g) Patient Zip Code – The five digit United States Postal Service ZIP Code of the patient's permanent residence. Use 00009 for foreign residences. Use 00007 for homeless patients. Use 00000 where efforts to obtain the information have been unsuccessful. A required entry. ~~A five digit zip code of the patient's permanent address: XXXXX~~

(h) Patient Visit Beginning Date – The date at the beginning of the patient's visit for ambulatory surgery or the date at the time of registration in the emergency department. ~~MMDDYYYY~~ ~~An~~ A ten character ~~8 digit~~ field in the format YYYY-MM-DD where MM represents the numbered months of the year from 1 to 12, DD represents numbered days of the month from 1 to 31, and YYYY represents the year in four digits. ~~field.~~ Patient visit beginning date must equal or precede the patient visit ending date. A required entry.

(i) Principal Payer Code – Describes the primary source of expected reimbursement for services rendered. A required entry. Must be a ~~A~~ one character field using upper case as follows:

1. A – Medicare.

2. B – Medicare HMO.

3. C – Medicaid.

4. D – Medicaid HMO.

5. E – Commercial Insurance.

6. F – Commercial HMO.

7. G – Commercial PPO.

8. H – Workers' Compensation.

9. I – CHAMPUS.

10. J – VA.

11. K – Other State/Local Government ~~Govt.~~

12. L – Self Pay. No third party coverage. ~~Self Pay (No third party coverage).~~

13. M – Other.

14. N – Charity.

15. O – KidCare. Includes ~~KidCare (Report~~ Healthy Kids, MediKids and Children's Medical Services. ~~Required for ambulatory visits occurring on or after January 1, 2003.)~~

16. P – Unknown. Unknown shall be reported if principal payer information is not available and type of service is "2" and patient status is "07".

(j) Principal Diagnosis Code – The code representing the diagnosis chiefly responsible for the services performed during the visit. Must contain a valid ICD-9-CM or ICD-10-CM diagnosis code if type of service is "1" indicating ambulatory

surgery. Must contain a valid ICD-9-CM or ICD-10-CM diagnosis code if type of service is "2" indicating an emergency department visit unless patient status is "07" indicating that the patient left against medical advice or discontinued care. A blank field is permitted if type of service is "2" and patient status is "07" consistent with the records of the reporting entity. If not space filled, must contain a valid ICD-9-CM diagnosis code or valid ICD-10-CM diagnosis code for the reporting period. Inconsistency between the principal diagnosis code and patient sex must be verified by the reporting entity. Inconsistency between the principal diagnosis code and patient age must be verified by the reporting entity. A diagnosis code cannot be used more than once as a principal or other diagnosis for each visit reported. The code must be entered with a decimal point that is included in the valid code and without use of a zero or zeros that are not included in the valid code. ~~The ICD-9-CM codes(s). Enter the primary diagnosis related to the services provided. Left-justified, space filled, no decimal. Make certain that blank spaces are not interspersed between codes.~~

(k) ~~through (n)~~ Other Diagnosis Code (1), Other Diagnosis (2), Other Diagnosis (3), Other Diagnosis (4), Other Diagnosis (5), Other Diagnosis (6), Other Diagnosis (7), Other Diagnosis (8), Other Diagnosis (9) ~~Codes~~ – A code representing a diagnosis related to the services provided during the visit. If no principal diagnosis code is reported, other diagnosis code must not be reported. No more than nine other diagnosis codes may be reported. Less than nine entries or no entry is permitted consistent with the records of the reporting entity. If not space filled, must contain a valid ICD-9-CM code or valid ICD-10-CM code for the reporting period. Inconsistency between the diagnosis code and patient sex must be verified by the reporting entity. Inconsistency between the diagnosis code and patient age must be verified by the reporting entity. A diagnosis code cannot be used more than once as a principal or other diagnosis for each visit reported. The code must be entered with use of a decimal point that is included in the valid code and without use of a zero or zeros that are not included in the valid code. ~~The ICD-9-CM codes(s). Enter all other diagnoses related to the services provided. Left-justified, space filled, no decimal, includes E codes. Make certain that blank spaces are not interspersed between codes.~~

(l)~~(o)~~ Principal CPT or HCPCS ~~Primary~~ Procedure Code – The code representing the procedure or service most related to the principal diagnosis. Must contain a valid CPT code between 10000 and 69999, inclusive, or between 93500 and 93599, inclusive if type of service is "1" indicating ambulatory surgery. Must contain a valid HCPCS or CPT evaluation and management code if type of service is "2" indicating an emergency department visit and patient status is not "07." Must contain a valid HCPCS or CPT evaluation and management code, or a blank field, consistent with the records of the reporting entity, if type of service is "2" indicating an emergency department visit and patient status is "07" indicating that the patient left against medical advice or discontinued care. If not space filled, must contain a valid CPT or HCPCS procedure code. Inconsistency between the principal procedure code and patient sex must be verified by the reporting entity. Inconsistency between the principal procedure code and patient age must be verified by the reporting entity. The code must be five digits and valid for the reporting period. ~~The CPT codes(s). Enter the primary procedure codes for services provided. Enter five digits. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted. This code is directly related to the primary diagnosis.~~

~~(p) Primary Procedure Modifier Code (Optional) The CPT modifier code. Enter primary procedure modifier.~~

~~(q) Primary Procedure Modifier Code (Optional) The CPT modifier code. Enter primary procedure modifier.~~

(m)~~(r)~~ Other CPT Procedure Code (1), Other CPT Procedure Code (2), Other CPT Procedure Code (3), Other CPT Procedure Code (4), Other CPT Procedure Code (5), Other CPT Procedure Code (6), Other CPT Procedure Code (7) Other CPT Procedure Code (8), Other CPT Procedure Code (9) – A code representing a procedure or service provided during the visit. If no principal CPT or HCPCS procedure is reported, other CPT procedure code must not be reported. No more than nine other CPT procedure codes may be reported. Less than nine entries or no entry is permitted consistent with the records of the reporting entity. If not space filled, must be a valid CPT or HCPCS code. Inconsistency between the procedure code and patient sex must be verified by the reporting entity. Inconsistency between the procedure code and patient age must be verified by the reporting entity. The code must be five digits and valid for the reporting period. ~~The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.~~

~~(s) Other Procedure Modifer Code (Optional) The CPT modifier code. Enter other procedure (r) modifier.~~

~~(t) Other Procedure Modifer Code (Optional) The CPT modifier code. Enter other procedure (r) modifier.~~

~~(u) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.~~

~~(v) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (u) modifier.~~

~~(w) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (u) modifier.~~

(x) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.

(y) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (x) modifier.

(z) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (x) modifier.

(aa) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.

(bb) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (aa) modifier.

(cc) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (aa) modifier.

(dd) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.

(ee) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (dd) modifier.

(ff) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (dd) modifier.

(gg) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.

(hh) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (gg) modifier.

(ii) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (gg) modifier.

(jj) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes mustbe recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.

(kk) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (jj) modifier.

(ll) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (jj) modifier.

(mm) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes mustbe recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.

(nn) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (mm) modifier.

(oo) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (mm) modifier.

(pp) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.

(qq) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (pp) modifier.

(rr) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (pp) modifier.

(ss) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.

(tt) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (ss) modifier.

(uu) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (ss) modifier.

(vv) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.

(ww) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (vv) modifier. (xx) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (vv) modifier.

(yy) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.

(zz) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (yy) modifier.

(aaa) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (yy) modifier.

(bbb) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed

~~between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.~~

~~(eee) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (bbb) modifier.~~

~~(ddd) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (bbb) modifier. (eee) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.~~

~~(fff) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (eee) modifier.~~

~~(ggg) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (eee) modifier.~~

(n)~~(hhh)~~ Attending ~~Ordering~~ Physician Identification Number ID # – The Florida license number of the attending physician, dentist, podiatrist or chiropractor. Report the physician who had primary responsibility for the patient's care during the visit. ~~Enter the Florida license number of the attending physician, beginning with "FL".~~ An ~~eleven character~~ alpha-numeric field of up to eleven characters (e.g., FLME1234567). ~~If out-of-state physician, fill with the physician's state two letter abbreviation and 9's (e.g., NY999999999 for a physician from New York). For non-U.S. physicians (a physician licensed and practicing in another country and not licensed in the U.S.), fill with "XX" and 9's (e.g., XX999999999).~~ For military physicians not licensed in Florida, use US. ~~fill with "US" and 9's (e.g., US999999999)~~. Use NA if the patient was not treated by a physician, dentist, podiatrist or chiropractor. A required entry.

~~(iii) Blank Field A six character alpha-numeric field to be left blank.~~

(o)~~(jjj)~~ Other ~~Operating or Performing~~ Physician Identification Number ~~ID #~~ – The Florida license number of a physician, dentist, podiatrist or chiropractor who rendered care to the patient other than the physician, dentist, podiatrist or chiropractor reported in (n) above. ~~Enter the Florida license number of the operating or performing physician, beginning with "FL".~~ An ~~eleven character~~ alpha-numeric field of up to eleven characters ~~(e.g., FLME1234567)~~. A blank or no entry is permitted consistent with the records of the reporting entity.

~~(kkk) Blank Field A six character alpha-numeric field to be left blank.~~

(p)~~(lll)~~ Pharmacy Charges – Charges for medication, reported in dollars numerically without dollar signs or commas, excluding cents. Report 0 (zero) if there are no pharmacy charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry. ~~Enter up to 6 digits to reflect total pharmacy charges.~~

(q) Medical and Surgical Supply Charges – Charges for supply items required for patient care, reported in dollars numerically without dollar signs or commas, excluding cents. Report 0 (zero) if there are no medical and surgical supply charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

~~(mmm) Med./Surgical Supp. Charges Enter up to 6 digits to reflect total medical and surgical supply charges.~~

~~(nnn) Radiation Oncology Charges Enter up to 6 digits to reflect total oncology charges.~~

(r)~~(ooo)~~ Laboratory Charges – Charges for the performance of diagnostic and routine clinical laboratory tests, reported in dollars numerically without dollar signs or commas, excluding cents. Report 0 (zero) if there are no laboratory charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry. ~~Enter up to 6 digits to reflect total laboratory charges.~~

(s) Radiology and Other Imaging Charges – Charges for the performance of diagnostic and therapeutic radiology services including computed tomography, mammography, magnetic resonance imaging, nuclear medicine, and chemotherapy, reported in dollars numerically without dollar signs or commas, excluding cents. Report 0 (zero) if there are no radiology or computed tomography charges.

~~(ppp) CT Scan Charges Enter up to 6 digits to reflect total computerized axial tomography (CAT) scan charges.~~

(t) Cardiology Charges – Charges for cardiac procedures rendered such as heart catheterization, reported in dollars numerically without dollar signs or commas, excluding cents. Report 0 (zero) if there are no cardiology charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(u)~~(qqq)~~ Operating Room Charges – Charges for the use of the operating room, reported in dollars numerically without dollar signs or commas, excluding cents. Report 0 (zero) if there are no operating room charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry. ~~Enter up to 6 digits to reflect total operating room charges.~~

~~(rrr) Anesthesia Charges Enter up to 6 digits to reflect total anesthesia charges.~~

~~(sss) MRI Charges Enter up to 6 digits to reflect total magnetic resonance imaging (MRI) charges.~~

(v) Emergency Room Charges – Charges for medical examinations and emergency treatment, reported in dollars numerically without dollar signs or commas, excluding cents. Report 0 (zero) if there are no emergency room charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

~~(ttt) Recovery Room Charges Enter up to 6 digits to reflect total recovery room charges.~~

(w)~~(uuu)~~ Treatment or Observation Room Charges – Charges for use of a treatment room or for the room charge associated with observation services, reported in dollars numerically without dollar signs or commas, excluding cents. Report 0 (zero) if there are no treatment or observation room charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry. ~~Enter up to 6 digits to reflect total treatment or observation room charges.~~

(x)~~(vvv)~~ Other Charges – Other facility charges not included in (p) to (u) above, reported in dollars numerically without dollar signs or commas, excluding cents. Report 0 (zero) if there are no other charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry. ~~Enter up to 6 digits to reflect any other charges that do not fall into any of the categories above.~~

(y)~~(www)~~ Total Gross Charges – The total of undiscounted ~~A required field. Enter up to 8 digits. Total~~ billed charges ~~to the patient~~ for services rendered ~~for the visit~~ by the reporting entity, reported in dollars numerically without dollar signs or commas, excluding cents. Include charges for services rendered by the ambulatory center excluding professional fees. Zero (0) or negative amounts are not permitted unless verified separately by the reporting entity. Amounts exceeding 50000 must be verified separately by the reporting entity if type of service is "1" indicating ambulatory surgery. Amounts exceeding 100000 must be verified separately by the reporting entity if type of service is "2" indicating an emergency department visit. The sum of pharmacy charges, medical and surgical supply charges, laboratory charges, operating room charges, emergency room charges, treatment or observation room charges, and other charges must equal total charges, plus or minus 10. A required entry. ~~Include charges for the standard package of surgical procedure services as defined by CPT and charges for all other technical services and professional radiological services if facility bills globally, provided for this encounter. Round to the nearest dollar. No negative numbers.~~

(z) Type of Service Code – A code designating the type of service, either ambulatory surgery or emergency department visit. A required entry. Must be a one digit code as follows:

1. 1 – Ambulatory surgery, as described in paragraph 59B-9.015(2)(a), F.A.C.

2. 2 – Emergency department visit, as described in paragraph 59B-9.015(2)(b), F.A.C.

(aa) Patient Visit Ending Date – The date at the end of the patient's visit. ~~MMDDYYYY An~~ A ten character ~~8 digit~~ field in the format YYYY-MM-DD where MM represents the numbered months of the year from 1 to 12, DD represents numbered days of the month from 1 to 31, and YYYY represents the year in four digits. ~~field.~~ Patient visit ending date must equal or follow the patient visit beginning date. Patient visit ending data must occur within the calendar quarter recorded on the CD-ROM or diskette external label and header record. A visit exceeding 2 days as determined by the patient visit beginning date and patient visit ending date must be verified by the reporting entity. A blank field is not permitted unless type of service is "2" indicating an emergency department visit and patient status is "07" indicating the patient left against medical advice or discontinued care.

(bb) Hour of Arrival – The hour on a 24-hour clock during which the patient's visit for ambulatory surgery began or during which registration in the emergency department occurred. A required entry. Use 99 where efforts to obtain the information have been unsuccessful. Must be two digits as follows:

1. 00 – 12:00 midnight to 12:59
2. 01 – 01:00 to 01:59
3. 02 – 02:00 to 02:59
4. 03 – 03:00 to 03:59
5. 04 – 04:00 to 04:59
6. 05 – 05:00 to 05:59
7. 06 – 06:00 to 06:59
8. 07 – 07:00 to 07:59
9. 08 – 08:00 to 08:59
10. 09 – 09:00 to 09:59
11. 10 – 10:00 to 10:59
12. 11 – 11:00 to 11:59
13. 12 – 12:00 noon to 12:59
14. 13 – 01:00 to 01:59
15. 14 – 02:00 to 02:59
16. 15 – 03:00 to 03:59
17. 16 – 04:00 to 04:59
18. 17 – 05:00 to 05:59
19. 18 – 06:00 to 06:59
20. 19 – 07:00 to 07:59
21. 20 – 08:00 to 08:59
22. 21 – 09:00 to 09:59
23. 22 – 10:00 to 10:59
24. 23 – 11:00 to 11:59
25. 99 – Unknown.

(cc) Patient's Reason for Visit (Admitting Diagnosis) – The code representing the patient's chief complaint or stated reason for seeking care. Must contain a valid ICD-9-CM code or valid ICD-10-CM code for the reporting period if type of service is "2" indicating an emergency department visit unless the patient fails to disclose or the information is unavailable. A blank field is permitted if the patient fails to disclose or efforts to obtain the information have been unsuccessful consistent with the records of the reporting entity. If not space filled, must contain a valid ICD-9-CM or ICD-10-CM diagnosis code. The code must be entered with use of a decimal point that is included in the valid code and without use of a zero or zeros that are not included in the valid code. Space fill if type of service is "1" indicating ambulatory surgery.

~~(xxx) Radiology Professional Fees Indicator A required field. A one digit code. 1 = Yes. 2 = No. "Yes" means total charges reported in the data field (www) include professional fees for radiology. "No" means total charges in data field (www) do not include professional fees for radiology services.~~

~~(yyy) Blank Field A two character alpha numeric field to be left blank.~~

(dd)~~(zzz)~~ Principal ICD Procedure Code ~~(Optional)~~ – The code representing the procedure or service most related to the principal diagnosis. A blank field is permitted if type of service is "1" indicating ambulatory surgery. A blank or no entry is permitted consistent with the records of the reporting entity if type of service is "2" indicating an emergency department visit. If not space filled, must contain a valid ICD-9-CM or ICD-10-CM procedure code for the reporting period. Inconsistency between the principal procedure code and patient sex must be verified by the reporting entity. Inconsistency between the principal procedure code and patient age must be verified by the reporting entity. The code must be entered with use of a decimal point that is included in the valid code and without use of a zero or zeros that are not included in the valid code. ~~The ICD-9-CM code. Enter the principal procedure code related to the primary procedure. Left-justified, space filled, no decimal.~~

(ee) Other ICD Procedure Code (1), Other ICD Procedure Code (2), Other ICD Procedure Code (3), Other ICD Procedure Code (4) – A code representing a procedure or service provided during the visit. If no principal ICD procedure is reported, other ICD procedure code must not be reported. No more than four other ICD procedure codes may be reported. A blank or no entry is permitted if type of service is "1." Less than four or no entry is permitted if type of service is "2" consistent with the records of the reporting entity. If not space filled, must be a valid ICD-9-CM or ICD-10-CM procedure code for the reporting period. Inconsistency between the procedure code and patient sex must be verified by the reporting entity. Inconsistency between the procedure code and patient age must be verified by the reporting entity. The code must be entered with use of a decimal point that is included in the valid code and without use of a zero or zeros that are not included in the valid code.

(ff) External Cause of Injury Code (1), External Cause of Injury Code (2), and External Cause of Injury Code (3) – A code representing circumstances or conditions as the cause of the injury, poisoning, or other adverse effects recorded as a diagnosis. No more than three external cause of injury codes may be reported. Less than three or no entry is permitted consistent with the records of the reporting entity. If not space filled, must be a valid ICD-9-CM or ICD-10-CM cause of injury code for the reporting period. An external cause of injury code cannot be used more than once for each visit reported. The code must be entered with use of a decimal point that is included in the valid code and without use of a zero or zeros that are not included in the valid code.

(gg)~~(aaaa)~~ Patient Status – Patient disposition at end of visit. A required entry. Must be a ~~Required for ambulatory visits occurring on or after January 1, 2003 A~~ two digit code ~~indicating patient disposition~~ as follows:

1. 01 – Released home or self care (with or without planned outpatient medical care). ~~01 Home~~

2. 02 – Transferred to ~~To~~ a short-term general hospital. ~~hospital~~

3. 03 – Transferred to ~~To~~ a skilled nursing facility. ~~facility~~

4. 04 – Transferred to an intermediate care facility. ~~04 - Other~~

5. 05 – Transferred to another type of institution (psychiatric, cancer or children's hospital or distinct part unit).

6. 06 – Home under care of home health care organization.

7. 07 – Left against medical advice or discontinued care.

8. 08 – Home under care of home IV provider.

9. 20 – Expired.

10. 50 – Discharged to hospice – home.

11. 51 – Discharged to hospice – medical facility.

12. 62 – Transferred to an inpatient rehabilitation facility including distinct part units of a hospital.

~~(bbbb) Data Type Enter "AS10" for ambulatory patient data.~~

~~(cccc) Filler A blank field of 66 spaces.~~

(3) Trailer Record: The last record in the data file shall be a trailer record and must accompany each data set. If diskettes are submitted, the trailer record must be placed as the last record on the last diskette of the data set. One data element, number of records, must be entered in the trailer record. Report the total number of patient data records contained in the file, excluding header and trailer records. The number entered must equal the number of records processed.

~~This record must follow any documentation submitted for ambulatory patient data records. This record is entered into the file once. All fields are required unless otherwise specified.~~

~~DATA ELEMENT DESCRIPTION~~

~~(a) Transaction Code "T" for the trailer record.~~

~~(b) AHCA Number A 10 digit identification number assigned by AHCA for reporting purposes. A numeric field, right justify.~~

~~(c) Florida License Number Zero fill for the trailer record only.~~

~~(d) Provider Medicaid Number A 10 digit number provided for Medicaid providers. If not a Medicaid provider, zero fill.~~

~~(e) Provider Medicare Number A 10 digit number provided for Medicare providers. If not a Medicare provider, zero fill.~~

~~(f) Provider Mailing Address The address of the health care entity providing the patient data records.~~

~~(g) Provider Mailing Address City The city of the address of the health care entity providing the patient data records.~~

~~(h) Provider Mailing Address State The mailing address of the health care entity providing the patient data records.~~

~~(i) Provider Mailing Address Zip Code The zip code of the health care entity providing the patient data records.~~

~~(j) Submitter Mailing Address The address of the organization that is submitting the data file.~~

~~(k) Submitter Mailing Address City The city of the organization that is submitting the data file.~~

~~(l) Submitter Mailing Address State The state of the organization submitting the data file.~~

~~(m) Submitter Mailing Address Zip Code The zip code of the organization submitting the data file.~~

~~(n) Number of Records The total number of patient data records contained in the file, excluding header and trailer records. Must equal the number of records processed.~~

~~(o) Filler A blank field of 206 spaces.~~

~~(4) The effective date of all data reporting changes in Rule 59B-9.018, F.A.C., as amended after 12-28-98, shall be for discharges occurring on or after January 1, 2002 unless a later date is indicated in Rule 59B-9.018, F.A.C.~~

Specific Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History–New 9-6-93, Formerly 59B-7.018, Amended 6-29-95, 12-28-98, 7-11-01, 2-25-02, _____.

59B-9.019 Ambulatory Patient Data Format – Record Layout.

Specific Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History–New 9-6-93, Formerly 59B-7.019, Amended 6-29-95, 12-28-98, 7-11-01, 2-25-02, Repealed _____.

59B-9.020 Data Standards.

Specific Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History–New 9-6-93, Formerly 59B-7.020, Amended 6-29-95, 12-28-98, 7-11-01, 2-25-02, Repealed _____.

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Board of Architecture and Interior Design

RULE CHAPTER TITLE: RULE CHAPTER NO.:
Certificate of Authorization for Architecture or Interior Design Businesses 61G1-26

RULE TITLES: RULE NOS.:
Individual Licensee Responsibilities 61G1-26.001
Business Responsibilities 61G1-26.002

PURPOSE AND EFFECT: The Board proposes the development of new rules to reiterate the necessity of certificates of authorization for a design business and to emphasize the responsibilities of those licensees qualifying for the business or providing responsible supervisory control.

SUBJECT AREA TO BE ADDRESSED: Certificates of authorization for architecture or interior design businesses.

SPECIFIC AUTHORITY: 481.2055, 481.219 FS.

LAW IMPLEMENTED: 481.219 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE SCHEDULED AND ANNOUNCED IN THE FAW.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Juanita Chastain, Executive Director, Board of Architecture and Interior Design, Northwood Centre, 1940 North Monroe Street, Tallahassee, Florida 32399-0750

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

61G1-26.001 Individual Licensee Responsibilities.

(1) Any application for certificate of authorization must contain the name of the architect or interior designer who will be in responsible supervisory control at each office as well as the name of the qualifier for the business.

(2) The architect or interior designer providing responsible supervisory control must be a full time employee of that business.

(3) An architect or interior designer may be a qualifier of several business entities but can only provide responsible supervisory control over one business location.

(4) Any changes to the person in responsible supervisory control or the qualifier must be reported in writing within thirty (30) days. The qualifier of record is responsible for such notification.

(5) The qualifier has the responsibility to assure each business location/office has a person in responsible supervisory control.

Specific Authority 481.2055, 481.219 FS. Law Implemented 481.219 FS. History–New _____.

61G1-26.002 Business Responsibilities.

The failure of a qualifier to notify the Board of changes in responsible supervisory control or of his or her termination as qualifier does not relieve the partnership or corporation of its duty under Section 481.219(10), F.S. The business entity's failure to notify the Board in a timely fashion in writing of such changes will constitute grounds for disciplinary action against the certificate of authorization.

Specific Authority 481.2055, 481.219 FS. Law Implemented 481.219 FS. History–New _____.

DEPARTMENT OF ENVIRONMENTAL PROTECTION

Pursuant to Chapter 2003-145, Laws of Florida, all notices for the Department of Environmental Protection are published on the Internet at the Department of Environmental Protection's home page at http://www.dep.state.fl.us/ under the link or button titled "Official Notices."

DEPARTMENT OF HEALTH

Board of Respiratory Care

RULE TITLE: RULE NO.:
Provider Approval and Renewal Procedures 64B32-6.005

PURPOSE AND EFFECT: The Board proposes to update existing rule text.

SUBJECT AREA TO BE ADDRESSED: Provider Approval and Renewal Procedures.

SPECIFIC AUTHORITY: 456.025(4), 468.361(3) FS.

LAW IMPLEMENTED: 456.025(7), 468.361(3) FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE TIME, DATE AND PLACE TO BE PUBLISHED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Kaye Howerton, Board Executive Director, Board of Respiratory Care, 4052 Bald Cypress Way, Bin #C05, Tallahassee, Florida 32399-3255

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

64B32-6.005 Provider Approval and Renewal Procedures.

(1) through (4) No change.

(5) Every provider shall:

(a) through (d) No change.

~~(e) Shall provide the board with semi-annual reports of all offerings provided for the previous six months.~~

(6) through (8) No change.

(9) The provider seeking approval for home study courses also shall understand and agree:

(a) through (b) No change.

(c) Instead of the information submitted for in-person programs, the provider shall submit the following for pre-approval:

1. A statement of the educational goals and objectives of the program, including the criteria for successful completion of the program and the number of correct answers required on the test by a participant to receive credit for having taken the program;

2. All materials to be read by the participant, and the testing questions to be answered for successful completion;

3. A current curriculum vitae of each person substantially involved in the preparation of the substance of the program;

4. The identification procedures for verification that the named licensee has taken the home study course;

5. A sample certificate of completion; and

6. If not completely original, references and permission for use or reprint of any copyrighted materials regardless of source.

(10) No change.

Specific Authority 456.025(4), 468.361(3) FS. Law Implemented 456.025(7), 468.361(3) FS. History–New 4-24-96, Amended 5-7-97, Formerly 59R-75.0041, Amended 4-23-98, 6-9-99, Formerly 64B8-75.0041, Amended 7-4-02, _____.

Section II
Proposed Rules

DEPARTMENT OF INSURANCE

Division of State Fire Marshal

RULE CHAPTER TITLE:	RULE CHAPTER NO.:
Uniform Fire Safety Standards for Residential Child Care Facilities	4A-41
RULE TITLES:	**RULE NOS.:**
PART I: RESIDENTIAL CHILD CARE FACILITIES FOR SIX OR MORE CHILDREN	
PART II: RESIDENTIAL CHILD CARE FACILITIES FOR FIVE OR FEWER CHILDREN	
Scope	4A-41.101
Definitions	4A-41.102
Standards of the National Fire Protection Association Adopted	4A-41.103
Occupancy Capacity of Each Facility	4A-41.104
Emergency Egress and Relocation Drills	4A-41.105
Inspections	4A-41.106
Cooking Equipment; Exception	4A-41.107
Special Requirements	4A-41.108

PURPOSE AND EFFECT: Provide firesafety standards for residential child care homes for facilities with five or fewer children, based upon changes to Chapter 409, Florida Statutes, and Rule Chapter 65C-14, Florida Administrative Code.

SUMMARY: Provides firesafety standards for residential child care homes for facilities with five or fewer children.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: None.

Any person who wishes to provide information regarding the statement of estimated regulatory costs, or to provide a proposal for a lower cost regulatory alternative, must do so in writing within 21 days of this notice.

SPECIFIC AUTHORITY: 409.175(6)(f), 633.01(1) FS.

LAW IMPLEMENTED: 409.175(6)(f), 633.022 FS.