

TABLE OF CONTENTS

June 17, 2016 Volume 40, Issue 25

PROPOSED RULES

COMMERCE COMMISSION, ILLINOIS

Standards of Service for Local Exchange Telecommunications Carriers
83 Ill. Adm. Code 730.....8257

Wholesale Service Quality for Telecommunications Carriers
83 Ill. Adm. Code 731.....8264

Service Quality Requirements Applicable to Wireless Eligible
Telecommunications Carriers
83 Ill. Adm. Code 736.....8270

ADOPTED RULES

PUBLIC HEALTH, DEPARTMENT OF

Emergency Medical Services, Trauma Center, Comprehensive Stroke
Center, Primary Stroke Center and Acute Stroke Ready Hospital
Code
77 Ill. Adm. Code 515.....8274

STATE UNIVERSITIES RETIREMENT SYSTEM

Universities Retirement
80 Ill. Adm. Code 1600.....8437

PEREMPTORY RULES

CENTRAL MANAGEMENT SERVICES, DEPARTMENT OF

Pay Plan
80 Ill. Adm. Code 310.....8462

SECOND NOTICES RECEIVED

JOINT COMMITTEE ON ADMINISTRATIVE RULES

Second Notices Received.....8490

REGULATORY AGENDA

OFFICE OF THE ATTORNEY GENERAL

Tobacco Products Manufacturers' Escrow Enforcement Act of 2003
14 Ill. Adm. Code 250.....8491

PROPERTY TAX APPEAL BOARD

Practice and Procedure for Appeals Before the Property Tax
Appeal Board
86 Ill. Adm. Code 1910.....8493

NOTICE OF PUBLICATION ERROR

OFFICE OF THE STATE FIRE MARSHAL

School Inspections
41 Ill. Adm. Code 111.....8495

EXECUTIVE ORDERS AND PROCLAMATIONS

PROCLAMATIONS

Food Allergy Awareness Week
16-152.....8496

Illinois Pollinator Week	
16-153.....	8496
Allied Orders of the Grand Army of the Republic Day	
16-154.....	8497
Complex Regional Pain Syndrome Awareness Day	
16-155.....	8498
Men's Health Week	
16-156.....	8499
Vive tu Vida! Get Up! Get Moving! Wellness Day	
16-157.....	8500
Ron Magers Day	
16-158.....	8501
National Scoliosis Awareness Month	
16-159.....	8502
American Eagle Day	
16-160.....	8503
Rail Safety Week	
16-161.....	8504
Juneteenth Day	
16-162.....	8505
General Aviation Appreciation Month	
16-163.....	8506
Grandparent Alienation Awareness Day	
16-164.....	8507
America's Cup Days	
16-165.....	8508
Children's Day	
16-166.....	8508
Immigrant Heritage Month	
16-167.....	8509
Philippine Independence Day	
16-168.....	8510
Italian National Day	
16-169.....	8511

INTRODUCTION

The Illinois Register is the official state document for publishing public notice of rulemaking activity initiated by State governmental agencies. The table of contents is arranged categorically by rulemaking activity and alphabetically by agency within each category.

Rulemaking activity consists of proposed or adopted new rules; amendments to or repealers of existing rules; and rules promulgated by emergency or preemptory action. Executive Orders and Proclamations issued by the Governor; notices of public information required by State Statute; and activities (meeting agendas; Statements of Objection or Recommendation, etc.) of the Joint Committee on Administrative Rules (JCAR), a legislative oversight committee which monitors the rulemaking activities of State Agencies; is also published in the Register.

The Register is a weekly update of the Illinois Administrative Code (a compilation of the rules adopted by State agencies). The most recent edition of the Code, along with the Register, comprise the most current accounting of State agencies' rulemakings.

The Illinois Register is the property of the State of Illinois, granted by the authority of the Illinois Administrative Procedure Act [5 ILCS 100/1-1, et seq.].

ILLINOIS REGISTER PUBLICATION SCHEDULE FOR 2016

Issue#	Rules Due Date	Date of Issue
1	December 21, 2015	January 4, 2016
2	December 28, 2015	January 8, 2016
3	January 4, 2016	January 15, 2016
4	January 11, 2016	January 22, 2016
5	January 19, 2016	January 29, 2016
6	January 25, 2016	February 5, 2016
7	February 1, 2016	February 16, 2016
8	February 8, 2016	February 19, 2016
9	February 16, 2016	February 26, 2016
10	February 22, 2016	March 4, 2016
11	February 29, 2016	March 11, 2016
12	March 7, 2016	March 18, 2016
13	March 14, 2016	March 25, 2016
14	March 21, 2016	April 1, 2016
15	March 28, 2016	April 8, 2016
16	April 4, 2016	April 15, 2016
17	April 11, 2016	April 22, 2016
18	April 18, 2016	April 29, 2016
19	April 25, 2016	May 6, 2016
20	May 2, 2016	May 13, 2016
21	May 9, 2016	May 20, 2016
22	May 16, 2016	May 27, 2016

23	May 23, 2016	June 3, 2016
24	May 31, 2016	June 10, 2016
25	June 6, 2016	June 17, 2016
26	June 13, 2016	June 24, 2016
27	June 20, 2016	July 1, 2016
28	June 27, 2016	July 8, 2016
29	July 5, 2016	July 15, 2016
30	July 11, 2016	July 22, 2016
31	July 18, 2016	July 29, 2016
32	July 25, 2016	August 5, 2016
33	August 1, 2016	August 12, 2016
34	August 8, 2016	August 19, 2016
35	August 15, 2016	August 26, 2016
36	August 22, 2016	September 2, 2016
37	August 29, 2016	September 9, 2016
38	September 6, 2016	September 16, 2016
39	September 12, 2016	September 23, 2016
40	September 19, 2016	September 30, 2016
41	September 26, 2016	October 7, 2016
42	October 3, 2016	October 14, 2016
43	October 11, 2016	October 21, 2016
44	October 17, 2016	October 28, 2016
45	October 24, 2016	November 4, 2016
46	October 31, 2016	November 14, 2016
47	November 7, 2016	November 18, 2016
48	November 14, 2016	November 28, 2016
49	November 21, 2016	December 2, 2016
50	November 28, 2016	December 9, 2016
51	December 5, 2016	December 16, 2016
52	December 12, 2016	December 27, 2016
53	December 19, 2016	December 30, 2016

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED AMENDMENT

- 1) Heading of the Part: Standards of Service for Local Exchange Telecommunications Carriers
- 2) Code Citation: 83 Ill. Adm. Code 730
- 3) Section Number: 730.550 Proposed Action: Amendment
- 4) Statutory Authority: Implementing Sections 8-301, 8-505 and 13-712 and authorized by Section 10-101 of the Public Utilities Act [220 ILCS 5/8-301, 8-505, 13-712 and 10-101]
- 5) A Complete Description of the Subjects and Issues Involved: The proposed amendment is a product of the biennial review of telecommunications-related rules that the Commission is required to undertake pursuant to Section 13-512 of the Public Utilities Act [220 ILCS 5/13-512]. The amendment would align the network outage reporting requirements of Part 730 with federal requirements, reducing the burden of compliance with the rule without reducing the quality of the information supplied. The proposed amendment would also allow carriers to report outages to the Commission by e-mail.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rule currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objective: The proposed rulemaking neither creates nor expands any State mandate on units of local government, school districts, or community college districts.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Comments should be filed, within 45 days after the date of this issue of the *Illinois Register*, in Docket No. 16-0308 with:

Elizabeth Rolando, Chief Clerk

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED AMENDMENT

Illinois Commerce Commission
527 East Capitol Avenue
Springfield IL 62701

217/782-7434

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: This rulemaking will affect any subject jurisdictional entities that are also small businesses as defined in the Illinois Administrative Procedure Act. This rulemaking will not affect any small municipalities or not-for-profit corporations.
 - B) Reporting, bookkeeping or other procedures required for compliance:
Bookkeeping and filing procedures
 - C) Types of professional skills necessary for compliance: Managerial and accounting skills
- 14) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was not included on either of the two most recent Agendas because: The Commission did not anticipate the need for this rulemaking at that time.

The full text of the Proposed Amendment begins on the next page:

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED AMENDMENT

TITLE 83: PUBLIC UTILITIES
CHAPTER I: ILLINOIS COMMERCE COMMISSION
SUBCHAPTER f: TELEPHONE UTILITIES

PART 730
STANDARDS OF SERVICE FOR LOCAL EXCHANGE
TELECOMMUNICATIONS CARRIERS

SUBPART A: GENERAL

Section	
730.100	Application of Part
730.105	Definitions
730.110	Waiver
730.115	Reporting
730.120	Penalties

SUBPART B: RECORDS AND REPORTS

Section	
730.200	Preservation of Records

SUBPART C: ENGINEERING

Section	
730.300	Construction
730.305	Maintenance of Plant and Equipment
730.310	Grade of Service
730.315	Interoffice Trunks (Repealed)
730.320	Network Service
730.325	Emergency Operation
730.330	Construction Work Near Utility Facilities
730.335	Network Interface
730.340	Incorporation of National Codes and Standards

SUBPART D: CALL DATA, INSPECTIONS, AND TESTS

Section	
730.400	Provisions for Testing

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED AMENDMENT

- 730.405 Call Data Records
- 730.410 Call Data Reading Interval
- 730.415 Call Data Recording Equipment and Test Facilities
- 730.420 Call Data Recording Equipment Requirements
- 730.425 Initial Test
- 730.430 As-Found Tests
- 730.435 Routine Tests
- 730.440 Request Tests
- 730.445 Referee Tests
- 730.450 Test Records

SUBPART E: STANDARDS OF QUALITY OF SERVICE

- Section
- 730.500 Adequacy of Service
- 730.505 Operator Handled Calls
- 730.510 Answering Time
- 730.515 Central Office Administrative Requirements
- 730.520 Interoffice Trunks
- 730.525 Transmission Requirements
- 730.530 Coin Telephone Service (Repealed)
- 730.535 Interruptions of Service
- 730.540 Installation Requests
- 730.545 Trouble Reports
- 730.550 Network Outages and Notification

SUBPART F: SAFETY

- Section
- 730.600 Safety Program
- 730.605 Accident Reports (Repealed)

SUBPART G: BOUNDARIES

- Section
- 730.700 Map Requirements
- 730.705 Map Specifications
- 730.710 Application for Certificate (Repealed)
- 730.711 Changes to Existing Boundaries

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED AMENDMENT

- 730.715 Service Outside Exchange Boundaries
 730.720 Map Maintenance
 730.725 District Boundaries (Repealed)

AUTHORITY: Implementing Sections 8-301, 8-505 and 13-712 and authorized by Section 10-101 of the Public Utilities Act [220 ILCS 5/8-301, 8-505, 13-712 and 10-101].

SOURCE: Filed November 6, 1970; amended at 7 Ill. Reg. 2147, effective February 4, 1983; codified at 8 Ill. Reg. 12191; Part repealed and new Part adopted at 15 Ill. Reg. 16060, effective November 1, 1991; amended at 24 Ill. Reg. 13861, effective September 1, 2000; amended at 27 Ill. Reg. 17997, effective December 1, 2003; amended at 35 Ill. Reg. 8808, effective June 1, 2011; amended at 36 Ill. Reg. 14990, effective October 1, 2012; amended at 39 Ill. Reg. 355, effective December 22, 2014; amended at 40 Ill. Reg. _____, effective _____.

SUBPART E: STANDARDS OF QUALITY OF SERVICE

Section 730.550 Network Outages and Notification

a) Notification

- 1) Each local exchange carrier shall inform the Commission by telephone or by e-mail of any service interruption exceeding 30 minutes~~15 minutes~~ duration caused by a complete or partial central office failure or complete or partial isolation of an exchange due to toll circuit failure, including cut cables. A reportable outage is any one of the following occurrences with a duration, unless otherwise specified, of at least 30 minutes affecting more than 50% of the customers and affecting more than 100 access lines in the affected exchange:~~The notification shall be made via telephone call to (217)558-6166 and shall consist of the following information:~~
 - A) Toll isolation;~~Affected Area Code/Prefix~~
 - B) Loss of dial tone;~~Exchange Name~~
 - C) Isolation of one or more end offices or MSC switches or host/remote clusters from 9-1-1 service;~~Company Name~~
 - D) Loss of ANI/ALI processing;~~Cause of Interruption~~

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED AMENDMENT

- E) ~~Simplex conditions exceeding 5 days. Outage Date and Time~~
 - F) ~~Restoral Date and Time~~
 - G) ~~Effect on 9-1-1 Service~~
 - H) ~~Name and Number of Person Reporting the Service Interruption.~~
- 2) The notification shall be made via telephone call to (217)558-6166 or by e-mail to the outage notification e-mail address posted on the Commission's website and shall consist of the following information:
- A) Affected Area Code/Prefix
 - B) Exchange Name
 - C) Company Name
 - D) Cause of Interruption
 - E) Outage Date and Time
 - F) Restoral Date and Time
 - G) Effect on 9-1-1 Service
 - H) Name and Number of Person Reporting the Service Interruption.
- 32) **Written Report**
A follow-up written report shall be filed within 30 days, either via U.S. Postal Service, facsimile or e-mail.
- 43) ~~Reporting Timeframes~~
- A) ~~Minor outages shall be reported within 24 hours or during the next normal business day, when more than 100 access lines experience an outage. Minor outages consist of loss of local or toll service affecting fewer than 50% of the customers and affecting more than~~

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED AMENDMENT

~~100 access lines in the affected exchange for a period of time not to exceed 12 hours.~~

- ~~B) Major outages shall be reported immediately via telephone call to (217)558-6166.~~
- ~~C) Major outages consist of complete loss of local or toll service affecting at least 50% of the customers in the affected exchange or when any outage is expected to exceed 12 hours.~~
- ~~D) All outages affecting 9-1-1 services shall be reported in accordance with 83 Ill. Adm. Code 725, Standards Applicable to 9-1-1 Emergency Systems. In particular, any cut cables or loss of host-remote links that result in the physical staffing of 9-1-1 call boxes are to be reported as soon as possible.~~

- b) Whenever it is necessary to interrupt customer service for the purpose of working on the distribution system or central office equipment, the work should be completed with minimal customer impact. The local exchange carrier shall use reasonable efforts to notify in advance public service customers (e.g., 9-1-1 entities, police, fire, hospitals) it reasonably believes may be most seriously affected by the interruption. Any customer credits for interrupted service shall be made pursuant to 83 Ill. Adm. Code 732.

(Source: Amended at 40 Ill. Reg. _____, effective _____)

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED AMENDMENT

- 1) Heading of the Part: Wholesale Service Quality for Telecommunications Carriers
- 2) Code Citation: 83 Ill. Adm. Code 731
- 3) Section Number: 731.205 Proposed Action:
Amendment
- 4) Statutory Authority: Implementing Sections 13-712(g) and 13-902(c)(3) of the Public Utilities Act [220 ILCS 5/13-712(g) and 13-902(c)(3)]
- 5) A Complete Description of the Subjects and Issues Involved: The proposed amendment is a product of the biennial review of telecommunications-related rules that the Commission is required to undertake pursuant to Section 13-512 of the Public Utilities Act [220 ILCS 5/13-512]. The draft amendment would eliminate duplicative and unnecessary provisions in Section 205 of the Part that require large telecommunications carriers to provide notice to the Commission of extensions in the terms of their existing plans or of the maintenance of their existing plans without any changes. In addition, in the same Section the amendment would update references to a position title to reflect the agency's current organizational structure.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rule currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objective: The proposed rulemaking neither creates nor expands any State mandate on units of local government, school districts, or community college districts.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Comments should be filed, within 45 days after the date of this issue of the *Illinois Register* in Docket No. 16-0309 with:

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED AMENDMENT

Elizabeth Rolando, Chief Clerk
Illinois Commerce Commission
527 East Capitol Avenue
Springfield IL 62701

217/782-7434

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: This rulemaking will affect any subject jurisdictional entities that are also small businesses as defined in the Illinois Administrative Procedure Act. This rulemaking will not affect any small municipalities or not-for-profit corporations.
 - B) Reporting, bookkeeping or other procedures required for compliance:
Bookkeeping and filing procedures
 - C) Types of professional skills necessary for compliance: Managerial and accounting skills
- 14) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was not included on either of the two most recent agendas because: The Commission did not anticipate the need for this rulemaking at that time.

The full text of the Proposed Amendment begins on the next page:

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED AMENDMENT

TITLE 83: PUBLIC UTILITIES
CHAPTER I: ILLINOIS COMMERCE COMMISSION
SUBCHAPTER f: TELEPHONE COMPANIES

PART 731

WHOLESALE SERVICE QUALITY FOR TELECOMMUNICATIONS CARRIERS

SUBPART A: GENERAL

Section

- 731.100 Purpose and Application of Part
- 731.105 Definitions
- 731.110 Classifications of Carriers

SUBPART B: PROCEDURE FOR LEVEL 1 CARRIERS

Section

- 731.200 Applicability of Subpart B
- 731.205 Submission of Wholesale Service Quality Plans
- 731.210 Investigation or Review of Wholesale Service Quality Plans
- 731.220 Wholesale Service Quality Plan Filing Requirements
- 731.230 Effective Wholesale Service Quality Plan Pending Review and Approval by the Commission

SUBPART C: PLAN REQUIREMENTS FOR LEVEL 1 CARRIERS

Section

- 731.300 Applicability of Subpart C
- 731.305 General Plan Requirements
- 731.310 Types of Service Covered
- 731.315 Measures and Standards
- 731.320 Remedies
- 731.325 Reporting
- 731.330 Auditing

SUBPART D: PROVISIONS APPLICABLE TO ALL LEVEL 1 CARRIERS

Section

- 731.400 Applicability of Subpart D

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED AMENDMENT

- 731.405 Treatment and Effect of Wholesale Service Emergency Situations
- 731.410 Additional Reporting Requirements
- 731.420 Effect of Interconnection Agreements

SUBPART E: COMMISSION REVIEW AND APPROVAL OF PLANS FOR LEVEL 1 CARRIERS

Section

- 731.500 Applicability of Subpart E
- 731.505 Commission Review and Approval of Wholesale Service Quality Plans

SUBPART F: OBLIGATIONS OF LEVEL 2 CARRIERS

Section

- 731.600 Applicability of Subpart F
- 731.605 Types of Service Covered by and Exemption from Reporting Requirements from Subpart F
- 731.610 Measures and Standards under Subpart F
- 731.615 Remedies under Subpart F
- 731.620 Reporting under Subpart F
- 731.625 Auditing under Subpart F
- 731.630 Effect of Interconnection Agreement
- 731.635 Application of Level 1 Requirements to Level 2 Carriers and Conversion to Level 1

SUBPART G: PROVISIONS APPLICABLE TO LEVEL 3 CARRIERS

Section

- 731.700 Applicability of Subpart G
- 731.705 Conversion to Level 2

SUBPART H: PROVISIONS APPLICABLE TO LEVEL 4 CARRIERS

Section

- 731.800 Applicability of Subpart H
- 731.805 Types of Service Covered and Exemptions from Certain Subparts
- 731.810 Measures and Standards under Subpart H
- 731.815 Remedies under Subpart H

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED AMENDMENT

731.820 Application of Level 2 Requirements to Level 4 Carriers and Conversion to Level 2

SUBPART I: PROVISIONS APPLICABLE TO ALL CARRIERS

731.900 Applicability of Subpart I

731.905 Notice of Termination of Wholesale Service

AUTHORITY: Implementing Sections 13-712(g) and 13-902(c)(3) of the Public Utilities Act [220 ILCS 5/13-712(g) and 13-902(c)(3)].

SOURCE: Adopted at 28 Ill. Reg. 12083, effective September 1, 2004; amended at 40 Ill. Reg. _____, effective _____.

SUBPART B: PROCEDURE FOR LEVEL 1 CARRIERS

Section 731.205 Submission of Wholesale Service Quality Plans

- a) ~~Each~~ On or before September 15, 2004, and every three years thereafter, every Level 1 carrier shall submit to the Manager of the Telecommunications Division of the Commission its Wholesale Service Quality Plan as specified in, and pursuant to, Subparts B, C, D and E of this Part. Additional submissions shall be made each time a Level 1 carrier's wholesale service quality plan is amended, that carrier shall submit. ~~With each submission, the Level 1 carrier shall include a brief explanation of any changes to the plan, provided that the Level 1 carrier is not required to make a submission when the only change to the plan is an extension in its term. For any submission due after September 15, 2004, if a Level 1 carrier proposes to maintain, without any additions, deletions or modifications, its existing wholesale service quality plan, the Level 1 carrier may file a submission to the Manager of the Telecommunications Division, in the form of a verified statement establishing that it proposes to maintain its existing plan in effect, without any additions, deletions or modifications.~~
- b) Any carrier designated by the Commission as a Level 1 carrier pursuant to Section 731.110 or 731.635 shall submit to the Director of the Policy Division ~~Manager of the Telecommunications Division~~ its wholesale service quality plan within 90 days after its designation as a Level 1 carrier by the Commission, and, after one year from the submission of its initial wholesale

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED AMENDMENT

service quality plan, shall submit all amended wholesale service quality plans pursuant to subsection (a).

- c) If the Commission has reason to believe that implementation of a Level 1 carrier's wholesale service quality plan discriminates against a telecommunications carrier that is not a party to the agreement, or if the Commission has reason to believe that implementation of the plan is not consistent with the public interest, convenience and necessity, it may initiate a proceeding to investigate that wholesale service quality plan. After an investigation and notice and an opportunity to be heard, the Commission may modify, update, or in any way amend the plan prior to the end of the triennial period. If the Commission initiates a docket investigating a plan, a verified answer to the initiating order shall be filed and served on the appropriate parties within 30 days after the date upon which the initiating order issued.
- d) 45 days' prior notice of any proposed change or modification to a Plan, other than an extension in its term, shall be served on the Director of the Policy Division ~~Manager of the Telecommunications Division~~ of the Commission and all affected carriers via mail, with postage prepaid, or fax, or e-mail and shall be available for inspection on that Level 1 carrier's website. Any carrier contesting the proposed change must file, within 30 days after the date of service of the notice of the proposed change, a complaint, with the Commission, in which the complaining carrier sets forth the reasons it contests the change. A verified answer to a complaint shall be filed and served on the appropriate parties within 30 days after the date upon which the complaint was filed.
- e) At any hearing regarding a change or modification to a plan, the carrier proposing the change or modification to the plan shall have the burden of proof to establish the justness and reasonableness of the changes or modifications.

(Source: Amended at 40 Ill. Reg. _____, effective _____)

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED AMENDMENT

- 1) Heading of the Part: Service Quality Requirements Applicable to Wireless Eligible Telecommunications Carriers
- 2) Code Citation: 83 Ill. Adm. Code 736
- 3) Section Number: 736.500 Proposed Action: Amendment
- 4) Statutory Authority: Implementing Sections 13-101, 13-304, 13-305, and 13-712 and authorized by Section 10-101 of the Public Utilities Act [220 ILCS 5/13-101, 13-304, 13-305, 13-712, and 10-101]
- 5) A Complete Description of the Subjects and Issues Involved: The proposed amendment is a product of the biennial review of telecommunications-related rules that the Commission is required to undertake pursuant to Section 13-512 of the Public Utilities Act [220 ILCS 5/13-512]. The draft amendment would adopt the current version of the Wireless Association® (CTIA) Consumer Code for Wireless Service (CTIA Code) that Part 736 incorporates by reference as a source for service quality and consumer protection provisions.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rule currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? Yes
- 10) Are there any other rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objective: The proposed rulemaking neither creates nor expands any State mandate on units of local government, school districts, or community college districts.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Comments should be filed, within 45 days after the date of this issue of the *Illinois Register* in Docket No. 16-0310 with:

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED AMENDMENT

Elizabeth Rolando, Chief Clerk
Illinois Commerce Commission
527 East Capitol Avenue
Springfield IL 62701

217/782-7434

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: This rulemaking will affect any subject jurisdictional entities that are also small businesses as defined in the Illinois Administrative Procedure Act. This rulemaking will not affect any small municipalities or not-for-profit corporations.
 - B) Reporting, bookkeeping or other procedures required for compliance:
Bookkeeping and filing procedures
 - C) Types of professional skills necessary for compliance: Managerial and accounting skills
- 14) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was not included on either of the two most recent Agendas because: The Commission did not anticipate the need for this rulemaking at that time.

The full text of the Proposed Amendment begins on the next page:

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED AMENDMENT

TITLE 83: PUBLIC UTILITIES
CHAPTER I: ILLINOIS COMMERCE COMMISSION
SUBCHAPTER f: TELEPHONE UTILITIES

PART 736

SERVICE QUALITY REQUIREMENTS APPLICABLE TO WIRELESS ELIGIBLE
TELECOMMUNICATIONS CARRIERS

SUBPART A: GENERAL

Section

- 736.100 Application of Part
- 736.105 Definitions
- 736.110 Waiver
- 736.115 Reporting (Repealed)
- 736.120 Enforcement

SUBPART B: ENGINEERING

Section

- 736.300 Construction and Maintenance of Plant and Equipment (Repealed)
- 736.305 Emergency Operation
- 736.310 Incorporation of National Codes and Standards (Repealed)

SUBPART C: STANDARDS OF QUALITY OF SERVICE

Section

- 736.500 Adequacy of Service
- 736.505 Answering Time (Repealed)
- 736.510 Interoffice Trunks (Repealed)
- 736.515 Dropped Calls and Signal Strength (Repealed)
- 736.520 Service Outages and Notification (Repealed)
- 736.525 Installation Requests – Failure to Provide Service (Repealed)
- 736.530 Trouble Reports (Repealed)
- 736.540 Directory Notification (Repealed)

SUBPART D: OTHER WETC REQUIREMENTS

Section

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED AMENDMENT

736.550	Obligation to Serve (Repealed)
736.555	WETC Service Area
736.610	Customer Billing (Repealed)
736.620	Deferred Payment Agreements (Repealed)
736.630	Applicants for Service (Repealed)
736.640	Present Customers (Repealed)
736.650	Deposits (Repealed)
736.660	Discontinuance or Refusal of Service (Repealed)
736.670	Illness Provision (Repealed)
736.680	Payment for Service (Repealed)
736.685	Past Due Bills (Repealed)
736.690	Service Restoration Charge (Repealed)
736.695	Dispute Procedures (Repealed)
736.700	Commission Complaint Procedures (Repealed)
736.705	Second Language (Repealed)
736.710	Customer Information Booklet (Repealed)

736.APPENDIX A Notice of Discontinuance of Service (Repealed)

736.APPENDIX B Requirements to Avoid Shutoff of Service in the Event of Illness (Repealed)

AUTHORITY: Implementing Sections 13-101, 13-304, 13-305, and 13-712 and authorized by Section 10-101 of the Public Utilities Act [220 ILCS 5/13-101, 13-304, 13-305, 13-712, and 10-101].

SOURCE: Adopted at 32 Ill. Reg. 18935, effective December 1, 2008; amended at 38 Ill. Reg. 21064, effective October 23, 2014; amended at 40 Ill. Reg. _____, effective _____.

SUBPART C: STANDARDS OF QUALITY OF SERVICE

Section 736.500 Adequacy of Service

Each WETC shall comply with the service quality and consumer protection provisions contained in the Wireless Association® (CTIA) Consumer Code for Wireless Service (CTIA Code). The Commission adopts the version in effect on ~~September 10, 2013~~ August 24, 2015. The CTIA Code may be viewed on the Commission's web site at: <http://www.icc.illinois.gov>.

(Source: Amended at 40 Ill. Reg. _____, effective _____)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: Emergency Medical Services, Trauma Center, Comprehensive Stroke Center, Primary Stroke Center and Acute Stroke-Ready Hospital Code
- 2) Code Citation: 77 Ill. Adm. Code 515
- 3)

<u>Section Numbers:</u>	<u>Adopted Actions:</u>
515.100	Amendment
515.210	Amendment
515.220	Amendment
515.250	Amendment
515.255	New Section
515.330	Amendment
515.445	Amendment
515.830	Amendment
515.3090	Amendment
515.4000	Amendment
515.4010	Amendment
515.4020	Amendment
515.5000	Amendment
515.5002	New Section
515.5004	New Section
515.5010	Amendment
515.5015	New Section
515.5016	New Section
515.5017	New Section
515.5020	Amendment
515.5030	Amendment
515.5040	Amendment
515.5050	Amendment
515.5060	Amendment
515.5070	Amendment
515.5080	Amendment
515.5083	New Section
515.5085	New Section
515.5087	New Section
515.5090	Amendment
515.APPENDIX K	Amendment
515.APPENDIX L	Amendment
515.APPENDIX N	Amendment

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

515.APPENDIX O Amendment
515.APPENDIX P Amendment

4) Statutory Authority: Emergency Medical Services (EMS) Systems Act [210 ILCS 50]

5) Effective Date of Rules: June 3, 2016

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? No

8) A copy of the adopted rules, including any material incorporated by reference, is on file in the Agency's principal office and is available for public inspection.

9) Notice of Proposed published in the *Illinois Register*: 39 Ill. Reg. 14321; November 6, 2015

10) Has JCAR issued a Statement of Objection to this rulemaking? No

11) Differences between Proposal and Final Version: The following changes were made a result of comments received during the first notice or public comment period:

In Section 515.220(a)(9), with regard to the EMS Medical Directors Committee part of the EMS Regional Plan content, the Department added a sentence that states that regional stroke data will be considered as it becomes available for the development of protocols for triage, treatment and transport of possible acute stroke patients.

In Section 515.5050(b), to clarify when a stroke designation name change will occur, the Department added that an Emergent Stroke Ready Hospital will be converted to an Acute Stoke-Ready Hospital at the time of the hospital's renewal application or annual attestation to the Department.

In addition, various typographical, grammatical, and form, changes were made in response to the comments from JCAR.

12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes

13) Will this rulemaking replace an emergency rule currently in effect? No

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- 14) Are there any rulemakings pending on this Part? Yes

<u>Section Numbers:</u>	<u>Proposed Actions:</u>	<u>Illinois Register Citation:</u>
515.220	Amendment	40 Ill. Reg. 5374; April 1, 2016
515.500	Amendment	40 Ill. Reg. 5374; April 1, 2016
515.725	Amendment	40 Ill. Reg. 5374; April 1, 2016
515.825	Amendment	40 Ill. Reg. 5374; April 1, 2016
515.830	Amendment	40 Ill. Reg. 5374; April 1, 2016
515.950	Amendment	40 Ill. Reg. 5374; April 1, 2016
515.975	Amendment	40 Ill. Reg. 5374; April 1, 2016
515.995	Amendment	40 Ill. Reg. 5374; April 1, 2016

- 15) Summary and Purpose of Rulemaking: This rulemaking implements PA 98-1001 which created the designation of Acute Stroke-Ready Hospitals and Comprehensive Stroke Centers and PA 98-973 which modified terminology and provided for licensure of pre-hospital registered nurses, emergency communications registered nurses and emergency medical responders.

This rulemaking also amends provisions of the Part with respect to pediatric services. Pediatric amendments seek to allow existing physicians with many years of pediatric Emergency Room (ER) experience to continue to work in hospital emergency rooms that are designated as Emergency Department Approved for Pediatrics (EDAP); eliminate the waiver provisions with respect to board certified ER physicians; update the Part to current national pediatric medical standards; and permit healthcare professionals working in an out of state hospital (but close to the boarder) that participates in an Illinois EMS system to utilize qualified individuals licensed in the state where the facility is located and removes the requirement for dual licensing.

- 16) Information and questions regarding these adopted rules shall be directed to:

Elizabeth Paton
 Assistant General Counsel
 Division of Legal Services
 Illinois Department of Public Health
 535 W. Jefferson St., 5th floor
 Springfield IL 62761

217/782-2043

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

e-mail: dph.rules@illinois.gov

The full text of the Adopted Amendments begin on the next page:

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER f: EMERGENCY SERVICES AND HIGHWAY SAFETY

PART 515

EMERGENCY MEDICAL SERVICES, TRAUMA CENTER,
COMPREHENSIVE STROKE CENTER, PRIMARY STROKE CENTER AND
ACUTE STROKE-READY HOSPITAL~~EMERGENT STROKE READY HOSPITAL~~ CODE

SUBPART A: GENERAL PROVISIONS

Section

515.100	Definitions
515.125	Incorporated and Referenced Materials
515.150	Waiver Provisions
515.160	Facility, System and Equipment Violations, Hearings and Fines
515.165	Suspension, Revocation and Denial of Licensure
515.170	Employer Responsibility
515.180	Administrative Hearings
515.190	Felony Convictions

SUBPART B: EMS REGIONS

Section

515.200	Emergency Medical Services Regions
515.210	EMS Regional Plan Development
515.220	EMS Regional Plan Content
515.230	Resolution of Disputes Concerning the EMS Regional Plan
515.240	Bioterrorism Grants
515.250	Hospital Stroke Care Fund
<u>515.255</u>	<u>Stroke Data Collection Fund</u>

SUBPART C: EMS SYSTEMS

Section

515.300	Approval of New EMS Systems
515.310	Approval and Renewal of EMS Systems
515.315	Bypass Status Review
515.320	Scope of EMS Service
515.330	EMS System Program Plan

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

515.340	EMS Medical Director's Course
515.350	Data Collection and Submission
515.360	Approval of Additional Drugs and Equipment
515.370	Automated Defibrillation (Repealed)
515.380	Do Not Resuscitate (DNR) Policy
515.390	Minimum Standards for Continuing Operation
515.400	General Communications
515.410	EMS System Communications
515.420	System Participation Suspensions
515.430	Suspension, Revocation and Denial of Licensure of EMTs (Repealed)
515.440	State Emergency Medical Services Disciplinary Review Board
515.445	Pediatric Care
515.450	Complaints
515.455	Intra- and Inter-system Dispute Resolution
515.460	Fees
515.470	Participation by Veterans Health Administration Facilities

SUBPART D: EMERGENCY MEDICAL TECHNICIANS

Section	
515.500	Emergency Medical Technician-Basic Training
515.510	Emergency Medical Technician-Intermediate Training
515.520	Emergency Medical Technician-Paramedic Training
515.530	EMT Testing
515.540	EMT Licensure
515.550	Scope of Practice – Licensed EMT
515.560	EMT-B Continuing Education
515.570	EMT-I Continuing Education
515.580	EMT-P Continuing Education
515.590	EMT License Renewals
515.600	EMT Inactive Status
515.610	EMT Reciprocity
515.620	Felony Convictions (Renumbered)
515.630	Evaluation and Recognition of Military Experience and Education
515.640	Reinstatement

SUBPART E: EMS LEAD INSTRUCTOR, EMERGENCY MEDICAL DISPATCHER, FIRST RESPONDER, PRE-HOSPITAL REGISTERED NURSE, EMERGENCY COMMUNICATIONS REGISTERED NURSE, AND TRAUMA NURSE SPECIALIST

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Section

515.700	EMS Lead Instructor
515.710	Emergency Medical Dispatcher
515.715	Provisional Licensure for First Responders and Emergency Medical Responders
515.720	First Responder (Repealed)
515.725	First Responder/Emergency Medical Responder
515.730	Pre-Hospital Registered Nurse
515.740	Emergency Communications Registered Nurse
515.750	Trauma Nurse Specialist
515.760	Trauma Nurse Specialist Program Plan

SUBPART F: VEHICLE SERVICE PROVIDERS

Section

515.800	Vehicle Service Provider Licensure
515.810	EMS Vehicle System Participation
515.820	Denial, Nonrenewal, Suspension and Revocation of a Vehicle Service Provider License
515.825	Alternate Response Vehicle
515.830	Ambulance Licensing Requirements
515.833	In-Field Service Level Upgrade – Rural Population
515.835	Stretcher Van Provider Licensing Requirements
515.840	Stretcher Van Requirements
515.845	Operation of Stretcher Vans
515.850	Reserve Ambulances
515.860	Critical Care Transport

SUBPART G: LICENSURE OF SPECIALIZED EMERGENCY
MEDICAL SERVICES VEHICLE (SEMSV) PROGRAMS

Section

515.900	Licensure of SEMSV Programs – General
515.910	Denial, Nonrenewal, Suspension or Revocation of SEMSV Licensure
515.920	SEMSV Program Licensure Requirements for All Vehicles
515.930	Helicopter and Fixed-Wing Aircraft Requirements
515.935	EMS Pilot Specifications
515.940	Aeromedical Crew Member Training Requirements
515.945	Aircraft Vehicle Specifications and Operation

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

515.950	Aircraft Medical Equipment and Drugs
515.955	Vehicle Maintenance for Helicopter and Fixed-wing Aircraft Programs
515.960	Aircraft Communications and Dispatch Center
515.963	Flight Program Safety Standards
515.965	Watercraft Requirements
515.970	Watercraft Vehicle Specifications and Operation
515.975	Watercraft Medical Equipment and Drugs
515.980	Watercraft Communications and Dispatch Center
515.985	Off-Road SEMSV Requirements
515.990	Off-Road Vehicle Specifications and Operation
515.995	Off-Road Medical Equipment and Drugs
515.1000	Off-Road Communications and Dispatch Center

SUBPART H: TRAUMA CENTERS

Section

515.2000	Trauma Center Designation
515.2010	Denial of Application for Designation or Request for Renewal
515.2020	Inspection and Revocation of Designation
515.2030	Level I Trauma Center Designation Criteria
515.2035	Level I Pediatric Trauma Center
515.2040	Level II Trauma Center Designation Criteria
515.2045	Level II Pediatric Trauma Center
515.2050	Trauma Center Uniform Reporting Requirements
515.2060	Trauma Patient Evaluation and Transfer
515.2070	Trauma Center Designation Delegation to Local Health Departments
515.2080	Trauma Center Confidentiality and Immunity
515.2090	Trauma Center Fund
515.2100	Pediatric Care (Renumbered)
515.2200	Suspension Policy for Trauma Nurse Specialist Certification

SUBPART I: EMS ASSISTANCE FUND

Section

515.3000	EMS Assistance Fund Administration
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SUBPART J: EMERGENCY MEDICAL SERVICES FOR CHILDREN

Section

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- 515.3090 Pediatric Recognition of Hospital Emergency Departments and Inpatient Critical Care Services
- 515.4000 Facility Recognition Criteria for the Emergency Department Approved for Pediatrics (EDAP)
- 515.4010 Facility Recognition Criteria for the Standby Emergency Department Approved for Pediatrics (SEDP)
- 515.4020 Facility Recognition Criteria for the Pediatric Critical Care Center (PCCC)

SUBPART K: COMPREHENSIVE STROKE CENTERS, PRIMARY STROKE CENTERS AND ACUTE STROKE-READY HOSPITALS~~EMERGENT STROKE READY HOSPITALS~~

- 515.5000 Definitions
- 515.5002 State Stroke Advisory Subcommittee
- 515.5004 Regional Stroke Advisory Subcommittee
- 515.5010 Stroke Care – Restricted Practices
- 515.5015 Comprehensive Stroke Center (CSC) Designation
- 515.5016 Request for Comprehensive Stroke Center Designation
- 515.5017 Suspension and Revocation of Comprehensive Stroke Center Designation
- 515.5020 Primary Stroke Center (PSC) Designation
- 515.5030 Request for Primary Stroke Center Designation
- 515.5040 Suspension and Revocation of Primary Stroke Center Designation
- 515.5050 Acute Stroke-Ready Hospital (ASRH)~~Emergent Stroke Ready Hospital (ESRH)~~ Designation without National Certification
- 515.5060 Acute Stroke-Ready Hospital~~Emergent Stroke Ready Hospital~~ Designation Criteria without National Certification
- 515.5070 Request for Acute Stroke-Ready Hospital~~Emergent Stroke Ready Hospital~~ Designation without National Certification
- 515.5080 Suspension and Revocation of Acute Stroke-Ready Hospital~~Emergent Stroke Ready Hospital~~ Designation without National Certification
- 515.5083 Acute Stroke-Ready Hospital Designation with National Certification
- 515.5085 Request for Acute Stroke-Ready Hospital Designation with National Certification
- 515.5087 Suspension and Revocation of Acute Stroke-Ready Hospital Designation with National Certification
- 515.5090 Data Collection and Submission
- 515.5100 Statewide Stroke Assessment Tool
- 515.APPENDIX A A Request for Designation (RFD) Trauma Center
- 515.APPENDIX B A Request for Renewal of Trauma Center Designation
- 515.APPENDIX C Minimum Trauma Field Triage Criteria

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

515.APPENDIX D	Standing Medical Orders
515.APPENDIX E	Minimum Prescribed Data Elements
515.APPENDIX F	Template for In-House Triage for Trauma Centers
515.APPENDIX G	Credentials of General/Trauma Surgeons Level I and Level II
515.APPENDIX H	Credentials of Emergency Department Physicians Level I and Level II
515.APPENDIX I	Credentials of General/Trauma Surgeons Level I and Level II Pediatric Trauma Centers
515.APPENDIX J	Credentials of Emergency Department Physicians Level I and Level II Pediatric Trauma Centers
515.APPENDIX K	Application for Facility Recognition for Emergency Department with Pediatrics Capabilities
515.APPENDIX L	Pediatric Equipment Recommendations for Emergency Departments
515.APPENDIX M	Inter-facility Pediatric Trauma and Critical Care Consultation and/or Transfer Guideline
515.APPENDIX N	Pediatric Critical Care Center (PCCC)/Emergency Department Approved for Pediatrics (EDAP) Recognition Application
515.APPENDIX O	Pediatric Critical Care Center Plan
515.APPENDIX P	Pediatric Critical Care Center (PCCC) Pediatric Equipment/Supplies/Medications Requirements

AUTHORITY: Implementing and authorized by the Emergency Medical Services (EMS) Systems Act [210 ILCS 50].

SOURCE: Emergency Rule adopted at 19 Ill. Reg. 13084, effective September 1, 1995 for a maximum of 150 days; emergency expired January 28, 1996; adopted at 20 Ill. Reg. 3203, effective February 9, 1996; emergency amendment at 21 Ill. Reg. 2437, effective January 31, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 5170, effective April 15, 1997; amended at 22 Ill. Reg. 11835, effective June 25, 1998; amended at 22 Ill. Reg. 16543, effective September 8, 1998; amended at 24 Ill. Reg. 8585, effective June 10, 2000; amended at 24 Ill. Reg. 9006, effective June 15, 2000; amended at 24 Ill. Reg. 19218, effective December 15, 2000; amended at 25 Ill. Reg. 16386, effective December 20, 2001; amended at 26 Ill. Reg. 18367, effective December 20, 2002; amended at 27 Ill. Reg. 1277, effective January 10, 2003; amended at 27 Ill. Reg. 6352, effective April 15, 2003; amended at 27 Ill. Reg. 7302, effective April 25, 2003; amended at 27 Ill. Reg. 13507, effective July 25, 2003; emergency amendment at 29 Ill. Reg. 12640, effective July 29, 2005, for a maximum of 150 days; emergency expired December 25, 2005; amended at 30 Ill. Reg. 8658, effective April 21, 2006; amended at 32 Ill. Reg. 16255, effective September 18, 2008; amended at 35 Ill. Reg. 6195, effective March 22, 2011; amended at 35 Ill. Reg. 15278, effective August 30, 2011; amended at 35 Ill. Reg. 16697, effective September 29, 2011; amended at 35 Ill. Reg. 18331, effective October 21, 2011; amended at 35

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Ill. Reg. 20609, effective December 9, 2011; amended at 36 Ill. Reg. 880, effective January 6, 2012; amended at 36 Ill. Reg. 2296, effective January 25, 2012; amended at 36 Ill. Reg. 3208, effective February 15, 2012; amended at 36 Ill. Reg. 11196, effective July 3, 2012; amended at 36 Ill. Reg. 17490, effective December 3, 2012; amended at 37 Ill. Reg. 5714, effective April 15, 2013; amended at 37 Ill. Reg. 7128, effective May 13, 2013; amended at 37 Ill. Reg. 10683, effective June 25, 2013; amended at 37 Ill. Reg. 18883, effective November 12, 2013; amended at 37 Ill. Reg. 19610, effective November 20, 2013; amended at 38 Ill. Reg. 9053, effective April 9, 2014; amended at 38 Ill. Reg. 16304, effective July 18, 2014; amended at 39 Ill. Reg. 13075, effective September 8, 2015; amended at 40 Ill. Reg. 8274, effective June 3, 2016.

SUBPART A: GENERAL PROVISIONS

Section 515.100 Definitions

Act – the Emergency Medical Services (EMS) Systems Act [210 ILCS 50].

Acute Stroke-Ready Hospital or ASRH – a hospital that has been designated by the Department as meeting the criteria for providing emergent stroke care. Designation may be provided after a hospital has been certified or through application and designation as an Acute Stroke-Ready Hospital. (Section 3.116 of the Act)

Advanced Life Support Services or ALS Services – an advanced level of pre-hospital and inter-hospital emergency care and non-emergency medical ~~services~~ that includes basic life support care, cardiac monitoring, cardiac defibrillation, electrocardiography, intravenous therapy, administration of medications, drugs and solutions, use of adjunctive medical devices, trauma care, and other authorized techniques and procedures as outlined in the National EMS Education Standards ~~Advanced Life Support National Curriculum of the United States Department of Transportation~~ and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act)

Aeromedical Crew Member or Watercraft Crew Member or Off-road Specialized Emergency Medical Services Vehicle (SEMSV) Crew Member – an individual, other than an EMS pilot, who has been approved by an SEMSV Medical Director for specific medical duties in a helicopter or fixed-wing aircraft, on a watercraft, or on an off-road SEMSV used in a Department-certified SEMSV Program.

Alternate EMS Medical Director or Alternate EMS MD – the physician who is

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

designated by the Resource Hospital to direct the ALS/~~Advanced~~/ILS/BLS operations in the absence of the EMS Medical Director.

Alternate Response Vehicle – ambulance assist vehicles and non-transport vehicles as defined in Section 515.825.

Ambulance – any publicly or privately owned on-road vehicle that is specifically designed, constructed or modified and equipped for, and is intended to be used for, and is maintained or operated for, the emergency transportation of persons who are sick, injured, wounded or otherwise incapacitated or helpless, or the non-emergency medical transportation of persons who require the presence of medical personnel to monitor the individual's condition or medical apparatus being used on such individuals~~an individual~~. (Section 3.85 of the Act)

Ambulance Service Provider and Vehicle Service Provider Upgrades – Rural Population – a practice that allows an ambulance, alternate response vehicle, specialized emergency medical services vehicle or vehicle service provider that serves a population of 7,500 or fewer to upgrade the level of service of the provider vehicle using pre-approved System personnel and equipment.

Ambulance Service Provider ~~or Ambulance Provider~~ – any individual, group of individuals, corporation, partnership, association, trust, joint venture, unit of local government or other public or private ownership entity that owns and operates a business or service using one or more ambulances or EMS vehicles for the transportation of emergency patients.

Applicant – an individual or entity applying for a Department-issued license or certification.

Associate Hospital – a hospital participating in an approved EMS System in accordance with the EMS System Program Plan, fulfilling the same clinical and communications requirements as the Resource Hospital. This hospital has neither the primary responsibility for conducting training programs nor the responsibility for the overall operation of the EMS System program. The Associate Hospital must have a basic or comprehensive emergency department with 24-hour physician coverage. It shall have a functioning Intensive Care Unit or a Cardiac Care Unit.

Associate Hospital EMS Coordinator – the Paramedic~~EMT Paramedic (EMT-P)~~

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

or Registered Nurse at the Associate Hospital who shall be responsible for duties in relation to the ALS, Intermediate Life Support, ~~Advanced-(ILS)~~ or Basic Life Support-~~(BLS)~~ System, in accordance with the Department-approved EMS System Program Plan.

Associate Hospital EMS Medical Director – the physician at the Associate Hospital who shall be responsible for the day-to-day operations of the Associate Hospital in relation to the ALS, ILS, or BLS System, in accordance with the Department-approved EMS System Program Plan.

Basic Emergency Department – a classification of a hospital emergency department where at least one physician is available in the emergency department at all times; physician specialists are available in minutes; and ancillary services, including laboratory, x-ray and pharmacy, are staffed or are "on-call" at all times in accordance with Section 250.710 of the Hospital Licensing Requirements.

Basic Life Support or BLS Services – a basic level of pre-hospital and inter-hospital emergency care and non-emergency medical ~~services~~ that includes airway management, cardiopulmonary resuscitation (CPR), control of shock and bleeding and splinting of fractures, as outlined ~~in the National EMS Education Standards in a Basic Life Support National Curriculum of the United States Department of Transportation~~ and any modifications to that curriculum ~~standards~~ specified in this Part. (Section 3.10 of the Act)

Board Eligible in Emergency Medicine – completion of a residency in Emergency Medicine in a program approved by the Residency Review Committee for Emergency Medicine or the Council on Postdoctoral Training (COPT) for the American Osteopathic Association (AOA).

Certified Registered Nurse Anesthetist or CRNA – a licensed registered professional nurse who has had additional education beyond the registered professional nurse requirements at a school/program accredited by the National Council on Accreditation; who has passed the certifying exam given by the National Council on Certification; and who, by participating in 40 hours of continuing education every two years, has been recertified by the National Council on Recertification.

Child Abuse and Neglect – see the definitions of "abused child" and "neglected child" in Section 3 of the Abused and Neglected Child Reporting Act.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Child Life Specialist – A person whose primary role is to minimize the adverse effects of children's experiences by facilitating coping and the psychosocial adjustment of children and their families through the continuum of care.

Comprehensive Emergency Department – a classification of a hospital emergency department where at least one licensed physician is available in the emergency department at all times; physician specialists shall be available in minutes; ancillary services, including laboratory and x-ray, are staffed at all times; and the pharmacy is staffed or "on-call" at all times in accordance with Section 250.710 of the Hospital Licensing Requirements.

Comprehensive Stroke Center or CSC – a hospital that has been certified and has been designated as a Comprehensive Stroke Center under Subpart K. (Section 3.116 of the Act)

CPR for Healthcare Providers – a course in cardiopulmonary resuscitation that meets or exceeds the American Heart Association course "BLS for Healthcare Providers".

Critical Care Transport or CCT – A Specialty Care Transport (SCT) level of inter-facility or 911 service that uses paramedic, pre-hospital registered nurse (~~PHRN~~) and, on occasion, specialized nursing staff to perform skills and interventions at levels above the usual and customary scope of paramedic practice within the State of Illinois. Advanced education, continuing education and special certifications are required. All Critical Care Transport Programs shall be under the direction of a Department-approved ALS EMS System.

Department or IDPH – the Illinois Department of Public Health. (Section 3.5 of the Act)

Director – the Director of the Illinois Department of Public Health or his/her designee. (Section 3.5 of the Act)

Door-to-_____ – The time from patient arrival at the health care facility until the specified result, procedure or intervention occurs.

Dysrhythmia – a variation from the normal electrical rate and sequences of cardiac activity, also including abnormalities of impulse formation and

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

conduction.

Effective Radiated Power or ERP – the power gain of a transmitting antenna multiplied by the net power accepted by the antenna from the connected transmitter.

Electrocardiogram or EKG – a single lead graphic recording of the electrical activity of the heart by a series of deflections that represent certain components of the cardiac cycle.

Emergency – a medical condition of recent onset and severity that would lead a prudent ~~lay person~~ ~~lay person~~, possessing an average knowledge of medicine and health, to believe that urgent or unscheduled medical care is required. (Section 3.5 of the Act)

Emergency Communications Registered Nurse or ECRN – a registered professional nurse, licensed under the Nurse Practice Act, who has successfully completed supplemental education in accordance with this Part and who is approved by an EMS Medical Director to monitor telecommunications from and give voice orders to EMS System personnel, under the authority of the EMS Medical Director and in accordance with System protocols. (Section 3.80 of the Act) For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.

Emergency Department Approved for Pediatrics or EDAP – a hospital participating in an approved EMS System and designated by the Department pursuant to Section 515.4000 of this Part as being capable of providing optimal emergency department care to pediatric patients 24 hours per day.

Emergency Medical Dispatcher or EMD – a person who has successfully completed a training course in emergency medical dispatching ~~meeting or exceeding the National Curriculum of the United States Department of Transportation~~ in accordance with this Part, who accepts calls from the public for emergency medical services and dispatches designated emergency medical services personnel and vehicles. (Section 3.70 of the Act)

Emergency Medical Dispatch Priority Reference System or EMDPRS – an EMS System's organized approach to the receipt, management and disposition of a

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

request for emergency medical services.

Emergency Medical Services Personnel or EMS Personnel – includes Emergency Medical Responder, Emergency Medical Dispatcher, Emergency Medical Technician, Advanced Emergency Medical Technician, Emergency Medical Technician-Intermediate, Paramedic, Emergency Communications Registered Nurse and Pre-Hospital Registered Nurse.

Emergency Medical Responder or EMR (AKA First Responder) – a person who has successfully completed a course of instruction for the Emergency Medical Responder as approved by the Department, who provides Emergency Medical Responder services prior to the arrival of an ambulance or specialized emergency medical services vehicle, in accordance with the level of care established in the National EMS Educational Standards for Emergency Medical Responders as modified by the Department.

Emergency Medical Responder Services – a preliminary level of pre-hospital emergency care that includes cardiopulmonary resuscitation (CPR), monitoring vital signs and control of bleeding, as outlined in the Emergency Medical Responder curriculum of the National EMS Education standards and any modifications to that curriculum (standards) specified in this Part. (Section 3.10 of the Act)

Emergency Medical Services Personnel or EMS Personnel – persons licensed as an Emergency Medical Responder (First Responder), Emergency Medical Dispatcher, Emergency Medical Technician, Emergency Medical Technician-Intermediate, Advanced Emergency Medical Technician (A-EMT), Paramedic, Emergency Communications Registered Nurse, or Pre-Hospital Registered Nurse. (Section 3.5 of the Act)

Emergency Medical Services System or EMS System or System – an organization of hospitals, vehicle service providers and personnel approved by the Department in a specific geographic area, which coordinates and provides pre-hospital and inter-hospital emergency care and non-emergency medical transports at a BLS, Advanced, ILS and/or ALS level pursuant to a System Program Plan submitted to and approved by the Department, and pursuant to the EMS ~~Region~~Regional Plan adopted for the EMS Region in which the System is located. (Section 3.20 of the Act)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Emergency Medical Services System Survey – a questionnaire that provides data to the Department for the purpose of compiling annual reports.

Emergency Medical Technician-~~Basic or EMT-B~~ – a person who has successfully completed a course-~~of instruction~~ in basic life support as approved~~prescribed~~ by the Department, is currently licensed by the Department in accordance with standards prescribed by the Act and this Part and practices within an EMS System. (Section 3.50 of the Act)

Emergency Medical Technician-Coal Miner – for purposes of the Coal Mine Medical Emergencies Act, an ~~EMT, EMT-B, A-EMT, EMT-I or Paramedic~~~~EMT-P~~ who has received additional education~~training~~ emphasizing extrication from a coal mine.

Emergency Medical Technician-Intermediate or EMT-I – a person who has successfully completed a course-~~of instruction~~ in intermediate life support as approved by the Department, is currently licensed by the Department in accordance with the standards prescribed ~~in by the Act and~~ this Part and practices within an Intermediate or Advanced Life Support EMS System. (Section 3.50 of the Act)

~~Emergency Medical Technician-Paramedic or EMT-P – a person who has successfully completed a course of instruction in advanced life support care as prescribed by the Department, is licensed by the Department in accordance with standards prescribed by the Act and this Part and practices within an Advanced Life Support EMS System. (Section 3.50 of the Act)~~

Emergent Stroke Care – emergency medical care that includes diagnosis and emergency medical treatment of suspected or known~~suspected or known~~ acute stroke patients. (Section 3.116 of the Act)

Emergent Stroke Ready Hospital – a hospital that has been designated by the Department as meeting the criteria for providing emergency stroke care as set forth in the Act and Section 515.5060. (Section 3.116 of the Act)

EMS – emergency medical services.

EMS Administrative Director – the administrator, appointed by the Resource Hospital in consultation with the EMS Medical Director, in accordance with this

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

~~*Part, responsible for the administration of the EMS System. (Section 3.35 of the Act) with the approval of the EMS Medical Director, responsible for the administration of the EMS System.*~~

EMSC – Emergency Medical Services for Children.

~~*EMS Medical Director or EMS MD—the physician, appointed by the Resource Hospital, who has the responsibility and authority for total management of the EMS System.*~~

EMS Lead Instructor – a person who has successfully completed a course of education as approved~~prescribed~~ by the Department in this Part, and who is currently approved by the Department to coordinate or teach education, training and continuing education courses, in accordance with this Part. (Section 3.65 of the Act)

EMS Medical Director or EMS MD – the physician, appointed by the Resource Hospital, who has the responsibility and authority for total management of the EMS System.

EMS Regional Plan – a plan established by the EMS Medical Director's Committee in accordance with Section 3.30 of the Act.

EMS System Coordinator – ~~an~~~~the designated~~ individual responsible to the EMS Medical Director and EMS Administrative Director for coordination of the educational and functional aspects of the System program.

EMS System Program Plan – the document prepared by the Resource Hospital and approved by the Department that describes the EMS System program and directs the program's operation.

~~*First Responder—a person who is at least 18 years of age, who has successfully completed a course of instruction in emergency medical responder as prescribed by the Department, who provides first response services prior to the arrival of an ambulance or specialized emergency medical services vehicle, in accordance with the level of care established in the emergency medical responder course. (Section 3.60 of the Act)*~~

~~*First Response Services—a preliminary level of pre-hospital emergency care that*~~

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

~~includes cardiopulmonary resuscitation (CPR), monitoring vital signs and control of bleeding, as outlined in the First Responder curriculum of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act)~~

Fixed-Wing Aircraft – an engine-driven aircraft that is heavier than air, and is supported in-flight by the dynamic reaction of the air against its wings.

Full-Time – on duty a minimum of 36 hours, ~~four days~~ a week.

Half-Duplex Communications – a radio or device that transmits and receives signals in only one direction at a time.

Health Care Facility – a hospital, nursing home, physician's office or other fixed location at which medical and health care services are performed. It does not include "pre-hospital emergency care settings" ~~that~~ which utilize EMS Personnel ~~EMTs~~ to render pre-hospital emergency care prior to the arrival of a transport vehicle, as defined in the Act and this Part. (Section 3.5 of the Act)

Helicopter or Rotorcraft – an aircraft that is capable of vertical take offs and landings, including maintaining a hover.

Helicopter Shopping – the practice of calling various operators until a helicopter emergency medical services (HEMS) operator agrees to take a flight assignment, without sharing with subsequent operators that the previously called operators declined the flight, or the reasons why the flight was declined.

Hospital – *has the meaning ascribed to that term in Section 3 of the Hospital Licensing Act. (Section 3.5 of the Act)*

Hospitalist – a physician who primarily provides unit-based/in-hospital services.

In-Field Service Level Upgrade – a practice that allows the delivery of advanced care from a lower level service provider by a licensed higher level of care ambulance, alternate response vehicle, or specialized emergency medical services vehicle according to a pre-approved written plan approved by the local EMS Medical Director.

Instrument Flight Rules or IFR – the operation of an aircraft in weather

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

minimums below the minimums for flight under visual flight rules (VFR). (See General Operating and Flight Rules, 14 CFR 91.115 through 91.129.)

Instrument Meteorological Conditions or IMC – meteorological conditions expressed in terms of visibility, distance from clouds and ceiling, which require Instrument Flight Rules.

*Intermediate Life Support Services or ILS Services – an intermediate level of pre-hospital and inter-hospital emergency care and non-emergency medical ~~services~~ care that includes basic life support care, plus intravenous cannulation and fluid therapy, invasive airway management, trauma care, and other authorized techniques and procedures as outlined in the Intermediate Life Support ~~national curriculum~~ *National Curriculum* of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act)*

Level I Trauma Center – a hospital participating in an approved EMS System and designated by the Department pursuant to Section 515.2030 of this Part to provide optimal care to trauma patients and to provide all essential services in-house, 24 hours per day.

Level II Trauma Center – a hospital participating in an approved EMS System and designated by the Department pursuant to Section 515.2040 of this Part to provide optimal care to trauma patients, to provide some essential services available in-house 24 hours per day, and to provide other essential services readily available 24 hours a day.

Licensee – an individual or entity to which the Department has issued a license.

Limited Operation Vehicle – a vehicle which is licensed by the Department to provide basic, intermediate or advanced life support emergency or non-emergency medical services that are exclusively limited to specific events or locales. (Section 3.85 of the Act)

Local System Review Board – a group established by the Resource Hospital to hear appeals from ~~EMS Personnel~~ *EMTs* or other providers who have been suspended or have received notification of suspension from the EMS Medical Director.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Mobile Radio – a two-way radio installed in an EMS vehicle, which may not be readily removed.

Morbidity – a negative outcome that is the result of the original medical or condition or treatment rendered or omitted.

911 – an emergency answer and response system in which the caller need only dial 9-1-1 on a telephone or mobile device to obtain emergency services, including police, fire, medical ambulance and rescue.

Non-emergency Medical Care – medical ~~care or monitoring services~~ rendered to patients whose ~~condition~~ ~~condition~~ ~~does~~ not meet the Act's definition of emergency, before or during transportation of such patients to or from health care facilities visited for the purpose of obtaining medical or health care services that which are not emergency in nature, using a vehicle regulated by the Act and this Part. (Section 3.10 of the Act)

Nurse Practitioner – a person who is licensed as a nurse practitioner under the Nurse Practice Act. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.

Off-Road Specialized Emergency Medical Services Vehicle or Off-Road SEMSV or Off-Road SEMS Vehicle – a motorized cart, golf cart, all-terrain vehicle (ATV), or amphibious vehicle that is not intended for use on public roads.

Paramedic or EMT-P – a person who has successfully completed a course in advanced life support care as approved by the Department, is currently licensed by the Department in accordance with standards prescribed by the Act and this Part and practices within an Advanced Life Support EMS System. (Section 3.50 of the Act)

Participating Hospital – a hospital participating in an approved EMS System in accordance with the EMS System Program Plan, which is not a Resource Hospital or an Associate Hospital.

Pediatric Critical Care Center or PCCC – a hospital participating in an approved EMS System and designated by the Department as being capable of providing

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

optimal critical and specialty care services to pediatric patients, and of providing all essential services either in-house or readily available 24 hours per day.

Pediatric Patient –patient from birth through 15 years of age.

Physician – any person licensed to practice medicine in all of its branches under the Medical Practice Act of 1987. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.

Physician Assistant – a person who is licensed under the Physician Assistant Practice Act. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.

Pilot or EMS Pilot – a pilot certified by the Federal Aviation Administration who has been approved by an SEMSV Medical Director to fly a helicopter or fixed-wing aircraft used in a Department-certified SEMSV Program.

Portable Radio – a hand-held radio that accompanies the user during the conduct of emergency medical services.

Pre-Hospital Care – those ~~emergency~~ medical services rendered to ~~emergency~~ patients for analytic, resuscitative, stabilizing, or preventive purposes, precedent to and during transportation of such patients to healthcare facilities. (Section 3.10(e) of the Act)~~hospitals.~~

Pre-Hospital Care ~~Participants~~ Provider – Any EMS Personnel, a System Participant or any EMT-B, I, P, Ambulance, Ambulance Service Provider, EMS Vehicle, Associate Hospital, Participating Hospital, EMS Administrative Director, EMS System Coordinator, Associate Hospital EMS Coordinator, Associate Hospital EMS Medical Director, ECRN, Resource Hospital, Emergency Dispatch Center or physician ~~Physician~~ serving on an ambulance or non-transport vehicle or giving voice orders ~~for~~ over an EMS System and who are subject to suspension by the EMS Medical Director of that System in accordance with the policies of the EMS System Program Plan approved by the Department.

Pre-Hospital Registered Nurse or ~~Pre-Hospital RN or~~ PHRN – a registered professional nurse, with an unencumbered registered nurse license in the state in

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

which he or she practices licensed under the Nurse Practice Act, who has successfully completed supplemental education in accordance with this Part and who is approved by an Illinois EMS Medical Director to practice within an EMS System ~~as emergency medical services personnel~~ for pre-hospital and inter-hospital emergency care and non-emergency medical transports. (Section 3.80 of the Act) For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.

Primary Stroke Center or PSC – a hospital that has been certified by a Department-approved, nationally recognized certifying body and designated as a Primary Stroke Center by the Department. (Section 3.116 of the Act)

Regional EMS Advisory Committee – a committee formed within an Emergency Medical Services ~~(EMS)~~ Region to advise the Region's EMS Medical Directors Committee and to select the Region's representative to the State Emergency Medical Services Advisory Council, consisting of at least the members of the Region's EMS Medical Directors Committee, the Chair of the Regional Trauma Committee, the EMS System Coordinators from each Resource Hospital within the Region, one administrative representative from an Associate Hospital within the Region, one administrative representative from a Participating Hospital within the Region, one administrative representative from the vehicle service provider which responds to the highest number of calls for emergency service within the Region, one administrative representative of a vehicle service provider from each System within the Region, one individual from each level of license provided by the Act, one Emergency Medical Technician (EMT)/Pre-Hospital RN from each level of EMT/one Pre-Hospital Registered Nurse RN practicing within the Region, and one registered professional nurse currently practicing in an emergency department within the Region. Of the ~~two~~ administrative representatives of vehicle service providers, at least one shall be an administrative representative of a private vehicle service provider. The Department's Regional EMS Coordinator for each Region shall serve as a non-voting member of that Region's EMS Advisory Committee. (Section 3.25 of the Act)

Regional EMS Coordinator – the designee of the Chief, Division of Emergency Medical Services and Highway Safety, Illinois Department of Public Health.

Regional EMS Medical Directors Committee – a group comprised of the Region's

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

EMS Medical Directors, along with the medical advisor to a fire department vehicle service provider. For ~~regions~~Regions that include a municipal fire department serving a population of over 2,000,000 people, that fire department's medical advisor shall serve on the Committee. For other ~~regions~~Regions, the fire department vehicle service providers shall select which medical advisor to serve on the Committee on an annual basis. (Section 3.25 of the Act)

Regional Stroke Advisory Subcommittee – a subcommittee formed within each Regional EMS Advisory Committee to advise the Director and the Region's EMS Medical Directors Committee on the triage, treatment, and transport of possible acute stroke patients and to select the Region's representative to the State Stroke Advisory Subcommittee. (Section 3.116 of the Act) The composition of the Subcommittee shall be as set forth in Section 3.116 of the Act.

Regional Trauma Advisory Committee – a committee formed within an Emergency Medical Services-~~(EMS)~~ Region, to advise the Region's Trauma Center Medical Directors Committee, consisting of at least the Trauma Center Medical Directors and Trauma Coordinators from each ~~trauma center~~Trauma Center within the Region, one EMS Medical Director from a Resource Hospital within the Region, one EMS System Coordinator from another Resource Hospital within the Region, one representative each from a public and private vehicle service provider which transports trauma patients within the Region, an administrative representative from each ~~trauma center~~Trauma Center within the Region, one ~~EMR, EMD, EMT, EMT-I, A-EMT, Paramedic, ECRN, or PHRN~~EMT representing the highest level of ~~EMS Personnel~~EMT practicing within the Region, one emergency physician and one Trauma Nurse Specialist ~~(TNS)~~currently practicing in a ~~trauma center~~Trauma Center. The Department's Regional EMS Coordinator for each Region shall serve as a non-voting member of that Region's Trauma Advisory Committee. (Section 3.25 of the Act)

Registered Nurse or Registered Professional Nurse or RN – a person who is licensed as a professional nurse under the Nurse Practice Act. For out-of-state facilities that have Illinois recognition under the ~~EMS~~, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.

Resource Hospital – the hospital with the authority and the responsibility for an EMS System as outlined in the Department-approved EMS System Program Plan. The Resource Hospital, through the EMS Medical Director, assumes

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

responsibility for the entire program, including the clinical aspects, operations and educational programs. This hospital agrees to replace medical supplies and provide for equipment exchange for participating EMS vehicles.

Rural Ambulance Service Provider – an ambulance service provider licensed under the Act that serves a rural population of 7,500 or fewer inhabitants. (Section 3.87(a) of the Act)

Rural In-Field Service Level Upgrade – a practice that allows the delivery of advanced care for a lower level service provider that serves a rural population of 7,500 or fewer inhabitants, through use of EMS System approved EMS personnel.

Rural Vehicle Service Provider – an entity that serves a rural population of 7,500 or fewer inhabitants and is licensed by the Department to provide emergency or non-emergency medical services in compliance with the Act, this Part and an operational plan approved by the entity's EMS System, utilizing at least an ambulance, alternate response vehicle as defined by the Department in this Part, or specialized emergency medical services vehicle. (Section 3.87(a) of the Act)

Screening – a preliminary procedure or assessment, such as a test or examination, to detect the most characteristic sign or signs of a disorder or condition that may require further investigation (for example, assessing for potential abuse or neglect through interview responses and behavioral/physical symptom clues).

SEMSV Medical Control Point or Medical Control Point – the communication center from which the SEMSV Medical Director or his or her designee issues medical instructions or advice to the aeromedical, watercraft, or off-road SEMSV crew members.

SEMSV Medical Director or Medical Director – the physician appointed by the SEMSV Program who has the responsibility and authority for total management of the SEMSV Program, subject to the requirements of the EMS System of which the SEMSV Program is a part.

SEMSV Program or Specialized Emergency Medical Services Vehicle Program – a program operating within an EMS System, pursuant to a program plan submitted to and certified by the Department, using specialized emergency medical services vehicles to provide emergency transportation to sick or injured persons.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Special-Use Vehicle – any publicly or privately owned vehicle that is specifically designed, constructed or modified and equipped, and is intended to be used for, and is maintained or operated solely for, the emergency or non-emergency transportation of a specific medical class or category of persons who are sick, injured, wounded or otherwise incapacitated or helpless (e.g., high-risk obstetrical patients, neonatal patients). (Section 3.85 of the Act)

Specialized Emergency Medical Services Vehicle or SEMSV – a vehicle or conveyance, other than those owned or operated by the federal government, that is primarily intended for use in transporting the sick or injured by means of air, water, or ground transportation, that is not an ambulance as defined in the Act. The term includes watercraft, aircraft and special purpose ground transport vehicles not intended for use on public roads. (Section 3.85 of the Act)

"Primarily intended", for the purposes of this definition, means one or more of the following:

Over 50 percent of the vehicle's operational (i.e., in-flight) hours are devoted to the emergency transportation of the sick or injured;

The vehicle is owned or leased by a hospital or ambulance provider and is used for the emergency transportation of the sick or injured;

The vehicle is advertised as a vehicle for the emergency transportation of the sick or injured;

The vehicle is owned, registered or licensed in another state and is used on a regular basis to pick up and transport the sick or injured within or from within this State; or

The vehicle's structure or permanent fixtures have been specifically designed to accommodate the emergency transportation of the sick or injured.

Standby Emergency Department – a classification of a hospital emergency department where at least one of the registered nurses on duty in the hospital is available for emergency services at all times, and a licensed physician is "on-call" to the emergency department at all times in accordance with Section 250.710 of the Hospital Licensing Requirements.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Standby Emergency Department Approved for Pediatrics or SEDP – a hospital participating in an approved EMS System and designated by the Department, pursuant to Section 515.4010 of this Part, as being capable of providing optimal standby emergency department care to pediatric patients and to have transfer agreements and transfer mechanisms in place when more definitive pediatric care is needed.

State EMS Advisory Council – a group that advises the Department on the administration of the Act and this Part whose members are appointed in accordance with Section 3.200 of the Act.

Stretcher Van – a vehicle used by a licensed stretcher van provider to transport non-emergency passengers in accordance with the Act and this Part.

Stretcher Van Provider – an entity licensed by the Department to provide non-emergency transportation of passengers on a stretcher in compliance with the Act and this Part, utilizing stretcher vans. (Section 3.86 of the Act)

Stroke Network – a voluntary association of hospitals, including a hospital with a board eligible or board certified neurosurgeon or neurologist, that may, among other activities, share stroke protocols; provide medical consultations on possible or known acute stroke patients or on inter-facility transfers of possible or known acute stroke patients; or provide education specific to improving acute stroke care. Participating hospitals in a stroke network may be in-state or out-of-state.

Substantial Compliance – meeting requirements except for variance from the strict and literal performance that results in unimportant omissions or defects given the particular circumstances involved.

Substantial Failure – the failure to meet requirements other than a variance from the strict and literal performance that results in unimportant omissions or defects given the particular circumstances involved.

Sustained Hypotension – two systolic blood pressures of 90 mmHg five minutes apart or, in the case of a pediatric patient, two systolic blood pressures of 80 mmHg five minutes apart.

System Participation Suspension – the suspension from participation within an

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

EMS System of an individual or individual provider, as specifically ordered by that System's EMS Medical Director.

Telecommunications Equipment – a ~~communication system~~radio capable of transmitting and receiving voice and electrocardiogram (EKG) signals.

Telemetry – the transmission of data ~~through a communication system by wire, radio, or other means from remote sources~~ to a receiving station for recording, ~~interpretation~~ and analysis.

Trauma – any significant injury which involves single or multiple organ systems. (Section 3.5 of the Act)

Trauma Category I – a classification of trauma patients in accordance with Appendix C and Appendix F of this Part.

Trauma Category II – a classification of trauma patients in accordance with Appendix C and Appendix F of this Part.

Trauma Center – a hospital which: within designated capabilities provides optimal care to trauma patients; participates in an approved EMS System; and is duly designated pursuant to the provisions of the Act. (Section 3.90 of the Act)

Trauma Center Medical Director – the trauma surgeon appointed by a Department-designated Trauma Center who has the responsibility and authority for the coordination and management of patient care and trauma services at the Trauma Center. He or she must have 24-hour independent operating privileges and shall be board certified in surgery with at least one year of experience in trauma care.

Trauma Center Medical Directors Committee – a group composed of the Region's Trauma Center Medical Directors. (Section 3.25 of the Act)

Trauma Coordinator – a registered nurse working in conjunction with the Trauma Medical Director. The Trauma Coordinator is responsible for the organization of service and systems necessary for a multidisciplinary approach throughout the continuum of trauma care.

Trauma Nurse Specialist or TNS – a registered professional nurse licensed under

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

the Nurse Practice Act who has successfully completed supplemental education and testing requirements as prescribed by the Department, and is ~~licensed~~certified in accordance with this Part. (Section 3.75 of the Act) For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric program, the professional shall have an unencumbered license in the state in which he or she practices.

Trauma Nurse Specialist Course Coordinator or TNSCC – a registered nurse appointed by the Chief Executive Officer of a hospital designated as a TNS Training Site, who meets the requirements of Section 515.750 ~~of this Part~~.

Trauma Service – an identified hospital surgical service in a Level I or Level II Trauma Center functioning under a designated trauma director in accordance with Sections 515.2030(c) and 515.2040(c) ~~of this Part~~.

Unit Identifier – a number assigned by the Department for each EMS vehicle in the State to be used in radio communications.

Vehicle Service Provider – an entity licensed by the Department to provide emergency or non-emergency medical services in compliance with the Act and this Part and an operational plan approved by its EMS System(s), utilizing at least ambulances or specialized emergency medical service vehicles (SEMSV). (Section 3.85(a) of the Act)

Watercraft – a nautical vessel, boat, airboat, hovercraft or other vehicle that operates in, on or across water.

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

SUBPART B: EMS REGIONS

Section 515.210 EMS Regional Plan Development

- a) *Within six months after designation of an EMS Region, an EMS Region Plan addressing at least the information prescribed in Section 515.220 ~~of this Part~~ shall be submitted to the Department for approval. The plan shall be developed by the Region's EMS Medical Directors Committee with advice from the Regional EMS Advisory Committee; portions of the plan concerning trauma shall be developed jointly with the Region's Trauma Center Medical Directors or Trauma*

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Center Medical Directors Committee, whichever is applicable, with advice from the Regional Trauma Advisory Committee, if such Advisory Committee has been established in the Region. (Section 3.25(a) of the Act)

- b) *Portions of the Plan concerning stroke shall be developed jointly with the Regional Stroke Advisory Subcommittee as identified in Section 515.5004. (Section 3.25(a) of the Act) The Director will coordinate with and assist the EMS System Medical Directors and Regional Stroke Advisory Subcommittee within each EMS Region to establish *protocols* related to the *triage, treatment, and transport of possible acute stroke patients* by licensed emergency medical services providers. (Section 3.30(a)(9) of the Act)*
- c) The Regional Stroke Subcommittee shall provide updates to the Regional EMS Advisory Committee at the Regional EMS Advisory Committee's regularly scheduled meetings. *The Plan shall also be updated at least annually to consider the most current nationally recognized standards of stroke care and to incorporate each Comprehensive Stroke Center, Primary Stroke Center or Acute Stroke-Ready Hospital ~~Emergency Stroke-Ready Hospital~~ into the Region Plan.*
- d) *A Region's Trauma Center Medical Directors may choose to participate in the development of the EMS Region Plan through membership on the Regional EMS Advisory Committee, rather than through a separate Trauma Center Medical Directors Committee. If that option is selected, the Region's Trauma Center Medical Director shall also determine whether a separate Regional Trauma Advisory Committee is necessary for the Region. (Section 3.25(b) of the Act)*
- e) *In the event of disputes over content of the Plan between the Region's EMS Medical Directors Committee and the Region's Trauma Center Medical Directors or Trauma Center Medical Directors Committee, whichever is applicable, the Director of the Illinois Department of Public Health shall intervene through a review in accordance with Section 515.230. (Section 3.25(c) of the Act)*
- f) *If after six months a Plan or portions of a Plan are not submitted, the Director will contact the EMS Medical Directors to seek input as to disputes, problems, or issues concerning areas not developed in the Plan. If necessary, the Director will contact members of the Regional EMS Advisory Committee to seek input into portions of the Plan that are not agreed upon. After consulting with the Committee and reviewing the plans submitted by the surrounding Regions, the Director will develop proposed policies and procedures for the Region. The*

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Committee shall approve these policies within 30 days or submit its own policies to the Director for approval. If the Committee has not submitted a complete Plan after 30 days, the Region will implement the policies and procedures developed by the Director in its EMS Region Plan.

- g) *Every 2 years, the members of the Region's EMS Medical Directors Committee shall rotate serving as Committee Chair, and select the Associate Hospital, Participating Hospital and vehicle service providers ~~that~~^{which} shall send representatives to the Advisory Committee, and the EMS Personnel EMTs/Pre-Hospital RN and nurse who shall serve on the Advisory Committee. (Section 3.25(d) of the Act) Each System in the Region must have at least one representative on the Committee.*
- h) *Every 2 years, the members of the Trauma Center Medical Directors Committee shall rotate serving as Committee Chair, and select the vehicle service providers, EMS Personnel EMT, emergency physician, EMS System Coordinator and TNS who shall serve on the Advisory Committee. (Section 3.25(e) of the Act) It is recommended that the committee chair be held by Trauma Center Medical Directors of the Level I Trauma Centers in the Region.*

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.220 EMS Regional Plan Content

- a) *The EMS Medical Directors Committee portion of the Regional Plan shall address at least the following:*
- 1) *Protocols for inter-System/inter-Region patient transports, including protocols for pediatric patients and pediatric patients with special health care needs, identifying the conditions of emergency patients ~~that~~^{which} may not be transported to the different levels of emergency department, based on their department classifications and relevant Regional considerations (e.g., transport times and distances);*
 - 2) *Regional standing medical orders;*
 - 3) *Patient transfer patterns, including criteria for determining whether a patient needs the specialized service of a trauma center, along with protocols for the bypassing of or diversion to any hospital, trauma center*

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

or ~~regional~~*Regional* trauma center, Comprehensive Stroke Center, Primary Stroke Center, Acute Stroke-Ready Hospital or Emergent Stroke Ready Hospital, which are consistent with individual System bypass or diversion protocols and protocols for patient choice or refusal;

- 4) *Protocols for resolving ~~regional~~Regional or inter-System conflict;*
- 5) *An EMS disaster preparedness plan which includes the actions and responsibilities of all EMS participants within the Region for care and transport of both the adult and pediatric population;*
- 6) *Regional standardization of continuing education requirements;*
- 7) *Regional standardization of Do Not Resuscitate (DNR) policies, and protocols for power of attorney for health care;*
- 8) *Protocols for disbursement of Department grants (Section 3.30(a)(1-8) of the Act);*
- 9) *Protocols for the triage, treatment, and transport of possible acute stroke patients developed jointly with the Regional Stroke Advisory Subcommittee (Section 3.30(a)(9) of the Act). Regional Stroke Data will be considered as it becomes available regarding development of stroke transport protocols;*
- 10) *Protocols for stroke screening;*
- 11) *Development of protocols to improve and integrate EMS for children (or EMSC) into the current delivery of emergency services within the Region; and*
- 12) *Development of a policy in regard to incidents involving school buses, which shall include, but not be limited to:*
 - A) *Assessment of the incident, including mechanism and extent of damage to the vehicle;*
 - B) *Passenger assessment/extent of injuries;*

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- C) A provision for transporting all children with special healthcare needs and those with communication difficulties;
 - D) Age specific issues; and
 - E) Use of a release form for nontransports.
- b) *The Trauma Center Medical Directors or Trauma Center Medical Directors Committee portion of the Regional Plan shall address at least the following:*
- 1) *The identification of ~~regional trauma centers~~~~Regional Trauma Centers~~ and identification of trauma centers that specialize in pediatrics;*
 - 2) *Protocols for inter-System and inter-Region trauma patient transports, including identifying the conditions of emergency patients which may not be transported to the different levels of emergency department, based on their department classifications and relevant Regional considerations (e.g., transport times and distances);*
 - 3) *Regional trauma standing medical orders;*
 - 4) *Trauma patient transfer patterns, including criteria for determining whether a patient needs the specialized services of a trauma center, along with protocols for the bypassing of or diversion to any hospital, trauma center or ~~regional~~~~Regional~~ trauma center which are consistent with individual System bypass or diversion protocols and protocols for patient choice or refusal (These policies must include the criteria of Section 515.Appendix C.);*
 - 5) *The identification of which types of patients can be cared for by Level I and Level II Trauma Centers;*
 - 6) *Criteria for inter-hospital transfer of trauma patients, including the transfer of pediatric patients;*
 - 7) *The treatment of trauma patients in each trauma center within the Region;*
 - 8) *~~The establishment of a Regional trauma quality assurance and improvement subcommittee, consisting of trauma surgeons, which shall~~*

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

~~perform periodic medical audits of each trauma center's trauma services, and forward tabulated data from such reviews to the Department; and~~

~~8)9) A program for conducting a quarterly conference which shall include at a minimum a discussion of morbidity and mortality between all professional staff involved in the care of trauma patients. (Section 3.30(b)(1-9) of the Act)~~

- A) This shall include but not be limited to all cases that have been deemed potentially preventable or preventable in the trauma center review using Resources for Optimal Care of the Injured Patient. This review should exclude trauma patients who were dead on arrival.
- B) In addition, the review shall include all patients who were transferred more than two hours after time of arrival at the initial institution and who meet one or more of the following criteria at the receiving trauma center:
- i) Admitted to an intensive care unit;
 - ii) Admitted to a bed with telemetry monitoring;
 - iii) Went directly to the operating room;
 - iv) Went to the operating room from the emergency department;
 - v) Discharged to a rehabilitation or skilled care facility;
 - vi) Died following arrival.
- C) The Region shall include a review of morbidity/audit filters that have been determined by the Region.
- D) Cumulative ~~regional~~Regional reports will be made available upon request from the Department; ~~and-~~

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- 9) *The establishment of a regional trauma quality assurance and improvement subcommittee, consisting of trauma surgeons, that shall perform periodic medical audits of each trauma center's trauma services, and forward tabulated data from those reviews to the Department. (Section 3.30(b)(9) of the Act)*
- c) The Regional Stroke Advisory Subcommittee portion of the Region Plan shall address at least the following:
- 1) The identification of Comprehensive Stroke Centers, Primary Stroke Centers, Acute Stroke-Ready Hospitals and Emergent Stroke Ready Hospitals and their incorporation in the Region Plan and the System Program Plan;
 - 2) In conjunction with the EMS Medical Directors, development of protocols for identifying and transporting acute stroke patients to the nearest appropriate facility capable of providing acute stroke care. These protocols shall be consistent with individual System bypass or diversion protocols and protocols for patient choice;
 - 3) Regional stroke transport protocols recommended by the Regional Stroke Advisory Subcommittee and approved by the EMS Medical Directors Committee; and
 - 4) With the EMS Medical Directors, joint development of acute stroke patient transfer patterns, including criteria for determining whether a patient needs the specialized services of a Comprehensive Stroke Center, Primary Stroke Center, Acute Stroke-Ready Hospital or Emergent Stroke Ready Hospital, along with protocols for the bypassing of, or diversion to, any hospital, which are consistent with individual inter-system bypass or diversion protocols and protocols for patient choice or refusal.
- d) *The Director shall coordinate with and assist the EMS System Medical Directors and Regional Stroke Advisory Subcommittee within each EMS Region to establish protocols related to the assessment, treatment, and transport of possible acute stroke patients by licensed emergency medical services providers. These protocols shall include regional transport plans for the triage and transport of possible acute stroke patients to the most appropriate Comprehensive Stroke Center, Primary Stroke Center or Acute Stroke-Ready Hospital Emergent Stroke*

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Ready Hospital, unless circumstances warrant otherwise. (Section 3.118.5(f) of the Act)

- e) *The Region's EMS Medical Directors and Trauma Center Medical Directors Committees shall appoint any subcommittees which they deem necessary to address specific issues concerning Region activities.* (Section 3.30(c) of the Act)
- f) Internal Disaster Plans
 - 1) Each System hospital shall submit an internal disaster plan to the EMS Medical Directors Committee and the Trauma Center Medical Directors Committee.
 - 2) The hospital internal disaster plan shall be coordinated with, or a part of, the hospital's overall disaster plan.
 - 3) The plan shall be coordinated with local and State disaster plans.
 - 4) The hospital internal disaster plan shall be developed by a hospital committee and shall at a minimum:
 - A) Identify the authority to implement the internal disaster plan, including the chain of command and how notification shall be made throughout the hospital;
 - B) Identify the critical operational elements required in the hospital in an internal disaster;
 - C) If the facility needs to go on bypass or resource limitation status, identify the person responsible for notification and the persons both outside and within the hospital who should be notified;
 - D) Identify a person or group responsible for ensuring that needed resources and supplies are available;
 - E) Identify a person to communicate with representatives from other agencies, organizations, and the EMS System;

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- F) Identify a person who is responsible for procuring all supplies required to manage the facility and return the facility to the pre-incident status;
- G) Identify the plan and procedure for educating facility employees on their role and responsibilities during the disaster;
- H) Designate a media spokesperson;
- I) Establish a method for resource coordination between departments and individuals to address management of staff, patients and patient flow patterns;
- J) Designate a person (safety officer) with responsibility for establishing safety policies to include, but not be limited to, decontamination operations, safety zones, site safety plans, evacuation parameters, and traffic patterns;
- K) Designate a location where personnel, not actually committed to the incident, will report for assignments, as needed (i.e., a staging area);
- L) Include notification procedures to EMS Systems, area ambulances, both public and private, and police and fire authorities of the type of incident that caused the hospital to implement its internal disaster plan and of any special instructions, e.g., use of a different driveway or entrance;
- M) Establish a designated form of communication, both internal and external, to maintain two-way communication (e.g., Mobile Emergency Communications of Illinois (MERCIE), ham radio, walkie talkies);
- N) Include a policy to call in additional nursing staff when an identified staffing shortage exists;
- O) Include the policy developed pursuant to Section 515.315(f);

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- P) *Include contingency plans for the transfer of patients to other facilities if an evacuation of the hospital becomes necessary due to a catastrophe, including but not limited to a power failure (Section 3.30 of the Act); and*
- Q) Address biological and chemical incidents and the availability of decontamination.

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.250 Hospital Stroke Care Fund

- a) When funding is available, the Director will annually distribute, through *matching grants*, moneys deposited into the Hospital Stroke Care Fund, ~~*a special fund of the State Treasury to encourage the establishment and retention of Primary Stroke Centers, Emergent Stroke Ready Hospitals and stroke networks throughout the State.*~~ The Director will provide funds to the following:
- 1) Illinois hospitals that have been certified as Comprehensive Stroke Centers, Primary Stroke Centers and Acute Stroke-Ready Hospitals or that seek certification or designation or both as Comprehensive Stroke Centers, Primary Stroke Centers and Acute Stroke-Ready Hospitals. ~~*hospitals that have been certified as Primary Stroke Centers or that seek certification or designation or both as Primary Stroke Centers*~~ If certification or designation is not achieved within 12 months after receipt of the grant, all grant funds shall be returned to the Hospital Stroke Care Fund.
 - 2) Illinois hospitals that have been designated as Acute Stroke-Ready Hospitals or that seek designation as Acute Stroke-Ready-Hospitals. ~~*hospitals that have been designated as Emergent Stroke Ready Hospitals or that seek designation as Emergent Stroke Ready Hospitals.*~~ If designation is not achieved within 12 months after receipt of the grant, all grant funds shall be returned to the Hospital Stroke Care Fund.
 - 3) ~~*Illinois hospitals for the development, expansion, or enhancement of, or quality improvement efforts for, stroke networks in Illinois. (Section 3.226 of the Act)*~~

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- b) ~~Money~~*Moneys*, including appropriations, donations and grants, shall be deposited into the fund and allocated according to the hospital needs in each region. ~~collected by the Department pursuant to its authority to designate Primary Stroke Centers and Emergent Stroke Ready Hospitals shall be deposited in the Fund and shall be allocated according to the hospital needs within each EMS region and used solely for the purposes described in Section 3.117.5 of the Act. (Sections 3.117.5 and 3.226 of the Act)~~
- c) Award of Funds
- 1) Any hospital licensed under the Hospital Licensing Act or operated under the University of Illinois Hospital Act may apply to the Department for funds.
 - 2) Applications shall be made in a manner and form prescribed by the Department. The form and instructions, including timelines for application submission and approval, will be posted on the Department's website.
 - 3) Each Regional Stroke Advisory Subcommittee shall forward to the Department matching grant recommendations that reflect a consensus of Comprehensive Stroke Centers, Primary Stroke Centers and Acute Stroke-Ready Hospitals~~Emergent Stroke Ready Hospitals~~, or other hospitals seeking certification or designation, within their EMS Region. The Department will consider the Subcommittee's recommendations when awarding matching grants to hospitals seeking to improve stroke care.
 - 4) When applications exceed available funds, the Department *may consider prioritizing grant awards to hospitals in areas with the highest incidence of stroke, taking into account geographic diversity* ~~and health care disparities~~, *where possible.* (Section 3.117.5(d) of the Act)
 - 5) All grant funds awarded shall be used exclusively for the establishment and retention of Comprehensive Stroke Centers, Primary Stroke Centers, Acute Stroke-Ready Hospitals~~Emergent Stroke Ready Hospitals~~, stroke networks and improvement of stroke systems of care. Grant funds used for personnel costs shall be directly related to enhancement of stroke care. All grant funds are subject to the Illinois Grant Funds Recovery Act.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- d) Subject to appropriation, the Director will award matching grants to:
- 1) *Hospitals for the acquisition and maintenance of necessary infrastructure, including personnel, equipment, ~~supplies~~supplies, and pharmaceuticals for the ~~prevention~~prevention, diagnosis, treatment and ~~management~~and management of acute stroke patients (Section 3.117.5(a) of the Act);*
 - 2) *Hospitals to pay the fee for certifications and re-certifications by Department-approved, nationally recognized certifying bodies or to provide additional certification, education or training for directors of stroke care, physicians, hospital staff, or emergency medical services personnel authorized under the Act (Section 3.117.5(a) of the Act);*
 - 3) *~~Comprehensive Stroke Centers, Primary Stroke Centers and Acute Stroke-Ready Hospitals~~Emergent Stroke-Ready Hospitals for developing or enlarging stroke networks, for stroke education, and to enhance the ability of the EMS System to respond to possible acute stroke patients (Section 3.117.5(b) of the Act);*
 - 4) *Hospitals that have been certified as Comprehensive Stroke Centers, Primary Stroke Centers or Acute Stroke-Ready Hospitals (Section 3.226(b)(1) of the Act);*
 - 5) *Hospitals that seek certification or designation or both as Comprehensive Stroke Centers, Primary Stroke Centers or Acute Stroke-Ready Hospitals (Section 3.226(b)(2) of the Act);*
 - 6) *Hospitals that have been designated Acute Stroke-Ready Hospitals (Section 3.226(b)(3) of the Act);*
 - 7) *Hospitals that seek designation as Acute Stroke-Ready Hospitals (Section 3.226(b)(4) of the Act); and*
 - 8) *Grants will also be awarded for the development of stroke networks (Section 3.226(b)(5) of the Act).*
- e) *Interfund transfers from the Hospital Stroke Care Fund shall be prohibited. (Section 3.226(d) of the Act)*

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.255 Stroke Data Collection Fund

- a) The Stroke Data Collection Fund is created as a special fund in the State treasury for the purpose of receiving appropriations, donations and grants collected by the Department pursuant to Department designation of Comprehensive Stroke Centers, Primary Stroke Centers and Acute Stroke-Ready Hospitals. ((Section 3.117.75 of the Act)
- b) Moneys in the fund shall be used by the Department to support the data collection provided for in Section 3.118 of the Act.
- c) Any surplus funds beyond what are needed to support the data collection provided for in Section 3.118 of the Act shall be used by the Department to support the salary of the Department Stroke Coordinator or for other stroke-care initiatives, including administrative oversight of stroke care. (Section 3.117.75(b) of the Act)

(Source: Added at 40 Ill. Reg. 8274, effective June 3, 2016)

SUBPART C: EMS SYSTEMS

Section 515.330 EMS System Program Plan

An ~~EMSEmergency Medical Services (EMS)~~ System Program Plan shall contain the following information:

- a) The name, address and fax number of the Resource Hospital;
- b) The names and resumes of the following persons:
 - 1) The EMS MD_;
 - 2) The Alternate EMS MD_;
 - 3) The EMS Administrative Director_;
 - 4) The EMS System Coordinator;

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- c) The name, address and fax number of each Associate or Participating Hospital (see subsection (i));
- d) The name and address of each ambulance provider participating within the EMS System;
- e) A map of the EMS System's service area indicating the location of all hospitals and ambulance providers participating in the System;
- f) Current letters of commitment from the following persons at the Resource Hospital, which describe the commitment of the writer and his or her office to the development and ongoing operation of the EMS System, and which state the writer's understanding of and commitment to any necessary changes, such as emergency department staffing and educational requirements:
 - 1) The Chief Executive Officer of the hospital;^{3,5}
 - 2) The Chief of the Medical Staff;^{3,5} and
 - 3) The Director of the Nursing Services;
- g) A letter of commitment from the EMS MD that describes the EMS MD's agreement to:
 - 1) Be responsible for the ongoing education of all System personnel, including ~~coordinating~~ didactic and clinical experience;
 - 2) Develop and authorize written standing orders (treatment protocols, standard operating procedures) ~~to be used in the EMS MD's absence~~ and certify that all involved personnel will be knowledgeable and competent in emergency care ~~and capable of providing treatment and using communications equipment once the program is operational~~;
 - 3) Be responsible for supervising all personnel participating within the System, as described in the System Program Plan;

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- 4) Develop or approve one or more ~~patient care reports~~~~ambulance emergency run reports (run sheets)~~ covering all types ~~of patient care responses of ambulance runs~~ performed by System ~~ambulance~~ providers;
 - 5) Ensure that the Department has access to all records, equipment and vehicles under the authority of the EMS MD during any Department inspection, investigation or site survey;
 - 6) Notify the Department of any changes in personnel providing pre-hospital care in accordance with the EMS System Program Plan approved by the Department;
 - 7) Be responsible for the total management of the System, including the enforcement of compliance with the System Program Plan by all participants within the System;
 - 8) ~~Direct the applicant to the IDPH EMS website for access to an~~ ~~a copy of the application for independent renewal form for~~ ~~(a form supplied by the Department) is provided to~~ ~~EMS Personnel~~ every EMT-B, EMT-I or EMT-P within the System who ~~have~~ ~~has~~ not been recommended for ~~relicensure~~ ~~re-licensure~~ by the EMS MD; and
 - 9) Be responsible for compliance with the provisions of Sections 515.400 and 515.410 ~~of this Part~~;
- h) A description of the method of providing EMS services, which includes:
- 1) Single vehicle response and transport;
 - 2) Dual vehicle response;
 - 3) Level of first response vehicle;
 - 4) Level of transport vehicle;
 - 5) A policy that describes in-field service level upgrade, using advanced level EMS vehicle service providers;

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- 6) A policy that describes ambulance service provider and vehicle service provider upgrade – rural population (optional);
 - 7) Use of mutual aid agreements; and
 - 8) Informing the caller requesting an emergency vehicle of the estimated time of arrival when this information is requested by the caller;
- i) A letter of commitment from each Associate Hospital, Participating Hospital or Veterans Health Administration facility within the System, which includes the following:
- 1) Signed statements by the hospital's Chief Executive Officer, Chief of the Medical Staff and Director of the Nursing Service describing their commitments to the standards and procedures of the System;
 - 2) A description of how the hospital will relate to the EMS System Resource Hospital, its involvement in the ongoing planning and development of the program, and its use of the education and continuing education aspects of the program;
 - 3) Only at an Associate Hospital, a commitment to meet the System's educational standards for ECRNs;
 - 4) An agreement to provide exchange of all drugs and equipment with all pre-hospital providers participating in the System or other EMS system whose ambulances transport to them;
 - 5) An agreement to use the standard treatment orders as established by the Resource Hospital;
 - 6) An agreement to follow the operational policies and protocols of the System;
 - 7) A description of the level of participation in the training and continuing education of ~~EMSpre-hospital~~ personnel;
 - 8) An agreement to collect and provide relevant data as determined by the Resource Hospital;

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- 9) A description of the hospital's data collection and reporting methods and the personnel responsible for maintaining all data;
 - 10) An agreement to allow the Department access to all records, equipment and vehicles relating to the System during any Department inspection, investigation or site survey;
 - 11) If the hospital is a participant in another System, a description of how it will interact within both Systems and how it will ensure that communications interference as a result of this dual participation will be minimized; and
 - 12) The names and resumes of the Associate Hospital EMS MD and Associate Hospital EMS Coordinator;
- j) A letter of commitment from each ambulance provider participating within the System, which indicates compliance with Section 515.810 ~~of this Part~~;
 - k) Descriptions and documentation of each communications requirement provided in Section 515.400 ~~of this Part~~;
 - l) The Program Plan shall consist of the EMS System Manual, which shall be made accessible ~~provided~~ to all System participants and shall include the following Sections:
 - 1) ~~Education and Training~~
 - A) Curricula for all education ~~Content and curricula of training~~ programs for EMS Personnel offered or authorized within the System shall be consistent with national EMS education standards, including any necessary transitional or bridge education to align System personnel with the current national EMS education standards. ~~EMT, Emergency Medical Dispatcher, First Responder, Pre-Hospital RN, ECRN and Lead Instructor candidates, including:~~
 - i) ~~Entrance and completion requirements;~~
 - ii) ~~Program schedules;~~

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- iii) ~~Goals and objectives;~~
 - iv) ~~Subject areas;~~
 - v) ~~Didactic requirements, including skills laboratories;~~
 - vi) ~~Clinical requirements; and~~
 - vii) ~~Testing formats.~~
- B) ~~Education, testing and credentialing requirements for ECRN and PHRN. Training program for Pre-arrival Medical Instructions, if applicable, including:~~
- i) ~~Entrance and completion requirements;~~
 - ii) ~~Description of course materials; and~~
 - iii) ~~Testing formats.~~
- C) Continuing education for EMS Personnel~~EMTs, Pre-Hospital RNs, and ECRNs~~, including:
- i) System requirements (hours, types of ~~content~~programs, etc.);
 - ii) A plan for measurement of ongoing competency for all System participants (i.e., quality assurance)~~System program for System participants: types of activities covered (e.g., telemetry review, and morbidity and mortality conferences) and protocols for enrollment and completion;~~
 - iii) Requirements for approval of academic course work;
 - iv) Didactic programs offered by the System;
 - v) Clinical opportunities available within the System; and

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- vi) ~~Recordkeeping~~Record-keeping requirements for participants, which must be maintained at the Resource Hospital.
- D) Renewal Protocols
- i) System examination requirements for EMS Personnel~~EMTs, Pre-Hospital RNs, ECRNs~~;
 - ii) Procedures for approval and the renewal of EMS Personnel~~Pre-Hospital RN and ECRN approvals~~;
 - iii) Requirements for submission of transaction cards for EMS Personnel~~EMTs~~ meeting renewal requirements; and
 - iv) Department renewal application forms for EMS Personnel~~EMTs~~ who have not met renewal requirements according to System records.
- E) System participant education and information, including:
- i) Distribution of System Manual amendments;
 - ii) In-services for policy and protocol changes;
 - iii) Methods for communicating updates on System and regional~~Regional~~ activities, and other matters of medical, legal and/or professional interest; and
 - iv) Locations of library/resource materials, forms, schedules, etc.
- F) A plan that describes how Emergency Medical dispatch agencies and First Responders/Emergency Medical Responder participate within the EMS System Program Plan (see Sections 515.710 and 515.720~~of this Part~~).
- G) A System may require that up to one-half of the continuing education hours that are required toward relicensure~~re-licensure~~, as

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

determined by the Department, be earned through attendance at system-~~required~~~~taught~~ courses.

H) A didactic continuing education offering/course that has received a State site code or has been approved by other Department approved national accrediting bodies shall be accepted by the System, subject only to the requirements of subsection (l)(1)(C).

2) Drugs and Equipment

A) A list of all drugs and equipment required for each type of System vehicle; and

B) Procedures for obtaining replacements at System hospitals.

3) Personnel Requirements for EMS Personnel~~EMTs~~

A) Minimum staffing for each type and level of vehicle; and

B) Guidelines for EMS Personnel~~EMT~~ patient interaction.

4) In-Field Protocols, including medical-legal policies, but not limited to:

A) The Regional Standing Medical Orders;

B) System Standing Medical Orders as listed in Section 515. Appendix D, to include Department-approved protocols for medical treatment, including, but not limited to, burns, hypothermia, respiratory distress, shock, trauma, cardiac arrest, stroke and toxic exposure (e.g., Department-approved BLS medical treatment protocol, EMSC medical treatment protocol) at a minimum;

C) Appropriate interaction with law enforcement on the scene;

D) When and how to notify a coroner or medical examiner;

E) Appropriate interaction with an independent physician/nurse on the scene;

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- F) The use of restraints;
 - G) Consent for treatment of minors;
 - H) Patient choice and refusal regarding treatment, transport, or destination;
 - I) The duty to perform all services without unlawful discrimination;
 - J) Offering immediate and adequate information regarding services available to victims of abuse, for any person suspected to be a victim of domestic abuse;
 - K) Patient abandonment;
 - L) Emotionally disturbed patients;
 - M) Patient confidentiality and release of information;
 - N) Durable power of attorney for health care;
 - O) Do Not Resuscitate (DNR) orders (see Section 515.380); ~~and~~
 - P) A policy concerning the use of latex-free supplies; ~~and~~
 - Q) A policy that addresses the treatment, follow-up and transport of patients with suspected or diagnosed infectious diseases.
- 5) Communications standards and protocols, including:
- A) The information contained in the System Program Plan relating to the requirements of Sections 515.410(a)(1), (2), (3) and (4) and 515.390(b) and (g);
 - B) Protocols ensuring that physician direction and voice orders to EMS vehicle personnel and other hospitals participating in the System are provided from the operational control point of the Resource or Associate Hospital;

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- C) Protocols ensuring that the voice orders via radio and using telemetry shall be given by or under the direction of the EMS MD or the EMS MD's designee, who shall be either an ECRN; or physician; and
 - D) Protocols defining when an ECRN should contact a physician.
- 6) Quality improvement measures for both adult and pediatric patient care shall be performed on a quarterly basis and be available upon Department request; ambulance operation and System training activities, including, but not limited to, monitoring training activities to ensure that the instructions and materials are consistent with United States Department of Transportation training standards for EMTs and Section 3.50 of the Act; unannounced inspections of pre-hospital services; and peer review.
- 7) Data collection and evaluation methods that include:
- A) The process that will facilitate problem identification, evaluation and monitoring in reference to patient care and/or reporting discrepancies from hospital and pre-hospital providers;
 - B) A copy of the pre-hospital reporting form; and
 - C) A sample of the information and data to be reported to the Department summarizing System activity (see Section 515.350).
- 8) Operational policies that delineate the respective roles and responsibilities of all providers in the System regarding the provision of emergency service, including:
- A) Resource Hospital overrides (situations in which Associate Hospital orders are overruled by the Resource Hospital);
 - B) Infectious disease and disinfection procedures, including the policy on health care worker exposure to an infectious disease; significant exposure;
 - C) Reporting and documenting problems; and

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- D) Protocols for A-EMT/ILS/ALS System personnel to assess the condition of a patient being initially treated in the field by BLS personnel, for the purpose of determining whether a higher level of care is warranted and transfer of care of the patient to the A-EMT, ILS or ALS personnel is therefore appropriate. The protocols shall include a requirement that neither the assessment nor the transfer of care can be initiated if it would appear to jeopardize the patient's condition, and shall require that the activities of the System personnel be under the immediate direction of the EMS MD or designee.
- 9) Any procedures regarding disciplinary or suspension decisions and the review of those decisions that the System has elected to follow in addition to those required by the Act.
- 10) Any System policies regarding abuse of controlled substances or conviction of a felony crime by System personnel whether on or off duty.
- 11) The responsibilities of the EMS System Coordinator, as designated by the EMS MD, including, but not limited to, data evaluation, quality management, complaint investigation, supervision of all clinical, didactic and clinical education and field experiences~~experience training~~, and physician and nurse education as required.
- 12) Each EMS System shall develop an administrative policy that provides the IDPH Division of EMS and Highway Safety and its State Regional EMS Coordinator with notification the next business day when an Illinois licensed EMS crew member is killed in the line of duty.
- 13) The responsibilities of the EMS MD;
- m) *Written protocols for the bypassing of or diversion to any hospital, trauma center or regional trauma center, Comprehensive Stroke Center, Primary Stroke Center, Acute Stroke-Ready Hospital or Emergent Stroke Ready Hospital, which provide that a person shall not be transported to a facility other than the nearest hospital, regional trauma center or trauma center, Comprehensive Stroke Center, Primary Stroke Center, Acute Stroke-Ready Hospital or Emergent Stroke Ready Hospital unless the medical benefits to the patient reasonably expected from the provision of appropriate medical treatment at a more distant facility outweigh the increased*

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

risks to the patient from transport to the more distant facility, or the transport is in accordance with the System's protocols for patient choice or refusal. (Section 3.20(c)(5) of the Act) The bypass status policy shall include criteria to address how the hospital will manage pre-hospital patients with life threatening conditions within the hospital's then-current capabilities while the hospital is on bypass status. In addition, a hospital can declare a resource limitation, which is further outlined in the System Plan, for the following conditions:

- 1) There are no critical or monitored beds available in the hospital; or
- 2) An internal disaster occurs in the hospital;
- n) Bypass status may not be honored if three or more hospitals in a geographic area are on bypass status and transport time by an ambulance to the nearest facility exceeds 15 minutes;
- o) Each hospital shall have a policy addressing peak census procedures, such as the model policy developed by the Department.

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.445 Pediatric Care

- a) Upon the availability of federal funds for development of an emergency medical services for children (EMSC) program, the Department shall appoint an Advisory Board to advise the Department on all matters concerning emergency medical service for children and to develop and implement a plan to address identified pediatric areas of need. The Advisory Board shall assist in the formulation of policy ~~that reflects to effect~~ the purposes of the Act and this Part. The Advisory Board shall consist of 26 members to be appointed by the Director for a term of three years. Membership of the Advisory Board shall include:
 - 1) One practicing pediatrician, one pediatric critical care physician and one board certified pediatric emergency physician, to be recommended by the Illinois Chapter of the American Academy of Pediatrics;
 - 2) One pediatric surgeon, to be recommended by the Illinois Chapter of the American College of Surgeons, or a trauma nurse manager/coordinator recommended by the Illinois Trauma Coordinators Coalition;

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- 3) Two emergency physicians, one to be recommended by the Illinois Chapter of the American College of Emergency Physicians and one to be recommended by the National Association of EMS Physicians;
- 4) One family ~~medicine~~practice physician, to be recommended by the Illinois Chapter of the American Academy of Family Physicians;
- 5) Two registered nurses, one to be appointed upon recommendation of the ~~American Nurses Association-Illinois (ANA-Illinois)~~Illinois Nurses Association and one to be appointed upon recommendation of the Illinois ~~State Council, Chapter of the~~ Emergency Nurses Association (ENA);
- 6) Two ~~EMS Personnel~~emergency medical technicians of differing levels, to be appointed, one each, upon recommendation of the Illinois EMT Association and Illinois Fire Fighters Association;
- 7) An EMS Coordinator ~~recommended by the Northern Illinois and Southern Illinois EMS Coordinators Association~~;
- 8) A representative from each of the following: Division of Specialized Care for Children; Illinois State Police; Illinois Fire Chiefs Association; Illinois State Ambulance Association; Illinois State Medical Society; Illinois Department of Transportation; SAFEKIDS Coalition; Illinois Hospital Association; Metropolitan Chicago Healthcare Council; Illinois Department of Children and Family Services; a pediatric rehabilitation representative; a community organization; a child advocate group; and a parent representative;
- 9) A non-voting member from the Department's Division of Emergency Medical Systems and Highway Safety and the Department of Human Services' Division of Family Health. EMS Regional representation shall be through board members who serve as representatives of other designated constituencies. ~~The Such~~ members shall have dual representation status in advising the Department, but shall retain one vote. The Department shall consider Regional representation when making advisory board appointments.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- b) The Advisory Board members with medical backgrounds shall have expertise and interest in emergency or critical care medical services for children. Vacancies on the Advisory Board shall be filled for the unexpired term by appointment of the Director in the same manner as originally filled. The members of the Advisory Board shall serve without compensation, but shall be reimbursed for necessary expenses incurred in the performance of their duties, including travel expenses. A majority of the members of the Advisory Board shall constitute a quorum for the conduct of business of the advisory committee. A majority vote of the members present at a meeting at which a quorum is established shall be necessary to validate any action of the committee.
- c) A majority of the members of the Advisory Board shall constitute a quorum for the conduct of the Board's business. A majority vote of the members present at a meeting at which a quorum is established shall be necessary to validate any action.
- d) The Advisory Board shall act pursuant to bylaws that it adopts, which shall include the annual election of a Chair and Vice-Chair.
- e) The Department, with the advice of the Advisory Board, shall address and establish through the EMSC program at least the following:
- 1) Initial and continuing education programs for emergency medical services personnel, which shall include training in the emergency care of infants and children;
 - 2) Guidelines for referring children to the appropriate emergency or critical care medical facilities;
 - 3) Guidelines for pre-hospital, hospital and other pediatric emergency or critical care medical service equipment;
 - 4) Guidelines and protocols for pre-hospital and hospital facilities encompassing all levels of pediatric emergency medical services, hospital and pediatric critical care services, including, but not limited to, triage, stabilization, treatment, transfers and referrals;
 - 5) Guidelines for hospital-based emergency departments appropriate for pediatric care to assess, stabilize, and treat critically ill infants and

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

children and if necessary to prepare the child for transfer to a pediatric intensive care unit or pediatric trauma center;

- 6) Guidelines for pediatric intensive care units, pediatric trauma centers and intermediate care units fully equipped and staffed by appropriately trained critical care pediatric physicians, surgeons, nurses and therapists;
- 7) An inter-facility transfer system for critically ill or injured children;
- 8) Guidelines for pediatric rehabilitation units to ensure staffing by rehabilitation specialists and capabilities to provide any service required to assure maximum recovery from the physical, emotional and cognitive effects of critical illness and severe trauma;
- 9) Guidelines for the implementation of public education and injury prevention programs throughout the State in conjunction with local fire, public safety and school personnel;
- 10) Guidelines for the collection, analysis and dissemination of pediatric quality improvement information regarding ongoing improvements in the EMSC program;
- 11) Guidelines and protocols for pre-hospital providers and hospital facilities for the treatment, documentation, reporting and professional interactions with family members, and for referrals to social, psychological and rehabilitation services in suspected cases of child maltreatment; and
- 12) Guidelines addressing pediatric disaster/all-hazards preparedness.

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

SUBPART F: VEHICLE SERVICE PROVIDERS

Section 515.830 Ambulance Licensing Requirements

- a) Vehicle Design
 - 1) Each new vehicle used as an ambulance shall comply with the criteria established by the U.S. General Services Administration's Specification

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

for Ambulance (KKK-A-1822F), with the exception of Section 3.16.2, Color, Paint and Finish.

- 2) *A licensed vehicle shall be exempt from subsequent vehicle design standards or specifications required by the Department in this Part, as long as the vehicle is continuously in compliance with the vehicle design standards and specifications originally applicable to that vehicle, or until the vehicle's title of ownership is transferred. (Section 3.85(b)(8) of the Act)*
- 3) The following requirements listed in Specification KKK-A-1822F shall be considered mandatory in Illinois even though they are listed as optional in that publication:
 - A) 3.7.7.1 Each vehicle will be equipped with either a battery charger or battery conditioner (see 3.15.3 item 7).
 - B) 3.8.5.2 Patient compartment checkout lights will be provided (see 3.15.3 item 9).
 - C) 3.12.1 An oxygen outlet will be provided above the secondary patient (see 3.15.4 M9).
 - D) 3.15.4M3 Electric clock with sweep second hand will be provided.
- b) Equipment Requirements – Basic Life Support Vehicles Each ambulance used as a Basic Life Support vehicle shall meet the following equipment requirements, as determined by the Department by an inspection:
 - 1) Stretchers, Cots, and Litters
 - A) Primary Patient Cot
Shall meet the requirements of sections 3.11.5, 3.11.8.1 of KKK-A-1822F.
 - B) Secondary Patient Stretcher
Shall meet the requirements of sections 3.11.5, 3.11.5.1, 3.11.8.1 of KKK-A-1822F.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- 2) Oxygen, portable
Shall meet the operational requirements of section 3.12.2 of KKK-A-1822-F.
- 3) Suction, portable
 - A) Shall meet the operational requirements of section 3.12.4 of KKK-A-1822F.
 - B) A manually operated suction device is acceptable if approved by the Department.
- 4) Medical Equipment
 - A) Squeeze bag-valve-mask ventilation unit with adult size transparent mask, and child size bag-valve-mask ventilation unit with child, infant and newborn size transparent masks
 - B) Lower-extremity traction splint, adult and pediatric sizes
 - C) Blood pressure cuff, one each, adult, child and infant sizes and gauge
 - D) Stethoscopes, two per vehicle
 - E) Pneumatic counterpressure trouser kit, adult size, optional
 - F) Long spine board with three sets of torso straps, 72" x 16" minimum
 - G) Short spine board (32" x 16" minimum) with two 9-foot torso straps, one chin and head strap or equivalent vest type (wrap around) per vehicle; extrication device optional
 - H) Airway, oropharyngeal – adult, child, and infant, sizes ~~000~~-5
 - I) Airway, nasopharyngeal with lubrication, sizes ~~1412~~-34F

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- J) Two adult and two pediatric sized non-rebreather oxygen masks per vehicle
 - K) Two infant partial re-breather oxygen masks per vehicle
 - L) Three nasal cannulas, adult and child size, per vehicle
 - M) Bandage shears, one per vehicle
 - N) Extremity splints, adult, two long and short per vehicle
 - O) Extremity splints, pediatric, two long and short per vehicle
 - P) Rigid cervical collars – one pediatric, small, medium, and large sizes or adjustable size collars per vehicle. Shall be made of rigid material to minimize flexion, extension, and lateral rotation of the head and cervical spine when spine injury is suspected
 - Q) Patient restraints, arm and leg, sets
 - R) Pulse oximeter with pediatric and adult probes
 - S) AED or defibrillator that includes pediatric capability
- 5) Medical Supplies
- A) Trauma dressing – six per vehicle
 - B) Sterile gauze pads – 20 per vehicle, 4 inches by 4 inches
 - C) Bandages, soft roller, self-adhering type, 10 per vehicle, 4 inches by 5 yards
 - D) Vaseline gauze – two per vehicle, 3 inches by 8 inches
 - E) Adhesive tape rolls – two per vehicle
 - F) Triangular bandages or slings – five per vehicle

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- G) Burn sheets – two per vehicle, clean, individually wrapped
- H) Sterile solution (normal saline) – four per vehicle, 500 cc or two per vehicle, 1,000 cc plastic bottles or bags
- I) Thermal absorbent blanket and head cover, aluminum foil roll or appropriate heat reflective material – minimum one
- J) Obstetrical kit, sterile – minimum one, pre-packaged with instruments and bulb syringe
- K) Cold packs, three per vehicle
- L) Hot packs, three per vehicle, optional
- M) Emesis basin – one per vehicle
- N) Drinking water – one quart, in non-breakable container; sterile water may be substituted
- O) Ambulance emergency run reports – 10 per vehicle, on a form prescribed by the Department or one that contains the data elements from the Department-prescribed form as described in Section 515. Appendix E or electronic documentation with paper backup
- P) Pillows – two per vehicle, for ambulance cot
- Q) Pillowcases – two per vehicle, for ambulance cot
- R) Sheets – two per vehicle, for ambulance cot
- S) Blankets – two per vehicle, for ambulance cot
- T) CPR mask – one per vehicle, with safety valve to prevent backflow of expired air and secretions
- U) Urinal

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- V) Bedpan
- W) Remains bag, optional
- X) Nonporous disposable gloves
- Y) Impermeable red biohazard-labeled isolation bag
- Z) Face protection through any combination of masks and eye protection and field shields
- AA) Suction catheters – sterile, single use, two each, 6, 8, 10, 12, 14 and 18F, plus three tonsil tip semi-rigid pharyngeal suction tip catheters per vehicle; all shall have a thumb suction control port
- BB) Child and infant or convertible car seats
- CC) Current equipment/drug dosage sizing tape or pediatric equipment/drug age/weight chart
- DD) Flashlight, two per vehicle, for patient assessment
- EE) Current Illinois Department of Transportation Safety Inspection sticker in accordance with Section 13-101 of the Illinois Vehicle Code
- FF) Illinois Poison Center telephone number
- GG) Department of Public Health Central Complaint Registry telephone number posted where visible to the patient
- HH) Medical Grade Oxygen
- II) [Ten disaster triage tags](#)
- JJ) [State-approved Mass Casualty Incident \(MCI\) triage algorithms \(START/JumpSTART\)](#)

- c) Equipment Requirements – Intermediate and Advanced Life Support Vehicles

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Each ambulance used as an Intermediate Life Support vehicle or as an Advanced Life Support vehicle shall meet the requirements in subsections (b) and (d) and shall also comply with the equipment and supply requirements as determined by the EMS Medical Director in the System in which the ambulance and its crew participate. Drugs shall include both adult and pediatric dosages. These vehicles shall have a current pediatric equipment/drug dosage sizing tape or pediatric equipment/drug dosage age/weight chart.

- d) **Equipment Requirements – Rescue and/or Extrication**
The following equipment shall be carried on the ambulance, unless the ambulance is routinely accompanied by a rescue vehicle:
- 1) Wrecking bar, 24"
 - 2) Goggles for eye safety
 - 3) Flashlight – one per vehicle, portable, battery operated
 - 4) Fire Extinguisher – two per vehicle, ABC dry chemical, minimum 5-pound unit with quick release brackets. One mounted in driver compartment and one in patient compartment
- e) **Equipment Requirements – Communications Capability**
Each ambulance shall have reliable ambulance-to-hospital radio communications capability and meet the requirements provided in Section 515.400 ~~of this Part~~.
- f) **Equipment Requirements – Epinephrine**
A person currently licensed as an EMT-B, EMT-I, or EMT-P who has successfully completed a Department-approved course in the administration of epinephrine shall be required to carry epinephrine (both adult and pediatric doses) with him or her in the ambulance or drug box as part of the EMT medical supplies whenever he or she is performing the duties of an emergency medical technician, within the context of the EMS System plan. (Section 3.55(a-7) of the Act)
- g) **Personnel Requirements**
- 1) Each Basic Life Support ambulance shall be staffed by a minimum of one EMT Basic, Intermediate, Paramedic or Pre-Hospital RN and one other

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

EMT Basic, Intermediate, Paramedic, Pre Hospital RN or physician on all responses.

- 2) Each ambulance used as an Intermediate Life Support vehicle shall be staffed by a minimum of one Intermediate, Paramedic or Pre-Hospital RN and one other EMT Basic, Intermediate, Paramedic, Pre-Hospital RN or physician on all responses.
- 3) Each ambulance used as an Advanced Life Support vehicle shall be staffed by a minimum of one Paramedic or Pre-Hospital RN and one other EMT Basic, Intermediate, Paramedic, Pre-Hospital RN or physician on all responses.

h) Alternate Rural Staffing Authorization

- 1) A Vehicle Service Provider *that serves a rural or semi-rural population of 10,000 or fewer inhabitants and exclusively uses volunteers or paid-on-call personnel or a combination* to provide patient care may apply for alternate rural staffing authorization to authorize the ambulance, Non-Transport Vehicle, Special-Use Vehicle, or Limited Operation Vehicle to be staffed by one EMT licensed at or above the level at which the vehicle is licensed, plus one First Responder/Emergency Medical Responder when two licensed Emergency Services Personnel are not available to respond. (Section 2.85(b)(3) of the Act)
- 2) The EMT licensed at or above the level at which the ambulance is licensed shall be the primary patient care provider in route to the health care facility.
- 3) The Vehicle Service Provider shall obtain the prior written approval for alternate rural staffing from the EMS MD. The EMS MD shall submit to the Department a request for an amendment to the existing EMS System plan that clearly demonstrates the need for alternate rural staffing in accordance with subsection (h)(4) and that the alternate rural staffing will not reduce the quality of medical care established by the Act and this Part.
- 4) A Vehicle Service Provider requesting alternate rural staffing authorization shall clearly demonstrate all of the following:

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- A) That it has undertaken extensive efforts to recruit and train licensed EMS ~~Personnel~~ ~~personnel~~;
 - B) That, despite its exhaustive efforts, licensed EMS ~~Personnel~~ ~~personnel~~ are not available; and
 - C) That, without alternate rural staffing authorization, the rural or semi-rural population of 10,000 or fewer inhabitants served will be unable to meet staffing requirements as specified in subsection (g).
- 5) The alternate rural staffing authorization and subsequent authorizations shall include beginning and termination dates not to exceed 48 months. The EMS MD shall re-evaluate subsequent requests for authorization for compliance with subsections (h)(4)(A) through (C). Subsequent requests for authorization shall be submitted to the Department for approval in accordance with this Section.
 - 6) Alternate rural staffing authorization may be suspended or revoked, after an opportunity for hearing, if the Department determines that a violation of this Part has occurred. Alternate rural staffing authorization may be summarily suspended by written order of the Director, served on the Vehicle Service Provider, if the Director determines that continued operation under the alternate rural staffing authorization presents an immediate threat to the health or safety of the public. After summary suspension, the Vehicle Service Provider shall have the opportunity for an expedited hearing.
 - 7) Vehicle Service Providers that cannot meet the alternate rural staffing authorization requirements of this Section may apply through the EMS MD to the Department for a staffing waiver pursuant to Section 515.150.
- i) Alternate Response Authorization
 - 1) A Vehicle Service Provider that exclusively uses volunteers or paid-on-call personnel or a combination to provide patient care who are not required to be stationed with the vehicle may apply to the Department for alternate response authorization to authorize the ambulance, Non-Transport Vehicle, Special-Use Vehicle, or Limited Operation Vehicle licensed by the Department to travel to the scene of an emergency staffed

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

by at least one licensed Emergency Medical Responder, Emergency Medical Technician, Advanced Emergency Medical Technician, Emergency Medical Technician-Intermediate, Paramedic or Pre-Hospital RN ("Emergency Services Personnel").

- 2) A Vehicle Service Provider operating under alternate response authorization shall ensure that a second licensed Emergency Services Personnel is on scene or in route to the emergency response location.
 - 3) The Vehicle Service Provider shall demonstrate to the Department that it has safeguards to ensure that no patient will be transported with fewer than two EMTs, at least one of whom shall be licensed at or above the level of the license for the vehicle, unless the Vehicle Service Provider is approved for alternate rural staffing authorization.
 - 4) Alternate response authorization may be suspended or revoked, after an opportunity for hearing, if the Department determines that a violation of this Part has occurred. Alternate response authorization may be summarily suspended by written order of the Director, served on the Vehicle Service Provider, if the Director determines that continued operation under the alternate response authorization presents an immediate threat to the health or safety of the public. After summary suspension, the licensee shall have the opportunity for an expedited hearing (see Section 515.180).
- j) Alternate Response Authorization – Secondary Response Vehicles
- 1) A Vehicle Service Provider that uses volunteers or paid-on-call personnel or a combination to provide patient care, and staffs its primary response vehicle with personnel stationed with the vehicle, may apply for alternate response authorization for its secondary response vehicles. The secondary or subsequent ambulance, Non-Transport Vehicle, Special-Use Vehicle, or Limited Operation Vehicle licensed by the Department at the BLS, ILS or ALS level, when personnel are not stationed with the vehicle, may respond to the scene of an emergency when the primary vehicle is on another response. The vehicle shall be staffed by at least one licensed Emergency Services Personnel.
 - 2) A Vehicle Service Provider operating under the alternate response authorization shall ensure that a second licensed Emergency Services

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Personnel provider is on the scene or in route to the emergency response location.

- 3) The Vehicle Service Provider shall demonstrate to the Department that it has written safeguards to ensure that no patient will be transported with fewer than two EMTs, at least one of whom shall be licensed at or above the level of the license for the ambulance, unless the Vehicle Service Provider is approved for alternate rural staffing authorization under subsection (h).
 - 4) Alternate response authorization for secondary response vehicles may be suspended or revoked, after an opportunity for hearing, if the Department determines that a violation of this Part has occurred. Alternate response authorization for secondary response vehicles may be summarily suspended by written order of the Director, served on the Vehicle Service Provider, if the Director determines that continued operation under the alternate response authorization for secondary vehicles presents an immediate threat to the health or safety of the public. After summary suspension, the Vehicle Service Provider shall have the opportunity for an expedited hearing (see Section 515.180).
- k) Operational Requirements
- 1) An ambulance that is transporting a patient to a hospital shall be operated in accordance with the requirements of the Act and this Part.
 - 2) A licensee shall operate its ambulance service in compliance with this Part, 24 hours a day, every day of the year. Except as required in this subsection (k), each individual vehicle within the ambulance service shall not be required to operate 24 hours a day, as long as at least one vehicle for each level of service covered by the license is in operation at all times. An ALS vehicle can be used to provide coverage at either an ALS, ILS or BLS level, and the coverage shall meet the requirements of this Section.
 - A) At the time of application for initial or renewal licensure, and upon annual inspection, the applicant or licensee shall submit to the Department for approval a list containing the anticipated hours of operation for each vehicle covered by the license.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- i) A current roster shall also be submitted that lists the EMS Personnel, Pre-Hospital RNs and physicians who are employed or available to staff each vehicle during its hours of operation. The roster shall include each staff person's name, license number, license expiration date and daytime telephone number, and shall state whether the person is scheduled to be on site or on call.
 - ii) An actual or proposed four-week staffing schedule shall also be submitted, which covers all vehicles, includes staff names from the submitted roster, and states whether each staff member is scheduled to be on site or on call during each work shift.
 - B) Licensees shall obtain the EMS MD's approval of their vehicles' hours of operation prior to submitting an application to the Department. An EMS MD may require specific hours of operation for individual vehicles to assure appropriate coverage within the System.
 - C) A Vehicle Service Provider that advertises its service as operating a specific number of vehicles or more than one vehicle shall state in the advertisement the hours of operation for those vehicles, if individual vehicles are not available 24 hours a day. Any advertised vehicle for which hours of operation are not stated shall be required to operate 24 hours a day.
- 3) For each patient transported to a hospital, the ambulance staff shall, at a minimum, measure and record the information required in Section 515. Appendix E.
 - 4) A Vehicle Service Provider shall provide emergency service within the service area on a per-need basis without regard to the patient's ability to pay for the service.
 - 5) A Vehicle Service Provider shall provide documentation of procedures to be followed when a call for service is received and a vehicle is not available, including copies of mutual aid agreements with other ambulance providers. (See Section 515.810(h).)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- 6) A Vehicle Service Provider shall not operate its ambulance at a level exceeding the level for which it is licensed (basic life support, intermediate life support, advanced life support), unless the vehicle is operated pursuant to an EMS System-approved in-field service level upgrade or ambulance service upgrades – rural population.
- 7) The Department will inspect ambulances each year. If the Vehicle Service Provider has no violations of this Section that threaten the health of safety of patients or the public for the previous five years and has no substantiated complaints against it, the Department will inspect the Vehicle Service Provider's ambulances in alternate years, and the Vehicle Service Provider may, with the Department's prior approval, self-inspect its ambulances in the other years. The Vehicle Service Provider shall use the Department's inspection form for self-inspection. Nothing contained in this subsection (k)(7) shall prevent the Department from conducting unannounced inspections.
- l) A licensee may use a replacement vehicle for up to 10 days without a Department inspection provided that the Department is notified of the use of the vehicle by the second working day.
- m) *Patients, individuals who accompany a patient, and emergency services personnel may not smoke while inside an ambulance or SEMSV. The Department of Public Health shall impose a civil penalty on an individual who violates this subsection (m) in the amount of \$100. (Section 3.155(h) of the Act)*
- n) Any provider may request a waiver of any requirements in this Section under the provisions of Section 515.150.

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

SUBPART J: EMERGENCY MEDICAL SERVICES FOR CHILDREN

Section 515.3090 Pediatric Recognition of Hospital Emergency Departments and Inpatient Critical Care Services

- a) Any hospital seeking recognition as a Standby Emergency Department Approved for Pediatrics (SEDP), Emergency Department Approved for Pediatrics (EDAP)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

or Pediatric Critical Care Center (PCCC) shall submit an application as outlined by the Department in Appendix K and Appendix N ~~of this Part~~.

- b) All EMS Resource Hospitals are required to receive recognition as a SEDP, EDAP or PCCC. All Illinois hospitals are encouraged to obtain and maintain SEDP or EDAP status.
- c) The Department shall recognize applicant hospitals as an SEDP, EDAP or PCCC if they meet all of the requirements established by this Part.
- d) Hospitals applying for PCCC recognition shall also meet all of the EDAP requirements.
- e) Recognition as a SEDP, EDAP or PCCC shall be for ~~four~~three years.
- f) All requests for renewal of SEDP, EDAP or PCCC recognition shall be filed in writing with the Department before the recognition expiration date, along with submission of a Department-approved renewal application.
- g) The Department shall deny an application for recognition or a request for renewal of recognition when its findings show failure to comply with this Part.
- h) The Department shall provide written notice, via certified mail, of its decision to deny an application for recognition or request for renewal of recognition. Hospitals may appeal the denial by submitting a written request to the Illinois Department of Public Health, Division of EMS & Highway Safety.
- i) Any SEDP, EDAP or PCCC may voluntarily terminate recognition prior to the expiration date by notifying the Department in writing. The hospital shall notify the Illinois Department of Public Health, Division of EMS & Highway Safety at least 60 days prior to termination and shall identify how area pre-hospital provider agencies, area hospitals, and the Illinois EMSC Office will be notified.
- j) The Department shall inspect recognized hospitals to assure compliance with ~~the provisions of~~ this Part.
- k) The Department shall take the following action, as appropriate, after determining that an SEDP, EDAP or PCCC is in violation of this Part.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- 1) If the Director determines that the violation presents an immediate threat of death or serious physical harm to a patient, and if the SEDP, EDAP or PCCC fails to eliminate the violation immediately or within a fixed period of time, not exceeding 10 days, as determined by the Director, the Director shall immediately revoke the recognition.
 - 2) If the Department determines that the violation does not present an immediate threat of death or serious physical harm to a patient, the Director shall issue a notice of violation and request a plan of correction, which shall be subject to the Department's approval.
- 1) No hospital shall use the recognition levels of SEDP, EDAP or PCCC in relation to itself or hold itself out as an SEDP, EDAP or PCCC without first obtaining recognition pursuant to this Part.

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.4000 Facility Recognition Criteria for the Emergency Department Approved for Pediatrics (EDAP)

- a) Professional Staff: Physicians
 - 1) Qualifications
Twenty-four hour coverage of the emergency department (excluding designated areas utilized to care for minor illnesses or injuries, i.e., fast track, urgent care) shall be provided by ~~at least~~ one or more physicians ~~physician~~ responsible for the care of all critically ill or injured children. Each physician shall hold ~~who holds~~ one of the following qualifications:
 - A) Certification in emergency medicine by the American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) or residency trained/board eligible in emergency medicine and in the first cycle of the board certification process; or
 - B) Sub-board Certification in pediatric emergency medicine by the American Board of Pediatrics or the ABEM or residency

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

trained/board eligible in pediatric emergency medicine and in the first cycle of the board certification process; or

- C) Certification by one of the following boards and current American Heart Association – American Academy of Pediatrics (AHA-AAP) Pediatric Advanced Life Support (PALS) recognition or American College of Emergency Physicians – American Academy of Pediatrics (ACEP-AAP) Advanced Pediatric Life Support (APLS) recognition. PALS and APLS courses shall include both cognitive and practical skills evaluation.
- i) Certification in family ~~medicinepractice~~ by the American Board of Family ~~Medicine (ABFM)Practice (ABFP)~~ or American Osteopathic Board of Family ~~Medicine (AOBFM)Practice (AOBFP)~~; or
 - ii) Certification in pediatrics by the ABP or American Osteopathic Board of Pediatrics (AOBP); or
 - iii) Residency trained/board eligible in either family ~~medicinepractice~~ or pediatrics and in the first cycle of the board certification process; or
- D) ~~Alternate Criteria: The physician has worked in the emergency department prior to January 1, 2018 and has completed 12 months of internship followed by at least 7000 hours of hospital-based emergency medicine, including pediatric patients, over the last 60-month period (including at least 2800 hours within one continuous 24-month period), certified in writing by the hospitals at which the internship and subsequent hours were completed. The physician shall have current AHA-AAP PALS or ACEP-AAP APLS recognition and have completed at least 16 hours of pediatric CME within the past two years. A physician who has received a waiver from the Department based on one of the following criteria. Physicians shall reapply for a waiver with each renewal cycle (as applicable) and provide verification of continued compliance with the waiver requirements.~~

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- i) ~~An emergency department physician who has already received a waiver in accordance with Section 515.2030(e) or Section 515.2040(f) of this Part and has current AHA-AAP PALS or ACEP-AAP APLS recognition. PALS and APLS courses shall include both cognitive and practical skills evaluation; or~~
- ii) ~~Completion of 12 months of internship followed by at least 7000 hours of hospital-based emergency medicine, including pediatric patients, over the last 60-month period (including 2800 hours within one 24-month period), verified in writing by the hospitals at which the internship and subsequent hours were completed and current AHA-AAP PALS or ACEP-AAP APLS recognition. PALS and APLS courses shall include both cognitive and practical skills evaluation; or~~
- iii) ~~Completion of professional activities spent in the practice of pediatric emergency medicine (PEM), over the last 60-month period and totaling a minimum of 6000 hours, focused on the care of pediatric patients in the emergency department, and current AHA-AAP PALS or ACEP-AAP APLS recognition (PALS and APLS courses shall include both cognitive and practical skills evaluation). Of the 6000 hours, 2800 hours shall have been accrued in a 24-month (maximum) consecutive period of time. A minimum of 4000 of the 6000 hours shall have been spent in the clinical practice of PEM. (If practiced in general ED, only time spent exclusively in pediatric practice can be used for credit.) The remaining 2000 hours may be spent in either clinical care or a mixture of related non-clinical activities clearly focused on PEM, including administration, teaching, pre-hospital care, quality improvement, research or other academic activities.~~
- 2) Continuing Medical Education
~~All full- and part-time emergency physicians~~All full- or part-time emergency physicians caring for children in the emergency department or fast track/urgent care area shall have documentation of completion of a

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

minimum of 16 hours of continuing medical education (AMA Category I or II) in pediatric emergency topics every two years. CME hours shall be earned by, but not limited to, verified attendance at or participation in formal CME programs (i.e., Category I) or informal CME programs (i.e., Category II), all of which shall have pediatrics as the majority of their content. The CME may be obtained from a pediatric specific program/course or may be a pediatric lecture/presentation from a workshop/conference. To meet Category II, teaching time needs to have undergone review and received approval by a university/hospital as Category II CME. The Illinois Department of Financial and Professional Regulation can provide guidance related to criteria for acceptable Category I or II credit.

3) Physician Coverage

At least one physician meeting the requirements of subsection (a)(1) shall be on duty in the emergency department 24 hours a day.

4) Consultation

Telephone consultation with a physician who is board certified or eligible in pediatrics or pediatric emergency medicine shall be available 24 hours a day. Consultation can be with an on-staff physician or in accordance with Appendix M ~~of this Part.~~

5) Physician Backup

A backup physician whose qualifications and training are equivalent to subsection (a)(1) shall be available to the EDAP within one hour after notification to assist with critical situations, increased surge capacity or disasters.

6) On-Call Physicians

Guidelines shall be established that address on-site response time for all on-call specialty physicians.

- b) Professional Staff: Nurse Practitioner and Physician Assistant ~~Mid-Level Practitioners~~
Nurse practitioners and ~~A mid-level practitioner is a nurse practitioner or~~
physician ~~assistants~~ assistant working under the supervision of a physician who meets the qualifications of subsection (a)(1) ~~of this Section.~~

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

1) Qualifications

A) Nurse practitioners shall meet the following criteria~~have~~:

i) Completion of: Completed

- a nurse practitioner program with a focus on the pediatric patient, such as a pediatric nurse practitioner program or emergency nurse practitioner program or family practice nurse practitioner program; ~~or the Department will grant a waiver based on the following criteria: has completed 2000 hours of hospital-based emergency department or acute care as a nurse practitioner over the last 24-month period that includes the care of the pediatric patient (nurse practitioners shall reapply for a waiver with each renewal cycle (as applicable) and provide verification of continued compliance with the waiver requirements; and~~
- Alternate Criteria: The nurse practitioner worked in the emergency department prior to January 1, 2018 and has completed at least 2000 hours of hospital-based emergency department or acute care as a nurse practitioner over the last 24-month period that includes the care of pediatric patients certified in writing by the hospitals at which the hours were completed.

ii) Current Illinois advanced practice nursing license. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices; ~~and~~

iii) Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient as defined by the hospital credentialing process.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- B) Physician assistants shall ~~meet the following criteria~~have:
- i) Current Illinois licensure. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices; and
 - ii) Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient as defined by the hospital credentialing process.
- ~~C) All nurse practitioners and physician assistants shall successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS, the ACEP-AAP APLS or the Emergency Nurses Association (ENA) Emergency Nursing Pediatric Course (ENPC). PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.~~
- 2) Continuing Education
- A) All full- or part-time nurse practitioners and physician assistants caring for children in the emergency department shall successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS, the ACEP-AAP APLS or the Emergency Nurses Association (ENA) Emergency Nursing Pediatric Course (ENPC). PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.~~shall have documentation of a minimum of 16 hours of continuing education units in pediatric emergency topics every two years that are approved by an accrediting agency.~~
 - B) All ~~nurse practitioners and full- or part-time~~ physician assistants caring for children in the emergency department and fast track/urgent care area shall have documentation of a minimum of 16 hours of continuing education in pediatric emergency topics every two years that are approved by an accrediting agency.~~shall~~

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

~~have documentation of a minimum of 16 hours of continuing medical education (AMA Category I) in pediatric emergency topics every two years. Credit for CME shall be approved by an accrediting agency.~~

- c) Professional Staff: Nursing
 - 1) Qualifications
 - A) At least one registered nurse (RN) on duty each shift who is responsible for the direct care of the child in the emergency department shall successfully complete and maintain current recognition in one of the following courses in pediatric emergency care:
 - i) AHA-AAP PALS;
 - ii) ACEP-AAP APLS; or
 - iii) ENA ENPC.
 - B) All emergency department nurses shall successfully complete and maintain current recognition in one of the above educational requirements within 24 months after employment. PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.
 - 2) Continuing Education

All nurses assigned to the emergency department shall have documentation of a minimum of eight hours of pediatric emergency/critical care continuing education every two years. Continuing education may include, but is not limited to, PALS, APLS or ENPC; CEU offerings; case presentations; competency testing; teaching courses related to pediatrics; and/or publications. These continuing education hours can be integrated with other existing continuing education requirements, provided that the content is pediatric specific.
- d) Guidelines, Policies and Procedures

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- 1) Inter-facility Transfer
 - A) The hospital shall have current transfer agreements that cover pediatric patients. The transfer agreements shall include a provision that addresses communication and quality improvement measures between the referral and receiving hospitals, as related to patient stabilization, treatment prior to and subsequent to transfer, and patient outcome.
 - B) The hospital shall have written pediatric inter-facility transfer guidelines and policies/procedures concerning transfer of critically ill and injured patients, which include a defined process for initiation of transfer, including the roles and responsibilities of the referring hospital and referral center; a process for selecting the appropriate care facility; a process for selecting the appropriately staffed transport service to match the patient's acuity level; a process for patient transfer (including obtaining informed consent); a plan for transfer of patient medical record information, signed transport consent, and belongings; and a plan for provision of referral hospital information to family. Incorporating the components of Appendix M of this Part into the emergency department transfer policy/procedure will meet this requirement.
- 2) Suspected Child Abuse and Neglect

The hospital shall have policies/procedures addressing child abuse and neglect. These policies/procedures shall include, but not be limited to: the identification (including screening), evaluation, treatment and referral to the Department of Children and Family Services (DCFS) of victims of suspected child abuse and neglect in accordance with State law.
- 3) Emergency Department Treatment Guidelines

The hospital shall have emergency department guidelines, order sets or policies and procedures addressing initial ~~response and~~ assessment and management for its high-volume and high-risk pediatric population (i.e., fever, trauma, respiratory distress, seizures).
- 4) Latex-Allergy Policy

The hospital shall have a policy addressing the assessment of latex allergies and the availability of latex-free equipment and supplies.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- 5) Disaster Preparedness
The hospital shall integrate pediatric components into its hospital Disaster/Emergency Operations Plan.

e) Quality Improvement

1) Multidisciplinary Quality Activities Policy

A) Pediatric emergency medical care shall be included in the EDAP's emergency department or section quality improvement (QI) program and reported to the hospital Quality Committee.

B) Multidisciplinary quality improvement (QI) processes/activities shall be established (e.g., committee, ~~task force~~).

C) Quality monitors shall be documented that address pediatric care within the emergency department, with identified clinical indicators, monitor tools, defined and/or outcomes for care, feedback loop processes and target timeframes for closure of issues. These activities shall include children from birth up to and including 15 years of age and shall consist of, but are not limited to, all ~~pediatric~~ emergency department: ~~deaths, inter-facility transfers, child abuse and neglect cases, critically ill or injured children in need of stabilization (e.g., respiratory failure, sepsis, shock, altered level of consciousness, cardio/pulmonary failure) and pediatric strategic priorities of the institution.~~

i) Pediatric deaths;

ii) Pediatric inter-facility transfers;

iii) Child abuse and neglect cases;

iv) Critically ill or injured children in need of stabilization (e.g., respiratory failure, sepsis, shock, altered level of consciousness, cardio/pulmonary failure); and

v) Pediatric quality and safety priorities of the institution.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

D) *All information contained in or relating to any medical audit/quality improvement monitor performed of a PCCC's, EDAP's or SEDP's pediatric services pursuant to this Section shall be afforded the same status as is provided information concerning medical studies in Article VIII, Part 21 of the Code of Civil Procedure. (Section 3-110(a) of the Act)*

2) Pediatric Physician Champion

The emergency department medical director shall appoint a physician to champion pediatric quality improvement activities. The pediatric physician champion shall work with and provide support to the pediatric quality coordinator.

3) Pediatric Quality Coordinator

A member of the professional staff who has ongoing involvement in the care of pediatric patients shall be designated to serve in the role of the pediatric quality coordinator. The pediatric quality coordinator shall have a job description that includes the allocation of appropriate time and resources by the hospital. This individual may be employed in an area other than the emergency department and shall have a minimum of two years of pediatric critical care or emergency department experience.

Working with the pediatric physician champion, the responsibilities of the pediatric quality coordinator shall include:~~The responsibilities of the pediatric quality coordinator, working with the pediatric physician champion, shall include:~~

A) Working in conjunction with the ED nurse manager and ED medical director to ensure compliance with and documentation of the pediatric continuing education of all emergency department staff in accordance with subsections (a), (b), and (c)~~of this Section.~~

B) Coordinating data collection for identified clinical indicators and outcomes (see subsection (e)(1)(C)~~of this Section.~~

C) Reviewing selected pediatric cases transported to the hospital by pre-hospital providers and providing feedback to the EMS Coordinator/System.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- D) Participating in regional QI activities, including preparing a written QI report and attending the Regional QI subcommittee. These activities shall be supported by the hospital. One representative from the Regional QI subcommittee shall report to the EMS Regional Advisory Board.
- E) Providing QI information to the Department upon request. (See Section 3.110(a) of the Act.)
- f) Equipment, Trays, and Supplies
See Appendix L ~~of this Part.~~

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.4010 Facility Recognition Criteria for the Standby Emergency Department Approved for Pediatrics (SEDP)

- a) Professional Staff: Physicians
 - 1) Qualifications
 - A) All physicians shall have training in the care of pediatric patients through residency training, clinical training, or practice.
 - B) All physicians shall successfully complete and maintain current recognition in the AHA-AAP PALS or the ACEP-AAP APLS. Physicians who are board certified or eligible in emergency medicine (ABEM or AOBEM) or in pediatric emergency medicine (ABP/ABEM) are excluded from this requirement. PALS and APLS shall include both cognitive and practical skills evaluation.
 - 2) Continuing Medical Education
All full and part-time emergency physicians caring for children in the emergency department or fast track/urgent care area shall have documentation of a minimum of 16 hours of continuing medical education (AMA Category I or II) in pediatric emergency topics every two years. CME hours shall be earned by, but not limited to, verified attendance at or participation in formal CME programs (i.e., Category I) or informal CME

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

programs (i.e., Category II), all of which shall have pediatrics as the majority of their content. The CME may be obtained from a pediatric specific program/course or may be a pediatric lecture/presentation from a workshop/conference. To meet Category II, teaching time needs to have undergone review and received approval by a university/hospital as Category II CME. The Illinois Department of Financial and Professional Regulation can provide guidance related to criteria for acceptable Category I or II credit.

3) Coverage

At least one physician meeting the requirements of subsection (a)(1), or a ~~physician assistant or~~ nurse practitioner or physician assistant meeting the requirements of subsection (b)(1), shall be on duty in the emergency department 24 hours a day or immediately available. A policy shall define when a physician is to be consulted/called in at times when the emergency department is covered by a mid-level provider.

4) Consultation

Telephone consultation with a physician who is board certified or eligible in pediatrics or pediatric emergency medicine shall be available 24 hours a day. Consultation may be with an on-call physician or in accordance with Appendix M ~~of this Part.~~

5) Physician Backup

A backup physician whose qualifications and training are equivalent to subsection (a)(1) ~~of this Section~~ shall be available to the SEDP within one hour after notification to assist with critical situations, increased surge capacity or disasters.

6) On-Call Physicians

Guidelines shall address response time for on-call physicians.

- b) Professional Staff: Nurse Practitioner and Physician Assistant ~~Mid-level Practitioners~~
Nurse practitioners and ~~A mid-level practitioner is a nurse practitioner or~~ physician assistants ~~assistant~~ working under the supervision of a physician who meets the qualifications of subsection (a)(1) ~~of this Section.~~

1) Qualifications

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- A) Nurse practitioners shall meet the following criteria~~have~~:
- i) Completion of: Completed
- a nurse practitioner program with a focus on the pediatric patient, such as a pediatric nurse practitioner program or emergency nurse practitioner program or family practice nurse practitioner program; ~~or, or the Department will grant a waiver based on the following criteria: completion of 2000 hours of hospital-based emergency department or acute care as a nurse practitioner over the last 24-month period that includes the care of the pediatric patient. Nurse practitioners shall reapply for a waiver with each renewal cycle (as applicable) and provide verification of continued compliance with the waiver requirements; and~~
 - Alternate Criteria: The nurse practitioner worked in the emergency department prior to January 1, 2018 and has completed at least 2000 hours of hospital-based emergency department or acute care as a nurse practitioner over the last 24-month period that includes the care of pediatric patients certified in writing by the hospitals at which the hours were completed.
- ii) Current~~A current~~ Illinois advanced practice nursing license~~; and For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.~~
- iii) Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient as defined by the hospital credentialing process.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- B) Physician assistants shall meet the following criteria~~have~~:
- i) Current Illinois physician assistant licensure; and For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.
 - ii) Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient as defined by the hospital credentialing process.
- C) ~~All nurse practitioners and physician assistants shall successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS, the ACEP-AAP APLS or the ENA ENPC. PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.~~
- 2) Continuing Education
- A) ~~All full or part-time nurse practitioners and physician assistants caring for children in the emergency department shall successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS, the ACEP-AAP APLS or the Emergency Nurses Association (ENA) Emergency Nursing Pediatric Course (ENPC). PALS, APLS and ENPC shall include both cognitive and practical skills evaluation have documentation of a minimum of 16 hours of continuing education in pediatric emergency topics every two years. Credit for continuing education shall be approved by an accrediting agency.~~
 - B) All nurse practitioners and full or part-time physician assistants shall have documentation of a minimum of 16 hours of continuing education in pediatric emergency topics every two years that are approved by an accrediting agency.~~shall have documentation of a minimum of 16 hours of continuing medical education (AMA~~

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

~~Category I) in pediatric emergency topics every two years. Credit for CME shall be approved by an accrediting agency.~~

- c) Professional Staff: Nursing
- 1) Qualifications
At least one RN on duty each shift who is responsible for the direct care of the child in the emergency department shall successfully complete and maintain current recognition in one of the following courses in pediatric emergency care:
 - A) AHA-AAP PALS;
 - B) ACEP-AAP APLS; or
 - C) ENA ENPC.
 - 2) Continuing Education
At least one ~~Registered Nurse~~~~RN~~ on duty on each shift who is responsible for the direct care of the child in the emergency department shall have documentation of a minimum of eight hours of pediatric emergency/critical care continuing education every two years. Continuing education may include, but is not limited to, PALS, APLS or ENPC; CEU offerings; case presentations; competency testing; teaching courses related to pediatrics; ~~and/or~~ publications. The continuing education hours may be integrated with other existing continuing education requirements, provided that the content is pediatric specific. PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.
- d) Policies and Procedures
- 1) Inter-facility Transfer
 - A) The hospital shall have current transfer agreements that cover pediatric patients. The transfer agreements shall include a provision that addresses~~address~~ communication and quality improvement measures between the referral and receiving hospitals, as related to patient stabilization, treatment prior to and subsequent to transfer, and patient outcome.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- B) The hospital shall have written pediatric inter-facility transfer guidelines/ policies/procedures concerning transfer of critically ill and injured patients, ~~which that~~ include a defined process for initiation of transfer, including the roles and responsibilities of the referring hospital and referral center; a process for selecting the appropriate care facility; a process for selecting the appropriately staffed transport service to match the patient's acuity level; a process for patient transfer (including obtaining informed consent); a plan for transfer of patient medical record information, signed transport consent, and belongings; and a plan for provision of referral hospital information to family. Incorporating the components of Appendix M ~~of this Part~~ into the emergency department transfer policy/procedure will meet this requirement.
- 2) Suspected Child Abuse and Neglect
The hospital shall have policies/procedures addressing child abuse and neglect. These policies/procedures shall include, but not be limited to: the identification (including screening), evaluation, treatment and referral to DCFS of victims of suspected child abuse and neglect in accordance with State law.
- 3) Emergency Department Treatment Guidelines
The hospital shall have emergency department guidelines, order sets or policies and procedures addressing initial ~~response and~~ assessment and management for its high-volume and high-risk pediatric population (i.e., fever, trauma, respiratory distress, seizures).
- 4) Latex-Allergy Policy
The hospital shall have a policy addressing the assessment of latex allergies and the availability of latex-free equipment and supplies.
- 5) Disaster Preparedness
The hospital shall integrate pediatric components into its Disaster/Emergency Operations Plan.
- e) Quality Improvement
- 1) Multidisciplinary Quality Activities Policy

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- A) Pediatric emergency medical care shall be included in the SEDP's emergency department or section QI program and reported to the hospital Quality Committee.
- B) Multidisciplinary quality improvement processes/ activities shall be established (e.g., committee, ~~task force~~).
- C) Quality monitors shall be documented that address pediatric care within the emergency department, with identified clinical indicators, ~~monitor tools, and defined~~ outcomes for care, feedback loop processes and target timeframes for closure of issues. These activities shall include children from birth up to and including 15 years of age and shall consist of, but are not limited to, all ~~pediatric~~ emergency department:
- i) Pediatric deaths;
 - ii) Pediatric inter-facility transfers;
 - iii) Child abuse and neglect cases;
 - iv) Critically ill or injured children in need of stabilization (e.g., respiratory failure, sepsis, shock, altered level of consciousness, cardio/pulmonary failure; and
 - v) Pediatric quality and safety priorities of the institution.
- ~~deaths, inter-facility transfers, child abuse and neglect cases, critically ill or injured children in need of stabilization (e.g., respiratory failure, sepsis, shock, altered level of consciousness, cardio/pulmonary failure) and pediatric strategic priorities of the hospital.~~
- D) *All information contained in or relating to any medical audit/quality improvement monitor performed of a PCCC's, EDAP's or SEDP's pediatric services pursuant to this Section shall be afforded the same status as is provided information concerning*

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

medical studies in Article VIII, Part 21 of the Code of Civil Procedure. (Section 3.110(a) of the Act)

- 2) **Pediatric Physician Champion**
The emergency department medical director shall appoint a physician to champion pediatric quality improvement activities. The pediatric physician champion shall work with and provide support to the pediatric quality coordinator.
- 3) **Pediatric Quality Coordinator**
A member of the professional staff who has ongoing involvement in the care of pediatric patients shall be designated to serve in the role of the pediatric quality coordinator. The pediatric quality coordinator shall have a job description that includes the allocation of appropriate time and resources by the hospital. This individual may be employed in an area other than the emergency department and shall have a minimum of two years of pediatric critical care or emergency department experience. Working with the pediatric physician champion, the responsibilities of the pediatric quality coordinator shall include:
 - A) Working in conjunction with the ED nurse manager and ED medical director to ensure compliance with and documentation of the pediatric continuing education of all emergency department professional staff in accordance with subsections (a), (b), and (c) ~~of this Section.~~
 - B) Coordinating data collection for identified clinical indicators and outcomes (see subsection (e)(1)(C) ~~of this Section.~~
 - C) Reviewing selected pediatric cases transported to the hospital by pre-hospital providers and providing feedback to the EMS Coordinator/System.
 - D) Participating in regional QI activities, including preparing a written QI report and attending the Regional QI subcommittee meetings. These activities shall be supported by the hospital. One representative from the Regional QI subcommittee shall report to the EMS Regional Advisory Board.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- E) Providing QI information to the Department upon request. (See Section 3.110(a) of the Act.)
- f) Equipment, Trays, and Supplies
See Appendix L ~~of this Part.~~

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.4020 Facility Recognition Criteria for the Pediatric Critical Care Center (PCCC)

Any facility seeking PCCC level recognition shall meet requirements for both the EDAP and PCCC levels.

- a) Facility Requirements
A facility recognized as a PCCC Center shall provide the following:
 - 1) An EDAP-recognized emergency department;
 - 2) A distinct Pediatric Intensive Care Unit (PICU);
 - 3) A PICU Committee established as a standing (interdisciplinary) committee within the hospital with membership including, but not limited to, physicians, nurses, respiratory therapists, and others directly involved in PICU activities;
 - 4) Helicopter landing capabilities approved by State and federal authorities;
 - 5) Computerized axial tomography (CAT) scan availability 24 hours a day;
 - 6) Laboratory 24 hours a day in-house, providing:
 - A) Standard analysis of blood, urine and body fluids;
 - B) Blood typing and cross-matching;
 - C) Coagulation studies;

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- D) Comprehensive blood bank or an agreement with a community central blood bank;
 - E) Blood gases and pH determinations;
 - F) Microbiology, including the ability to initiate aerobic and anaerobic cultures on site; and
 - G) Drug and alcohol screening;
- 7) Hemodialysis capabilities or a transfer agreement;
 - 8) Staff, including a child life specialist, occupational therapy, speech therapy, physical therapy, social work, dietary, psychiatry and child protective services;
 - 9) Hospital support staff to act as a resource and participate in multidisciplinary regional pediatric critical care education;
 - 10) A plan for implementing a program of public information/education concerning emergency care services for pediatrics; and
 - 11) Support for active institutional and collaborative regional research.
- b) PICU Medical Director Requirements
A Medical Director shall be appointed, and a record of appointment and acceptance shall be in writing.
- 1) Qualifications
The PICU shall have a dedicated Medical Director who is:
 - A) Board certified in Pediatrics by the ABP or the AOBP, and Board certified or in the process of certification in Pediatric Critical Care Medicine by ABP, or Pediatric Intensive Care by AOBP; or
 - B) Board certified in Pediatrics by the ABP or the AOBP, and Board certified in a pediatric subspecialty with at least 50% practice in pediatric critical care. In this situation, a physician who meets the

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

criteria in subsection (b)(1)(A) shall be appointed as Co-director;
or

- C) Board certified in Anesthesiology by the American Board of Anesthesiology (ABA), or the American Osteopathic Board of Anesthesiology (AOBA), with practice limited to infants and children and with a subspecialty certification in Critical Care Medicine. In this situation, a physician who meets the criteria in subsection (b)(1)(A) shall be appointed as Co-director; or
- D) Board-certified in Pediatric Surgery by the American Board of Surgery (ABS) with a subspecialty certification in Surgical Critical Care Medicine by the ABS. In this situation (ABS), a physician who meets the criteria in subsection (b)(1)(A) shall be appointed as Co-director.

- 2) The Medical Director and/or Co-Director shall achieve certification within seven years after his/her initial acceptance into the certification process for pediatric critical care or intensive care medicine, and shall maintain certification.

c) PICU Medical Staff Requirements

1) Qualifications

- A) The PICU shall have 24-hour in-hospital coverage provided by a Board-certified pediatric intensivist, certified by ABP or AOBP, or Board-eligible pediatric intensivist in the process of certification by ABP or AOBP, who is responsible for the supervision of the physicians listed in subsections (c)(1)(A)(i) and (ii), and who is available within 30 minutes in-house after the determination is made that he or she is needed. If the intensivist is not in-house, then one of the following shall be available in-house:
 - i) Board-certified pediatrician certified by ABP or AOBP, or Board-eligible in pediatrics and in the process of Board certification; or

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- ii) A resident of PGY-2 or greater under the auspices of a Pediatric Training Program, in the unit, with a PGY-3 in-house.

 - B) All physicians listed in subsection (c)(1)(A) shall successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS or ACEP-AAP APLS. PALS and APLS shall include both cognitive and practical skills evaluation.~~either the ACEP-AAP PALS course or the APLS course.~~
- 2) Physician Specialist Availability
- If the applying hospital is a Pediatric Trauma Center, the applicable requirements for physician response times that meet Sections 515.2035 and 515.2045 shall be followed.
- A) Attending level physician specialists shall be on staff and are required to have the following:
 - i) Pediatric proficiency as defined by the hospital credentialing process;
 - ii) Board/sub-board certification in their specialty. If residency trained/board prepared in their specialty, physicians shall achieve certification within seven~~five~~ years after initial acceptance into the board/sub-board certification process, and maintain certification; and
 - iii) 10 hours per year of pediatric CME (category I or II) in his/her specialty.

 - B) The following on-call surgeons with pediatric proficiency shall be available in-house within 60 minutes after the determination is made that they are needed:
 - i) Surgeon; and
 - ii) Neurosurgeon, or transfer agreement with another facility.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- C) On-call attending anesthesiologists with pediatric proficiency shall be available in-house within 60 minutes after the determination is made that they are needed. CRNAs with pediatric proficiency may initiate appropriate procedures as identified in hospital by-laws.
- D) On-staff subspecialists with the following pediatric proficiency shall be available to the institution or by phone for consultation within 60 minutes after the determination is made that they are needed:
- i) Cardiologist;
 - ii) Neonatologist;
 - iii) Nephrologist;
 - iv) Neurologist;
 - v) Orthopedic surgeon;
 - vi) Otolaryngologist; and
 - vii) Radiologist.
- E) The following physician specialists shall be available in the hospital or by consultation or transfer agreement with another hospital:
- i) Allergist or immunologist;
 - ii) Cardiothoracic surgeon;
 - iii) Craniofacial (plastic) surgeon;
 - iv) Endocrinologist;
 - v) Gastroenterologist;
 - vi) Hand surgeon;

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- vii) Hematologist-oncologist;
- viii) Infectious disease;
- ix) Micro-vascular surgeon;
- x) Obstetrics/gynecology;
- xi) Ophthalmologist;
- xii) Oral surgeon;
- xiii) Physiatrist (physical medicine & rehabilitation);
- xiv) Psychiatrist/psychologist;
- xv) Pulmonologist; and
- xvi) Urologist.

d) PICU Nurse Practitioner and Physician Assistant~~Mid-level Providers~~
Qualifications

- 1) Nurse practitioner shall have credentialing as evidenced by the following:
 - A) Completion of a Pediatric Nurse Practitioner program or Pediatric Critical Care Nurse Practitioner Program and certification as an Acute Care ~~Nurse~~ Pediatric Nurse Practitioner, ~~;~~ ~~and~~
 - B) Current Illinois advanced practice nursing license. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices. An Illinois Advanced Practice Nurse license within one year after hire.
- 2) Physician assistant shall have credentialing as evidenced by the following:

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- A) Current Illinois Physician Assistant licensure. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices; and
- B) Credentialing that reflects orientation, ongoing training and specific demonstrated competencies in the care of the critically ill and injured pediatric patient as defined by the hospital credentialing process. Completion of a documented, precepted post-graduate clinical experience in the management of critically ill pediatric patients.
- 3) All nurse practitioners and physician assistants shall successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS or ACEP-AAP APLS. PALS and APLS shall include both cognitive and practical skills evaluation.~~of the following courses: PALS, APLS or ENPC.~~
- 4) All nurse practitioners and physician assistants shall have documentation of a minimum of 50 hours of ~~CME or~~ continuing education ~~units~~ in pediatric critical care topics every two years that are approved by an accrediting agency within a two-year period.
- e) PICU Nursing Staff Requirements
- 1) Nurse manager
The PICU shall have a designated nurse manager who shall:
- A) Be licensed as a Registered Nursean RN under the Nurse Practice Act;
- B) Have three years of clinical critical care experience, with a minimum of one year in clinical pediatric care; and
- C) Successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS or ACEP-AAP APLS. PALS and APLS shall include both cognitive and practical skills evaluation.~~the following courses: PALS, APLS or ENPC.~~

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- 2) Advanced practice nurse
Clinical nurse specialist (CNS), nurse practitioner (NP): The PICU shall have a designated pediatric CNS or pediatric NP who is available to provide clinical leadership in the nursing management of patients. Certified advanced practice nurses shall:
- A) Have completed a Pediatric Nurse Practitioner program or Pediatric Clinical Nurse Specialist Program and hold certification as a Pediatric Nurse Practitioner or Pediatric Clinical Nurse Specialist. Have completed a documented, precepted post-graduate clinical experience in the management of critically ill pediatric patients;
 - B) Have an Illinois Advanced Practice Nurse License. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric program, the professional shall have an unencumbered license in the state in which he or she practices; within one year after hire;
 - C) Successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS or ACEP-AAP APLS. PALS and APLS shall include both cognitive and practical skills evaluation. courses: PALS, APLS or ENPC; and
 - D) Have documentation of a minimum of 50 hours of CME or continuing education units in pediatric critical care topics every two years that are approved by an accrediting agency within a two-year period.
- 3) Nursing patient care services
All nurses engaged in direct patient care activities shall:
- A) Successfully complete a documented hospital and unit orientation according to hospital guidelines before assuming full responsibility for patient care;
 - B) Complete a yearly competency review of high-risk, low-frequency therapies;

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- C) Successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS, the ACEP-AAP APLS or the ENA ENPC. PALS, APLS and ENPC shall include both cognitive and practical skills evaluation~~PALS, APLS or ENPC~~; and
- D) Complete a minimum of 16 hours of pediatric emergency/critical care continuing education hours every two years~~within a two-year period~~. Continuing education may include, but is not limited to, CEU offerings, case presentations, competency testing, teaching courses related to pediatrics or publications.
- f) PICU Policies, Procedures, and Treatment Protocols
The PICU will include, but not be limited to, having the following age-specific policies/protocols in place:
- 1) Admission and discharge criteria;
 - 2) A staffing policy that addresses nursing shift staffing patterns based on patient acuity;
 - 3) A policy for managing the psychiatric needs of the PICU patient; and
 - 4) Protocols, order sets, pathways or guidelines for management of high- and low-frequency diagnoses.
- g) Inter-facility Transfer/Transport Requirements
A PCCC shall:
- 1) Provide necessary consultation to those hospitals with which a transfer agreement is established; accept pediatric transfers from those hospitals; provide feedback as well as quality review to those hospitals on the transfer and management process;
 - 2) Have or be affiliated with a transport system and team to assist referral hospitals in arranging safe pediatric patient transport; and
 - 3) Have a transfer/transport policy that addresses the special needs of the pediatric population during transport.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- h) Quality Improvement Requirements
- 1) Each PCCC shall have members from the PICU, including the Medical Director, and from the Pediatric Department who serve on the Multidisciplinary Pediatric Quality Improvement Committee, which will include, but not be limited to: emergency department, pediatric department, respiratory, laboratory, social service and radiology staff.
 - 2) The Multidisciplinary Pediatric Quality Improvement Committee shall perform focused outcome analyses of its PICU and other pediatric inpatient unit services on a quarterly basis that consist of a review of at least the following:
 - A) All pediatric deaths;
 - B) All pediatric inter-facility transfers;
 - C) All pediatric morbidities or negative outcomes that are a result of treatment rendered or omitted;
 - D) Pediatric quality metrics that audit filters. ~~An audit filter is a clinical and internal resource indicator used to~~ examine the process of care and ~~to~~ identify potential patient care and internal resource problems;
 - E) Child abuse and neglect cases unless review is performed by another committee in the hospital;
 - F) All re-admissions within 48 hours after discharge from the emergency department or inpatient care that result in admission to the PICU; and
 - G) Review of all potential and unanticipated adverse outcomes.
- i) PICU Equipment (See Appendix O ~~of this Part~~)
The PCCC shall meet all equipment requirements as outlined in Appendix O ~~of this Part~~. In addition, a specialized pediatric resuscitation cart with measuring

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

device shall be readily available on each pediatric unit, containing the required equipment.

- j) Pediatric Inpatient Care Service Requirements
- 1) Physician requirements
 - A) The Chair of Pediatrics or the Pediatric Inpatient Director shall have certification in pediatrics by the ABP or the AOBP.
 - B) All hospitalists, credentialed by their hospital to provide pediatric unit care, shall successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS or the ACEP-AAP APLS. PALS and APLS shall include both cognitive and practical skills evaluation.~~PALS or APLS.~~
 - C) The Medical Director of the PICU, or his/her designee, shall be available on call and for consultation for all pediatric in-house patients who may require critical care.
 - 2) Nurse manager requirements
The nurse manager shall:
 - A) Be licensed as an Illinois Registered Nurse. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.~~Be licensed as an RN under the Nurse Practice Act;~~
 - B) Have three years of pediatric experience; and
 - C) Complete and maintain current recognition in one of the following courses: AHA-AAP PALS, the ACEP-AAP APLS or the ENA ENPC. PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.~~PALS, APLS or ENPC.~~
 - 3) Nursing patient care services
All nurses engaged in direct patient care activities shall:

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- A) Be licensed as an Illinois Registered Nurse. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.
- B)A) Complete a documented hospital and unit orientation according to hospital guidelines before assuming full responsibility for patient care;
- C)B) Complete a yearly competency review of high-risk, low-frequency therapies based on patient population;
- D)C) Complete and maintain current recognition in one of the following courses: AHA-AAP PALS, the ACEP-AAP APLS or the ENA ENPC. PALS, APLS and ENPC shall include both cognitive and practical skills evaluation~~PALS, APLS or ENPC~~; and
- E)D) Complete a minimum of 16 hours of pediatric continuing education hours within a two-year period. Continuing education may include, but is not limited to, CEU offerings, case presentations, competency testing, teaching courses related to pediatrics and/or publications.
- k) Hospital General Pediatric Department Policies, Procedures and Treatment Protocols
The pediatric department shall have, but not be limited to:
- 1) A policy or scope of services that outlines the pediatric department services, ages of patients served, and admission guidelines;
 - 2) A staffing policy that addresses nursing shift staffing patterns based on patient acuity;
 - 3) A safety and security policy for the patient in the unit;
 - 4) An inter-facility transport policy that addresses safety and acuity;
 - 5) An intra-facility transport policy that addresses safety and acuity;

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- 6) A latex allergy policy;
- 7) A pediatric organ procurement/donation policy;
- 8) An isolation precautions policy that incorporates appropriate infection control measures;
- 9) A disaster/terrorism policy that addresses the specific medical and psychosocial needs of the pediatric population;
- 10) Protocols, order sets, pathways or guidelines for management of high-risk and low-frequency diagnoses;
- 11) A pediatric policy that addresses the resources available to meet the psychosocial needs of patients and family and appropriate social work referral for the following indicators:
 - A) Child death;
 - B) Child has been a victim of or witness to violence;
 - C) Family needs assistance in obtaining resources to take the child home;
 - D) Family needs a payment resource for their child's health needs;
 - E) Family needs to be linked back to their primary health, social service or educational system;
 - F) Family needs support services to adjust to their child's health condition or the increased demands related to changes in their child's health conditions; and
 - G) Family needs additional education related to the child's care needs to care for the child at home.
- 12) A discharge planning policy or protocol that includes the following:

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- A) Documentation of appropriate primary care/specialty follow-up provisions;
- B) Mechanism to access a primary care resource for children who do not have a provider;
- C) Discharge summary provision to appropriate medical care provider, parent/guardian, which includes the following:
 - i) Information on the child's hospital course;
 - ii) Discharge instructions and education; and
 - iii) Follow-up arrangements;
- D) Appropriate referral of patients to rehabilitation or specialty services for children who may have any of the following problems:
 - i) Require the assistance of medical technology;
 - ii) Do not exhibit age-appropriate activity in cognitive, communication or motor skills, behavioral, or social/emotional realms;
 - iii) Additional medical or rehabilitation needs that may require specialized care, such as medication, hospice care, physical therapy, home health, or speech/language services;
 - iv) Brain injury – mild, moderate or severe;
 - v) Spinal cord injury;
 - vi) Seizure behavior exhibited during acute care or a history of seizure disorder and is not currently linked with specialty follow up;
 - vii) Submersion injury, such as a near drowning;
 - viii) Burn (other than a superficial burn);

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- ix) Pre-existing condition that experiences a change in health or functional status;
 - x) Neurological, musculoskeletal or developmental disability; or
 - xi) Sudden onset of behavioral change, for example, in cognition, language or affect.
- l) Quality Improvement Requirements
Representatives from the pediatric unit shall participate in the multidisciplinary Pediatric Quality Improvement Committee (see subsection (h)).
- m) Equipment Requirements (See Appendix O ~~of this Part.~~)
The PCCC shall meet all equipment requirements as outlined in Appendix O ~~of this Part.~~ In addition, a specialized pediatric resuscitation cart with measuring device shall be readily available on each pediatric unit, containing the required equipment.

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

SUBPART K: COMPREHENSIVE STROKE CENTERS, PRIMARY STROKE CENTERS AND ACUTE STROKE-READY HOSPITALS ~~EMERGENT STROKE READY HOSPITALS~~

Section 515.5000 Definitions

For the purposes of this Subpart K:

- a) "*Certification*" or "*certified*" means certification of a Comprehensive Stroke Center (CSC), Primary Stroke Center or Acute Stroke-Ready Hospital using evidence-based standards, from a nationally recognized certifying body approved by the Department. (Section 3.116 of the Act) The State Stroke Advisory Subcommittee shall forward recommendations of certifying bodies to the Department at least annually, ~~or more often as needed.~~ The Department will consult the State Stroke Advisory Subcommittee when reviewing and approving certifying bodies. The Department will maintain and post on the Department's website a current list of the names, phone numbers and website information, if

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

available, of the approved certifying bodies. The list will be reviewed at least annually.

- b) *"Designation" or "designated" means the Department's recognition of a hospital as a CSC, Primary Stroke Center or Acute Stroke-Ready Hospital~~Emergent Stroke-Ready Hospital~~. (Section 3.116 of the Act)*

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.5002 State Stroke Advisory Subcommittee

- a) The State Stroke Advisory Subcommittee shall establish bylaws to ensure equal membership that rotates and clearly delineates committee responsibilities and structure; and
- b) Annually, the State Stroke Advisory Subcommittee and the Department will consider adopting new nationally recognized recommendations.

(Source: Added at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.5004 Regional Stroke Advisory Subcommittee

- a) Of the members first appointed, one-third shall be appointed for a term of one year, one-third shall be appointed for a term of 2 years, and the remaining members shall be appointed for a term of 3 years. The terms of subsequent appointees shall be 3 years. (Section 3.116 of the Act)
- b) The Regional Stroke Advisory Subcommittee shall function as a subcommittee of the Regional EMS Advisory Committee and report biannually at regularly scheduled meetings as identified in Section 515.210(b) and (c). The Regional Stroke Advisory Subcommittee shall make recommendations to the Regional EMS Medical Directors related to the establishment and revision of evidence based protocols for the triage, treatment and transport of possible acute stroke patients to the appropriate CSC, Primary Stroke Center or Acute Stroke-Ready Hospital. The Regional Stroke Advisory Subcommittee shall assist with the development of stroke networks.
- c) The Regional Stroke Advisory Committee shall collect and evaluate de-identified stroke care data from regional stroke network hospitals and EMS Systems to

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

evaluate and make recommendations to the Regional EMS MDs for improvement in regional stroke systems of care.

(Source: Added at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.5010 Stroke Care – Restricted Practices

Sections in the Act pertaining to CSCs, Primary Stroke Centers or Acute Stroke-Ready Hospitals~~Emergent Stroke-Ready Hospitals~~ are not medical practice guidelines and shall not be used to restrict the authority of a hospital to provide services for which it has received a license under State law. (Section 3.119 of the Act)

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.5015 Comprehensive Stroke Center (CSC) Designation

- a) Subject to Section 515.5040, Comprehensive Stroke Center designation shall remain valid at all times while the hospital maintains its certification as a CSC, in good standing, with the certifying body.
- b) The duration of a CSC designation shall coincide with the duration of its CSC certification.
- c) Each designated CSC shall have its designation automatically renewed upon the Department's receipt of a copy of the certifying body's certification renewal and an application form available through the Department. (Section 3.117(a-5)(5) of the Act)
- d) A hospital shall submit a copy of its certification renewal from the certifying body as soon as practical, but no later than 30 business days after the hospital receives the certification.

(Source: Added at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.5016 Request for Comprehensive Stroke Center Designation

- a) A hospital that is already certified as a CSC by a nationally recognized certifying body approved by the Department shall send a copy of the certificate and annual

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

fee to the Department along with an application available through the Department. (Section 3.117(a-5)(1) and (2) of the Act)

- b) Within 30 business days after the Department receives the hospital's certificate indicating that the hospital is a certified CSC in good standing with the certifying body and the application available through the Department, the hospital shall be deemed to be a State-designated Comprehensive Stroke Center.
- c) The Department will send designation notices to hospitals that it designates as Comprehensive Stroke Centers. A list of designated Comprehensive Stroke Centers will be maintained on the Department's website at <http://www.dph.illinois.gov/topics-services/emergency-preparedness-response/ems/stroke-program>. Names of designated Comprehensive Stroke Centers will be added upon designation. Names will be removed from the website designation list in accordance with Section 3.118(c) of the Act.
- d) The application available through the Department shall include a statement that the hospital meets the requirements for CSC designation in Section 3.117 of the Act. The applicant hospital shall provide the following:
 - 1) Hospital name and address;
 - 2) Hospital chief executive officer/administrator typed name and signature;
 - 3) Hospital stroke medical director typed name and signature; and
 - 4) Contact person typed name, e-mail address and phone number.
- e) The application available through the Department will instruct the hospital to provide proof of current CSC certification from a nationally recognized certifying body approved by the Department.
- f) A hospital designated as a CSC shall pay an annual fee of \$500.

(Source: Added at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.5017 Suspension and Revocation of Comprehensive Stroke Center Designation

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- a) *A hospital that no longer meets nationally recognized, evidence-based standards for CSCs, or loses its CSC certification, shall notify the Department, the hospital's EMS MD, and the Regional EMS Advisory Committee, in writing, within 5 business days, upon notification from the certifying body. (Section 3.117(a-5)(6)(A) of the Act)*
- b) Suspension of Designation
- 1) *The Department shall have the authority and responsibility to suspend or revoke the hospital's CSC designation upon receiving notice that the hospital's CSC certification has lapsed or been revoked by the State recognized certifying body. (Section 3.117(a-5)(4)(A) of the Act)*
 - 2) *The Department shall have the authority and responsibility to suspend the hospital's CSC designation, in extreme circumstances in which patients may be at risk for immediate harm or death, until such time as the certifying body investigates and makes a final determination regarding certification. (Section 3.117(a-5)(4)(B) of the Act) The Department will notify the hospital's certifying body and provide the hospital and EMS MD with written notice of the Department's decision to suspend designation.*
 - 3) *Upon receipt of the Department's written notice to suspend designation, the hospital shall have 15 business days in which to make a written request for an administrative hearing to contest the Department's decision. Administrative hearings will be conducted in accordance with Section 515.180. The Department will notify the hospital, the EMS MD, and the hospital's certifying body of the Department's final administrative decision to revoke designation.*
 - 4) *The Department will suspend the hospital's CSC designation at the request of a hospital seeking to suspend its own Department designation. (Section 3.117(a-5)(4)(D) of the Act)*
 - 5) *The Department shall have the authority to conduct investigations. All applicants for designation and designees shall fully cooperate with any Department investigation, including providing patient medical records as requested by the Department. (Section 3.125(d) of the Act) The failure to fully cooperate shall be grounds for denying, suspending or revoking a designation.*

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- c) The Department will restore any previously suspended or revoked Department designation upon notice to the Department that the certifying body has confirmed or restored the CSC certification of that previously designated hospital. (Section 3.117(a-5)(4)(C) of the Act)

(Source: Added at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.5020 Primary Stroke Center (PSC) Designation

- a) Subject to Section 515.5040, *Primary Stroke Center ~~designation~~Designation shall remain valid at all times while the hospital maintains its certification as a ~~PSCPrimary Stroke Center~~, in good standing with the Department-approved certifying body. (Section 3.117(a)(4) of the Act)*
- b) *The duration of a ~~PSC designation~~Primary Stroke Center Designation shall coincide with the duration of its ~~PSCPrimary Stroke Center~~ certification. (Section 3.117(a)(4) of the Act)*
- c) *Each designated ~~PSCPrimary Stroke Center~~ shall have its designation automatically renewed upon the Department's receipt of a copy of the certifying body's certification renewal and an application available through the Departmentthe Request for IDPH Primary Stroke Center Designation form. (Section 3.117(a)(4) of the Act)*
- d) *The Department shall consult with the State Stroke Advisory Subcommittee in developing designation, re-designation, and de-designation processes for ~~PSCs~~Primary Stroke Centers. (Section 3.117(c) of the Act)*
- e) A hospital shall submit a copy of its certification renewal from the certifying body as soon as practical, but no later than ~~3045~~ business days after the hospital receives the certification. Upon receipt of the certification renewal, the Department will begin the re-designation process.

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.5030 Request for Primary Stroke Center Designation

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- a) *A hospital that is already certified as a Primary Stroke Center by a nationally recognized certifying body approved by the Department shall send a copy of the certificate and annual fee to the Department, along with an application available through the Department Request for Primary Stroke Center Designation form. (Section 3.117(a)(2) of the Act)*
- b) *Within 30 business days after the Department receives the hospital's certificate indicating that the hospital is a certified PSC Primary Stroke Center in good standing with the certifying body, and the completed application available through the Department Request for Primary Stroke Center Designation form, the hospital shall be deemed to be a State-designated PSC Primary Stroke Center. (Section 3.117(a)(2) and (4) of the Act)*
- c) *The Department will send designation notices to hospitals that it designates and will add the names of designated PSCs Primary Stroke Centers to the website listing immediately upon designation. Subject to Section 515.5040, the Department will remove the name of a hospital from the website listing when a hospital loses its designation after notice and, if requested by the hospital, a hearing. (Section 3.118(c) of the Act)*
- d) *The application available through the Department Request for Primary Stroke Center Designation shall include a statement that the hospital meets the requirements for PSC designation Primary Stroke Center Designation in Section 3.117 of the Act. The applicant hospital shall provide the following:*
- 1) Hospital name and address;
 - 2) Hospital chief executive officer/administrator typed name and signature;
 - 3) Hospital stroke medical director typed name and signature; and
 - 4) Contact person typed name, e-mail address and phone number.
- e) *The application available through the Department Request for Primary Stroke Center Designation will instruct the hospital to provide proof of current PSC Primary Stroke Center certification from a nationally recognized certifying body approved by the Department.*
- f) *A hospital designated as a PSC shall pay an annual fee of \$350.*

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.5040 Suspension and Revocation of Primary Stroke Center Designation

- a) *A hospital that no longer meets nationally recognized, evidence-based standards for Primary Stroke Centers, or loses its ~~PSC Primary Stroke Center~~ certification, shall ~~immediately~~ notify the Department, the hospital's EMS MD, and the Regional EMS Advisory Committee, in writing, within 5 business days, upon notification from the certifying body. (Section 3.117(a)(5) of the Act)*
- b) Suspension of Designation
 - 1) *The Department shall have the authority and responsibility to suspend a hospital's ~~PSC Primary Stroke Center~~ designation upon receiving notice from the hospital's certifying body that the hospital's ~~PSC Primary Stroke Center~~ certification has lapsed, or been revoked, suspended or cancelled. (Section ~~3.117(a)(3.5)(A)~~3-117(a)(3)(A) of the Act)*
 - 2) *In extreme circumstances where patients may be at risk for immediate harm or death, as determined by the Director, the Department shall have the authority and responsibility to suspend a hospital's ~~PSC designation~~Primary Stroke Center Designation, until such time as the certifying body investigates and makes a final determination regarding certification. (Section ~~3.117 (a)(3.5)(B)~~3-117(a)(3)(B) of the Act) The Department will notify the hospital's certifying body and provide the hospital and EMS MD with written notice of its decision to suspend designation.*
 - 3) *Upon receipt of the Department's written notice to suspend designation, the hospital shall have 15 business days in which to make a written request for an administrative hearing to contest the Department's decision. Administrative hearings will be conducted in accordance with Section 515.180. The Department will notify the hospital, the EMS MD, and the hospital's certifying body of the Department's final administrative decision to revoke designation.*
 - 4) *The Department will suspend a hospital's ~~PSC Primary Stroke Center~~ designation at the request of a hospital seeking to suspend its own*

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Department designation. (Section ~~3.117(a)(3.5)(D)~~~~3.117(a)(3)(D)~~ of the Act)

- 5) The Department shall have the authority to conduct investigations. All applicants for designation and designees *shall fully cooperate with any Department investigation, including providing patient medical records as requested by the Department.* (Section 3.125(d)) The failure to fully cooperate shall be grounds for denying, suspending or revoking a designation.
- c) Revocation of Designation. The Department *shall have the authority and responsibility to* revoke a hospital's designation if the hospital's certification has been *revoked by the State-recognized certifying body.* (Section ~~3.117(a)(3.5)(A)~~~~3.117(a)(3)~~ of the Act)
- d) The Department will *restore any previously suspended or revoked Department designation upon notice to the Department that the certifying body has confirmed or restored the Primary Stroke Center certification of that previously designated hospital.* (Section ~~3.117(a)(3.5)(C)~~~~3.117(a)(3)(C)~~ of the Act)
- e) *The Department shall consult with the State Stroke Advisory Subcommittee in developing designation and de-designation processes for PSCs~~Primary Stroke Centers~~.* (Section 3.117(c) of the Act)

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.5050 Acute Stroke-Ready Hospital (ASRH)~~Emergent Stroke Ready Hospital (ESRH)~~ Designation without National Certification

- a) The Department recognizes that diagnostic capabilities and treatment modalities for the care of stroke patients will change because of rapid advances in science and medicine. Nothing in this Part shall prohibit a hospital, without designation, from providing emergency stroke care. Requirements pertaining to Acute Stroke-Ready Hospitals~~Emergent Stroke Ready Hospitals~~ shall not be used to restrict the authority of a hospital to provide services for which it has received a license under State law.
- b) Upon receipt of hospital applications, *the Department shall attempt to designate hospitals as Acute Stroke-Ready Hospitals~~Emergent Stroke Ready Hospitals~~*

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

~~*capable of providing emergent stroke care in all areas of the State. For any hospital that is designated as an Emergent Stroke Ready Hospital at the time that the Department begins the designation of ASRHs, the Emergent Stroke Ready designation shall remain intact for the duration of the 12 month period. (Section 3.117(b) of the Act) The ESRH will convert to ASRH at the time of the hospital's renewal application or annual attestation to the Department.*~~

- c) ~~*The Department shall attempt to designate hospitals as ASRHs in all areas of the State as long as they meet the criteria in this Section. (Section 3.117(b) of the Act) The Department shall designate as many Emergent Stroke Ready Hospitals as apply for that designation as long as they meet the criteria in this Section and Section 3.117 of the Act.*~~
- d) Any hospital seeking designation as an ~~ASRH Emergent Stroke Ready Hospital~~ shall apply for and receive ~~ASRH Emergent Stroke Ready Hospital~~ designation from the Department, provided that the hospital attests, on an application available through the Department ~~a Request for Emergent Stroke Ready Hospital Designation form~~ (see Section 515.5060), that it meets, and will continue to meet, the criteria for ~~ASRH designation and pays an annual fee Emergent Stroke Ready Hospital Designation~~. (Section 3.117(b)(2) of the Act) The Department will post and maintain ~~ASRH-ESRH~~ designation instructions, including the request form, on its website.
- e) Upon receipt of a completed ~~application available through the Department Request for Emergent Stroke Ready Hospital designation form~~ attesting that the hospital meets the criteria set forth in the Act and this Part, signed by a hospital administrator or designee, the Department will designate a hospital as an ~~ASRH Emergent Stroke Ready Hospital~~ no more than ~~30-20~~ business days after receipt of an attestation that meets the requirements for attestation in Section 515.5070(a), ~~unless the Department, within 30 days after receipt of the attestation, chooses to conduct an onsite survey prior to designation. If the Department chooses to conduct an onsite survey prior to designation, then the onsite survey shall be conducted within 90 days after receipt of the attestation.~~ (Section 3.117(b)(4)(B) of the Act) The Department will notify the hospital of the designation in writing. The Department has the authority to conduct on-site visits to assess compliance with this Part.
- f) ~~*The Department shall add the names of designated ASRHs Emergent Stroke Ready Hospitals to the website listing immediately upon designation (Section 3.118(c) of*~~

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

~~the Act) and shall immediately remove the name of a hospital from the website listing when a hospital loses its designation after notice and, if requested by the hospital, a hearing (Section 3.117(b)(4)(A-5) of the Act). and shall immediately remove the name when a hospital loses its designation, after written notice and, if requested by the hospital, a hearing. (Section 3.118(c) of the Act)~~

- g) The Department will ~~require annual written attestation by ASRHs Emergent Stroke-Ready Hospitals to indicate compliance with ASRH Emergent Stroke-Ready Hospital criteria, as described in the Act and this Part, and will automatically renew ASRH Emergent Stroke-Ready Hospital designation of the hospital.~~ (Section 3.117(b)(4)(C) of the Act) The hospital shall provide the attestation, along with any necessary supporting documentation, ~~within 45 business days after receipt of the notification.~~ Supporting documentation shall include any documents supporting the attestation that have changed significantly since the previous annual attestation.
- h) ~~ASRH designation requires annual written attestation, on a Department form, by an ASRH to indicate compliance with ASRH criteria, as described in this Part. The Department, after determining that the ASRH meets the requirements for attestation, will automatically renew the ASRH designation of the hospital. (Section 3.117(b)(4)(C) Within 30 business days, the Department will provide written acknowledgment of the hospital's designation renewal. (Section 3.117(b)(4)(B) of the Act). Emergent Stroke-Ready Hospital Designation shall automatically renew upon the Department's receipt of a completed annual Request for Emergent Stroke-Ready Hospital Designation form that meets the requirements for attestation in Section 515.5070(a).~~

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.5060 Acute Stroke-Ready Hospital Emergent Stroke-Ready Hospital Designation Criteria without National Certification

- a) ~~Hospitals Develop Hospitals seeking Acute Stroke-Ready Hospital designation that do not have national certification Emergent Stroke-Ready Hospital shall develop policies and; procedures; that are consistent with protocols that consider and reflect nationally recognized, evidence-based protocols for the provision of emergent stroke care. (Section 3.117(b)(3) of the Act)~~

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- b) *Hospital policies, procedures or protocols relating to emergent stroke care and stroke patient outcome shall be reviewed at least annually, or more often as needed, by a hospital committee that oversees quality improvement. Adjustments shall be made as necessary to advance the quality of stroke care delivered. (Section 3.117(b)(3) of the Act)*
- c) *Criteria for ~~ASRH designation~~Emergent Stroke Ready Hospital Designation of hospitals shall be limited to the ability of the hospital to:*
- 1) *Create written acute care policies, procedures, or protocols related to emergent stroke care, including transfer criteria~~including transfer criteria~~ (Section 3.117(b)(3)(A) of the Act);*
 - 2) *Participate in the data collection system provided in Section 3.118 of the Act, if available (Section 3.117(b)(3)(A-5) of the Act);*
 - 3)2) *Maintain a written transfer agreement with one or more hospitals that have neurosurgical expertise (Section 3.117(b)(3)(B) of the Act);*
 - 4)3) *Designate a Clinical Director of Stroke Care who shall be a clinical member of the hospital staff with training or experience, as defined by the facility, in the care of patients with cerebrovascular disease. This training or experience may include, but is not limited to, completion of a fellowship or other specialized training in the area of cerebrovascular disease, attendance at national courses, or prior experience in neuroscience intensive care units. The Clinical Director of Stroke Care may be a neurologist, neurosurgeon, emergency medicine physician, internist, radiologist, advanced practice nurse, or physician assistant. (Section 3.117(b)(3)(C) of the Act)~~director of stroke care, which may be a clinical member of the hospital staff or the designee of the hospital administrator, to oversee the hospital's stroke care policies, protocols, or procedures;~~*
 - 5) *Provide rapid access to an acute stroke team, as defined by the facility, that considers and reflects nationally recognized, evidenced-based protocols or guidelines (Section 3.117(b)(3)(C-5) of the Act);*
 - 6)4) *Administer thrombolytic therapy, or subsequently developed medical therapies that meet nationally recognized, evidence-based stroke protocols or guidelines (Section 3.117(b)(3)(D) of the Act);*

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- ~~7)5)~~ *Conduct brain image tests at all times* [\(Section 3.117\(b\)\(3\)\(E\) of the Act\)](#), which shall consider and reflect current nationally recognized evidence-based protocols or guidelines;
- ~~8)6)~~ *Conduct blood coagulation studies at all times* [\(Section 3.117\(b\)\(3\)\(F\) of the Act\)](#), which shall consider and reflect current nationally recognized evidence-based protocols or guidelines;
- ~~9)7)~~ *Maintain a log of ~~acute~~ stroke patients, which shall be available for review upon request by the Department or any hospital that has a written transfer agreement with the ~~ASRHEmergent Stroke Ready Hospital~~.* [\(Section 3.117\(b\)\(3\)\(G\) of the Act\)\(B\)\(3\)\)](#) The stroke patient log shall be available to be used for internal hospital quality improvement purposes. Hospitals may alternatively participate in a nationally recognized stroke data registry. Hospitals shall submit data from their stroke patient log or nationally recognized stroke data registry to the Department upon request. The hospital may share unidentified patient data with its EMS Region, EMS System, or other stroke network partners for quality improvement purposes. Hospitals shall review and analyze the data elements listed in [this subsection \(c\)\(9\)subsections \(e\)\(7\)\(A\) through \(K\)](#) quarterly, at a minimum, and submit a summary to the Department with the annual written attestation. The stroke patient log shall contain, at a minimum:
- A) The patient's medical record number;
 - B) Date of emergency visit;
 - C) Mode of patient arrival;
 - D) Time presented in the emergency department;
 - E) Last time patient was observed to be free of current symptoms (i.e., time of last known well), if known;
 - F) Baseline initial stroke severity score upon arrival at the hospital (i.e., National Institutes of Health (NIH) Stroke Scale);
 - G) Time of blood coagulation results available;

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- H) Time of brain imaging;
- I) Time of brain imaging results available;
- J) Time and type of thrombolytic therapy or nationally recognized evidence-based exclusion criteria;
- K) Time of transfer from the emergency department;
- L) Time of transfer if from another location in the hospital; and
- M) Transfer/discharge diagnosis and destination;

- 10) *Admit stroke patients to a unit that can provide appropriate care that considers and reflects nationally recognized, evidence-based protocols or guidelines or transfer stroke patients to an ASRH, PSC, or CSC, or another facility that can provide the appropriate care that considers and reflects nationally recognized, evidence-based protocols or guidelines (Section 3.117(b)(3)(H) of the Act);*
- 11) *At a minimum, demonstrate compliance with nationally recognized quality indicators (Section 3.117(b)(3)(I) of the Act) referenced in subsection (c)(9); and*
- 12) *Comply with nationally accepted guidelines regarding stroke awareness community education, hospital education and EMS education provided by the hospital regarding stroke treatment.*

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.5070 Request for Acute Stroke-Ready Hospital~~Emergent Stroke-Ready Hospital~~ Designation without National Certification

- a) Any hospital seeking designation as an Acute Stroke-Ready Hospital~~Emergent Stroke-ready Hospital~~ shall *apply for, and receive ASRH designation, Emergent Stroke-Ready Hospital Designation* from the Department, provided that the hospital attests, on a form developed by the Department in consultation with the State Stroke Advisory Subcommittee, that the hospital meets, and will continue to

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

meet, the criteria for ~~ASRH designation~~Emergent Stroke Ready Hospital Designation located in (see Section 515.5060) and pays an annual fee. (Section 3.117(b)(2) of the Act) The Department will post and maintain ~~ASRH~~ESRH designation instructions, including ~~an application available on the Department's website~~an application available on the Department's Request for Emergent Stroke Ready Hospital Designation form, on its website.

- b) The ~~application available through the Department's Request for Emergent Stroke Ready Hospital Designation form~~Request for Emergent Stroke Ready Hospital Designation form shall include a statement that the hospital meets each requirement in Section 3.117 of the Act, including the designation criteria in Section 3.117(b)(3) of the Act and Section 515.5060 of this Part. The hospital shall provide the following:
- 1) Hospital name and address;
 - 2) Hospital chief executive officer/administrator typed name and signature;
 - 3) Chief medical officer (or designee) typed name and signature;
 - 4) Hospital stroke director typed name, clinical credentials and signature; and
 - 5) Contact person typed name, e-mail address and phone number.
- c) The hospital shall indicate on the ~~application~~Request for Emergent Stroke Ready Designation form whether it is applying for an initial ~~ASRH~~ESRH designation or ~~an ESRH designation~~renewal.
- d) The hospital shall provide the Department with supporting documentation indicating compliance with each designation criterion in Section 3.117(b)(3) of the Act and Section 515.5060 of this Part with the initial ~~ASRH~~ESRH application, as follows:
- 1) A copy of the hospital's stroke policies, procedures or *protocols related to the provision of emergent stroke care*;
 - 2) A copy of the hospital's *transfer agreement with one or more hospitals that have board certified or board eligible neurosurgical expertise*, and policies, procedures or protocols related to the transfer;

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- 3) The hospital stroke director's name, contact information and curriculum vitae or resume to demonstrate that the Director is *a clinical member of the hospital staff or a clinical designee of the hospital administrator*;
 - 4) A copy of the hospital's policies, procedures or protocols related to the administration of *thrombolytic therapy, or subsequently developed medical therapies that meet nationally recognized evidence-based stroke protocols or guidelines*;
 - 5) A letter from the stroke director or hospital administrator indicating how the hospital *conducts and interprets brain image tests at all times* that consider and reflect nationally recognized evidence-based stroke protocols or guidelines;
 - 6) Documentation of laboratory accreditation by a nationally recognized accrediting body;
 - 7) A sample *stroke log* or verification of use of a nationally recognized stroke data registry that meets the minimum requirements (see Section 515.5090) (Section 3.117(b)(3) of the Act)
 - 8) Each ASRHESRH shall submit a description of its comprehensive ongoing quality improvement plan, including, but not limited to, all of the quality measurements in subsection (e). The description shall include the steps an ASRHESRH would use to implement performance improvement processes.
- e) For re-designation, the hospital shall provide the Department with updated supporting documentation, including quality outcomes, indicating compliance with ASRHemergent stroke ready designation criteria in Section 515.5060. Hospitals shall submit a full application every three years.
- f) Quality outcomes data shall include a summary of the following quality outcomes, as indicated by the stroke log:
- 1) Results time for door-to-blood coagulation study;
 - 2) Completed time for door-to-brain imaging;

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- 3) Results time for door-to-brain imaging;
 - 4) Time for door-to-thrombolytic therapy, if applicable;
 - 5) Time for door-to-transfer from emergency department, if applicable; and
 - 6) Non-emergency department patients transferred out of the hospital for stroke diagnosis.
- g) Each ASRHESRH shall submit a copy of its comprehensive quality assessment, including, but not limited to, all of the quality measurements in subsection (e) that do not meet nationally recognized evidenced-based stroke guidelines. For each outcome not meeting national guidelines, the ASRHESRH shall implement a written quality improvement plan.
- h) After receipt of a completed applicationRequest for Designation form that meets the requirements of this Section, the Department will designate a hospital as an ASRHEmergent Stroke Ready Hospital no more than 3020 business days after receipt of the form. The Department will notify the hospital, in writing, of the designation.
- i) A hospital designated as an ASRH shall pay an annual fee of \$250.

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.5080 Suspension and Revocation of Acute Stroke-Ready Hospital~~Emergent Stroke Ready Hospital~~ Designation without National Certification

- a) Emergency Suspension
- 1) *When the Director or his or her designee has determined that the hospital no longer meets the Acute Stroke-Ready Hospital~~Emergent Stroke Ready Hospital~~ criteria set forth in the Act and this Part, and the potential of an immediate and serious danger to public health, safety, and welfare exists, the Department will issue an emergency written order of suspension of ASRH designation~~Emergent Stroke Ready Hospital Designation~~. (Section 3.117(b)(4)(D) of the Act)*

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- 2) *If the ~~ASRH~~Emergent Stroke Ready Hospital fails to eliminate the violation immediately or within a fixed period of time, not exceeding 10 business days, as determined by the Director, the Director may immediately revoke by written order, the ~~ASRH designation~~Emergent Stroke Ready Hospital Designation (Section 3.117(b)(4)(D) of the Act).*

b) Suspension and Revocation

- 1) *The Director shall have the authority and responsibility to issue an emergency suspension of Emergent Stroke Ready Hospital designation when the Director has determined that the hospital no longer meets the Emergent Stroke Ready hospital criteria, as set forth in the Act and this Part, and an immediate and serious danger to the public health, safety, and welfare exists.*
- 1)2) *If the ~~ASRH~~Emergent Stroke Ready Hospital fails to eliminate the violation immediately or within a fixed period time, not exceeding 10 business days, as determined by the Director, the Director may immediately revoke the ~~ASRH designation~~Emergent Stroke Ready Hospital Designation by written order. The ~~ASRH~~Emergent Stroke Ready Hospital may appeal the revocation, by delivering to the Department a written request for within 15 days after receiving the Director's revocation order requesting an administrative hearing within 15 days after receipt of the written order of revocation. (Section 3.117(b)(4)(D) of the Act)*
- 2)3) *The Director shall have the authority and responsibility to suspend, revoke, or refuse to issue or renew an ~~ASRH designation~~Emergent Stroke Ready Hospital Designation, after notice and an opportunity for an administrative hearing, when the Department finds that the hospital is not in substantial compliance with current ~~ASRH~~Emergent Stroke Ready Hospital criteria as set forth in the Act and this Part. (Section 3-117(b)(4)(D) of the Act)*
- 3)4) *The Department shall consult with the State Stroke Advisory Subcommittee in developing the designation, re-designation, and de-designation processes for ~~ASRHs~~Emergent Stroke Ready Hospitals. (Section 3.117(c) of the Act)*

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Section 515.5083 Acute Stroke-Ready Hospital Designation with National Certification

- a) Subject to Section 515.5087, Acute Stroke-Ready Hospital designation shall remain valid at all times while the hospital maintains its certification as an ASRH, in good standing, with the certifying body. (Section 3.117(b)(2.5)(A) of the Act)
- b) The duration of an ASRH designation shall coincide with the duration of its ASRH certification. (Section 3.117(b)(2.5)(B) of the Act)
- c) Each designated ASRH shall have its designation automatically renewed upon the Department's receipt of a copy of the certifying body's certification renewal and an application available through the Department. (Section 3.117(b)(2.5)(C) of the Act)
- d) The Department shall consult with the State Stroke Advisory Subcommittee in developing designation, re-designation and de-designation processes for ASRHs. (Section 3.117(c) of the Act)
- e) A hospital must submit a copy of its certification renewal from the certifying body as soon as practical, but no later than 30 business days after that certification is received by the hospital. Upon the Department's receipt of the renewal certification, the Department shall renew the hospital's ASRH designation. (Section 3.117(b)(2.5)(D) of the Act)

(Source: Added at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.5085 Request for Acute Stroke-Ready Hospital Designation with National Certification

- a) The Department shall require a hospital that is already certified as an Acute Stroke-Ready Hospital, through a Department-approved certifying body, to send a copy of the certificate to the Department. (Section 3.117(b)(4)(A-5) of the Act)
- b) Within 30 business days after the Department's receipt of a hospital's ASRH certificate and an application available through the Department that indicates the hospital is a certified ASRH, in good standing, the hospital shall be deemed a State-designated ASRH. (Section 3.117(b)(4)(A-5) of the Act)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- c) The Department shall add the names of designated ASRHs to the website listing immediately upon designation (Section 3.118(c) of the Act) and shall immediately remove the name of a hospital from the website listing when a hospital loses its designation after notice and, if requested by the hospital, a hearing. (Section 3.117(b)(4)(A-5) of the Act)
- d) The application shall include a statement that the hospital meets the requirements for ASRH designation in Section 3.117 of the Act. The applicant hospital shall provide the following:
- 1) Hospital name and address;
 - 2) Hospital chief executive officer/administrator typed name and signature;
 - 3) Hospital stroke medical director typed name and signature; and
 - 4) Contact person typed name, e-mail address and phone number.
- e) Hospitals applying for ASRH designation via national ASRH certification shall provide to the Department proof of current ASRH certification, in good standing, by a nationally recognized certifying body. (Section 3.117(b)(4)(A-5) of the Act)
- f) A hospital designated as an ASRH shall pay an annual fee of \$250.

(Source: Added at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.5087 Suspension and Revocation of Acute Stroke-Ready Hospital Designation with National Certification

- a) The Department shall immediately remove the name of a hospital from the website listing when a hospital loses its designation after notice and, if requested by the hospital, a hearing. (Section 3.117(b)(4)(A-5) of the Act)
- b) The Department will issue an emergency suspension of ASRH designation when the Director has determined that the hospital no longer meets the ASRH criteria and an immediate and serious danger to the public health, safety and welfare exists. (Section 3.117(b)(4)(D) of the Act)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- c) *If the ASRH fails to eliminate the violation immediately or within a fixed period of time, not exceeding 10 days, as determined by the Director, the Director may immediately revoke the ASRH designation. (Section 3.117(b)(4)(D) of the Act)*
- d) *The ASRH may appeal the revocation, within 15 business days after receiving the Director's revocation order, by requesting an administrative hearing. (Section 3.117(b)(4)(D) of the Act)*
- e) *After notice and an opportunity for an administrative hearing, the Department will suspend, revoke or refuse to renew an ASRH designation when the Department finds that the hospital is not in substantial compliance with current ASRH criteria. (Section 3.117(b)(4)(E) of the Act)*

(Source: Added at 40 Ill. Reg. 8274, effective June 3, 2016)

Section 515.5090 Data Collection and Submission

- a) *The Department may administer a data collection system to collect data that is already reported by designated Comprehensive Stroke Centers, Primary Stroke Centers, and Acute Stroke-Ready Hospitals to their certifying body, to fulfill certification requirements. CSCs, PSCs and ASRHs~~Primary Stroke Centers~~ may provide data used in submission~~complete copies of the same reports that are submitted~~ to their certifying body, to satisfy any Department reporting requirements. The Department may require submission of data elements in a format that is used statewide. If the Department establishes reporting requirements for designated CSCs, PSCs and ASRHs~~Primary Stroke Centers~~, the Department shall permit each designated CSC, PSC and ASRH~~Primary Stroke Center~~ to capture information using existing electronic reporting tools used for certification purposes. Nothing in this Section shall be construed to empower the Department to specify the form of internal recordkeeping. (Section 3.118(e) of the Act)*
- b) *Stroke data collection systems and all stroke-related data collected from hospitals shall comply with the following requirements:*
 - 1) *The confidentiality of patient records shall be maintained in accordance with State and federal laws.*
 - 2) *Hospital proprietary information and the names of any hospital*

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

administrator, health care professional, or employee shall not be subject to disclosure.

- 3) *Information submitted to the Department shall be privileged and strictly confidential and shall be used only for the evaluation and improvement of hospital stroke care. Stroke data collected by the Department shall not be directly available to the public and shall not be subject to civil subpoena, nor discoverable or admissible in any civil, criminal, or administrative proceeding against a health care facility or health care professional.*
(Section 3.118(d) of the Act)

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Section 515.APPENDIX K Application for Facility Recognition for Emergency Department with Pediatrics CapabilitiesFACILITY RECOGNITION
Emergency Department with Pediatric Capabilities

Application Instructions

Follow these instructions to initiate the process to obtain recognition as an Emergency Department Approved for Pediatrics (EDAP) or Standby Emergency Department for Pediatrics (SEDP):

- 1) Complete the application form and obtain the appropriate signatures.
- 2) Using the Emergency Department Pediatric Plan Guideline and the EDAP or SEDP requirements, complete an Emergency Department Pediatric Plan. Attach all requested supporting documentation (credentialing forms, schedules, policies, procedures, protocols, guidelines, plans, etc.).
- 3) Submit the original signed application form plus three additional copies of the signed application form and four copies of the Emergency Department Pediatric Plan (including supporting documentation) to:

Chief, Division of EMS & Highway Safety
Illinois Department of Public Health
422 S. 5th Street
Springfield IL 62701

- 4) The Emergency Department Pediatric Plan shall follow the format outlined in the Emergency Department Pediatric Plan Guideline in this Appendix K and include all required documentation. The plan shall also address how each of the EDAP/SEDP requirements is currently being or will be met. The Pediatric Plan shall be developed through interaction and collaboration with all other appropriate disciplines.
- 5) Any submitted requests for equipment waiversto waive any of the requirements shall include the criteria by which compliance is considered to be a hardship and demonstrate that there will be no reduction in the provision of medical care.
- 6) The application should be submitted in a single-sided format and unstapled.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- | 7) Appendix M ~~of this Part~~ provides additional resource information related to pediatric inter-facility transfer and consultation and can be used in the development of the Emergency Department Pediatrics Plan.
- 8) For questions regarding the application process, specific requirements, or supporting documentation, please contact the Division of EMS & Highway Safety at 217-785-2080.

RECOGNITION OF EMERGENCY DEPARTMENT
PEDIATRIC CAPABILITIES
APPLICATION FORM

1) Name and address of hospital (typed)

2) Specify the recognition level for which your hospital is applying:

a) Emergency Department Approved for Pediatrics (EDAP) _____

b) Standby Emergency Department Approved for Pediatrics (SEDP) _____

3) The above-named hospital certifies that each requirement in this Request for Recognition is met and will be in operation by the date of recognition.

Typed name – CEO/Administrator

Signature – CEO/Administrator

Date

Typed name – Medical Director of Emergency Services

Signature – Medical Director of Emergency Services

Date

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Contact person – Typed name, credentials and title

Contact person – Phone number, fax number and email

EMERGENCY DEPARTMENT PEDIATRIC PLAN
GUIDELINE

Emergency Department Pediatric Plan (Please follow this guideline carefully. It provides information on the components that must be included in the submitted plan. Please include any applicable supplemental documentation.)

A. Emergency Department Organizational Structure

1. Provide a hospital Organizational Table identifying the administrative relationships among all departments in the hospital, especially as they relate to the emergency department. The table must include, but is not limited to, the following:
 - a. Board of Directors
 - b. Chief Executive Officers
 - c. Emergency Department
 - d. Department of Pediatrics
 - e. Trauma Service (if applicable)
 - f. Department of Radiology
2. In addition, provide a separate table showing the organization structure of the emergency department, including the relationship of the physician, nursing and ancillary services. Include the reporting structure for the ED Medical Director (to whom he/she reports).

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- a. Emergency Department Organizational Structure (Table)

B. Emergency Department Services

1. Description of the emergency department services
 - Provide a scope of services or policy outlining emergency department services, emergency department level, a description of the population served, types of pediatric patients seen, and annual emergency department visits that involve the pediatric patient.
 - Identify the age range that the hospital uses to define the pediatric patient, i.e., 0-15.
 - Provide information on participation/status in EMS system and trauma system as appropriate.
2. Description of the emergency department patient flow
 - Provide a narrative description or algorithm of patient path/flow from point of entry through disposition.
 - Provide any policies/guidelines that identify triaging/urgency categorization of patients.
 - Identify whether pediatric patients are seen in the general emergency department or in a separate area/bed space allocated for the pediatric patient.
 - If an emergency department fast-track area exists, provide triage criteria for this area and information on physician and nursing staffing/qualifications for assignment to the fast-track area.
3. Description of emergency medical services communication with identification of dedicated phone line, radio, and telemetry capabilities
 - Provide a policy or narrative description of the emergency services dedicated phone/telemetry radio communication capabilities.
 - Provide a policy outlining staffing qualifications to access and use such equipment.
4. Description of social service availability and capabilities
 - Provide a scope of services or policy that defines the services, capabilities and availability of social service department/personnel to the emergency department.
 - Describe typical mechanism and response by social worker to emergency department requests (i.e., handle over the phone, respond directly to the

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

emergency department, follow-up consult/appointment made).

C. Pediatric Department Services

1. Description of the pediatric department services
 - Identify whether there is a dedicated pediatric inpatient unit, dedicated pediatric inpatient beds and pediatric intensive care unit.
 - Provide a scope of services/policy outlining pediatric department services.
2. Description of the pediatric staffing and availability
 - Provide policy or scope of services outlining pediatric unit shift nursing staffing patterns based on patient acuity and any pediatric continuing education requirements/competencies verification.
 - If pediatric patients are admitted for care to an adult inpatient unit, provide documentation that identifies unit pediatrician staffing/coverage for such patients and how nurses are assigned to the inpatient pediatric patient, i.e., only nurses who have completed the PALS course.
3. Description/documentation of pediatric inpatient capabilities with identification of PICU and/or pediatric general floor bed availability and unit resources
 - Provide policy or scope of services that identifies what types of pediatric patients are typically admitted, i.e., types of conditions/diagnoses. Are there guidelines in place that define pediatric patients specifically by age parameters and/or diagnoses?
 - If a PICU is present, then a description of services, unit resources, and capabilities is needed. If a PICU is not present, then a description of where patients requiring such care are transferred, established relationships with pediatric tertiary care center, etc., is needed.

D. Professional Staff

1. Emergency Department Director
 - a. Copy of curriculum vitae
 - Provide a printed curriculum vitae.
 - Identify any board certification as outlined in the Facility Recognition Criteria (Sections 515.4000 and 515.4010).
 - b. Document Board Certification, as identified in the Facility Recognition

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Criteria, on the Emergency Department Credentialing Form. Documentation of board certification (as identified in Facility Recognition Criteria)

- ~~Provide a copy of board certification or verification of board certification.~~

2. Emergency Department Physicians
Documentation of the ability to meet recognition requirements in Section 515.4000 or Section 515.4010 ~~of this Part.~~

Hospital Recognition Requirement – Section 515.4000(a)(1) or 515.4010(a)(1)

- Provide a policy or description of emergency department physician staffing, coverage and availability (including fast track/urgent care area).
- Provide a completed Department approved credentialing form ~~forecomplete list/roster of~~ emergency department physician staff and a credentialing form for, including fast track/urgent care physicians area ~~(may use the Department approved credentialing form).~~
- Provide a one-month staffing schedule/calendar, including fast track/urgent care area (schedule should be from within the three month time period previous to the application submission).
- ~~Provide copies of physician current board certification or verification of board certification (or copies of CVs for SEDP level applications).~~
- ~~Provide copies of PALS or APLS course completion certificates for physician staff or a documented plan to complete such courses.~~ Provide documentation of a plan to maintain PALS or APLS recognition.
- Provide a policy that incorporates Section 515.4000(a)(1) or 515.4010(a)(1).

Hospital Recognition Requirement – Section 515.4000(a)(2) or 515.4010(a)(2)

- Provide a copy of the emergency department physician continuing education policy.
- Provide a description of how physician continuing education is currently tracked.
- Provide documentation of an implementation plan for attaining and tracking of pediatric specific continuing education hours (these hours can be integrated into the overall CME tracking process).
- Provide a policy that incorporates Section 515.4000(a)(2) or 515.4010(a)(2).

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Hospital Recognition Requirement – Section 515.4000(a)(3) or 515.4010(a)(3)

- Provide a staffing policy that incorporates Section 515.4000(a)(3) or 515.4010(a)(3).

Hospital Recognition Requirement – Section 515.4000(a)(4) or 515.4010(a)(4)

- Provide a one-month on-call schedule that identifies availability of a board certified/prepared pediatrician or pediatric emergency medicine physician for telephone consultation (schedule should be from within the three-month time period previous to the application submission).

Hospital Recognition Requirement – Section 515.4000(a)(5) or 515.4010(a)(5)

- Provide a copy of a policy that identifies physician back-up availability to assist with critical situations, increased surge capacity or disasters.

Hospital Recognition Requirement – Section 515.4000(a)(6) or 515.4010(a)(6)

- Provide a protocol/policy/bylaws that identifies maximum response time for all specialty on-call physicians.

3. Emergency department nurse practitioner and physician assistant~~Department Mid-Level Providers (Physician Assistant or Nurse Practitioner)~~

Note – Complete this section only if physician assistants and/or nurse practitioners and/or physician assistants practice in the emergency department and participate in the care of pediatric patients.

Provide documentation of the ability to meet hospital recognition requirements in Section 515.4000(b) or 515.4010(b) ~~of this Part.~~

Requirement – Section 515.4000(b)(1) or 515.4010(b)(1)

- Provide a policy of emergency department physician assistant and/or nurse practitioner and/or physician assistant staffing, coverage, availability, responsibilities and credentialing process.
- Provide a completed Department approved credentialing form for a list/roster of all emergency department, and a credentialing form for fast track physician assistant and nurse practitioner and physician assistant staff (may use Department approved credentialing form).
- Provide a copy of a one-month staffing schedule/calendar (schedule should be from within the three month time period previous to the application submission).
- ~~Provide a copy of printed licenses and curriculum vitae.~~

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- ~~Provide copies of PALS, APLS or ENPC completion certificates or a documented plan to complete such courses.~~ Provide documentation of a plan to maintain PALS, APLS or ENPC recognition.
- Provide a policy that incorporates Section 515.4000(b)(1) or 515.4010(b)(1) ~~of this Part.~~

Requirement – Section 515.4000(b)(2) or 515.4010(b)(2)

- Provide a copy of the emergency department and fast track nurse practitioner and physician assistant~~physician assistant/nurse practitioner~~ continuing education policy.
- Provide a description of how nurse practitioner and physician assistant~~physician assistant/nurse practitioner~~ continuing education is currently tracked.
- Provide documentation of an implementation plan for attaining and tracking of pediatric specific continuing education hours (these hours can be integrated into overall continuing education tracking process).
- Provide a policy that incorporates Section 515.4000(b)(2) or 515.4010(b)(2) ~~of this Part.~~

4. Emergency Department Registered Nurses

Provide documentation of the ability to meet hospital recognition requirements in Section 515.4000(c) or 515.4010(c) ~~of this Part.~~

Requirement – Section 515.4000(c)(1) or 515.4010(c)(1)

- Provide a policy/documentation outlining current nursing shift staffing plan/patterns.
- Provide a Department approved credentialing form for list/roster of all emergency department nursing staff. ~~(may use Department approved credentialing form).~~
- Provide a copy of a one-month nursing staffing schedule/calendar (schedule should be from within the three month time period previous to the application submission).
- Provide documentation of a plan to maintain PALS, APLS or ENPC recognition. ~~Provide copies of PALS, APLS or ENPC completion certificates or a documented plan to complete such courses.~~
- Provide a policy that incorporates Section 515.4000(c)(1) or 515.4010(c)(1).

Requirement – Section 515.4000(c)(2) or 515.4010(c)(2)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- Provide a policy identifying continuing education requirements and competency testing for emergency department nursing staff.
- Provide a description of how continuing education is currently tracked.
- Provide documentation of an implementation plan for attaining and tracking of pediatric specific continuing education hours.
- Provide a policy that incorporates Section 515.4000(c)(2) or 515.4010(c)(2) ~~of this Part.~~

E. Policies and Procedures

1. Policy/procedure for inter-facility transfer as identified in Section 515.4000(d)(1) or 515.4010(d)(1) ~~of this Part.~~
 - Provide a transfer agreement with a Pediatric Critical Care Center and identification of facilities to which the hospital typically transfers pediatric patients. The transfer agreements shall include a provision that addresses communication and quality improvement measures between the referral and receiving hospitals, as related to patient stabilization, treatment prior to and subsequent to transfer, and patient outcome.
 - Provide a transfer policy that incorporates the physiologic/other criteria identified in Appendix M: EMSC Inter-facility Pediatric Trauma and Critical Care Consultation and/or Transfer Guideline.
2. Policy/procedure for suspected child abuse and neglect as identified in Section 515.4000(d)(2) or 515.4010(d)(2) ~~of this Part.~~
 - Provide a policy that includes age-specific identification, assessment, evaluation and management measures for the suspected child abuse and neglect patient.
3. Treatment guidelines as identified in Section 515.4000(d)(3) or 515.4010(d)(3) ~~of this Part.~~
 - Provide copies of pediatric treatment guidelines as described.
 - The hospital shall have emergency department guidelines, order sets or policies and procedures addressing initial assessment and management for its high-volume and high-risk pediatric population (i.e., fever, trauma, respiratory distress, seizures). It is recommended that guidelines be based on high volume/high risk diagnoses (i.e., fever, trauma, respiratory distress, seizures) and that guidelines include desired outcomes in order to facilitate quality improvement monitoring.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

4. Policy for latex allergy as identified in Section 515.4000(d)(4) or 515.4010(d)(4) ~~of this Part.~~
 - Provide a policy that addresses assessment of latex allergies and the availability of latex-free equipment and supplies.

F. Quality Improvement

1. Describe and document the emergency department program for conducting outcome analysis or quality improvement and how pediatrics is integrated into the process.
 - Provide a policy/guideline that outlines the emergency department quality improvement program, i.e., describe the quality improvement process, ~~required~~ clinical indicators, ~~and/or outcome analysis and follow-up mechanisms, i.e.,~~ "loop closure" and target time frames for closure of issues.
 - Provide documentation outlining current and planned pediatric monitoring activities.
2. Document the ability to meet facility recognition requirements in Section 515.4000(e) or 515.4010(e) ~~of this Part.~~

Requirement – Section 515.4000(e)(1) or 515.4010(e)(1)

- Define the composition of the multidisciplinary QI committee (recommend broadening composition of committee beyond physician/nursing to include other essential disciplines such as pediatric, social services, respiratory therapy), frequency of committee meetings and reporting structure.
- Provide a copy of the emergency department quality improvement plan, including QI policy, pediatric indicators, feedback loop and target time frames for closure of issues. If implementation of pediatric monitoring activities is pending, define implementation plan and time frame.

Requirement – Section 515.4000(e)(2) or 515.4010(e)(2)

- Provide a curriculum vitae for the physician who will assume the pediatric physician champion role.
- Provide the name and title of the individual who will assume the pediatric quality coordinator role.
- Provide a job description that addresses allocation of time and resources to the role and includes each of the requirements outlined in Section

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

515.4000(e)(2) or 515.4010(e)(2) that will be carried out by the pediatric quality coordinator.

G. Equipment

Using the equipment list provided in Appendix L, place an "X" next to each equipment item that is currently available (as appropriate for the level applied for). If equipment/supply items are not available, a plan for securing the items shall be identified, i.e., submission of a purchase order to assure that the item is on order, or ~~equipment~~ waiver shall be submitted for each item.

Requests for ~~equipment waivers~~waiver shall include the criteria by which compliance is considered to be a hardship and shall demonstrate that there will be no reduction in the provision of medical care.

Site Survey Procedure

- 1) Within four to six weeks following receipt of the Application Form and supporting documents (schedules, policies, procedures, protocols, guidelines, etc.), the hospital will be informed as to the status of the application. If all documentation is in order, a site visit will be scheduled.
- 2) The site visit will include a survey of the emergency department and pediatric unit (including intensive care, if applicable), and a meeting with the following individuals:
 - a) The hospital's chief administrative/executive officer or designee
 - b) The chief nursing executive/director of nursing or designee
 - c) The chief of pediatrics or, if the hospital does not have a pediatric department, the designated pediatric consultant
 - d) The nursing director or nursing manager of the pediatric unit, if applicable
 - e) The emergency department medical director or pediatric emergency department medical director
 - f) The emergency department nursing director or nursing manager
 - g) The administrator of emergency services

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- h) The administrator of pediatric services, if applicable
 - i) The pediatric quality coordinator
 - j) The hospital quality improvement director or designee
 - k) The hospital emergency management/disaster preparedness coordinator
 - l) ~~Nurse practitioner~~ ~~Mid-level provider, i.e., nurse practitioner~~ or physician assistant, for those hospitals that use these practitioners ~~use mid-level providers~~ in their emergency department
 - m) For EMS Resource or Associate Hospitals only: the EMS Medical Director and EMS Coordinator
- 3) In preparation for the site visit, hospital personnel shall prepare evidence to verify adherence to the hospital recognition requirements.

Site Survey Team

The Chief of EMS & Highway Safety, in coordination with the Illinois EMSC Advisory Board, will appoint the survey team. Site survey teams will be composed of a physician/nurse (or nurse/nurse) team along with a representative from the Illinois Department of Public Health. All team members shall have attended formal training in the responsibilities, expectations, process and assessment of facility recognition.

Following the Site Survey

- 1) Within four to six weeks following the site visit, the Department will provide the hospital with the results of the survey. Those hospitals meeting all requirements will receive a formal "recognition" for their emergency department pediatric capabilities.
- 2) Hospitals may appeal the results of the survey by submitting a written request to the Illinois Department of Public Health, Division of EMS & Highway Safety.
- 3) Re-recognition shall occur every ~~four~~ three years, with site visits scheduled as necessary.

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Section 515.APPENDIX L Pediatric Equipment Recommendations for Emergency Departments

The following list identifies pediatric equipment items that are recommended for the two emergency department facility recognition levels. Equipment items are classified as "essential" (E) and "need to be stocked in the emergency department" (ED).

	EDAP	SEDP
Monitoring Devices		
Blood glucose measurement device (i.e., chemistry strip or glucometer)	E (ED)	E (ED)
Continuous end-tidal PCO ₂ monitor and pediatric CO ₂ colorimetric detector (disposable units may be substituted)	E (ED)	E (ED)
Doppler ultrasound blood pressure device (neonatal-adult thigh cuffs)	E (ED)	E (ED)
ECG monitor-defibrillator/cardioverter with pediatric and adult sized paddles, with pediatric dosage settings and pediatric-adult pacing electrodes	E (ED)	E (ED)
Hypothermia thermometer (Note: with a range of 28-42°C)	E (ED)	E (ED)
Pediatric monitor electrodes	E (ED)	E (ED)
Otoscope/ophthalmoscope/stethoscope	E (ED)	E (ED)
Pulse oximeter with pediatric and adult probes	E (ED)	E (ED)
Sphygmomanometer with cuffs (neonatal-adult thigh)	E (ED)	E (ED)
Vascular Access Supplies and Equipment		
Arm boards (sized infant through adult)	E (ED)	E (ED)
Blood gas kits	E (ED)	E (ED)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Butterfly-type needles (19-25 g)*	E (ED)	E (ED)
Catheter-over-needle devices (16-24 g)*	E (ED)	E (ED)
Central venous catheters (stock one small and one large size)	E (ED)	E (ED)
Infusion pumps, using <u>syringe pumps, or devices</u> drip or volumetric, with microinfusion capability <u>using</u> ; appropriate tubing & connectors	E (ED)	E (ED)
Intraosseous needles or bone marrow needles (13-18 g size range; stock one large/one small bore) or IO device (pediatric and adult sizes)	E (ED)	E (ED)
IV extension tubing, stopcocks, and T-connectors	E (ED)	E (ED)
IV fluid/blood warmer	E (ED)	E (ED)
IV solutions: standard crystalloid and colloid solutions (D10W, D5/.2 NS, D5/.45 NS, D5/.9 NS and 0.9 NS)	E (ED)	E (ED)
Syringes (1ml through 20 ml)	E (ED)	E (ED)
Tourniquets	E (ED)	E (ED)
Umbilical vein catheters (3.5 and 5 Fr; the same size feeding tube may be used for 5 Fr)*	E (ED)	E (ED)

Respiratory Equipment and Supplies

Bag-valve-mask device, self-inflating infant/child and adult (1000 ml) with O ₂ reservoir and clear masks (neonatal through large adult sizes)*; PEEP valve and manometer	E (ED)	E (ED)
<u>Manometer</u>	<u>E (ED)</u>	<u>E (ED)</u>
Bulb syringe	E (ED)	E (ED)
Endotracheal tubes:*		

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

<u>Cuffed or Uncuffed (sizes 2.5, and 3.0, <u>3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5 and 8.0</u>)</u>	E (ED)	E (ED)
Cuffed or Uncuffed (3.5, 4.0, 4.5, 5.0, 5.5)	E (ED)	E (ED)
Cuffed (sizes 6.0, 6.5, 7.0, 7.5, 8.0)	E (ED)	E (ED)
Stylets for endotracheal tubes (pediatric and adult)	E (ED)	E (ED)
Laryngoscope handle (pediatric and adult)	E (ED)	E (ED)
Laryngoscope blades (curved 2, 3; straight or Miller 0, 1, 2, 3)*	E (ED)	E (ED)
Magill forceps (pediatric and adult)	E (ED)	E (ED)
Meconium aspirator	E (ED)	E (ED)
Nasopharyngeal airways (sizes 14+2 , 16, 20, 24, 28, 30 Fr)*	E (ED)	E (ED)
Nebulized medication, administration set with pediatric and adult masks	E (ED)	E (ED)
Oral airways (sizes 0, 1, 2, 3, 4, 5 or size 50 mm, 60 mm, 70 mm, 80 mm, 90 mm, 100 mm)*	E (ED)	E (ED)
Oxygen delivery device with flow meter and tubing	E (ED)	E (ED)
Oxygen delivery adjuncts:		
Tracheostomy collar	E (ED)	E (ED)
Standard masks, clear (pediatric and adult sizes)	E (ED)	E (ED)
Partial-non-rebreather or non-rebreather masks, clear (pediatric and adult sizes)	E (ED)	E (ED)
Nasal cannula (infant, pediatric and adult)	E (ED)	E (ED)
Peak flow meter	E (ED)	E (ED)
Supplies/kit for patients with difficult air way conditions:	E (ED)	E (ED)
• LMA (sizes 1, 1.5, 2, 2.5, 3, 4 and 5); or		
• Cricothyrotomy kit or cricothyrotomy capabilities (i.e.,		

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

10 g needle and 3 mm ET tube adapter or 14 g needle
and 3.5 mm ET tube adapter)

Suction capability (wall)	E (ED)	E (ED)
Suction capability (portable)	E (ED)	E (ED)
Suction catheters (sizes 5/6, 8, 10, 12, 14, 16, <u>18</u> Fr and Yankauer-tip catheter)*	E (ED)	E (ED)
Tracheostomy tubes (sizes PED* 3.0, 3.5, 4.0, 4.5, 5.0, 5.5)* (correspond to PT 00, 0, 1, 2, 3, 4, in old schematization)	E (ED)	---
Tube thoracostomy tray and water seal drainage capacity with chest tubes (sizes 12-32 Fr)*	E (ED)	---

Medications (unit dose, prepackaged)

Access to the Illinois Poison Center 1-800-222-1222 through posting of phone number in ED	E (ED)	E (ED)
Activated charcoal (consider with and without Sorbitol)	E (ED)	E (ED)
Adenosine	E (ED)	E (ED)
Amiodarone	E (ED)	E (ED)
Antiemetics	E (ED)	E (ED)
Antimicrobial agents (parenteral and oral)	E (ED)	E (ED)
Antipyretics	E (ED)	E (ED)
Atropine	E (ED)	E (ED)
Barbiturates, e.g., Phenobarbital, Pentobarbital, Thiopental	E (ED)	E (ED)
Benzodiazepines, e.g., Lorazepam, Midazolam, Diazepam	E (ED)	E (ED)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Beta agonist for inhalation (Albuterol, Levalbuterol)	E (ED)	E (ED)
Beta blockers, e.g., Propranolol, Metoprolol	E (ED)	E (ED)
Calcium (chloride or gluconate)	E (ED)	E (ED)
Corticosteroids, e.g., Dexamethasone, Hydrocortisone, Methylprednisolone	E (ED)	E (ED)
Dextrose (25% and 50%)	E (ED)	E (ED)
Diphenhydramine	E (ED)	E (ED)
Dobutamine	E (ED)	---
Dopamine	E (ED)	---
Epinephrine (1:1,000 and 1:10,000)	E (ED)	E (ED)
Epinephrine (Racemic)	E (ED)	E (ED)
Fosphenytoin and/or Phenytoin	E (ED)	E (ED)
Furosemide	E (ED)	E (ED)
Glucagon or Glucose Paste	E (ED)	E (ED)
Insulin, regular	E (ED)	E (ED)
Lidocaine 1%	E (ED)	E (ED)
Magnesium Sulfate	E (ED)	E (ED)
Mannitol	E (ED)	E (ED)
Narcotics	E (ED)	E (ED)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Neuromuscular blocking agents (i.e., succinylcholine, rocuronium, vecuronium)	E (ED)	E (ED)
Ocular anesthetics	E (ED)	E (ED)
Poison Specific Antidotes		
Acetylcysteine	E (ED)	E (ED)
Cyanide antidote kit	E (ED)	E (ED)
Flumazenil	E (ED)	E (ED)
Naloxone	E (ED)	E (ED)
Procainamide	E (ED)	E (ED)
Sodium bicarbonate – 8.4% and 4.2%	E (ED)	E (ED)
Sedative/Hypnotic (e.g., Ketamine, Etomidate)	E (ED)	E (ED)
Tetanus Immune Globulin (Human)	E (ED)	E (ED)
Tetanus Vaccines (single or in combination with other vaccines)	E (ED)	E (ED)
Topical Anesthetics	E (ED)	E (ED)
Miscellaneous Equipment	E (ED)	E (ED)
Dosing device – length or weight based system for dosing and equipment	E (ED)	E (ED)
Dosing/equipment chart by weight	E (ED)	E (ED)
EMS communication equipment (i.e., telemetry, MERCI, cellular or dedicated phone)	E (ED)	E (ED)
Examination gloves, disposable	E (ED)	E (ED)
Fluorescein (eye strips)	E (ED)	E (ED)
Infant formulas, dextrose in water with various nipple sizes	E (ED)	E (ED)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Lubricant, water soluble	E (ED)	E (ED)
Nasogastric tubes 8 through-18 Fr* (may substitute feeding tubes 5F and 8F)	E (ED)	E (ED)
Oral rehydrating solution	E (ED)	E (ED)
Pain scale assessment tools appropriate for age	E (ED)	E (ED)
Pediatric emergency/crash cart or bag with defined list of contents attached to bag/cart	E (ED)	E (ED)
Restraining device, pediatric (papoose)	E (ED)	E (ED)
Resuscitation board	E (ED)	E (ED)
Urinary catheters (8-22 Fr)*	E (ED)	E (ED)
Warming devices, age appropriate	E (ED)	E (ED)
Weighing scales (in kilograms <u>only</u>) for infant and children	E (ED)	E (ED)
Woods lamp (blue light)	E (ED)	E (ED)

Specialized Pediatric Trays

Initial newborn resuscitation equipment (can include warming device, feeding tubes, neonatal mask)	E (ED)	E (ED)
Lumbar puncture tray, including a selection of needle sizes (size 18-22 g, 1½-3 inch needle)	E (ED)	E (ED)
Minor surgical instruments and sutures	E (ED)	E (ED)
Newborn kit/OB kit (including umbilical clamp, bulb syringe, towel)	E (ED)	E (ED)

Fracture Management Devices

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Extremity splints	E (ED)	E (ED)
Femur splint (child and adult)	E (ED)	E (ED)
Semi-rigid neck collars (child through adult) or cervical immobilization equipment suitable for children	E (ED)	E (ED)
Spinal immobilization board (child and adult)	E (ED)	E (ED)

* Shall minimally stock a range of each commonly available size noted or comparable sizes.

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Section 515.APPENDIX N Pediatric Critical Care Center (PCCC)/Emergency Department Approved for Pediatrics (EDAP) Recognition Application

Application Instructions

Follow these instructions to initiate the process to request recognition as a Pediatric Critical Care Center (PCCC) and Emergency Department Approved for Pediatrics (EDAP). The Pediatric Plan shall be developed through interaction and collaboration with all appropriate disciplines:

1. Complete the Request for Recognition of Pediatric Critical Care Center and Emergency Department Approved for Pediatrics Status Application Form and obtain the appropriate signatures.
2. Using the Pediatric Critical Care Center Plan Application Guideline and the PCCC/EDAP requirements, complete a PCCC and EDAP Pediatric Plan. The Pediatric Plan should follow the Pediatric Critical Care Center Plan Application Guideline checklist format provided in this application and include all requested supporting documentation, including, but not limited to, scope of services/care, credentialing forms, policies (both administrative and department specific), procedures, protocols, guidelines, flow charts, rosters, calendars, schedules, etc.
3. Complete and obtain signatures on the Department-approved physician, nurse practitioner and physician assistant~~mid-level provider~~ and nursing credentialing forms.
4. Complete the EDAP, PICU and Pediatric Unit Equipment Checklists.
5. Submit four copies of the hospital's Pediatric Plan (an original signed copy plus three additional copies) that each contain the following:
 - a. Signed Request for Recognition of Pediatric Critical Care Center and Emergency Department Approved for Pediatrics Status Application Form;
 - b. Completed PCCC Plan and EDAP Plan (including supporting documentation);
 - c. Completed physician, nurse practitioner and physician assistant~~mid-level provider~~ and nursing credentialing forms;
 - d. Completed EDAP, PICU and Pediatric Inpatient Unit Equipment Checklists.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

6. Submit these documents (including all supporting documentation) in the order listed in this application to: Division of EMS & Highway Safety, Illinois Department of Public Health, 422 S. 5th Street, Springfield IL 62701.
7. The Pediatric Plan shall be submitted in a single-sided format and unstapled.
8. Any submitted requests to waive any of the EDAP or PCCC equipment requirements shall include the criteria by which compliance is considered to be a hardship and shall demonstrate that there will be no reduction in the provision of medical care.

Site Survey Procedure

1. Within four to six weeks following the Department's receipt of the PCCC Pediatric Plan and supporting documents, the hospital will be informed as to the status of the application. If all documentation is in order, a site visit will be scheduled.
2. In preparation for the site visit, hospital personnel shall prepare evidence to verify adherence to the facility recognition requirements.
3. The site visit will include a survey of the Emergency Department, Pediatric Intensive Care Unit, Pediatric Units and a meeting with the following individuals:
 - a. chief administrative/executive officer or designee
 - b. chief of pediatrics
 - c. medical director of the pediatric intensive care services
 - d. medical directors of the pediatric units
 - e. medical director of pediatric ambulatory care
 - f. nursing director or nurse manager of the pediatric intensive care services
 - g. nursing director or nurse manager of the pediatric units
 - h. administrator of pediatric services
 - i. administrator of emergency services

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- j. pediatric quality coordinator
- k. hospital quality improvement department director or designee
- l. emergency department medical director and the pediatric emergency department medical director
- m. emergency department nurse manager and the pediatric emergency department nurse manager
- n. hospital emergency management/disaster preparedness coordinator
- o. transport team medical director
- p. transport team nurse coordinator
- q. Clinical nurse specialist, nurse practitioner~~mid-level provider, i.e., nurse practitioner~~ or physician assistant for those facilities that use these practitioners~~use mid-level providers in their emergency department or on their pediatric units~~
- r. For EMS Resource or Associate Hospitals: The EMS MD and EMS coordinator

Site Survey Team

The Director or the Chief, Division of EMS & Highway Safety, in coordination with the Illinois EMSC Advisory Board, will appoint the site survey team. Site survey teams will be composed of a physician/nurse team along with a representative from the Illinois Department of Public Health. All team members will attend formal training in the site survey responsibilities, expectations and process.

Following the Site Survey

1. Within four to six weeks following the site visit, the hospital shall receive the results of the survey from the Department. Those hospitals meeting all requirements will receive a formal recognition of their Pediatric Critical Care capabilities.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- 2. Hospitals that do not meet the requirements will receive a letter from the Illinois Department of Public Health outlining the areas of non-compliance. The Department shall deny a request for recognition if findings show failure to substantially comply with the EDAP and/or PCCC requirements. Hospitals may appeal the denial by submitting a written request to the Illinois Department of Public Health, Division of EMS & Highway Safety.
- 3. Re-recognition shall occur every three years, with site visits scheduled as necessary.

ILLINOIS EMSC
FACILITY RECOGNITION

Request for Recognition of Pediatric Critical Care Center (PCCC) and
Emergency Department Approved for Pediatrics (EDAP) Status

Application Form

Name of hospital and address (typed)

The above-named hospital is requesting PCCC and EDAP recognition. In addition, the above-named hospital certifies that each requirement in this Request for Recognition is met.

Typed name – CEO/Administrator

Signature – CEO/Administrator

Date

Typed name – Chairman of the Department of Pediatrics

Signature – Chairman of the Department of Pediatrics

Date

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Typed name – Medical Director of Emergency Services

Signature – Medical Director of Emergency Services

Date

Contact Person – Typed name, credentials and title

Contact Person – Phone number, fax number and email

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Section 515.APPENDIX O Pediatric Critical Care Center Plan

I. PEDIATRIC CRITICAL CARE CENTER PLAN

Application Checklist

Instructions: Please follow and complete this checklist carefully. It outlines the components that must be included in the submitted plan. Please include any applicable supplemental documentation.

A. Organizational Structure

1. Enclosed is an organizational table identifying the administrative relationships among all departments in the hospital, especially as they relate to the pediatrics department. The table shall include, but is not limited to, the following:

- board of directors
- chief executive officers
- emergency department
- department of pediatrics
- pediatric ambulatory care
- trauma service
- department of radiology
- laboratory services
- transport service team
- social services

2. Enclosed is an organizational table showing the organizational structure of the department of pediatrics, including the relationship of the physician, nursing and ancillary services for both the PICU and pediatric units. Include the reporting structure for the pediatric chairman (to whom he/she reports).

Department of Pediatrics Organizational Structure (Table)

3. Enclosed is an organizational table showing the organizational structure of the emergency department, including the relationship of the physician, nursing and ancillary services. Include the reporting structure for the emergency department director (to whom he/she reports).

Emergency Department Organizational Structure (Table)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

EDAP Checklist

Review the criteria in Section 515.4000(a)(1) and (2) for the physician staff qualifications and continuing medical education and submit each of the following:

- A policy or medical staff bylaws that incorporate the physician qualifications and CME requirements.
- A completed Credentials of Emergency Department Physicians form
- A completed Credentials of Fast Track Physicians form
- The curriculum vitae for the ED medical director
- A current one-month physician schedule for the ED

Review the criteria in Section 515.4000(a)(3) for the ED physician coverage and submit a policy that addresses this requirement.

Review the criteria in Section 515.4000(a)(4) for ED consultation and submit a one-month on-call schedule identifying availability of board certified/board prepared pediatricians or pediatric emergency medicine physicians.

Review the criteria in Section 515.4000(a)(5) for ED physician back-up and submit a policy that addresses this requirement.

Review the criteria in Section 515.4000(a)(6) for all on-call specialty physician response time and submit a policy that addresses this requirement.

Review the criteria in Section 515.4000(b)(1) and (2) for nurse practitioner and physician assistant mid-level provider qualifications and continuing medical education and submit the following (as applicable):

- A policy(s) that incorporates the mid-level provider qualifications and continuing education requirements
- A completed Credentials of Emergency Department and Fast Track Nurse Practitioner and Physician Assistant Mid-level Providers form
- A current one-month mid-level provider schedule for the emergency department and fast track area as applicable.

Review the criteria in Section 515.4000(c)(1) and (2) for nursing qualifications and continuing education and submit the following:

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- A policy that incorporates the nursing qualifications and CE requirements
- A completed Credentials of Emergency Department Nursing Staff form
- A one-month nurse staffing schedule for the emergency department

Review the criteria in Section 515.4000(d)(1) for inter-facility transfer and submit the following:

- An inter-facility transfer policy that addresses pediatric transfers
- A copy of current pediatric-specific transfer agreements with hospitals that provide pediatric specialty services, pediatric intensive care and burn care not available at your facility

Review the criteria in Section 515.4000(d)(2) for suspected child abuse and neglect and submit a policy that addresses this requirement.

Review the criteria in Section 515.4000(d)(3) for treatment protocols and submit all pediatric treatment protocols.

Review the criteria in Section 515.4000(d)(4) for latex allergy policy and submit a policy that addresses latex allergies and the availability of latex-free equipment and supplies.

Review the criteria in Section 515.4000(d)(5) for disaster preparedness and submit a completed pediatric disaster preparedness checklist.

Review the criteria in Section 515.4000(e)(1) for quality improvement activities and the multidisciplinary quality improvement committee and submit the following:

- A quality improvement plan, including a QI policy, pediatric indicators, feedback loop and target time frames for closure of issues
- The composition of the multidisciplinary QI committee

Review the criteria in Section 515.4000(e)(2) and (3) for the pediatric physician champion and the pediatric quality coordinator responsibilities and submit the following:

- A curriculum vitae for the pediatric physician champion
- A curriculum vitae and job description for the pediatric quality coordinator
- Documentation detailing the participation of the pediatric quality coordinator in regional QI activities and how that has affected pediatric quality care in the ED

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Review the criteria in Section 515.4000(f) for the list of emergency department equipment requirements and submit a completed checklist indicating the availability of all equipment.

Indicate in the pediatric plan whether each item is currently available. If equipment/supply items are not available, a plan for securing the items shall be identified (e.g., submission of a purchase order to assure that the item is on order) or **an equipment** waiver request shall be submitted for each item. Requests for waiver shall include the criteria by which compliance is considered to be a hardship and demonstrate that there will be no reduction in the provision of medical care.

If assistance is needed in identifying specific vendors for any of the equipment or supply items in this application, please contact the Marketing Administrator, Group Purchasing Services, Metropolitan Chicago Healthcare Council at 312-906-6122.

B. PCCC Checklist

1. Hospital Requirements

Review the criteria in Section 515.4020(a) of the PCCC requirements as related to hospital resources and submit documentation identifying the ability to meet each of the following:

- A scope of services/policy outlining PICU services, unit resources and capabilities. Include any guidelines that outline pediatric admission criteria based on age parameters and/or diagnoses
- A list of the members of the PICU Committee, as well as their disciplines, to meet subsection (a)(3)
- Documentation to substantiate that Section 515.4020(a)(4) (Helicopter landing) is met
- A statement regarding 24-hour availability to meet Section 515.4020(a)(5) (CAT scan)
- A statement regarding the ability to meet Section 515.4020(a)(6) (Laboratory)
- A statement of availability or transfer agreement to meet Section 515.4020(a)(7) (Hemodialysis capabilities)
- A statement or scope of service from each program identifying the availability of staff as required in Section 515.4020(a)(8) (Other staffing/services)
- A list of professional pediatric critical care educational trainings that staff have provided in the past year to meet Section 515.4020(a)(9) (include information on trainings held within the facility, within the region or surrounding geographic area)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- A list of pediatric emergency care classes that staff have provided in the past year to meet Section 515.4020(a)(10) (i.e., CPR, first aid, health fairs, etc., conducted for the patient population and the community, region or surrounding geographic area)
- Documentation of any pediatric research the facility has been engaged in during the past year to meet Section 515.4020(a)(11) (include the research project abstract, summary of projects or listing of research activities)

II. PICU SERVICE REQUIREMENTS

A. Professional Staff

1. PICU Medical Director

Review the criteria in Section 515.4020(b) for the Medical Director and Co-Director requirements and submit each of the following:

- A curriculum vitae for the appointed PICU medical director
- A copy of board certification or verification of board certification
- A curriculum vitae and board certification for the co-director (as applicable – see Section 515.4020(b)(1))

2. PICU Medical Staff Requirements

Review the criteria in Section 515.4020(c) and submit each of the following:

PICU Medical Staff

- A policy outlining PICU physician staffing, coverage, availability, and CME requirements that incorporates Section 515.4020(c)(1)(A) and (B)
- A completed Credentials of PICU Physicians form that includes the medical director (and co-director as applicable)
- A one-month staffing schedule/calendar (schedule should be from within the three-month time period previous to the application submission)

Physician Specialist Availability (Section 515.4020(c)(2))

- A policy or by-laws that address the response time and on-call scheduling of pediatric surgeons
- A policy/process outlining board or sub-board certification or board preparedness for all specialist physicians

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- A policy/process outlining how pediatric proficiency is defined and assuring that all specialist physicians maintain 10 hours of pediatric CME per year
- A policy/process outlining anesthesiologist on-call staffing and response time, subspecialty training in pediatric anesthesiology or pediatric proficiency as defined by institution, and 10 hours of pediatric CME per year; for Certified Registered Nurse Anesthetists, provide a copy of the by-laws that address their responsibilities and back up
- On-call schedules from the last month that list physician availability to meet Section 515.4020(c)(2)(C) and (D)

3. PICU Nurse Practitioner or Physician Assistant~~Mid-Level Providers (Physician Assistant or Nurse Practitioner)~~ Requirements

NOTE – Complete this section only if physician assistants or nurse practitioners practice in the PICU.

Review the criteria in Section 515.4020(d) and submit each of the following:

Nurse Practitioner (Section 515.4020(d)(1))

- A policy outlining PICU nurse practitioner staffing, coverage, availability, responsibilities and credentialing process
- A copy of a one-month staffing schedule/calendar (schedule should be from within the three-month time period previous to the application submission)
- A completed Credentials of PICU Nurse Practitioner or Physician Assistant~~Mid-Level Providers~~ form

Physician Assistant (Section 515.4020(d)(2))

- A policy outlining PICU physician assistant staffing, coverage, availability, responsibilities and credentialing process
- A copy of a one-month staffing schedule/calendar (schedule should be from within the three-month time period previous to the application submission)
- A completed Credentials of PICU Nurse Practitioner or Physician Assistant~~Mid-Level Providers~~ form

Education (Section 515.4020(d)(3) and (4))

- A policy that incorporates APLS, PALS or ENPC (Section 515.4020(d)(3))
- A copy of the PICU nurse practitioner and physician assistant~~physician assistant/nurse practitioner~~ continuing education policy that incorporates Section 515.4020(d)(4)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

4. PICU Nursing Staff Requirements

Review the criteria in Section 515.4020(e) and submit each of the following:

PICU Nurse Manager

- A curriculum vitae for the PICU manager
- A policy or job description that incorporates Section 515.4020(e)(1)(C)

PICU Advanced Practice Nurse

- A policy or job description of the role and responsibilities of the advanced practice nurse in the PICU
- A resume of the PICU advanced practice nurse
- A policy that incorporates Section 515.4020(e)(2)(C) and (D)

Nursing Patient Care Services

- A policy/documentation outlining current nursing shift staffing plan/patterns
- A completed Credentials of PICU Nursing Staff form that includes the PICU nurse manager and PICU advanced practice nurse
- A policy or job description for the PICU nurse that outlines the orientation process to the unit responsibilities and requirements of the Department (Section 515.4020(e)(3)(C) and (D))
- A copy of a one-month nurse staffing schedule/calendar (schedule shall be from within the three-month time period previous to the application submission)
- A policy reflecting yearly competency review requirements for the PICU staff

D. Policies, Procedures and Treatment Protocols

Review the criteria in Section 515.4020(f) and submit each of the following:

- An admission and discharge criteria policy
- A staffing policy that addresses nursing shift staffing patterns based on patient acuity
- A policy for managing the psychiatric needs of the PICU patient
- Protocols, order sets, pathways or guidelines for management of high- and low-frequency diagnoses

E. Inter-facility Transfer/Transport Requirements

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Review the criteria in Section 515.4020(g) and submit each of the following:

- A copy of the last annual report containing the number of annual transfers to the facility from transferring institutions
- A policy outlining the feedback process to transferring hospitals on the status of the referral patient and the methods for quality review of the transfer process
- Documentation outlining the pediatric inter-facility transport system capabilities and resources
- A transfer policy that addresses pediatric inter-facility transfers

F. Quality Improvement Requirements

Review the criteria in Section 515.4020(h) and submit each of the following:

- A list of the members of the Multidisciplinary Pediatric Quality Improvement Committee and their respective positions/disciplines
- An institutional Quality Improvement Organizational Chart
- The PICU outcome analysis plan and pediatric monitoring activities that meet Section 515.4020(h)(2) (minutes from the past year that reflect the activities of the Multidisciplinary Pediatric Quality Improvement Committee will be requested at the time of site survey)

G. Equipment

Review the criteria in Section 515.4020(i) and submit the following:

Indicate in the Pediatric Plan whether each item is currently available. If equipment/supply items are not available, a plan for securing the items shall be identified (e.g., submission of a purchase order to assure that the item is on order); if the item is not on order, an equipment waiver request shall be submitted for each item. Requests for an equipment waiver shall include the criteria by which compliance is considered to be a hardship and shall demonstrate that there will be no reduction in the provision of medical care.

If assistance is needed in identifying specific vendors for any of the equipment/supply items noted in this application, please contact the Marketing Administrator, Group Purchasing Services, Metropolitan Chicago Healthcare Council at 312-906-6122.

III. PEDIATRIC INPATIENT CARE SERVICE REQUIREMENTS

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

A. Professional Staff

1. Pediatric Unit Physician Requirements

Review the criteria in Section 515.4020(j) and submit each of the following:

- A curriculum vitae and a copy of board certification for the pediatric inpatient director
- A policy or a scope of services for the pediatric unit that defines responsibility for medical management of care
- If pediatric hospitalists are used, documentation that defines their scope of service, including their responsibilities to other attending physicians
- A completed Credentials of Pediatric Unit Hospitalists form
- A policy that incorporates Section 515.4020(j)(1)(B)
- A policy or scope of services outlining the responsibility of the PICU medical director or his/her designee as being available on call and for consultation on all pediatric in-house patients who may require critical care

2. Pediatric Unit Nurse Manager Requirements

Review the criteria in Section 515.4020(j)(2) and submit each of the following:

- A curriculum vitae for the pediatric unit manager
- A job description or policy incorporating Section 515.4020(j)(2)(C)

3. Pediatric Unit Nursing Care Services

Review the criteria in Section 515.4020(j)(3) and submit each of the following:

- A policy/documentation outlining current nursing shift staffing plan/patterns
- A policy describing annual competency review requirements for the pediatric nursing staff (Section 515.4020(j)(3)(B))
- A policy or job description for the pediatric unit nurse that outlines the orientation process to the unit responsibilities and requirements of the Department that address Section 515.4020(j)(3)(A) through (D)
- A copy of a one-month nursing staffing schedule/calendar (schedule shall be from within the three-month time period previous to the application submission)
- A completed Credentials for the Pediatric Unit Nursing Staff form that includes the Pediatric Unit Nurse Manager

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

B. Policies, Procedures and Treatment Protocols

Review the criteria in Section 515.4020(k) and submit each of the following:

- A policy or scope of services that outlines the pediatric department services, ages of patients served and admission guidelines
- A staffing policy that addresses nursing shift staffing patterns based on patient acuity
- A safety and security policy for the patient in the unit
- An inter-facility transport policy that addresses safety and acuity
- An intra-facility transport policy that addresses safety and acuity
- A latex allergy policy
- A pediatric organ procurement/donation policy
- An isolation precautions policy that incorporates appropriate infection control measures
- A disaster/terrorism policy that addresses the specific medical and psychosocial needs of the pediatric population
- Protocols, order sets, pathways or guidelines for management of high- and low-frequency diagnoses
- A pediatric policy that addresses the resources available to meet the psychosocial needs of patients and family, and appropriate social work referral for the following indicators (see Pediatric Bill of Rights in Appendix N):
 - Child death
 - Child has been a victim of or witness to violence
 - Family needs assistance in obtaining resources to take the child home
 - Family needs a payment resource for their child's health needs
 - Family needs to be linked back to their primary health, social service or educational system
 - Family needs support services to adjust to their child's health condition or the increased demands related to changes in their child's health condition
 - Family needs additional education related to the child's care needs to care for the child at home
- A discharge planning policy or protocol that includes the following:
 1. Documentation of appropriate primary care/specialty follow-up provisions
 2. Mechanism to access a primary care resource for children who do not have a provider
 3. Discharge summary provision to appropriate medical care provider, parent/guardian, that includes:

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

- Information on the child's hospital course
 - Discharge instructions and education
 - Follow-up arrangements
4. Appropriate referral of patients to rehabilitation or specialty services for children who may have any of the following problems:
- Require the assistance of medical technology
 - Do not exhibit age-appropriate activity in cognitive, communication or motor skills, behavioral or social/emotional realms
 - Have additional medical or rehabilitation needs that may require specialized care, such as medication, hospice care, physical therapy, home health or speech/language services
 - Have a brain injury – mild, moderate or severe
 - Have a spinal cord injury
 - Exhibit seizure behavior during an acute care episode or have a history of seizure disorder and are not currently linked with specialty follow-up
 - Have a submersion injury, such as a near drowning
 - Have a burn (other than a superficial burn)
 - Have a pre-existing condition that experiences a change in health or functional status
 - Have a neurological, musculoskeletal or developmental disability
 - Have a sudden onset of behavioral change, for example, in cognition, language or affect

C. Quality Improvement Requirements

Review the criteria in Section 515.4020(l) and submit the following:

- The titles of the pediatric unit representatives that serve on the Multidisciplinary Pediatric Quality Improvement Committee

D. Equipment Requirements

Review the criteria in Section 515.4020(m) and submit the following:

Indicate in the Pediatric Plan whether each item is currently available. If equipment/supply items are not available, a plan for securing the items shall be identified (e.g., submission of a purchase order to assure that the item is on order); if the item is not on order, an equipmenta

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

waiver request shall be submitted for each item. Requests for an equipment waiver shall include the criteria by which compliance is considered to be a hardship and shall demonstrate that there will be no reduction in the provision of medical care.

If assistance is needed in identifying specific vendors for any of the equipment/supply items noted in this application, please contact the Marketing Administrator, Group Purchasing Services, Metropolitan Chicago Healthcare Council at 312-906-6122.

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Section 515.APPENDIX P Pediatric Critical Care Center (PCCC) Pediatric Equipment/Supplies/Medications Requirements

All of the following equipment/supplies/medications shall be immediately available within the PICU and pediatric unit:

AIRWAY

Cricothyrotomy capabilities (i.e., 10 g needle and 3 mm ET tube adapter or 14 g needle and 3.5 mm ET tube adapter)

Endotracheal tubes:

Uncuffed or Cuffed (sizes 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0, 8.5)

~~Cuffed (sizes 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0, 8.5)~~

Stylets for endotracheal tubes (pediatric and adult)

Laryngoscope handle (pediatric and adult); bulbs (small and large); extra batteries

Laryngoscope blades (Curved 1, 2, 3; Straight or Miller 00, 0, 1, 2, 3)

Local anesthetic (i.e., lidocaine gel, cetacaine spray)

Magill forceps (pediatric and adult)

Oral airways (sizes ~~000~~, 1, 2, 3, 4, 5)

Stylets (pediatric and adult)

Tongue blades

Tracheostomy collar

Tracheostomy tubes (sizes PED 3.0, 3.5, 4.0, 4.5, 5.0, 5.5 or ET may be substituted); trach ties; surgilube

BREATHING

Bag-valve-mask device, self-inflating infant/child and adult with O₂ reservoir and clear masks (neonatal through large adult sizes), and PEEP-~~and manometer~~

C-PAP

End-tidal PCO₂ monitor and/or pediatric CO₂ detector (disposable units may be substituted)

Flow meter

Masks, clear (neonatal, toddler, infant, child, medium adult)

Nasogastric tubes (sizes 6, 8, 10, 12, 14 Fr). NOTE: Cannot use feeding tubes as a substitute.

Nasopharyngeal airways (sizes ~~14+2~~, 16, 20, 24, 28, 30 Fr)

O₂ Tank

O₂ Blender

O₂ connectors and spare O₂ tubing

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Partial non-rebreather O₂ masks (neonatal, pediatric, adult)
PEEP valves
Pulse oximeter with child, infant and neonatal probes
Stethoscope
Suction supplies (bulb syringe, suction catheters sizes 6, 8, 10, 12, 14 Fr and Yankauer-tip catheter)
Tube thoracostomy tray and water seal drainage capacity with chest tubes (sizes 8-40 Fr)
Ventilator-respirator, pediatric

CIRCULATION

Blood collection tubes, culture bottles, arterial blood gas syringe
Butterfly needles (19, 21, 23, 25 g)
Cardiac resuscitation board
Catheter over needle IV access (sizes 16, 18, 20, 22, 24 g)
CVP and arterial monitors
Doppler device
ECG monitor-defibrillator/cardioverter with pediatric and adult sized paddles (and/or pads), with pediatric dosage settings and pediatric/adult pacing electrodes
Intraosseous needles or bone-marrow aspiration needles (one large and one small bore) or IO device (pediatric and adult sizes)
IV fluid/blood warmer
~~IV pumps~~
IV tubing and extension tubing
~~Minidrip with metered chamber~~
Infusion pumps, syringe pumps, or devices with microinfusion capability utilizing appropriate tubing and connectors
Needles (sizes 16, 18, 20, 22/23, 25; intracardiac needle 21 g, 1½ inch; filter needle)
Non-invasive blood pressure device (neonatal through adult cuffs)
Rapid infusion pumps
Sphygmomanometer with cuffs (newborn, infant, child, small adult, adult)
Stopcocks
Syringes (TB, insulin U100, 1 ml-20 ml and catheter tip)
T-connectors
Tourniquets, arm boards, tape, alcohol wipes, skin prep, razor
Vascular access supplies using the Seldinger technique (3-8 Fr)
Warming devices, age appropriate

MEDICATIONS

Activated Charcoal

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Adenosine
Albumin 5% and 25%
Amiodarone
AquaMEPHYTON
Atropine
Bacteriostatic Water, 30 ml
Beta-agonist for inhalation
Benzodiazepines, e.g., Lorazepam, Midazolam, Diazepam
Calcium Chloride 10%
Calcium Gluconate 10%
Dexamethasone
Dextrose 10%, 25% and 50%
Diazepam
Digitalis antibody
Digoxin
Diphenhydramine
Dobutamine
Dopamine
Dosing device – length or weight based system for dosing and equipment/supplies
Epinephrine (1:1000 and 1:10,000)
Factor VIII, IX concentrate (pharmacy or blood bank)
Flumazenil
Furosemide
Glucagon
Insulin
IV solutions (D5W and 0.9 NS)
IV solutions, standard crystalloid (D10W, D5/0.2 NS, D5/0.45 NS and 0.9 NS)
Kayexalate
Ketamine
Lidocaine 1% and 2%
List of resuscitation drug dosages at patient bedside (based on child's weight)
Lorazepam (may be located in unit refrigerator)
Magnesium sulfate 10% and 50%
Mannitol 25%
Methylene blue
N-acetyl cysteine
Naloxone
Narcotics
Norepinephrine

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Neuromuscular blocking agents (i.e., succinylcholine, pancuronium, vecuronium) (NOTE:

May be refrigerated)

Oral rehydrating solution

Phenobarbital

Phenytoin and/or fosphenytoin

Potassium

Procainamide

Propranolol

Prostaglandin E1

Sodium Bicarbonate, 8.4% and 4.2%

Sodium Chloride 10 ml (multiple)

Steroids – parenteral, e.g., Dexamethasone, Hydrocortisone, Methylprednisolone

Thiopental

Topical anesthetic agent

Vasopressin (DDAVP)

Whole bowel irrigation solution

MISCELLANEOUS

Lumbar puncture tray, including a selection of needles (size 18-22 g, 1½-3 inch needle)

Feeding tubes (8-14)

Foley catheters (sizes 6, 8, 10, 12 Fr)

Hypothermia thermometer with rectal probe (28°-42° C)

Otoscope/ophthalmoscope

Weighing scales (in kilograms only) for infants and children

(Source: Amended at 40 Ill. Reg. 8274, effective June 3, 2016)

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: Universities Retirement
- 2) Code Citation: 80 Ill. Adm. Code 1600
- 3)

<u>Section Numbers:</u>	<u>Adopted Actions:</u>
1600.202	Amendment
1600.203	Amendment
1600.270	Amendment
1600.275	New Section
1600.510	New Section
- 4) Statutory Authority: 40 ILCS 5/15-177
- 5) Effective Date of Rules: June 3, 2016
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) The adopted rules including all material incorporated by reference, are on file at the SURS office and is available for public inspection. Yes
- 9) Notices of Proposed published in the *Illinois Register*: 40 Ill. Reg. 187; January 4, 2016
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between Proposal and Final Version: Various grammatical changes have been made since these rules was published on first notice. SURS added a 90 day deadline for employers to pay the final 6% bill before delinquent amount is certified to the Comptroller.
- 12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace any emergency rule currently in effect? No
- 14) Are there any rulemakings pending on this Part? No

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

- 15) Summary and Purpose of Rulemaking: Section 1600.275 of the Amendment seeks to implement the addition of Section 15-139.5 of the Illinois Pension Code [40 ILCS 5/15-139.5], initially enacted under PA 97-968, effective August 16, 2012, and subsequently amended under PA 98-596, effective November 19, 2013, and PA 98-1144, effective June 1, 2015. After the enactment of PA 97-968, SURS held various working groups with employers to create efficient reporting and monitoring mechanisms for employed annuitants, an unprecedented endeavor in the retirement system's history. During these efforts, SURS was advised of the likelihood of legislation that would substantially change the substance of Section 15-139.5. Therefore, to avoid waste of system resources, SURS decided to delay rulemaking pending these changes. After the enactment of PA 98-596, SURS continued to work with employers to build online database systems that efficiently collected and disseminated annuitant status reporting for purposes of Section 15-139.5. PA 98-1144 amended Section 15-139.5 further to exclude annuitants receiving \$10,000 or less annually from the scope of "affected annuitant" status. Soon after the enactment of PA 98-1144, the SURS Board tentatively approved the substance of the Amendments in June 2015, and finally approved their filing for First Notice in September 2015. In the absence of rulemaking, SURS has enforced Section 15-139.5 through the terms of that provision along with the general authorizations under the Illinois Pension Code regarding employer reporting [40 ILCS 5/15-168] and the carrying of reasonable activities which are deemed necessary to accomplish the purposes of the System [40 ILCS 5/15-177]. No employer appeals concerning Section 15-139.5 have been permitted in the absence of rulemaking. Sections 1600.202 and 1600.203 of the Amendment make conforming amendments necessary to implement Section 1600.275 while rearranging some provisions for easier reading.

Section 1600.510 of the Amendment provides a procedure for employer appeals of SURS staff decisions. Several provisions of the Illinois Pension Code require SURS to make decisions that affect employers in the administration of the system, including, but not limited to, informational reporting, determinations of pensionable earnings, determinations of service credit (contract dates, leaves of absence, part-time status, etc.), and employer contributions from trust, federal, or other funds. Under the 6% Rule [40 ILCS 5/15-156(g)], an employer may request a recalculation of the 6% bill while claiming certain exceptions. There is no statutory requirement that employers be provided a hearing to contest SURS staff decisions. Because staff decisions on employer matters are currently not appealable to the Executive Committee, the only recourse of an employer would be to seek Administrative Review in circuit court.

To reduce the expense and delay of seeking resolution of employer matters in court, SURS proposes to permit internal reviews of employer matters. Because employers, as

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

governmental bodies, are not subject to Due Process protections, SURS proposed a document review process, rather than a live-hearing process in order to conserve system resources and minimize administrative delays. Section 15-188 of the Illinois Pension Code [40 ILCS 5/15-188] provides that all final administrative decisions (including employer-related decisions) of the SURS Board are subject to appeal under the Administrative Review Law. Section 1600.270 of the Amendment makes a conforming amendment implementing Section 1600.510 in the 6% Rule process.

- 16) Information and questions regarding these adopted rules shall be directed to:

Albert Lee, Associate General Counsel
State Universities Retirement System
1901 Fox Drive
Champaign IL 61820

217/378-8861 or 217/378-8813

The full text of the Adopted Amendments begins on the next page:

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

TITLE 80: PUBLIC OFFICIALS AND EMPLOYEES
SUBTITLE D: RETIREMENT SYSTEMS
CHAPTER II: STATE UNIVERSITIES RETIREMENT SYSTEMPART 1600
UNIVERSITIES RETIREMENT

SUBPART A: GENERAL

Section

1600.100	Definitions
1600.110	Freedom of Information Act
1600.120	Open Meetings Act
1600.130	Procurement
1600.140	Compliance with the Internal Revenue Code
1600.145	Compliance with Final 415 Treasury Regulations
1600.150	Group Trust Provisions

SUBPART B: CONTRIBUTIONS AND SERVICE CREDIT

Section

1600.202	Return to Employment
1600.203	Independent Contractors
1600.205	Earnings Subject to Withholding and Crediting
1600.210	Crediting Interest on Participant Contributions and Other Reserves
1600.220	Election to Make Contributions Covering Leave of Absence at Less Than 50% Pay
1600.230	Election to Pay Contributions Based upon Employment that Preceded Certification as a Participant
1600.240	Election to Make Contributions Covering Periods of Military Leave Protected under USERRA
1600.241	Survivor Benefits for Members Who Die While on Military Leave Protected under USERRA
1600.250	Sick Leave Accrual Schedule
1600.260	Part-time/Concurrent Service Adjustment
1600.270	Employer Contributions for Benefit Increases Resulting from Earnings Increases Exceeding 6%
1600.275	Employer Contributions for Employing Affected Annuitants

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

SUBPART C: SURVIVORS AND BENEFICIARIES

Section

- 1600.300 Effective Beneficiary Designations
- 1600.305 Full-Time Student Survivors Insurance Beneficiaries
- 1600.310 Dependency of Beneficiaries
- | 1600.320 Disability Claims ~~Procedure~~[Procedures](#) (Renumbered)

SUBPART D: BENEFIT CALCULATION AND PAYMENT

Section

- 1600.400 Determination of Final Rate of Earnings Period
- 1600.410 Twenty Percent Limitation on Final Rate of Earnings Increases
- 1600.420 Making Preliminary Estimated Payments
- 1600.430 Excess Benefit Arrangement
- 1600.431 Indirect Payments to Minors and Legally Disabled Persons
- 1600.432 Indirect Payments to Child Survivors Through the Surviving Spouse
- 1600.440 Voluntary Deductions from Annuity Payments
- 1600.450 Overpayment Recovery

SUBPART E: DISABILITY CLAIMS AND ADMINISTRATIVE REVIEW

Section

- 1600.500 Administrative Staff Determinations and Rules for Appeal – Nature and Requirements of Formal Hearings
- | [1600.510 Employer-Related Determinations and Rules for Appeal](#)
- 1600.550 Disability Claims Procedure

SUBPART F: QUALIFIED ILLINOIS DOMESTIC RELATIONS ORDERS

Section

- 1600.600 Definitions
- 1600.605 Requirements for a Valid Qualified Illinois Domestic Relations Order
- 1600.610 Invalid Orders
- 1600.615 Filing a QILDRO with the System
- 1600.620 Modified QILDROs
- 1600.625 Benefits Affected by a QILDRO
- 1600.630 Effect of a Valid QILDRO
- 1600.635 QILDROs Against Persons Who Became Members Prior to July 1, 1999

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

1600.640	Alternate Payee's Address
1600.645	Electing Form of Payment
1600.650	Automatic Annual Increases
1600.655	Expiration of a QILDRO
1600.660	Reciprocal Systems QILDRO Policy Statement
1600.665	Providing Benefit Information for Divorce Purposes

SUBPART G: BOARD TRUSTEE ELECTION

Section

1600.700	Nomination of Candidates
1600.705	Election Date/Election Day – Defined
1600.710	Petitions
1600.715	Eligible Voters
1600.720	Election Materials
1600.725	Casting Votes
1600.730	Return of Ballots and Ballot Counting Process
1600.735	Certification of Ballot Counting
1600.740	Challenges to Election Results
1600.745	Candidate Informational Communication
1600.750	Filling a Vacancy in the Term of an Elected Trustee

AUTHORITY: Implementing and authorized by Section 15-177 of the Illinois Pension Code [40 ILCS 5/15-177].

SOURCE: Amended September 2, 1977; amended at 2 Ill. Reg. 31, p.53, effective July 30, 1978; amended at 7 Ill. Reg. 8139, effective June 29, 1983; codified at 8 Ill. Reg. 19683; amended at 11 Ill. Reg. 15656, effective September 9, 1987; amended at 13 Ill. Reg. 18939, effective November 21, 1989; amended at 14 Ill. Reg. 6789, effective April 20, 1990; emergency amendment at 21 Ill. Reg. 4864, effective March 26, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 6095, effective May 2, 1997; amended at 21 Ill. Reg. 11962, effective August 13, 1997; amended at 21 Ill. Reg. 12653, effective August 28, 1997; amended at 22 Ill. Reg. 4116, effective February 9, 1998; amended at 23 Ill. Reg. 13667, effective November 1, 1999; amended at 25 Ill. Reg. 10206, effective July 30, 2001; amended at 28 Ill. Reg. 2292, effective January 23, 2004; expedited correction at 28 Ill. Reg. 7575, effective January 23, 2004; amended at 29 Ill. Reg. 2729, effective March 1, 2005; amended at 29 Ill. Reg. 11819, effective July 12, 2005; amended at 29 Ill. Reg. 14060, effective September 1, 2005; amended at 29 Ill. Reg. 14351, effective September 6, 2005; amended at 30 Ill. Reg. 6170, effective March 21, 2006; amended at 30 Ill. Reg. 7778, effective April 5, 2006; amended at 30 Ill. Reg. 9911, effective

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

May 9, 2006; amended at 30 Ill. Reg. 17509, effective October 19, 2006; amended at 31 Ill. Reg. 4267, effective February 22, 2007; amended at 31 Ill. Reg. 4927, effective March 12, 2007; recodified at 31 Ill. Reg. 10194; amended at 32 Ill. Reg. 16515, effective September 25, 2008; emergency amendment at 33 Ill. Reg. 6525, effective April 27, 2009, for a maximum of 150 days; emergency expired September 23, 2009; amended at 33 Ill. Reg. 10757, effective July 1, 2009; amended at 33 Ill. Reg. 16755, effective November 23, 2009; amended at 34 Ill. Reg. 9523, effective June 25, 2010; amended at 35 Ill. Reg. 10952, effective June 22, 2011; amended at 36 Ill. Reg. 3938, effective February 22, 2012; amended at 37 Ill. Reg. 1309, effective January 15, 2013; amended at 37 Ill. Reg. 3866, effective March 15, 2013; amended at 37 Ill. Reg. 10698, effective June 26, 2013; amended at 37 Ill. Reg. 15517, effective September 12, 2013; amended at 38 Ill. Reg. 5659, effective February 11, 2014; emergency amendment at 38 Ill. Reg. 11376, effective May 9, 2014, for a maximum of 150 days; amended at 38 Ill. Reg. 16375, effective July 17, 2014; amended at 38 Ill. Reg. 17457, effective July 30, 2014; amended at 39 Ill. Reg. 8317, effective June 1, 2015; amended at 40 Ill. Reg. 8437, effective June 3, 2016.

SUBPART B: CONTRIBUTIONS AND SERVICE CREDIT

Section 1600.202 Return to Employment

Purpose. This Section defines terms used in Section 15-139 of the Code [40 ILCS 5/15-139] concerning annuitants who return to employment.

- a) ~~For the purposes of Section 15-139 of the Code:~~ "Annuitant", for purposes of Section 15-139 of the Code, means a person who is receiving a retirement annuity or who has received a lump-sum retirement benefit from SURS, or, if the retirement annuity payment or payments have not yet been paid due to SURS processing, a person whose retirement annuity payment period has commenced. However:
- 1A) a person who has received a lump-sum retirement benefit is not an annuitant for purposes of Section 15-139(b) of the Code; and
- 2B) a person who is receiving or who has received retirement benefits under the Self-Managed Plan is not an annuitant.
- b2) "Compensation", for purposes of Section 15-139(b) of the Code, means any remuneration paid by an employer that is reportable by the employer as "wages, tips, or other compensation" on Internal Revenue Service Form W-2, unless the remuneration is received for serving as a member of the Illinois Educational

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

Labor Relations Board. ~~"Retirement annuity payment period" means the annuity payment period beginning on the date specified by the participant submitting a written application, which date shall not be prior to termination of employment or more than one year before the application is received by the Board; however, if the participant is not an employee of an employer participating in this System or in a participating system as defined in Article 20 of the Code on April 1 of the calendar year next following the calendar year in which the participant attains age 70½, the annuity payment period shall begin on that date regardless of whether an application has been filed [40 ILCS 5/15-135(b)].~~

3) ~~"Employee" means an employee as defined by Section 15-107 of the Code.~~

c4) "Employment" ~~for purposes of Section 15-139(a) of the Code,~~ means a relationship with any "employer" ~~(as defined by Section 15-106 of the Code)~~ that would qualify the annuitant as an employee under common law, except for service as a member of the Illinois Educational Labor Relations Board.

d5) "Highest Annual Earnings"

1) ~~for purposes of Section 15-139(b) of the Code, means the greater of the following: "Compensation" means any remuneration paid by an employer that is reportable by the employer as "wages, tips, or other compensation" on Internal Revenue Service Form W-2, unless the remuneration is received for serving as a member of the Illinois Educational Labor Relations Board.~~

A) The highest aggregate earnings (as defined under Section 15-111 of the Code) paid in any 12 calendar month period, including and immediately preceding the month of termination, or any prior 12 calendar month period ending with the same calendar month. The 12 calendar month period shall begin on the first day of a month and end on the last day of a month, even if earnings were paid for only a portion of the month. For example, if an annuitant's final termination from employment occurred on May 15, 2014, the relevant period would begin on June 1 and end on May 31.

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

- B) The highest aggregate earnings (as defined under Section 15-111 of the Code) paid in any academic year (as defined under Section 15-126.1 of the Code) prior to retirement.
- 2) In the case of an annuitant receiving reciprocal benefits under Article 20 of the Code, "highest annual earnings" shall include earnings credits accrued with any participating system, as defined by Section 20-108 of the Code. The highest annual earnings shall not include any remuneration that is assumed as earnings for any purpose under Article 15 of the Code.
- eb) "Reemployed", for purposes of Section 15-139(c) of the Code, For purposes of Section 15-139(e) of the Code only, "reemployed" means the annuitant has established a relationship with any employer that would otherwise qualify the annuitant as an employee under Section 15-107 of the Code, not withstanding Section 15-107(a)(2) of the Code under applicable law; except, the employment must be on a permanent and continuous basis or in a position in which the annuitant is expected to serve for at least 9 months.
- fe) It shall be the duty of the employer and employee to notify SURS in a timely manner of any employment that could result in the cancellation or reduction of the retirement annuity under Section 15-139 of the Code.

(Source: Amended at 40 Ill. Reg. 8437, effective June 3, 2016)

Section 1600.203 Independent Contractors

Any individual claiming to be an independent contractor exempt from participation in SURS as an employee under Section 15-107 of the Code or from the provision governing annuitants who return to employment or receive compensation from any employer as set forth in ~~Sections~~Section 15-139, 15-139.1 and 15-139.5 of the Code must file Form SS-8 (Determination of Employee Work Status for Purposes of Federal Employment Taxes and Income Tax Withholding) with the IRS seeking confirmation of independent contractor status. An IRS Form SS-8 independent contractor determination must be filed with SURS before an individual can be considered to be exempt from SURS participation as an employee or reemployed employee. The individual shall file with SURS a copy of the IRS formal determination or information letter received in response to the Form SS-8, which may then be used in further consideration of the individual's independent contractor status.

(Source: Amended at 40 Ill. Reg. 8437, effective June 3, 2016)

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

Section 1600.270 Employer Contributions for Benefit Increases Resulting from Earnings Increases Exceeding 6%

Purpose. This Section implements Section 15-155(g), (h), (i), (j) and (k) of the Code. This Section shall not apply to benefits from other retirement systems or pension funds payable under the Retirement Systems Reciprocal Act (Article 20 of the Code).

- a) Calculation of the Employer Cost. This calculation is made when a monthly benefit is calculated from the participant's final rate of earnings (FRE). The "present value of the increase in benefits" described in Section 15-155(g), called the "Employer Cost", will be calculated as follows:
 - 1) The earnings, as defined in Section 15-111 of the Code, for every academic year in the FRE period, as defined in Section 15-112 of the Code, are adjusted on a full-time equivalent basis.
 - A) 48 Month FREs and Partial Academic Years. When the final rate of earnings for a participant is the average annual earnings during the 48 consecutive calendar month period ending with the last day of final termination of employment, any partial academic year at the beginning of the final rate of earnings period will be disregarded.
 - B) Full-Time Equivalent (FTE) Basis
 - i) SURS will adjust earnings from an employer in a manner consistent with the percent time employed reported by the employer.
 - ii) The FTE earnings of an academic year shall equal the total earnings in the academic year divided by the average percent time of employment.
 - C) Earnings credited during periods of service purchased under Sections 15-113.1 through 15-113.7 of the Code shall be determined on a FTE basis.

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

- D) For the purpose of Section 15-155(g), earnings do not include payments made under a collective bargaining agreement for unused sick leave or payments made for unused vacation.
- 2) The FTE earnings of each academic year in the FRE period are limited to 106% of the previous academic year's FTE earnings to yield the "Capped FTE Earnings" of each academic year.
 - 3) The Capped FTE Earnings of each academic year are multiplied by their respective average percent times of employment to yield the "Capped Earnings" for each academic year. The Capped Earnings shall be used to determine the "Capped FRE".
 - 4) The "Benefit Increase" shall equal the difference between the FRE and the Capped FRE, multiplied by the number of years of service, and further multiplied by 2.2%.
 - 5) The Employer Cost equals the actuarial present value of the Benefit Increase. This actuarial present value calculation will be made by using actuarial tables provided by SURS' actuary from time to time. The actuarial table used will correspond with the type of monthly benefit that is provided to the participant. A single-life annuity table will be used when a traditional benefit package participant has no eligible survivor at the time of retirement. If the participant had employment with more than one employer during the final rate of earnings period, the Employer Cost is calculated for each employer using only the earnings with that employer. However, no Employer Cost will be assessed among multiple, concurrent employers if the increase in total earnings for the concurrent academic year in the FRE period does not exceed 6% over the total earnings of the previous academic year.
- b) Employer Billing
- 1) Billing. *Whenever it determines that a payment is or may be required under Section 15-155(g), SURS will calculate the amount of the payment and bill the employer for the amount. The bill will specify the calculations used to determine the amount due.*

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

- 2) Request for Recalculation. *If the employer disputes the amount of the bill, it may, within 30 days after receipt of the bill, apply to SURS in writing for a recalculation. The application must specify the grounds of the dispute and, if the employer asserts the calculation is subject to Section 15-155(h) or (i), must include an affidavit setting forth and attesting to all facts within the employer's knowledge that are pertinent to the applicability of Section 15-155(h) or (i). Upon receiving a timely application for recalculation, SURS will review the application and, if appropriate, recalculate the amount due.*
 - 3) Payment. *The employer contributions required under Section 15-155(g) may be paid in the form of a lump sum within 90 days after the receipt of the bill. If the employer contributions are not paid within 90 days after receipt of the bill, then interest will be charged at a rate equal to SURS' prescribed rate of interest compounded annually from the 91st day after the receipt of the bill. Payments must be concluded within 3 years after the employer's receipt of the bill. [40 ILCS 5/15-155(g)]*
 - 4) Appeals of the Recalculation. The employer may appeal a recalculation pursuant to Section 1600.510.
- c) Exclusions for Earnings Increases Paid on or after June 1, 2005, but before July 1, 2011, under Section 15-155(h)
- 1) Grandfathering. *When assessing payment for any amount due under Section 15-155(g), SURS will exclude earnings increases paid to participants required under contracts or collective bargaining agreements entered into, amended, or renewed before June 1, 2005. [40 ILCS 5/15-155(h)] Such contracts are "grandfathered". For the purposes of Section 15-155(h):*
 - A) A contract or collective bargaining agreement is "entered into, amended or renewed" on the earliest of the following:
 - i) the date the governing body of the employer voted to accept the contract or collective bargaining agreement;
 - ii) the date the contract or collective bargaining agreement was executed in final form by the parties; or

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

- iii) the date the parties to the contract or collective bargaining agreement reached a tentative agreement regarding the terms of the contract or collective bargaining agreement, provided that the tentative agreement is subsequently approved by the governing body of the employer on or after June 1, 2005, without any changes to the terms that have the effects described under subsection (c)(1)(B)(i) or (ii).
- B) A contract or collective bargaining agreement will not exclude earnings increases paid under the contract or agreement if the contract or agreement is amended or renegotiated after June 1, 2005 to have the effect of:
- i) increasing the earnings usable for the FRE (except when the increase is the result of a salary reopener provision that was part of the contract or collective bargaining agreement prior to June 1, 2005); or
 - ii) extending the expiration date of the contract (in which case the earnings will be excluded only through the original expiration date of the contract).
- C) Miscellaneous
- i) A contract exception made by an employer for an individual shall disqualify that individual's earnings increases from grandfathering but shall not invalidate the grandfathering for any other persons.
 - ii) A memorandum of understanding between the employer and the collective bargaining unit to increase the credit hours available shall not invalidate the contract, but any earnings increases because of the increased credit hours shall not be excluded from the calculation under subsection (a), unless Section 15-155(h) or (i) applies.
 - iii) When a member has given notice to the employer of intent to retire pursuant to the terms of a grandfathered contract or

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

collective bargaining agreement, earnings provided under the contract or collective bargaining agreement shall be excluded so long as the earnings are provided to the member within four years after the expiration date of the contract or collective bargaining agreement.

- iv) Notwithstanding the other provisions of this subsection (c)(1), earnings paid under a grandfathered contract on or after July 1, 2011 shall not be excluded from earnings under subsection (a).
- 2) *Earnings 10 Years Prior to Retirement Eligibility. When assessing payment for any amount due under Section 15-155(g), SURS will exclude earnings increases paid to a participant at a time when the participant is 10 or more years from retirement eligibility under Section 15-135 of the Code. [40 ILCS 5/15-155(h)] Earnings increases paid in academic years preceding and including the academic year during which the participant was 10 years from attaining earliest retirement eligibility shall be excluded.*
- 3) **Overloads and Overtime**
- A) *Earnings increases resulting from overload work, including a contract for summer teaching, or overtime when the employer has certified to SURS, and SURS has approved the certification, that:*
- i) *in the case of overloads:*
- *the overload work is for the sole purpose of academic instruction in excess of the standard number of instruction hours for a full-time employee occurring during the academic year that the overload is paid; and*
 - *the earnings increases are equal to or less than the rate of pay for academic instruction computed using the participant's current salary rate and work schedule; and*
- ii) *in the case of overtime, the overtime was necessary for the educational mission. [40 ILCS 5/15-155(h)]*

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

- B) The certification shall be in the form adopted by SURS and be signed by a duly authorized representative of the employer. The certification must be accompanied by supporting documentation as required by the form.
 - C) The standard number of instruction hours for a full-time employee shall be consistent with employer policy in force for the academic year in which the overload earnings were earned.
- 4) Promotions
- A) *When assessing payment for any amount due under Section 15-155(g), SURS will exclude earnings increases resulting from:*
 - i) *a promotion for which the employee moves from one classification to a higher classification under the State Universities Civil Service System;*
 - ii) *a promotion in academic rank for a tenured or tenure-track faculty position; or*
 - iii) *a promotion that the Illinois Community College Board has recommended in accordance with Section 15-155(k).*
 - B) *The earnings increases referenced in subsection (c)(4)(A) shall be excluded only if the promotion is to a position that has existed and been filled by a member for no less than one complete academic year and the earnings increase as a result of the promotion is an increase that results in an amount no greater than the average salary paid for other similar positions. [40 ILCS 5/15-155(h)]*
 - C) The employer shall certify that the promotion is to a position that has existed and been filled by a member for no less than one complete academic year and the earnings increase as a result of the promotion is an increase that results in an amount no greater than the average salary paid for other similar positions. The certification shall be in the form adopted by SURS and be signed by a duly authorized representative of the employer. The

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

certification must be accompanied by supporting documentation as required by the form.

- D) The phrase "an amount no greater than the average salary paid for other similar positions" shall mean the midpoint of the salary range for the position or similar positions as most recently approved by the Merit Board of the State Universities Civil Service System or the current average salary paid for tenured or tenure-track faculty positions in the same department, as the case may be.
- d) Exclusions for earnings increases described in Section 15-155(h) paid on or after July 1, 2011, but before July 1, 2014, under a contract or collective bargaining agreement entered into, amended, or renewed on or after June 1, 2005, but before July 1, 2011, under Section 15-155(i). For the purpose of Section 15-155(i), a contract or collective bargaining agreement is "entered into, amended or renewed" on the earliest of the following:
- 1) the date the governing body of the employer voted to accept the contract or collective bargaining agreement;
 - 2) the date the contract or collective bargaining agreement was executed in final form by the parties; or
 - 3) the date the parties to the contract or collective bargaining agreement reached a tentative agreement regarding the terms of the contract or collective bargaining agreement, provided that the tentative agreement is subsequently approved by the governing body of the employer on or after July 1, 2011 without any changes to the terms that have the effect of extending the expiration date.
- e) The exclusions under subsections (c) and (d) shall not apply to earnings increases paid after June 30, 2014.

(Source: Amended at 40 Ill. Reg. 8437, effective June 3, 2016)

Section 1600.275 Employer Contributions for Employing Affected Annuitants

- a) Purpose and Applicability

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

- 1) This Section implements Section 15-139.5 of the Code concerning employer reporting and contribution requirements for employing or reemploying annuitants and affected annuitants, effective for academic years beginning on or after August 1, 2013.
- 2) Effective November 19, 2013, this Section shall not apply to an annuitant if the employer of that annuitant provides documentation to the System that:
 - A) the annuitant is employed in a status appointment position, as that term is defined in 80 Ill. Adm. Code 250.80; and
 - B) due to obligations contained under the State Universities Civil Service Act [110 ILCS 70], the employer does not have the ability to limit the earnings or duration of employment for the annuitant while employed in the status appointment position. [40 ILCS 5/15-139.5(j)]
- b) Definitions. For purposes of Section 15-139.5 of the Code and this Section, the following terms shall have the meanings ascribed in this subsection (b).
 - 1) "Academic Year" means the 12-month period beginning on September 1. [40 ILCS 5/15-139.5(a)]
 - 2) "Affected Annuitant"
 - A) Means an annuitant on the first day of the academic year following the academic year in which the annuitant first met the following conditions:
 - i) While receiving a retirement annuity under Article 15 of the Code, the annuitant was employed on or after August 1, 2013 by one or more employers under that Article and received or became entitled to receive during an academic year compensation for that employment in excess of 40% of his or her highest annual earnings prior to retirement; except that compensation paid from federal, corporate,

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

foundation, or trust funds or grants of State funds that identify the principal investigator by name is excluded.

ii) For the academic year containing June 1, 2015 and academic years thereafter, the annuitant received an annualized retirement annuity under Article 15 of at least \$10,000. [40 ILCS 5/15-139.5(b)] The annualized retirement annuity of at least \$10,000 shall be a gross monthly retirement annuity of at least \$833.33 per month.

B) A person who becomes an affected annuitant remains an affected annuitant, except for any period during which the person returns to active service and does not receive a retirement annuity from the System. [40 ILCS 5/15-139.5(b)]

3) "Annuitant" means a person who is receiving a retirement annuity or, if the retirement annuity payment or payments have not yet been paid due to SURS processing, a person whose retirement annuity payment period has commenced. A person is not an annuitant if he or she:

A) has received a lump-sum retirement benefit under the Portable Benefit Package; or

B) is receiving or has received retirement benefits under the Self-Managed Plan.

4) "Catastrophic Incident" means an occurrence of widespread or severe damage or loss of property resulting from any manmade or natural cause, including, but not limited to, fire (including arson), flood, earthquake, wind, storm, explosion or extended periods of severe inclement weather.

5) "Compensation" means any remuneration paid by an employer that is reportable to the Internal Revenue Service by the employer as "wages, tips, or other compensation" on IRS Form W-2.

6) "Critical Operations" means teaching services, medical services, student welfare services, and any other services that are critical to the mission of the employer. [40 ILCS 5/15-139.5(i)]

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

- 7) "Disaster" means an event that results in the Governor declaring that a disaster exists pursuant to Section 7 of the Illinois Emergency Management Agency Act [20 ILCS 3305/7] or an event that results in a municipality to declare that a state of emergency exists pursuant to 65 ILCS 5/11-1-6.
 - 8) "Employed or Reemployed" means the employer and annuitant have entered into an employer-employee relationship under common law and the annuitant is not an independent contractor. For the purposes of this Section, an annuitant whose employment by an employer extends over more than one academic year shall be deemed to be reemployed by that employer in each of those academic years.[40 ILCS 5/15-139.5(a)]
 - 9) "Highest Annual Earnings" shall have the meaning ascribed in Section 1600.202(d).
 - 10) "Retirement Annuity" means an annuity payable under Section 15-136, 15-136.1, 15-136.3 or 15-136.4 of the Code, excluding any survivor annuitant portion of a joint and survivor annuity.
- c) Initial Notification for Employed Annuitants. Within 60 days after the date of employing or reemploying an annuitant, the employer shall submit notification to the System of the following items:
- 1) A summary of the contract of employment or specify the rate of compensation and the anticipated length of employment of that annuitant [40 ILCS 5/15-139.5(a)]. If an employer enters into a new contract with an annuitant during the same academic year of employment or reemployment, the employer shall submit a new summary or rate of compensation and anticipated length of employment within 60 days after the effective date of the contract. The employer shall provide a copy of the contract upon SURS' request.
 - 2) A certification of whether the annuitant will be compensated from federal, corporate, foundation, or trust funds or grants of State funds that identify the principal investigator by name [40 ILCS 5/15-139.5(a)].
 - 3) Critical Operations

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

- A) A certification of whether the annuitant has become an affected annuitant and:
- i) if the annuitant is an affected annuitant, whether the annuitant was employed in order to continue critical operations in the event of either an employee's unforeseen illness, accident, or death or a catastrophic incident or disaster; or [40 ILCS 5/15-139.5(i)]
 - ii) if the annuitant is an affected annuitant, whether the employer has certified the annuitant as a participating employee under Section 15-139(c) of the Code.
- B) If the employment is for critical operations, the notice in this subsection (c) shall be submitted within 5 business days after employing or reemploying the annuitant.
- d) Annual Certification of Employed Annuitants. For each employed annuitant, an employer shall submit to the System the following information no later than 30 days following the conclusion of the academic year:
- 1) The amount of compensation paid to the annuitant for employment in the academic year; and
 - 2) The amount of compensation that comes from federal, corporate, foundation, or trust funds or grants of State funds that identify the principal investigator by name that has been paid to the annuitant in the academic year. [40 ILCS 5/15-139.5(a)]
- e) Affected Annuitants
- 1) It is the obligation of the employer to determine whether an annuitant is an affected annuitant before employing the annuitant. For that purpose, the employer may require the annuitant to disclose and document his or her relevant prior employment and earnings history. Failure of the employer to make this determination correctly and in a timely manner or to include this determination with the notification required under

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

subsection (d) does not excuse the employer from making the contribution required under subsection (g).

- 2) The System may assist the employer in determining whether a person is an affected annuitant. The System shall inform the employer if it discovers that the employer's determination is inconsistent with the employment and earnings information in the System's records. [40 ILCS 5/15-139.5(c)]

f) Annuitant and Employer Information Requests. Upon written request, the System will provide an annuitant or employer with the following information concerning the annuitant:

- 1) The annuitant's status as an annuitant or participating employee;
- 2) Whether an employer has determined and reported to the System that the annuitant is an affected annuitant;
- 3) The annuitant's highest annual earnings;
- 4) The compensation paid for the annuitant's post-retirement employment in each academic year as reported by employers;
- 5) Whether any of the annuitant's post-retirement employment or compensation has been certified to the System as being paid from federal, corporate, foundation, or trust funds or grants of State funds that identify the principal investigator by name. [40 ILCS 5/15-139.5(d)]

g) Payment of Employer Contributions

- 1) Certification of Contribution. If an employer employs or reemploys an affected annuitant in an academic year, and no exception applies, the System shall notify the employer and certify the amount of the contribution, which shall be equal to 12 times the amount of the gross monthly retirement annuity payable to the annuitant for the month in which the first paid day of employment in that academic year occurs, after any reduction in that annuity that may be imposed under Section 15-139(b) of the Code.

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

- 2) Multiple Employers. *If an affected annuitant is employed by more than one employer in an academic year, the employer contribution required under this Section shall be divided among those employers in proportion to their respective portions of the total compensation paid to the affected annuitant for that employment during that academic year.*
- 3) Double Contribution Penalty
- A) *If the System determines that an employer, without reasonable justification, has failed to make the determination of affected annuitant status correctly and in a timely manner, or has failed to notify the System or to correctly document or certify to the System any of the information required by this Section, and that failure results in a delayed determination by the System that a contribution is payable under this Section, then the amount of that employer's contribution otherwise determined under this Section shall be doubled.*
- B) *The System shall deem a failure to correctly determine the annuitant's status to be justified if the employer establishes to the System's satisfaction that the employer, after due diligence, made an erroneous determination that the annuitant was not an affected annuitant due to reasonable reliance on false or misleading information provided by the annuitant or another employer, or an error in the annuitant's official employment or earnings records.*
[40 ILCS 5/15-139.5(e)]
- 4) Payment Deadline and Interest. *The employer may pay the required contribution without interest at any time within one year after receipt of the certification. If the employer fails to pay within that year, then interest shall be charged at a rate equal to the System's prescribed rate of interest, compounded annually from the 366th day after receipt of the certification from the System. Payment must be concluded within 2 years after receipt of the certification by the employer. If the employer fails to make complete payment, including applicable interest, within 2 years, then the System may, after giving notice to the employer, certify the delinquent amount to the State Comptroller, and the Comptroller shall thereupon deduct the certified delinquent amount from State funds payable to the employer and pay them instead to the System.* [40 ILCS 5/15-139.5(f)]

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

The delinquent amount shall be certified to the Comptroller if the employer does not pay the delinquent amount within 90 days after the date on which SURS sent the notice of the delinquency to the employer.

- 5) Reparticipating Annuitants. If an employer is required to make a contribution to the System as a result of employing an affected annuitant and the annuitant later elects to forgo his or her annuity in that same academic year pursuant to Section 15-139(c) of the Code, then the required contribution by the employer shall be waived, and if the contribution has already been paid, it shall be refunded to the employer without interest. [40 ILCS 5/15-139.5(g)]
- 6) Employment for Critical Operations. Notwithstanding any other provision of this Section to the contrary, if an employer employs an affected annuitant in order to continue critical operations in the event of either an employee's unforeseen illness, accident, or death or a catastrophic incident or disaster, then, for one and only one academic year, the employer is not required to pay the contribution set forth in Section 15-139.5 of the Code for that annuitant. [40 ILCS 5/15-139.5(i)]
- 7) Appeals. The employer may appeal a certification of the contribution amount pursuant to Section 1600.510.

(Source: Added at 40 Ill. Reg. 8437, effective June 3, 2016)

SUBPART E: DISABILITY CLAIMS AND ADMINISTRATIVE REVIEW

Section 1600.510 Employer-Related Determinations and Rules for Appeal

This Section establishes procedures for employer appeals concerning matters of administration under the Illinois Pension Code.

- a) Administrative Determination. The Board of Trustees hereby delegates to the SURS administrative staff the responsibility for making determinations that affect the rights and obligations of employers, consistent with the provisions of the Illinois Pension Code.
- b) Review by Director of Member Services. Any employer adversely affected by a determination by System administrative staff may file, with the SURS Director of

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

Member Services or other person designated by the Executive Director, a Statement of Employer Appeal. The designee shall have all the powers and duties of the Director of Member Services set forth in this subsection (b). A Statement of Employer Appeal must be received within 35 days after the date of the decision from which review is sought. If a Statement of Employer Appeal is not timely filed, the determination by administrative staff is final for all purposes and not subject to administrative or judicial review. The review by the Director of Member Services shall be based on all materials contained in the record, as well as any additional materials the employer attaches to the Statement of Employer Appeal. All filings or submissions, whether optional or required under this Section, shall be considered timely if date stamped by SURS within the time prescribed. The decision of the Director of Member Services shall be served on the employer's authorized representative by delivery to a third-party commercial carrier or by registered or certified mail, return receipt requested.

c) Review by the Executive Committee

- 1) Any employer adversely affected by the disposition of a Statement of Employer Appeal made by the Director of Member Services or the designee may request, in writing, review by the Executive Committee of the Board by filing a Statement of Exceptions to the Executive Committee the Board by filing with the SURS General Counsel, within 35 days after the date of the decision from which review is sought, a Statement of Exceptions to the Executive Committee. The Statement of Exceptions shall not exceed 15 pages in length, unless agreed to by the SURS General Counsel. No additional filings or submissions, apart from those already contained in the record, may be enclosed with the Statement of Exceptions. If a Statement of Exceptions is not timely filed pursuant to this subsection (c)(1), the decision of the Director of Member Services or designee is final for all purposes and not subject to administrative or judicial review.
- 2) The Executive Committee shall render one of the following decisions with respect to the claim: affirmance of the decision of the Director of Member Services or designee, reversal of that decision, or remand of the case to the administrative staff for further consideration. Remand of the case to the administrative staff shall not be considered a final decision of the Executive Committee. A decision by the Executive Committee either reversing or affirming the decision of the Director of Members Services or

STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENTS

designee shall constitute a final decision for the purpose of review under the Administrative Review Law [735 ILCS 5/Art. III].

- 3) All notices of decisions of the Executive Committee shall indicate that the decision is final and subject to the Administrative Review Law.
- 4) Parties and their representatives shall be notified, personally, by delivery to a third-party commercial carrier, or by registered or certified mail, return receipt requested, of any decision of the Executive Committee. The date of mailing of the decision shall constitute the date of service for purposes of the Administrative Review Law or any other applicable law.

d) Effect of Appeal on Due Dates, Interest and Penalties

- 1) Due Dates. If any provision of the Code or SURS regulations requires the employer to make payment by a certain date, the due date shall not be extended during the pendency of the appeal. Any final decision under this Section that partially reduces the payment shall extend the due date of the remaining balance by the time period during which the matter was under appeal.
- 2) Interest and Penalties on Payments. If any provision the Code or SURS regulations imposes interest or penalties upon an employer after a certain date for nonpayment, the interest and/or penalties shall continue to accrue during the pendency of the appeal. Any final decision that partially reduces the payment shall also reduce the attributable interest and/or penalties. To avoid the accrual of interest and/or penalties, the employer may make payment under protest. A payment under protest must be submitted, at the latest, with the Statement of Employer Appeal filed pursuant to subsection (b). If made, the payment shall not be considered an admission of any liability and shall not constitute a waiver of any appeal rights under this Section.

(Source: Added at 40 Ill. Reg. 8437, effective June 3, 2016)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

- 1) Heading of the Part: Pay Plan
- 2) Code Citation: 80 Ill. Adm. Code 310
- 3)

<u>Section Numbers</u> :	<u>Peremptory Actions</u> :
310.210	Amendment
310.Appendix A Table L	Amendment
- 4) Reference to the Specific State or Federal Court Order, Federal Rule or Statute which requires this Peremptory Rulemaking: The Department of Central Management Services is amending the Pay Plan (80 Ill. Adm. Code 310) Section 310.210 to reflect:

Agreement between the Department of Central Management Services of the State of Illinois and Illinois Union of Bakery, Confectionary and Tobacco Workers effective July 1, 2015 through June 30, 2019 with an unknown signing date, Memorandum of Agreement between the State of Illinois (Department of Central Management Services) and International Union of Bakery, Confectionary and Tobacco Workers (Hourly Wage Rates Certification and Effective Dates) signed March 31, 2016, Side Letter on Recoupment Liability for Overpayment signed March 29, 2016, and Memorandum of Agreement between The State of Illinois (Department of Central Management Services) and the International Union of Bakery, Confectionary and Tobacco Workers (Fiscal Year 2016 Merit Pay) signed March 31, 2016. The prevailing rate class affected by these agreements is Baker;

Agreement between the Department of Central Management Services of the State of Illinois and International Union of United Food and Commercial Workers effective July 1, 2015 through June 30, 2019 signed December 4, 2015, Memorandum of Agreement between the State of Illinois (Department of Central Management Services) and the International Union of United Food and Commercial Workers (Hourly Wage Rates Certification and Effective Dates) signed March 30, 2016, Side Letter on Recoupment Liability for Overpayment signed May 11, 2016, Memorandum of Agreement between The State of Illinois (Department of Central Management Services) and the International Union of United Food and Commercial Workers (Fiscal Year 2016 Merit Pay) signed March 30, 2016, Memorandum of Understanding Between Central Management Services and the International Union of United Food and Commercial Workers (New Hire Rates and Relational Rates) signed May 11, 2016, and Memorandum of Understanding Between Central Management Services and the International Union of United Food and Commercial Workers (Calculation of Wages) with an unknown signing date. The

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

prevailing rate classes affected by these agreements are Barber, Beautician, Teacher of Barbering and Teacher of Beauty Culture;

Agreement between the Department of Central Management Services of the State of Illinois and International Brotherhood of Boilermakers - Iron Shipbuilders, Blacksmiths, Forgers, and Helpers effective July 1, 2015 through June 30, 2019 with an unknown signing date, Memorandum of Agreement between the State of Illinois (Department of Central Management Services) and the International Brotherhood of Boilermakers - Iron Shipbuilders, Blacksmiths, Forgers, and Helpers (Hourly Wage Rates Certification and Effective Dates) signed March 31, 2016, Side Letter on Recoupment Liability for Overpayment signed February 22, 2016, and Memorandum of Agreement between The State of Illinois (Department of Central Management Services) and the International Brotherhood of Boilermakers - Iron Shipbuilders, Blacksmiths, Forgers, and Helpers (Fiscal Year 2016 Merit Pay) signed March 31, 2016. The class affected by these agreements is the Boiler Safety Specialist;

Agreement between the Department of Central Management Services of the State of Illinois and Illinois State Bricklayers and Allied Craftworkers effective July 1, 2015 through June 30, 2019 with an unknown signing date, Memorandum of Agreement between the State of Illinois (Department of Central Management Services) and Illinois State Bricklayers and Allied Craftworkers (Hourly Wage Rates Certification and Effective Dates) signed April 6, 2016, Side Letter on Recoupment Liability for Overpayment signed February 9, 2016, and Memorandum of Agreement between The State of Illinois (Department of Central Management Services) and Illinois State Bricklayers and Allied Craftworkers (Fiscal Year 2016 Merit Pay) signed April 6, 2016. The prevailing rate classes affected by these agreements are Brickmason, Cement Finisher and Plasterer;

Agreement between the Department of Central Management Services of the State of Illinois and Service Employees International Union, Local 1, Fireman and Oilers Division effective July 1, 2015 through June 30, 2019 with an unknown signing date, Memorandum of Agreement between the State of Illinois (Department of Central Management Services) and Service Employees International Union, Local 1, Fireman and Oilers Division (Hourly Wage Rates Certification and Effective Dates) with an unknown signing date, Side Letter on Recoupment Liability for Overpayment signed March 29, 2016, and Memorandum of Agreement between The State of Illinois (Department of Central Management Services) and Service Employees International Union, Local 1, Fireman and Oilers Division (Fiscal Year 2016 Merit Pay) signed March 31, 2016. The

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

prevailing rate classes affected by these agreements are Stationary Fireman and Maintenance Worker (Power Plant);

Agreement between the Department of Central Management Services of the State of Illinois and International Brotherhood of Electrical Workers effective July 1, 2015 through June 30, 2019 with an unknown signing date, Memorandum of Agreement between the State of Illinois (Department of Central Management Services) and International Brotherhood of Electrical Workers (Hourly Wage Rates Certification and Effective Dates) signed March 31, 2016, Side Letter on Recoupment Liability for Overpayment signed March 30, 2016, and Memorandum of Agreement between The State of Illinois (Department of Central Management Services) and International Brotherhood of Electrical Workers (Fiscal Year 2016 Merit Pay) signed March 31, 2016. The prevailing rate class affected by these agreements is Electrician;

Agreement between the Department of Central Management Services of the State of Illinois and International Association of Machinist and Aerospace Workers effective July 1, 2015 through June 30, 2019 with an unknown signing date, Memorandum of Agreement between the State of Illinois (Department of Central Management Services) and International Association of Machinist and Aerospace Workers (Hourly Wage Rates Certification and Effective Dates) signed March 31, 2016, Side Letter on Recoupment Liability for Overpayment signed March 22, 2016, and Memorandum of Agreement between The State of Illinois (Department of Central Management Services) and International Association of Machinist and Aerospace Workers (Fiscal Year 2016 Merit Pay) signed March 30, 2016. The prevailing rate class affected by these agreements is Machinist;

Agreement between the Department of Central Management Services of the State of Illinois and International Union of Operating Engineers effective July 1, 2015 through June 30, 2019 with an unknown signing date, Memorandum of Agreement between the State of Illinois (Department of Central Management Services) and International Union of Operating Engineers (Hourly Wage Rates Certification and Effective Dates) signed March 31, 2016, Memorandum of Understanding Between International Union of Operating Engineers, Local 399 and the State of Illinois (New Employees Hired on or after December 1, 2013) signed March 14, 2016, and Memorandum of Agreement between The State of Illinois (Department of Central Management Services) and International Union of Operating Engineers (Fiscal Year 2016 Merit Pay) signed March 31, 2016. The prevailing rate classes affected by these agreements are Sewage Plant Operator, Stationary Engineer, Stationary Engineer-Assistant Chief, Stationary Engineer-Chief and Water Plant Operator;

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

Agreement between the Department of Central Management Services of the State of Illinois and International Union of Painters and Allied Trades effective July 1, 2015 through June 30, 2019 with an unknown signing date, Memorandum of Agreement between the State of Illinois (Department of Central Management Services) and International Union of Painters and Allied Trades (Hourly Wage Rates Certification and Effective Dates) signed March 30, 2016, Memorandum of Understanding between the State of Illinois Central Management Services and International Union of Painters and Allied Trades (Hourly Wage Rates Certification and Effective Dates) signed February 19, 2016, Side Letter on Recoupment Liability for Overpayment signed May 20, 2016, and Memorandum of Agreement between The State of Illinois (Department of Central Management Services) and International Union of Painters and Allied Trades (Fiscal Year 2016 Merit Pay) signed March 30, 2016. The prevailing rate classes affected by these agreements are Painter, Painter Foreman, Sign Painter and Sign Painter Helper;

Agreement between the Department of Central Management Services of the State of Illinois and United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of U.S.A. and Canada effective July 1, 2015 through June 30, 2019 with an unknown signing date, Memorandum of Agreement between the State of Illinois (Department of Central Management Services) and United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of U.S.A. and Canada (Hourly Wage Rates Certification and Effective Dates) with an unknown signing date, and Memorandum of Agreement between The State of Illinois (Department of Central Management Services) and United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of U.S.A. and Canada (Fiscal Year 2016 Merit Pay) signed March 31, 2016. The prevailing rate classes affected by these agreements are Plumber and Steamfitter;

Agreement between the Department of Central Management Services of the State of Illinois and International Association of Sheet Metal, Air, Rail and Transportation Workers (SMART) effective July 1, 2015 through June 30, 2019 with an unknown signing date, Memorandum of Agreement between the State of Illinois (Department of Central Management Services) and International Association of Sheet Metal, Air, Rail and Transportation Workers (SMART) (Hourly Wage Rates Certification and Effective Dates) signed April 18, 2016, Side Letter on Recoupment Liability for Overpayment signed February 10, 2016, and Memorandum of Agreement between The State of Illinois (Department of Central Management Services) and International Association of Sheet Metal, Air, Rail and Transportation Workers (SMART) (Fiscal Year 2016 Merit Pay)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

signed April 18, 2016. The prevailing rate class affected by these agreements is Tinsmith;

Agreement between the Department of Central Management Services of the State of Illinois and Laborer's International Union of North America effective July 1, 2015 through June 30, 2019 signed May 4, 2016, Memorandum of Agreement between the State of Illinois (Department of Central Management Services) and the Laborer's International Union of North America (Hourly Wage Rates Certification and Effective Dates) signed May 4, 2016, Side Letter on Recoupment Liability for Overpayment signed May 4, 2016, and Memorandum of Agreement between The State of Illinois (Department of Central Management Services) and the Laborer's International Union of North America (Fiscal Year 2016 Merit Pay) signed May 4, 2016. The prevailing rate classes affected by these agreements are Laborer, Laborer (Building), Laborer Foreman and Trades Tender; and

Agreement between the Department of Central Management Services of the State of Illinois and United Brotherhood of Carpenters and Joiners of America on behalf of Chicago regional Council of Carpenters, Mid-Central Illinois Regional Council and St. Louis-Kansas City Carpenter's Regional Council effective July 1, 2015 through June 30, 2019 with an unknown signing date, Memorandum of Agreement between the State of Illinois (Department of Central Management Services) and United Brotherhood of Carpenters and Joiners of America on behalf of Chicago regional Council of Carpenters, Mid-Central Illinois Regional Council and St. Louis-Kansas City Carpenter's Regional Council (Hourly Wage Rates Certification and Effective Dates) signed April 15, 2016, Side Letter on Recoupment Liability for Overpayment signed May 2, 2016, and Memorandum of Agreement between The State of Illinois (Department of Central Management Services) and United Brotherhood of Carpenters and Joiners of America on behalf of Chicago regional Council of Carpenters, Mid-Central Illinois Regional Council and St. Louis-Kansas City Carpenter's Regional Council (Fiscal Year 2016 Merit Pay) signed April 15, 2016. The prevailing rate classes affected by these agreements are Carpenter and Carpenter Foreman.

CMS) is amending the Pay Plan (80 Ill. Adm. Code 310) Section 310.Appendix A Table L to reflect the agreements with the International Brotherhood of Boilermakers - Iron Shipbuilders, Blacksmiths, Forgers, and Helpers noted above for the Boiler Safety Specialist class.

- 5) Statutory Authority: Authorized by Sections 8, 8a and 9(7) of the Personnel Code [20 ILCS 415/8, 20 ILCS 415/8a and 20 ILCS 415/9(7)], subsection (d) of Section 1-5 of the

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

Illinois Administrative Procedure Act [5 ILCS 100/1-5(d)] and by Sections 4, 6, 15 and 21 of the Illinois Public Labor Relations Act [5 ILCS 315/4, 5 ILCS 315/6, 5 ILCS 315/15 and 5 ILCS 315/21]

- 6) Effective Date: June 1, 2016
- 7) A Complete Description of the Subjects and Issues Involved: In Section 310.210, the pension formula adjustment change in subsection (d) is completely removed. The in-hire rate provision in subsection (e) is removed with the intent of the sentence "New employees hired on or after December 1, 2013 shall be paid the appropriate prevailing rate." contained in an added sentence at the end of the new subsection (d). The barbers, beauticians and teachers of barbering or beauty culture rates provision in subsection (f) is removed with its effect remaining in the new subsection (c). Along with the removals are changes. The first sentence in subsection (a) is moved to the new subsection (c) with the Department of Labor's role removed and the role is assumed by the Union. In subsection (b), the maximum security rate provision is moved to the new subsection (e). A reference is added to subsection (b) that the provisions of the Section apply also to the Boiler Safety Specialist class that is in 310.Appendix A Table L. A new subsection (c) is added containing the rate certification process and effective date. The subsection (c) pension formula adjustment provision is moved to the new subsection (d) along with a variation of the sentence noted earlier from subsection (e) and a new general statement referring to various agreements on who is eligible for the pension formula adjustment. The new subsection (e) contains the maximum security rate provision noted earlier. The new subsection (f) contains the provision on merit incentive (including time-off awards) and gain sharing programs. The new subsection (g) contains the FY2016 merit pay provision.
- In Section 310.Appendix A Table L, a reference to the 310.210 provisions applying to the Boiler Safety Specialist class is added. The January 1, 2011 pension formula adjustment change is removed.
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Date Filed with the Index Department: June 1, 2016
- 10) This and other Pay Plan amendments are available in the Division of Technical Services of the Bureau of Personnel.
- 11) Is this in compliance with Section 5-50 of the Illinois Administrative Procedure Act?
Yes

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

12) Are there any other rulemakings pending on this Part? Yes

<u>Section Numbers:</u>	<u>Proposed Actions:</u>	<u>Illinois Register Citations:</u>
310.45	Amendment	40 Ill. Reg. 5047; March 25, 2016
310.47	Amendment	40 Ill. Reg. 5047; March 25, 2016
310.50	Amendment	40 Ill. Reg. 5047; March 25, 2016
310.100	Amendment	40 Ill. Reg. 5047; March 25, 2016
310.130	Amendment	40 Ill. Reg. 5047; March 25, 2016
310.300	Amendment	40 Ill. Reg. 5047; March 25, 2016
310.410	Amendment	40 Ill. Reg. 5047; March 25, 2016
310.490	Amendment	40 Ill. Reg. 5047; March 25, 2016
310.500	Amendment	40 Ill. Reg. 5047; March 25, 2016
310.560	New Section	40 Ill. Reg. 5047; March 25, 2016
310.570	New Section	40 Ill. Reg. 5047; March 25, 2016
310.Appendix A Table E	Amendment	40 Ill. Reg. 5047; March 25, 2016
310.Appendix A Table F	Amendment	40 Ill. Reg. 5047; March 25, 2016
310.Appendix A Table O	Amendment	40 Ill. Reg. 5047; March 25, 2016
310.Appendix A Table AA	Amendment	40 Ill. Reg. 5047; March 25, 2016

13) Statement of Statewide Policy Objective: The amendments to the Pay Plan affect only the employees subject to the Personnel Code and does not set out any guidelines that affect local or other jurisdictions in the State.14) Information and questions regarding these preemptory rules shall be directed to:

Mr. Jason Doggett
 Manager
 Compensation Section
 Division of Technical Services and Agency Training and Development
 Bureau of Personnel
 Department of Central Management Services
 504 William G. Stratton Building
 Springfield IL 62706

217/782-7964
 fax: 217/524-4570
 CMS.PayPlan@Illinois.gov

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

The full text of the Peremptory Amendments begins on the next page:

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

TITLE 80: PUBLIC OFFICIALS AND EMPLOYEES
SUBTITLE B: PERSONNEL RULES, PAY PLANS, AND
POSITION CLASSIFICATIONS

CHAPTER I: DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

PART 310
PAY PLAN

SUBPART A: NARRATIVE

Section	
310.20	Policy and Responsibilities
310.30	Jurisdiction
310.40	Pay Schedules
310.45	Comparison of Pay Grades or Salary Ranges Assigned to Classifications
310.47	In-Hire Rate
310.50	Definitions
310.60	Conversion of Base Salary to Pay Period Units
310.70	Conversion of Base Salary to Daily or Hourly Equivalents
310.80	Increases in Pay
310.90	Decreases in Pay
310.100	Other Pay Provisions
310.110	Implementation of Pay Plan Changes (Repealed)
310.120	Interpretation and Application of Pay Plan
310.130	Effective Date
310.140	Reinstitution of Within Grade Salary Increases (Repealed)
310.150	Fiscal Year 1985 Pay Changes in Schedule of Salary Grades, effective July 1, 1984 (Repealed)

SUBPART B: SCHEDULE OF RATES

Section	
310.205	Introduction
310.210	Prevailing Rate
310.220	Negotiated Rate
310.230	Part-Time Daily or Hourly Special Services Rate (Repealed)
310.240	Daily or Hourly Rate Conversion
310.250	Member, Patient and Inmate Rate
310.260	Trainee Rate

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

310.270	Legislated Rate (Repealed)
310.280	Designated Rate
310.290	Out-of-State Rate (Repealed)
310.295	Foreign Service Rate (Repealed)
310.300	Educator Schedule for RC-063 and HR-010
310.310	Physician Specialist Rate
310.320	Annual Compensation Ranges for Executive Director and Assistant Executive Director, State Board of Elections (Repealed)
310.330	Excluded Classes Rate (Repealed)

SUBPART C: MERIT COMPENSATION SYSTEM

Section	
310.410	Jurisdiction
310.415	Merit Compensation Salary Range Assignments
310.420	Objectives
310.430	Responsibilities
310.440	Merit Compensation Salary Schedule
310.450	Procedures for Determining Annual Merit Increases and Bonuses
310.455	Intermittent Merit Increase (Repealed)
310.456	Merit Zone (Repealed)
310.460	Other Pay Increases
310.470	Adjustment
310.480	Decreases in Pay
310.490	Other Pay Provisions
310.495	Broad-Band Pay Range Classes
310.500	Definitions
310.510	Conversion of Base Salary to Pay Period Units (Repealed)
310.520	Conversion of Base Salary to Daily or Hourly Equivalent
310.530	Implementation
310.540	Annual Merit Increase and Bonus Guidechart
310.550	Fiscal Year 1985 Pay Changes in Merit Compensation System, effective July 1, 1984 (Repealed)

SUBPART D: FROZEN NEGOTIATED-RATES-OF-PAY DUE TO
FISCAL YEAR APPROPRIATIONS AND EXPIRED SALARY SCHEDULES IN
COLLECTIVE BARGAINING UNIT AGREEMENTS

Section	
310.600	Jurisdiction (Repealed)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

310.610	Pay Schedules (Repealed)
310.620	In-Hiring Rate (Repealed)
310.630	Definitions (Repealed)
310.640	Increases in Pay (Repealed)
310.650	Other Pay Provisions (Repealed)
310.660	Effective Date (Repealed)
310.670	Negotiated Rate (Repealed)
310.680	Trainee Rate (Repealed)
310.690	Educator Schedule for Frozen RC-063 and Frozen HR-010 (Repealed)
310.APPENDIX A	Negotiated Rates of Pay
310.TABLE A	RC-104 (Conservation Police Supervisors, Illinois Fraternal Order of Police Labor Council)
310.TABLE B	VR-706 (Assistant Automotive Shop Supervisors, Automotive Shop Supervisors and Meat and Poultry Inspector Supervisors, Laborers' – ISEA Local #2002)
310.TABLE C	RC-056 (Site Superintendents and Departments of Veterans' Affairs, Natural Resources, Human Services and Agriculture and Historic Preservation Agency Managers, IFPE)
310.TABLE D	HR-001 (Teamsters Local #700)
310.TABLE E	RC-020 (Teamsters Locals #330 and #705)
310.TABLE F	RC-019 (Teamsters Local #25)
310.TABLE G	RC-045 (Automotive Mechanics, IFPE)
310.TABLE H	RC-006 (Corrections Employees, AFSCME)
310.TABLE I	RC-009 (Institutional Employees, AFSCME)
310.TABLE J	RC-014 (Clerical Employees, AFSCME)
310.TABLE K	RC-023 (Registered Nurses, INA)
310.TABLE L	RC-008 (Boilermakers)
310.TABLE M	RC-110 (Conservation Police Lodge)
310.TABLE N	RC-010 (Professional Legal Unit, AFSCME)
310.TABLE O	RC-028 (Paraprofessional Human Services Employees, AFSCME)
310.TABLE P	RC-029 (Paraprofessional Investigatory and Law Enforcement Employees, IFPE)
310.TABLE Q	RC-033 (Meat Inspectors, IFPE)
310.TABLE R	RC-042 (Residual Maintenance Workers, AFSCME)
310.TABLE S	VR-704 (Departments of Corrections, Financial and Professional Regulation, Juvenile Justice and State Police Supervisors, Laborers' – ISEA Local #2002)
310.TABLE T	HR-010 (Teachers of Deaf, IFT)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

310.TABLE U	HR-010 (Teachers of Deaf, Extracurricular Paid Activities)
310.TABLE V	CU-500 (Corrections Meet and Confer Employees)
310.TABLE W	RC-062 (Technical Employees, AFSCME)
310.TABLE X	RC-063 (Professional Employees, AFSCME)
310.TABLE Y	RC-063 (Educators and Educator Trainees, AFSCME)
310.TABLE Z	RC-063 (Physicians, AFSCME)
310.TABLE AA	NR-916 (Departments of Central Management Services, Natural Resources and Transportation, Teamsters)
310.TABLE AB	RC-150 (Public Service Administrators Option 6, AFSCME) (Repealed)
310.TABLE AC	RC-036 (Public Service Administrators Option 8L Department of Healthcare and Family Services, INA)
310.TABLE AD	RC-184 (Blasting Experts, Blasting Specialists and Blasting Supervisors Department of Natural Resources, SEIU Local 73)
310.TABLE AE	RC-090 (Internal Security Investigators, Metropolitan Alliance of Police Chapter 294)
310.APPENDIX B	Frozen Negotiated-Rates-of-Pay (Repealed)
310.TABLE A	Frozen RC-104-Rates-of-Pay (Conservation Police Supervisors, Laborers' – ISEA Local #2002) (Repealed)
310.TABLE C	Frozen RC-056-Rates-of-Pay (Site Superintendents and Departments of Veterans' Affairs, Natural Resources, Human Services and Agriculture and Historic Preservation Agency Managers, IFPE) (Repealed)
310.TABLE H	Frozen RC-006-Rates-of-Pay (Corrections Employees, AFSCME) (Repealed)
310.TABLE I	Frozen RC-009-Rates-of-Pay (Institutional Employees, AFSCME) (Repealed)
310.TABLE J	Frozen RC-014-Rates-of-Pay (Clerical Employees, AFSCME) (Repealed)
310.TABLE K	Frozen RC-023-Rates-of-Pay (Registered Nurses, INA) (Repealed)
310.TABLE M	Frozen RC-110-Rates-of-Pay (Conservation Police Lodge) (Repealed)
310.TABLE N	Frozen RC-010 (Professional Legal Unit, AFSCME) (Repealed)
310.TABLE O	Frozen RC-028-Rates-of-Pay (Paraprofessional Human Services Employees, AFSCME) (Repealed)
310.TABLE P	Frozen RC-029-Rates-of-Pay (Paraprofessional Investigatory and Law Enforcement Employees, IFPE) (Repealed)
310.TABLE R	Frozen RC-042-Rates-of-Pay (Residual Maintenance Workers, AFSCME) (Repealed)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

310.TABLE S	Frozen VR-704-Rates-of-Pay (Departments of Corrections, Financial and Professional Regulation, Juvenile Justice and State Police Supervisors, Laborers' – ISEA Local #2002) (Repealed)
310.TABLE T	Frozen HR-010-Rates-of-Pay (Teachers of Deaf, IFT) (Repealed)
310.TABLE V	Frozen CU-500-Rates-of-Pay (Corrections Meet and Confer Employees) (Repealed)
310.TABLE W	Frozen RC-062-Rates-of-Pay (Technical Employees, AFSCME) (Repealed)
310.TABLE X	Frozen RC-063-Rates-of-Pay (Professional Employees, AFSCME) (Repealed)
310.TABLE Y	Frozen RC-063-Rates-of-Pay (Educators and Educator Trainees, AFSCME) (Repealed)
310.TABLE Z	Frozen RC-063-Rates-of-Pay (Physicians, AFSCME) (Repealed)
310.TABLE AB	Frozen RC-150-Rates-of-Pay (Public Service Administrators Option 6, AFSCME) (Repealed)
310.TABLE AD	Frozen RC-184-Rates-of-Pay (Public Service Administrators Option 8X Department of Natural Resources, SEIU Local 73) (Repealed)
310.TABLE AE	Frozen RC-090-Rates-of-Pay (Internal Security Investigators, Metropolitan Alliance of Police Chapter 294) (Repealed)
310.APPENDIX C	Comparison of Pay Grades or Salary Ranges Assigned to Classifications
310.ILLUSTRATION A	Classification Comparison Flow Chart: Both Classes are Whole
310.ILLUSTRATION B	Classification Comparison Flow Chart: One Class is Whole and One is Divided
310.ILLUSTRATION C	Classification Comparison Flow Chart: Both Classes are Divided
310.APPENDIX D	Merit Compensation System Salary Schedule
310.APPENDIX E	Teaching Salary Schedule (Repealed)
310.APPENDIX F	Physician and Physician Specialist Salary Schedule (Repealed)
310.APPENDIX G	Broad-Band Pay Range Classes Salary Schedule

AUTHORITY: Implementing and authorized by Sections 8 and 8a of the Personnel Code [20 ILCS 415/8 and 8a].

SOURCE: Filed June 28, 1967; codified at 8 Ill. Reg. 1558; emergency amendment at 8 Ill. Reg. 1990, effective January 31, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 2440, effective February 15, 1984; emergency amendment at 8 Ill. Reg. 3348, effective March 5, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 4249, effective March 16,

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 5704, effective April 16, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 7290, effective May 11, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 11299, effective June 25, 1984; emergency amendment at 8 Ill. Reg. 12616, effective July 1, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 15007, effective August 6, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 15367, effective August 13, 1984; emergency amendment at 8 Ill. Reg. 21310, effective October 10, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 21544, effective October 24, 1984; amended at 8 Ill. Reg. 22844, effective November 14, 1984; emergency amendment at 9 Ill. Reg. 1134, effective January 16, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 1320, effective January 23, 1985; amended at 9 Ill. Reg. 3681, effective March 12, 1985; emergency amendment at 9 Ill. Reg. 4163, effective March 15, 1985, for a maximum of 150 days; emergency amendment at 9 Ill. Reg. 9231, effective May 31, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 9420, effective June 7, 1985; amended at 9 Ill. Reg. 10663, effective July 1, 1985; emergency amendment at 9 Ill. Reg. 15043, effective September 24, 1985, for a maximum of 150 days; amended at 10 Ill. Reg. 3230, effective January 24, 1986; preemptory amendment at 10 Ill. Reg. 3325, effective January 22, 1986; emergency amendment at 10 Ill. Reg. 8904, effective May 13, 1986, for a maximum of 150 days; preemptory amendment at 10 Ill. Reg. 8928, effective May 13, 1986; emergency amendment at 10 Ill. Reg. 12090, effective June 30, 1986, for a maximum of 150 days; preemptory amendment at 10 Ill. Reg. 13675, effective July 31, 1986; preemptory amendment at 10 Ill. Reg. 14867, effective August 26, 1986; amended at 10 Ill. Reg. 15567, effective September 17, 1986; emergency amendment at 10 Ill. Reg. 17765, effective September 30, 1986, for a maximum of 150 days; preemptory amendment at 10 Ill. Reg. 19132, effective October 28, 1986; preemptory amendment at 10 Ill. Reg. 21097, effective December 9, 1986; amended at 11 Ill. Reg. 648, effective December 22, 1986; preemptory amendment at 11 Ill. Reg. 3363, effective February 3, 1987; preemptory amendment at 11 Ill. Reg. 4388, effective February 27, 1987; preemptory amendment at 11 Ill. Reg. 6291, effective March 23, 1987; amended at 11 Ill. Reg. 5901, effective March 24, 1987; emergency amendment at 11 Ill. Reg. 8787, effective April 15, 1987, for a maximum of 150 days; emergency amendment at 11 Ill. Reg. 11830, effective July 1, 1987, for a maximum of 150 days; preemptory amendment at 11 Ill. Reg. 13675, effective July 29, 1987; amended at 11 Ill. Reg. 14984, effective August 27, 1987; preemptory amendment at 11 Ill. Reg. 15273, effective September 1, 1987; preemptory amendment at 11 Ill. Reg. 17919, effective October 19, 1987; preemptory amendment at 11 Ill. Reg. 19812, effective November 19, 1987; emergency amendment at 11 Ill. Reg. 20664, effective December 4, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 20778, effective December 11, 1987; preemptory amendment at 12 Ill. Reg. 3811, effective January 27, 1988; preemptory amendment at 12 Ill. Reg. 5459, effective March 3, 1988; amended at 12 Ill. Reg. 6073, effective March 21, 1988; emergency amendment at 12 Ill. Reg. 7734, effective April 15, 1988, for a maximum of 150 days; preemptory amendment at 12 Ill. Reg. 7783, effective April 14, 1988; preemptory

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

amendment at 12 Ill. Reg. 8135, effective April 22, 1988; preemptory amendment at 12 Ill. Reg. 9745, effective May 23, 1988; emergency amendment at 12 Ill. Reg. 11778, effective July 1, 1988, for a maximum of 150 days; emergency amendment at 12 Ill. Reg. 12895, effective July 18, 1988, for a maximum of 150 days; preemptory amendment at 12 Ill. Reg. 13306, effective July 27, 1988; corrected at 12 Ill. Reg. 13359; amended at 12 Ill. Reg. 14630, effective September 6, 1988; amended at 12 Ill. Reg. 20449, effective November 28, 1988; preemptory amendment at 12 Ill. Reg. 20584, effective November 28, 1988; preemptory amendment at 13 Ill. Reg. 8080, effective May 10, 1989; amended at 13 Ill. Reg. 8849, effective May 30, 1989; preemptory amendment at 13 Ill. Reg. 8970, effective May 26, 1989; emergency amendment at 13 Ill. Reg. 10967, effective June 20, 1989, for a maximum of 150 days; emergency amendment expired November 17, 1989; amended at 13 Ill. Reg. 11451, effective June 28, 1989; emergency amendment at 13 Ill. Reg. 11854, effective July 1, 1989, for a maximum of 150 days; corrected at 13 Ill. Reg. 12647; preemptory amendment at 13 Ill. Reg. 12887, effective July 24, 1989; amended at 13 Ill. Reg. 16950, effective October 20, 1989; amended at 13 Ill. Reg. 19221, effective December 12, 1989; amended at 14 Ill. Reg. 615, effective January 2, 1990; preemptory amendment at 14 Ill. Reg. 1627, effective January 11, 1990; amended at 14 Ill. Reg. 4455, effective March 12, 1990; preemptory amendment at 14 Ill. Reg. 7652, effective May 7, 1990; amended at 14 Ill. Reg. 10002, effective June 11, 1990; emergency amendment at 14 Ill. Reg. 11330, effective June 29, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14361, effective August 24, 1990; emergency amendment at 14 Ill. Reg. 15570, effective September 11, 1990, for a maximum of 150 days; emergency amendment expired February 8, 1991; corrected at 14 Ill. Reg. 16092; preemptory amendment at 14 Ill. Reg. 17098, effective September 26, 1990; amended at 14 Ill. Reg. 17189, effective October 2, 1990; amended at 14 Ill. Reg. 17189, effective October 19, 1990; amended at 14 Ill. Reg. 18719, effective November 13, 1990; preemptory amendment at 14 Ill. Reg. 18854, effective November 13, 1990; preemptory amendment at 15 Ill. Reg. 663, effective January 7, 1991; amended at 15 Ill. Reg. 3296, effective February 14, 1991; amended at 15 Ill. Reg. 4401, effective March 11, 1991; preemptory amendment at 15 Ill. Reg. 5100, effective March 20, 1991; preemptory amendment at 15 Ill. Reg. 5465, effective April 2, 1991; emergency amendment at 15 Ill. Reg. 10485, effective July 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 11080, effective July 19, 1991; amended at 15 Ill. Reg. 13080, effective August 21, 1991; amended at 15 Ill. Reg. 14210, effective September 23, 1991; emergency amendment at 16 Ill. Reg. 711, effective December 26, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 3450, effective February 20, 1992; preemptory amendment at 16 Ill. Reg. 5068, effective March 11, 1992; preemptory amendment at 16 Ill. Reg. 7056, effective April 20, 1992; emergency amendment at 16 Ill. Reg. 8239, effective May 19, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 8382, effective May 26, 1992; emergency amendment at 16 Ill. Reg. 13950, effective August 19, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14452, effective September 4, 1992, for a maximum of 150 days; amended at 17 Ill. Reg. 238, effective December 23, 1992;

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

peremptory amendment at 17 Ill. Reg. 498, effective December 18, 1992; amended at 17 Ill. Reg. 590, effective January 4, 1993; amended at 17 Ill. Reg. 1819, effective February 2, 1993; amended at 17 Ill. Reg. 6441, effective April 8, 1993; emergency amendment at 17 Ill. Reg. 12900, effective July 22, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 13409, effective July 29, 1993; emergency amendment at 17 Ill. Reg. 13789, effective August 9, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 14666, effective August 26, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 19103, effective October 25, 1993; emergency amendment at 17 Ill. Reg. 21858, effective December 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 22514, effective December 15, 1993; amended at 18 Ill. Reg. 227, effective December 17, 1993; amended at 18 Ill. Reg. 1107, effective January 18, 1994; amended at 18 Ill. Reg. 5146, effective March 21, 1994; peremptory amendment at 18 Ill. Reg. 9562, effective June 13, 1994; emergency amendment at 18 Ill. Reg. 11299, effective July 1, 1994, for a maximum of 150 days; peremptory amendment at 18 Ill. Reg. 13476, effective August 17, 1994; emergency amendment at 18 Ill. Reg. 14417, effective September 9, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 16545, effective October 31, 1994; peremptory amendment at 18 Ill. Reg. 16708, effective October 28, 1994; amended at 18 Ill. Reg. 17191, effective November 21, 1994; amended at 19 Ill. Reg. 1024, effective January 24, 1995; peremptory amendment at 19 Ill. Reg. 2481, effective February 17, 1995; peremptory amendment at 19 Ill. Reg. 3073, effective February 17, 1995; amended at 19 Ill. Reg. 3456, effective March 7, 1995; peremptory amendment at 19 Ill. Reg. 5145, effective March 14, 1995; amended at 19 Ill. Reg. 6452, effective May 2, 1995; peremptory amendment at 19 Ill. Reg. 6688, effective May 1, 1995; amended at 19 Ill. Reg. 7841, effective June 1, 1995; amended at 19 Ill. Reg. 8156, effective June 12, 1995; amended at 19 Ill. Reg. 9096, effective June 27, 1995; emergency amendment at 19 Ill. Reg. 11954, effective August 1, 1995, for a maximum of 150 days; peremptory amendment at 19 Ill. Reg. 13979, effective September 19, 1995; peremptory amendment at 19 Ill. Reg. 15103, effective October 12, 1995; amended at 19 Ill. Reg. 16160, effective November 28, 1995; amended at 20 Ill. Reg. 308, effective December 22, 1995; emergency amendment at 20 Ill. Reg. 4060, effective February 27, 1996, for a maximum of 150 days; peremptory amendment at 20 Ill. Reg. 6334, effective April 22, 1996; peremptory amendment at 20 Ill. Reg. 7434, effective May 14, 1996; amended at 20 Ill. Reg. 8301, effective June 11, 1996; amended at 20 Ill. Reg. 8657, effective June 20, 1996; amended at 20 Ill. Reg. 9006, effective June 26, 1996; amended at 20 Ill. Reg. 9925, effective July 10, 1996; emergency amendment at 20 Ill. Reg. 10213, effective July 15, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 10841, effective August 5, 1996; peremptory amendment at 20 Ill. Reg. 13408, effective September 24, 1996; amended at 20 Ill. Reg. 15018, effective November 7, 1996; peremptory amendment at 20 Ill. Reg. 15092, effective November 7, 1996; emergency amendment at 21 Ill. Reg. 1023, effective January 6, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 1629, effective January 22, 1997; amended at 21 Ill. Reg. 5144, effective April 15, 1997; amended at 21 Ill. Reg. 6444, effective May 15, 1997; amended at 21 Ill. Reg. 7118, effective June 3, 1997; emergency

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

amendment at 21 Ill. Reg. 10061, effective July 21, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 12859, effective September 8, 1997, for a maximum of 150 days; preemptory amendment at 21 Ill. Reg. 14267, effective October 14, 1997; preemptory amendment at 21 Ill. Reg. 14589, effective October 15, 1997; preemptory amendment at 21 Ill. Reg. 15030, effective November 10, 1997; amended at 21 Ill. Reg. 16344, effective December 9, 1997; preemptory amendment at 21 Ill. Reg. 16465, effective December 4, 1997; preemptory amendment at 21 Ill. Reg. 17167, effective December 9, 1997; preemptory amendment at 22 Ill. Reg. 1593, effective December 22, 1997; amended at 22 Ill. Reg. 2580, effective January 14, 1998; preemptory amendment at 22 Ill. Reg. 4326, effective February 13, 1998; preemptory amendment at 22 Ill. Reg. 5108, effective February 26, 1998; preemptory amendment at 22 Ill. Reg. 5749, effective March 3, 1998; amended at 22 Ill. Reg. 6204, effective March 12, 1998; preemptory amendment at 22 Ill. Reg. 7053, effective April 1, 1998; preemptory amendment at 22 Ill. Reg. 7320, effective April 10, 1998; preemptory amendment at 22 Ill. Reg. 7692, effective April 20, 1998; emergency amendment at 22 Ill. Reg. 12607, effective July 2, 1998, for a maximum of 150 days; preemptory amendment at 22 Ill. Reg. 15489, effective August 7, 1998; amended at 22 Ill. Reg. 16158, effective August 31, 1998; preemptory amendment at 22 Ill. Reg. 19105, effective September 30, 1998; preemptory amendment at 22 Ill. Reg. 19943, effective October 27, 1998; preemptory amendment at 22 Ill. Reg. 20406, effective November 5, 1998; amended at 22 Ill. Reg. 20581, effective November 16, 1998; amended at 23 Ill. Reg. 664, effective January 1, 1999; preemptory amendment at 23 Ill. Reg. 730, effective December 29, 1998; emergency amendment at 23 Ill. Reg. 6533, effective May 10, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 7065, effective June 3, 1999; emergency amendment at 23 Ill. Reg. 8169, effective July 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 11020, effective August 26, 1999; amended at 23 Ill. Reg. 12429, effective September 21, 1999; preemptory amendment at 23 Ill. Reg. 12493, effective September 23, 1999; amended at 23 Ill. Reg. 12604, effective September 24, 1999; amended at 23 Ill. Reg. 13053, effective September 27, 1999; preemptory amendment at 23 Ill. Reg. 13132, effective October 1, 1999; amended at 23 Ill. Reg. 13570, effective October 26, 1999; amended at 23 Ill. Reg. 14020, effective November 15, 1999; amended at 24 Ill. Reg. 1025, effective January 7, 2000; preemptory amendment at 24 Ill. Reg. 3399, effective February 3, 2000; amended at 24 Ill. Reg. 3537, effective February 18, 2000; amended at 24 Ill. Reg. 6874, effective April 21, 2000; amended at 24 Ill. Reg. 7956, effective May 23, 2000; emergency amendment at 24 Ill. Reg. 10328, effective July 1, 2000, for a maximum of 150 days; emergency expired November 27, 2000; preemptory amendment at 24 Ill. Reg. 10767, effective July 3, 2000; amended at 24 Ill. Reg. 13384, effective August 17, 2000; preemptory amendment at 24 Ill. Reg. 14460, effective September 14, 2000; preemptory amendment at 24 Ill. Reg. 16700, effective October 30, 2000; preemptory amendment at 24 Ill. Reg. 17600, effective November 16, 2000; amended at 24 Ill. Reg. 18058, effective December 4, 2000; preemptory amendment at 24 Ill. Reg. 18444, effective December 1, 2000; amended at 25 Ill. Reg. 811, effective January 4, 2001; amended at 25 Ill. Reg. 2389,

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

effective January 22, 2001; amended at 25 Ill. Reg. 4552, effective March 14, 2001; preemptory amendment at 25 Ill. Reg. 5067, effective March 21, 2001; amended at 25 Ill. Reg. 5618, effective April 4, 2001; amended at 25 Ill. Reg. 6655, effective May 11, 2001; amended at 25 Ill. Reg. 7151, effective May 25, 2001; preemptory amendment at 25 Ill. Reg. 8009, effective June 14, 2001; emergency amendment at 25 Ill. Reg. 9336, effective July 3, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 9846, effective July 23, 2001; amended at 25 Ill. Reg. 12087, effective September 6, 2001; amended at 25 Ill. Reg. 15560, effective November 20, 2001; preemptory amendment at 25 Ill. Reg. 15671, effective November 15, 2001; amended at 25 Ill. Reg. 15974, effective November 28, 2001; emergency amendment at 26 Ill. Reg. 223, effective December 21, 2001, for a maximum of 150 days; amended at 26 Ill. Reg. 1143, effective January 17, 2002; amended at 26 Ill. Reg. 4127, effective March 5, 2002; preemptory amendment at 26 Ill. Reg. 4963, effective March 15, 2002; amended at 26 Ill. Reg. 6235, effective April 16, 2002; emergency amendment at 26 Ill. Reg. 7314, effective April 29, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 10425, effective July 1, 2002; emergency amendment at 26 Ill. Reg. 10952, effective July 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 13934, effective September 10, 2002; amended at 26 Ill. Reg. 14965, effective October 7, 2002; emergency amendment at 26 Ill. Reg. 16583, effective October 24, 2002, for a maximum of 150 days; emergency expired March 22, 2003; preemptory amendment at 26 Ill. Reg. 17280, effective November 18, 2002; amended at 26 Ill. Reg. 17374, effective November 25, 2002; amended at 26 Ill. Reg. 17987, effective December 9, 2002; amended at 27 Ill. Reg. 3261, effective February 11, 2003; expedited correction at 28 Ill. Reg. 6151, effective February 11, 2003; amended at 27 Ill. Reg. 8855, effective May 15, 2003; amended at 27 Ill. Reg. 9114, effective May 27, 2003; emergency amendment at 27 Ill. Reg. 10442, effective July 1, 2003, for a maximum of 150 days; emergency expired November 27, 2003; preemptory amendment at 27 Ill. Reg. 17433, effective November 7, 2003; amended at 27 Ill. Reg. 18560, effective December 1, 2003; preemptory amendment at 28 Ill. Reg. 1441, effective January 9, 2004; amended at 28 Ill. Reg. 2684, effective January 22, 2004; amended at 28 Ill. Reg. 6879, effective April 30, 2004; preemptory amendment at 28 Ill. Reg. 7323, effective May 10, 2004; amended at 28 Ill. Reg. 8842, effective June 11, 2004; preemptory amendment at 28 Ill. Reg. 9717, effective June 28, 2004; amended at 28 Ill. Reg. 12585, effective August 27, 2004; preemptory amendment at 28 Ill. Reg. 13011, effective September 8, 2004; preemptory amendment at 28 Ill. Reg. 13247, effective September 20, 2004; preemptory amendment at 28 Ill. Reg. 13656, effective September 27, 2004; emergency amendment at 28 Ill. Reg. 14174, effective October 15, 2004, for a maximum of 150 days; emergency expired March 13, 2005; preemptory amendment at 28 Ill. Reg. 14689, effective October 22, 2004; preemptory amendment at 28 Ill. Reg. 15336, effective November 15, 2004; preemptory amendment at 28 Ill. Reg. 16513, effective December 9, 2004; preemptory amendment at 29 Ill. Reg. 726, effective December 15, 2004; amended at 29 Ill. Reg. 1166, effective January 7, 2005; preemptory amendment at 29 Ill. Reg. 1385, effective January 4, 2005; preemptory amendment at 29 Ill. Reg. 1559, effective January 11, 2005; preemptory

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

amendment at 29 Ill. Reg. 2050, effective January 19, 2005; preemptory amendment at 29 Ill. Reg. 4125, effective February 23, 2005; amended at 29 Ill. Reg. 5375, effective April 4, 2005; preemptory amendment at 29 Ill. Reg. 6105, effective April 14, 2005; preemptory amendment at 29 Ill. Reg. 7217, effective May 6, 2005; preemptory amendment at 29 Ill. Reg. 7840, effective May 10, 2005; amended at 29 Ill. Reg. 8110, effective May 23, 2005; preemptory amendment at 29 Ill. Reg. 8214, effective May 23, 2005; preemptory amendment at 29 Ill. Reg. 8418, effective June 1, 2005; amended at 29 Ill. Reg. 9319, effective July 1, 2005; preemptory amendment at 29 Ill. Reg. 12076, effective July 15, 2005; preemptory amendment at 29 Ill. Reg. 13265, effective August 11, 2005; amended at 29 Ill. Reg. 13540, effective August 22, 2005; preemptory amendment at 29 Ill. Reg. 14098, effective September 2, 2005; amended at 29 Ill. Reg. 14166, effective September 9, 2005; amended at 29 Ill. Reg. 19551, effective November 21, 2005; emergency amendment at 29 Ill. Reg. 20554, effective December 2, 2005, for a maximum of 150 days; preemptory amendment at 29 Ill. Reg. 20693, effective December 12, 2005; preemptory amendment at 30 Ill. Reg. 623, effective December 28, 2005; preemptory amendment at 30 Ill. Reg. 1382, effective January 13, 2006; amended at 30 Ill. Reg. 2289, effective February 6, 2006; preemptory amendment at 30 Ill. Reg. 4157, effective February 22, 2006; preemptory amendment at 30 Ill. Reg. 5687, effective March 7, 2006; preemptory amendment at 30 Ill. Reg. 6409, effective March 30, 2006; amended at 30 Ill. Reg. 7857, effective April 17, 2006; amended at 30 Ill. Reg. 9438, effective May 15, 2006; preemptory amendment at 30 Ill. Reg. 10153, effective May 18, 2006; preemptory amendment at 30 Ill. Reg. 10508, effective June 1, 2006; amended at 30 Ill. Reg. 11336, effective July 1, 2006; emergency amendment at 30 Ill. Reg. 12340, effective July 1, 2006, for a maximum of 150 days; preemptory amendment at 30 Ill. Reg. 12418, effective July 1, 2006; amended at 30 Ill. Reg. 12761, effective July 17, 2006; preemptory amendment at 30 Ill. Reg. 13547, effective August 1, 2006; preemptory amendment at 30 Ill. Reg. 15059, effective September 5, 2006; preemptory amendment at 30 Ill. Reg. 16439, effective September 27, 2006; emergency amendment at 30 Ill. Reg. 16626, effective October 3, 2006, for a maximum of 150 days; preemptory amendment at 30 Ill. Reg. 17603, effective October 20, 2006; amended at 30 Ill. Reg. 18610, effective November 20, 2006; preemptory amendment at 30 Ill. Reg. 18823, effective November 21, 2006; preemptory amendment at 31 Ill. Reg. 230, effective December 20, 2006; emergency amendment at 31 Ill. Reg. 1483, effective January 1, 2007, for a maximum of 150 days; preemptory amendment at 31 Ill. Reg. 2485, effective January 17, 2007; preemptory amendment at 31 Ill. Reg. 4445, effective February 28, 2007; amended at 31 Ill. Reg. 4982, effective March 15, 2007; preemptory amendment at 31 Ill. Reg. 7338, effective May 3, 2007; amended at 31 Ill. Reg. 8901, effective July 1, 2007; emergency amendment at 31 Ill. Reg. 10056, effective July 1, 2007, for a maximum of 150 days; preemptory amendment at 31 Ill. Reg. 10496, effective July 6, 2007; preemptory amendment at 31 Ill. Reg. 12335, effective August 9, 2007; emergency amendment at 31 Ill. Reg. 12608, effective August 16, 2007, for a maximum of 150 days; emergency amendment at 31 Ill. Reg. 13220, effective August 30, 2007, for a maximum of 150 days; preemptory amendment at 31 Ill.

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

Reg. 13357, effective August 29, 2007; amended at 31 Ill. Reg. 13981, effective September 21, 2007; peremptory amendment at 31 Ill. Reg. 14331, effective October 1, 2007; amended at 31 Ill. Reg. 16094, effective November 20, 2007; amended at 31 Ill. Reg. 16792, effective December 13, 2007; peremptory amendment at 32 Ill. Reg. 598, effective December 27, 2007; amended at 32 Ill. Reg. 1082, effective January 11, 2008; peremptory amendment at 32 Ill. Reg. 3095, effective February 13, 2008; peremptory amendment at 32 Ill. Reg. 6097, effective March 25, 2008; peremptory amendment at 32 Ill. Reg. 7154, effective April 17, 2008; expedited correction at 32 Ill. Reg. 9747, effective April 17, 2008; peremptory amendment at 32 Ill. Reg. 9360, effective June 13, 2008; amended at 32 Ill. Reg. 9881, effective July 1, 2008; peremptory amendment at 32 Ill. Reg. 12065, effective July 9, 2008; peremptory amendment at 32 Ill. Reg. 13861, effective August 8, 2008; peremptory amendment at 32 Ill. Reg. 16591, effective September 24, 2008; peremptory amendment at 32 Ill. Reg. 16872, effective October 3, 2008; peremptory amendment at 32 Ill. Reg. 18324, effective November 14, 2008; peremptory amendment at 33 Ill. Reg. 98, effective December 19, 2008; amended at 33 Ill. Reg. 2148, effective January 26, 2009; peremptory amendment at 33 Ill. Reg. 3530, effective February 6, 2009; peremptory amendment at 33 Ill. Reg. 4202, effective February 26, 2009; peremptory amendment at 33 Ill. Reg. 5501, effective March 25, 2009; peremptory amendment at 33 Ill. Reg. 6354, effective April 15, 2009; peremptory amendment at 33 Ill. Reg. 6724, effective May 1, 2009; peremptory amendment at 33 Ill. Reg. 9138, effective June 12, 2009; emergency amendment at 33 Ill. Reg. 9432, effective July 1, 2009, for a maximum of 150 days; amended at 33 Ill. Reg. 10211, effective July 1, 2009; peremptory amendment at 33 Ill. Reg. 10823, effective July 2, 2009; peremptory amendment at 33 Ill. Reg. 11082, effective July 10, 2009; peremptory amendment at 33 Ill. Reg. 11698, effective July 23, 2009; peremptory amendment at 33 Ill. Reg. 11895, effective July 31, 2009; peremptory amendment at 33 Ill. Reg. 12872, effective September 3, 2009; amended at 33 Ill. Reg. 14944, effective October 26, 2009; peremptory amendment at 33 Ill. Reg. 16598, effective November 13, 2009; peremptory amendment at 34 Ill. Reg. 305, effective December 18, 2009; emergency amendment at 34 Ill. Reg. 957, effective January 1, 2010, for a maximum of 150 days; peremptory amendment at 34 Ill. Reg. 1425, effective January 5, 2010; peremptory amendment at 34 Ill. Reg. 3684, effective March 5, 2010; peremptory amendment at 34 Ill. Reg. 5776, effective April 2, 2010; peremptory amendment at 34 Ill. Reg. 6214, effective April 16, 2010; amended at 34 Ill. Reg. 6583, effective April 30, 2010; peremptory amendment at 34 Ill. Reg. 7528, effective May 14, 2010; amended at 34 Ill. Reg. 7645, effective May 24, 2010; peremptory amendment at 34 Ill. Reg. 7947, effective May 26, 2010; peremptory amendment at 34 Ill. Reg. 8633, effective June 18, 2010; amended at 34 Ill. Reg. 9759, effective July 1, 2010; peremptory amendment at 34 Ill. Reg. 10536, effective July 9, 2010; peremptory amendment at 34 Ill. Reg. 11864, effective July 30, 2010; emergency amendment at 34 Ill. Reg. 12240, effective August 9, 2010, for a maximum of 150 days; peremptory amendment at 34 Ill. Reg. 13204, effective August 26, 2010; peremptory amendment at 34 Ill. Reg. 13657, effective September 8, 2010; peremptory amendment at 34 Ill. Reg. 15897,

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

effective September 30, 2010; preemptory amendment at 34 Ill. Reg. 18912, effective November 15, 2010; preemptory amendment at 34 Ill. Reg. 19582, effective December 3, 2010; amended at 35 Ill. Reg. 765, effective December 30, 2010; emergency amendment at 35 Ill. Reg. 1092, effective January 1, 2011, for a maximum of 150 days; preemptory amendment at 35 Ill. Reg. 2465, effective January 19, 2011; preemptory amendment at 35 Ill. Reg. 3577, effective February 10, 2011; emergency amendment at 35 Ill. Reg. 4412, effective February 23, 2011, for a maximum of 150 days; preemptory amendment at 35 Ill. Reg. 4803, effective March 11, 2011; emergency amendment at 35 Ill. Reg. 5633, effective March 15, 2011, for a maximum of 150 days; preemptory amendment at 35 Ill. Reg. 5677, effective March 18, 2011; amended at 35 Ill. Reg. 8419, effective May 23, 2011; amended at 35 Ill. Reg. 11245, effective June 28, 2011; emergency amendment at 35 Ill. Reg. 11657, effective July 1, 2011, for a maximum of 150 days; emergency expired November 27, 2011; preemptory amendment at 35 Ill. Reg. 12119, effective June 29, 2011; preemptory amendment at 35 Ill. Reg. 13966, effective July 29, 2011; preemptory amendment at 35 Ill. Reg. 15178, effective August 29, 2011; emergency amendment at 35 Ill. Reg. 15605, effective September 16, 2011, for a maximum of 150 days; preemptory amendment at 35 Ill. Reg. 15640, effective September 15, 2011; preemptory amendment at 35 Ill. Reg. 19707, effective November 23, 2011; amended at 35 Ill. Reg. 20144, effective December 6, 2011; amended at 36 Ill. Reg. 153, effective December 22, 2011; preemptory amendment at 36 Ill. Reg. 564, effective December 29, 2011; preemptory amendment at 36 Ill. Reg. 3957, effective February 24, 2012; preemptory amendment at 36 Ill. Reg. 4158, effective March 5, 2012; preemptory amendment at 36 Ill. Reg. 4437, effective March 9, 2012; amended at 36 Ill. Reg. 4707, effective March 19, 2012; amended at 36 Ill. Reg. 8460, effective May 24, 2012; preemptory amendment at 36 Ill. Reg. 10518, effective June 27, 2012; emergency amendment at 36 Ill. Reg. 11222, effective July 1, 2012, for a maximum of 150 days; preemptory amendment at 36 Ill. Reg. 13680, effective August 15, 2012; preemptory amendment at 36 Ill. Reg. 13973, effective August 22, 2012; preemptory amendment at 36 Ill. Reg. 15498, effective October 16, 2012; amended at 36 Ill. Reg. 16213, effective November 1, 2012; preemptory amendment at 36 Ill. Reg. 17138, effective November 20, 2012; preemptory amendment at 37 Ill. Reg. 3408, effective March 7, 2013; amended at 37 Ill. Reg. 4750, effective April 1, 2013; preemptory amendment at 37 Ill. Reg. 5925, effective April 18, 2013; preemptory amendment at 37 Ill. Reg. 9563, effective June 19, 2013; amended at 37 Ill. Reg. 9939, effective July 1, 2013; emergency amendment at 37 Ill. Reg. 11395, effective July 1, 2013, for a maximum of 150 days; preemptory amendment at 37 Ill. Reg. 11524, effective July 3, 2013; preemptory amendment at 37 Ill. Reg. 12588, effective July 19, 2013; preemptory amendment at 37 Ill. Reg. 13762, effective August 8, 2013; preemptory amendment at 37 Ill. Reg. 14219, effective August 23, 2013; amended at 37 Ill. Reg. 16925, effective October 8, 2013; preemptory amendment at 37 Ill. Reg. 17164, effective October 18, 2013; preemptory amendment at 37 Ill. Reg. 20410, effective December 6, 2013; preemptory amendment at 38 Ill. Reg. 2974, effective January 9, 2014; amended at 38 Ill. Reg. 5250, effective February 4, 2014; preemptory amendment at 38 Ill. Reg.

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

6725, effective March 6, 2014; emergency amendment at 38 Ill. Reg. 9080, effective April 11, 2014, for a maximum of 150 days; peremptory amendment at 38 Ill. Reg. 9136, effective April 11, 2014; amended at 38 Ill. Reg. 9207, effective April 21, 2014; peremptory amendment at 38 Ill. Reg. 13416, effective June 11, 2014; amended at 38 Ill. Reg. 14818, effective July 1, 2014; peremptory amendment at 38 Ill. Reg. 15739, effective July 2, 2014; peremptory amendment at 38 Ill. Reg. 17481, effective July 29, 2014; amended at 38 Ill. Reg. 17556, effective August 6, 2014; peremptory amendment at 38 Ill. Reg. 18791, effective August 26, 2014; peremptory amendment at 38 Ill. Reg. 19806, effective September 26, 2014; amended at 38 Ill. Reg. 20695, effective October 14, 2014; amended at 38 Ill. Reg. 24005, effective December 9, 2014; peremptory amendment at 39 Ill. Reg. 728, effective December 23, 2014; emergency amendment at 39 Ill. Reg. 708, effective December 26, 2014, for a maximum of 150 days; peremptory amendment at 39 Ill. Reg. 6964, effective April 29, 2015; amended at 39 Ill. Reg. 7878, effective May 22, 2015; amended at 39 Ill. Reg. 11220, effective July 28, 2015; peremptory amendment at 39 Ill. Reg. 12004, effective August 13, 2015; peremptory amendment at 39 Ill. Reg. 15807, effective November 25, 2015; amended at 40 Ill. Reg. 5893, effective March 28, 2016; peremptory amendment at 40 Ill. Reg. 8462, effective June 1, 2016.

SUBPART B: SCHEDULE OF RATES

Section 310.210 Prevailing Rate

- a) Classes – ~~Prevailing rate means the rate of pay for each class and locality certified as being correct by the Director of the Illinois Department of Labor and approved by the Director of Central Management Services or as established under the Prevailing Wage Act [820 ILCS 130].~~ The following are prevailing rate classes:

Baker	Plasterer
Barber	Plumber
Beautician	Roofer
Brickmason	Sewage Plant Operator
Carpenter	Sign Painter
Carpenter Foreman	Sign Painter Helper
Cement Finisher	Stationary Engineer
Electrician	Stationary Engineer – Assistant Chief
Highway Construction Equipment Operator	Stationary Engineer – Chief
Laborer	Stationary Fireman
Laborer (Building)	Steamfitter
Laborer Foreman	Teacher of Barbering
Machinist	Teacher of Beauty Culture

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

Maintenance Worker (Power Plant)	Tinsmith
Painter	Trades Tender
Painter Foreman	Water Plant Operator

- b) Boiler Safety Specialist – This section shall apply to employees occupying positions in the Boiler Safety Specialist class that are represented by the RC-008 bargaining unit. Maximum Security Rates—Positions in maximum security institutions shall receive a \$50 a month adjustment to the employee's monthly wages for all employees with seven or more years of continuous service with the Department of Corrections. Employees shall receive the adjustment as long as they remain employees at a maximum security facility.
- c) Rate Certification Process and Effective Date – Prevailing rate means the rate of pay for each class and locality certified as being correct by the Designated Representative of the respective Union and approved by the Director of Central Management Services or as established under the Prevailing Wage Act [820 ILCS 130]. Copies of signed Agreements between contractors or other employers and the respective Union shall be certified to the Illinois Department of Central Management Services for each fiscal year of the State by the following process: The Designated Representative of the respective Union shall certify to the Illinois Department of Central Management Services or its designee copies of signed Agreements between contractors or other employers and the respective Union. These certified agreements and accompanying CMS Form shall be considered adequate proof of the prevailing rate of wages to be paid, minus the per hour costs of fringe benefits so designated by Agreement, if any, in keeping with past practice. The Illinois Department of Central Management Services will adjust the wages, retroactive to the contract date; and Certifications from the Union will include a copy of the signed Agreements and the negotiated CMS Prevailing Wage Certification Form. The effective dates of wage changes will be the effective dates reflected in the certified agreements.
- d) Pension Formula Adjustment – Effective January 1, 2006, employees shall be paid an additional 4.00% above the prevailing rate of wages for employees on the standard pension formula and 5.5% above the prevailing rate of wages for employees on the alternative pension formula, minus the per hour costs of fringe benefits. Employees newly hired into a prevailing rate class on or after December 1, 2013 shall be paid the appropriate prevailing rate and shall not be eligible for this pension formula adjustment unless otherwise agreed to by the union representative and the Director of Central Management Services.

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

- ~~ed~~) Maximum Security Rates – Positions in maximum security institutions shall receive a \$50 a month adjustment to the employee's monthly wages for all employees with seven or more years of continuous service with the Department of Corrections. Employees shall receive the adjustment as long as they remain employees at a maximum security facility. Pension Formula Adjustment Change – Effective January 1, 2011, newly hired employees into positions at the Department of Human Services allocated to the Barber, Beautician, Brickmason, Carpenter, Carpenter Foreman, Cement Finisher, Electrician, Machinist, Maintenance Worker (Power Plant), Painter, Plasterer, Plumber, Sewage Plant Operator, Sign Hanger, Sign Hanger Foreman, Sign Painter, Sign Painter Helper, Stationary Engineer, Stationary Engineer – Assistant Chief, Stationary Engineer – Chief, Stationary Fireman, Steamfitter, Teacher of Barbering, Teacher of Beauty Culture, Tinsmith and Water Plant Operator titles shall be paid an additional 4.00% above the prevailing rate of wages, minus the per hour costs of fringe benefits. Newly hired employees are employees hired on or after January 1, 2011 who have never been a member of the State Employees' Retirement System (SERS) or any other reciprocal retirement system. Other reciprocal retirement systems are the Chicago Teachers' Pension Fund, County Employees' Annuity and Benefit Fund of Cook County, Forest Preserve District Employees' Annuity and Benefit Fund of Cook County, General Assembly Retirement System (GARS), Illinois Municipal Retirement Fund (IMRF), Judges Retirement System (JRS), Laborers' Annuity and Benefit Fund of Chicago, Metropolitan Water Reclamation District Retirement Fund, Municipal Employees Annuity and Benefit Fund of Chicago, State Universities Retirement System (SURS) and Teachers' Retirement System of the State of Illinois (TRS). Effective December 9, 2013, Sign Hanger and Sign Hanger Foreman positions are represented by the HR-001 bargaining unit (Section 310 Appendix A Table D).
- fe) Merit Incentive (including Time-Off Awards) and Gain Sharing Programs – The parties agree to develop and implement a merit incentive program to reward and incentivize high-performing employees, or a group's/unit's performance. As a part of such efforts, the Employer may create an annual bonus fund for payout to those individuals deemed high performers or for a group's/unit's level of performance for the specific group/unit. Payment from this bonus fund will be based on the satisfaction of performance standards to be developed by the Employer in consultation with the Union. Such compensation either for a group/unit or an individual shall be considered a onetime bonus and will be offered only as a non-pensionable incentive, and that any employee who accepts

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

merit pay compensation does so voluntarily and with the knowledge and on the express condition that the merit pay compensation will not be included in any pension calculations and will not affect any future calculations regarding the prevailing wage rate. As a part of such efforts, the Employer may reward individual high-performing employees with time-off awards. High-performing employees may earn up to five (5) days of additional time-off in a calendar year, above and beyond the employee's accrued vacation time. Issuance of a time-off award will be based on the satisfaction of performance standards to be developed by the Employer in consultation with the Union. Scheduling the time-off requires supervisory approval, and only a non-bargaining-unit supervisor can reward an employee with a time-off award. Time off awards can be issued by any non-bargaining-unit supervisor in the employee's evaluation chain. Time-off awards, when taken by the employee, will not count against the employee's leave bank. Unused time-off awards shall not convert to a cash-pay out, nor will the hourly value of the time-off awards be used in any calculation for future wages under the provisions of the Prevailing Wage Act. Additionally, as a part of overall efforts to improve efficiency of state operations and align the incentives of the Employer with its employees, the Employer may develop gain sharing programs. Under such programs, employees or departments may propose initiatives that would achieve substantial savings for the State. Upon realization of such savings, the Employer may elect to return a portion of this savings to the employees who participated in the identified initiative. Such compensation either for a group/unit or an individual shall be considered a one-time bonus and will be offered only as a non-pensionable incentive, and that any employee who accepts merit pay compensation does so voluntarily and with the knowledge and on the express condition that the merit pay compensation will not be included in any pension calculations. The Employer will develop specific policies for both of these programs and will give the Union an opportunity to review and comment on such policies prior to their implementation. The Employer's intent is to develop policies that will reward employees or units of employees based on specific achievements and to prevent rewards that are influenced by favoritism, politics, or other purely subjective criteria. Compliance with the policies for both of these programs shall be subject to the grievance and arbitration procedure. The exercise of such rights by management may not conflict with the provisions of this agreement, except that it is understood that awards payable pursuant to such programs shall be performance-based only. Moreover, an employee's failure or refusal to participate in this program may not be grounds for any form of discipline. The Parties understand that the Merit Incentive Program will be effective after the Department of Central Management Services and the Unions

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

~~mutually agree to its process and procedures. In Hire Rates—The State shall provide to the union a listing of all vacancies in the bargaining unit for each agency by March 1, 2014 with a recommended prioritization in filling of the vacancies by June 1, 2014. If requested by the union, representatives of the State shall be available to meet with the union and to discuss and receive input related to the prioritization of filling of particular vacancies. New employees hired on or after December 1, 2013 shall be paid the appropriate prevailing rate. Between December 1, 2014 and June 30, 2015, the union can opt out of the rate for new employees if the State has not engaged in good faith discussions and actions, requested by and participated in by the union for the purpose of prioritizing the filling of vacancies, which results in the hiring of new employees when mutual need is agreed to by the State and union. If the State does not meet the obligations and the union opts out, the State shall retroactively pay 4% above the prevailing rate back to the date the union notified the State of its intent to opt out.~~

- gf) FY 2016 Merit Pay – The Employer and Union have agreed to the terms of a Collective Bargaining Agreement. The Agreement states that public employees represented by the Union will earn merit pay. For the Fiscal Year 2016, all bargaining unit employees who are in active employment status on June 30, 2016 and who have missed fewer than five (5) percent of their assigned work days between the effective date of this Agreement and June 30, 2016 and have committed no work policy violations during that period shall receive equal shares of the performance bonus. The performance bonus shall be paid based on 2% of the annual (fiscal year) base salary payroll costs for the bargaining unit. The effective date of this Agreement is April 1, 2016 through June 30, 2016.~~Barbers, Beauticians and Teachers of Barbering or Beauty Culture Rates—The prevailing rate for Barbers and Beauticians shall be set at \$25 per hour for the new hires effective January 1, 2013. Teachers of Barbering or Beauty Culture shall be paid a rate that is \$2.50 per hour higher than the prevailing rate for Barbers and Beauticians. Barbers and Beauticians hired prior to January 1, 2013 shall be grandfathered at the existing prevailing rate certified for July 2012.~~

(Source: Amended by peremptory rulemaking at 40 Ill. Reg. 8462, effective June 1, 2016)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

Section 310.APPENDIX A Negotiated Rates of Pay**Section 310.TABLE L RC-008 (Boilermakers)**

<u>Title</u>	<u>Title Code</u>	<u>Region</u>	<u>Hired</u>	<u>Effective Date</u>	<u>Monthly Salary</u>
Boiler Safety Specialist	04910	Northern		January 1, 2014	8005.74
Boiler Safety Specialist	04910	Central	Prior to December 1, 2013	January 1, 2015	6876.48
Boiler Safety Specialist	04910	Central	Hired on or after December 1, 2013	January 1, 2015	6612.00
Boiler Safety Specialist	04910	Southern	Prior to December 1, 2013	January 1, 2015	6032.58
Boiler Safety Specialist	04910	Southern	Hired on or after December 1, 2013	January 1, 2015	5801.16

Northern Region: Boone, Cook, DeKalb, DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry, Will, and Winnebago Counties.

Central Region: Bureau, Carroll, Champaign, DeWitt, Ford, Fulton, Hancock, Henderson, Henry, Iroquois, JoDaviess, Knox, LaSalle, Lee, Livingston, Logan, Marshall, Mason, McDonough, McLean, Mercer, Ogle, Peoria, Putnam, Rock Island, Schuyler, Stark, Stephenson, Tazewell, Vermilion, Warren, Whiteside, and Woodford Counties.

Southern Region: Adams, Alexander, Bond, Brown, Calhoun, Cass, Christian, Clark, Clay, Clinton, Coles, Crawford, Cumberland, Douglas, Edgar, Edwards, Effingham, Fayette, Franklin, Gallatin, Greene, Hamilton, Hardin, Jackson, Jasper, Jefferson, Jersey, Johnson, Lawrence, Macon, Macoupin, Madison, Marion, Massac, Menard, Monroe, Montgomery, Morgan, Moultrie, Perry, Piatt, Pike, Pope, Pulaski, Randolph, Richland, St. Clair, Saline, Sangamon, Scott, Shelby, Union, Wabash, Washington, Wayne, White, and Williamson Counties.

Section 310.210 shall apply to employees occupying positions in the Boiler Safety Specialist class that are represented by the RC-008 bargaining unit. Effective January 1, 2011, employees

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

~~newly hired into positions allocated to the Boiler Safety Specialist title at the Department of Human Services receive the negotiated regular pension formula rate for the State of Illinois. Employees newly hired are employees hired on or after January 1, 2011 who have never been a member of the State Employees' Retirement System (SERS) or any other reciprocal retirement system. Other reciprocal retirement systems are the Chicago Teachers' Pension Fund, County Employees' Annuity and Benefit Fund of Cook County, Forest Preserve District Employees' Annuity and Benefit Fund of Cook County, General Assembly Retirement System (GARS), Illinois Municipal Retirement Fund (IMRF), Judges Retirement System (JRS), Laborers' Annuity and Benefit Fund of Chicago, Metropolitan Water Reclamation District Retirement Fund, Municipal Employees Annuity and Benefit Fund of Chicago, State Universities Retirement System (SURS) and Teachers' Retirement System of the State of Illinois (TRS).~~

(Source: Amended by peremptory rulemaking at 40 Ill. Reg. 8462, effective June 1, 2016)

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

The following second notices were received during the period of May 31, 2016 through June 6, 2016. The rulemakings are scheduled for review at the Committee's July 12, 2016 meeting. Other items not contained in this published list may also be considered. Members of the public wishing to express their views with respect to a rulemaking should submit written comments to the Committee at the following address: Joint Committee on Administrative Rules, 700 Stratton Bldg., Springfield IL 62706.

<u>Second Notice Expires</u>	<u>Agency and Rule</u>	<u>Start of First Notice</u>	<u>JCAR Meeting</u>
7/16/16	<u>State Universities Civil Service System</u> , State Universities Civil Service System (80 Ill. Adm. Code 250)	1/8/16 40 Ill. Reg.345	7/12/16

OFFICE OF THE ATTORNEY GENERAL

JULY 2016 REGULATORY AGENDA

- a) Part (Heading and Code Citation): Tobacco Products Manufacturers' Escrow Enforcement Act of 2003 (14 Ill. Adm. Code 250)
- 1) Rulemaking:
- A) Description: The Attorney General is considering a revision of the way in which distributors, as that term is defined within the current rules, may receive notice of the addition or removal of tobacco product manufacturers or brand family names from the various directories maintained by the Office of the Attorney General. The current rules provide the option to send addition and removal notices via U.S. Mail or other commercial delivery. The proposed amendment would add electronic mail and facsimile to the list of available notification options, as well as permitting notice by publication on the Office of the Attorney General website.
- B) Statutory Authority: Tobacco Products Manufacturers' Escrow Enforcement Act of 2003 [30 ILCS 167/35(c)]
- C) Scheduled Meeting/Hearing Dates: No meetings or hearings are scheduled or anticipated at this time.
- D) Date Agency anticipates First Notice: July 2016
- E) Effect on small businesses, small municipalities or not-for-profit corporations: The proposed rulemaking would only affect small businesses by expanding the procedural options available for the Attorney General's Office to notify distributors, as defined within and covered by the rules, of the addition or removal of tobacco product manufacturers or brand family names from the relevant directory.
- F) Agency Contact Person for Information:

Marilyn A. Kueper
Chief, Tobacco Enforcement Bureau
Office of the Illinois Attorney General
500 South Second Street
Springfield IL 62706

217/785-8541

OFFICE OF THE ATTORNEY GENERAL

JULY 2016 REGULATORY AGENDA

- G) Related rulemakings and other pertinent information: None

PROPERTY TAX APPEAL BOARD

JULY 2016 REGULATORY AGENDA

- a) Part (Heading and Code Citations): Practice and Procedure for Appeals Before the Property Tax Appeal Board (86 Ill. Adm. Code 1910)

1) Rulemaking:

- A) Description: The Property Tax Appeal Board anticipates amending the following rules:

Section 1910.30 – Provide for the electronic filing of the petition and evidence by the appellant as well as the electronic service of the appellant's petition and evidence to the board of review.

Section 1910.31 – Provide for the electronic filing of amendments.

Section 1910.40 – Provide for the electronic filing of the board of review notes on appeal and supporting documentation as well as the electronic service of the board of review notes on appeal and supporting documentation to the appellant.

Section 1910.60 – Provide for the electronic filing of the request to intervene and supporting evidence. Allow for the electronic service of the request to intervene and supporting evidence to the appellant and board of review.

Section 1910.66 – Provide for the electronic filing of rebuttal evidence. Clarify that the Clerk shall cause the rebuttal evidence to become part of the appeal proceeding and record. Provide that the Clerk shall send a copy of the rebuttal evidence to the opposing parties by either United States mail or electronic means.

Section 1910.90 – Provide that decisions of the Property Tax Appeal Board may be served on the appellant, board of review and intervenor, if any, by either United States mail or electronic means.

Section 1910.95 – Allow for the electronic service of documents by the parties in those appeals where a change in assessed valuation of \$1 million or more is sought.

PROPERTY TAX APPEAL BOARD

JULY 2016 REGULATORY AGENDA

- B) Statutory Authority: [35 ILCS 200/Art. 7] and [35 ILCS 200/16-160 through 16-195]
- C) Scheduled Meeting/Hearing Dates: None.
- D) Date Agency anticipates First Notice: Unknown at this time.
- E) Effect on small businesses, small municipalities or not-for-profit corporations: None
- F) Agency Contact Person for Information:
- Louis G. Apostol, JD, CAE
Executive Director & General Counsel
Property Tax Appeal Board
Stratton Office Building, Room 402
401 South Spring Street
Springfield IL 62706
- 217/785-4456 or 847/294-4399
fax: 217/785-4425
email: louis.apostol@illinois.gov
- G) Related rulemakings and other pertinent information: None

JOINT COMMITTEE ON ADMINISTRATIVE RULES

OFFICE OF THE STATE FIRE MARSHAL

NOTICE OF PUBLICATION ERROR

- 1) Heading of the Part: School Inspections
- 2) Code Citation: 41 Ill. Adm. Code 111
- 3) Register Citation of adopted rulemaking and other pertinent action: 40 Ill. Reg. 7904; June 3, 2016
- 4) Explanation: When the rulemaking was published in the *Illinois Register*, the effective date was incorrectly listed as May 20, 2015 on the Notice Page, Main Source Note and Section Source Notes for Sections 111.10, 111.20, 111.30, 111.50, 111.60, 111.80, 111.90, 111.10 and 111.110. The correct date is May 20, 2016. JCAR regrets the error.

PROCLAMATIONS

2016-152**Food Allergy Awareness Week**

WHEREAS, as many as 15 million Americans have food allergies and nearly 6 million are children under the age of 18; and,

WHEREAS, research shows the prevalence of food allergies is increasing among children; and,

WHEREAS, eight foods cause 90% of all food allergy reactions in the U.S. which include shellfish, fish, milk, eggs, tree nuts, peanuts, soy, and wheat; and,

WHEREAS, symptoms of an allergenic reaction can include hives, vomiting, diarrhea, respiratory distress, and swelling of the throat; and,

WHEREAS, according to the Centers for Disease Control and Prevention, food allergies result in more than 300,000 ambulatory care visits a year involving children under 18 with reactions occurring when an individual unknowingly eats a food containing an ingredient to which they are allergic; and,

WHEREAS, there is no cure for food allergies, and scientists do not understand why, therefore strict avoidance of the offending food is the only way to prevent an allergic reaction; and,

WHEREAS, anaphylaxis is a serious allergic reaction that is rapid in onset and may cause death; and,

WHEREAS, Food Allergy Research and Education is a national, nonprofit organization dedicated to improving the quality of life and the health of individuals with food allergies, and to provide them hope through the promise of new treatments;

THEREFORE, I, Bruce Rauner, Governor of the State of Illinois, do hereby proclaim May 8-14, 2016, as **FOOD ALLERGY AWARENESS WEEK** in Illinois.

Issued by the Governor May 3, 2016

Filed by the Secretary of State June 2, 2016

2016-153**Illinois Pollinator Week**

WHEREAS, pollinator species such as birds and insects are essential partners of farmers and ranchers in producing much of our food supply; and,

PROCLAMATIONS

WHEREAS, pollination plays a vital role in the health of our national forests and grasslands, providing forage, fish and wildlife, timber, water, mineral resources, and recreational opportunities as well as enhanced economic development opportunities for communities; and,

WHEREAS, pollinator species provide significant environmental benefits necessary to maintain healthy, biodiverse ecosystems; and,

WHEREAS, the State of Illinois has managed wildlife habitats and public lands such as Illinois forests and grasslands for decades; and,

WHEREAS, the State of Illinois provides producers with conservation assistance to promote wise conservation stewardship, including the protection and maintenance of pollinators and their habitats on working lands and wild lands;

THEREFORE, I, Bruce Rauner, Governor of the State of Illinois, do hereby proclaim June 20-26, 2016, as **ILLINOIS POLLINATOR WEEK** in Illinois.

Issued by the Governor May 3, 2016

Filed by the Secretary of State June 2, 2016

2016-154**Allied Orders of the Grand Army of the Republic Day**

WHEREAS, since the incorporation of the Illinois Territory in 1809 through admission of Illinois as a State to the United States of America in 1818 and into the present day, citizens of Illinois have answered the call to defend their Nation and its values; and,

WHEREAS, the greatest of those calls came in 1861, when over the course of the next four years over 285,000 men from Illinois answered the battle cry to preserve the Union from those who would tear it asunder; and,

WHEREAS, after the American Civil War, Dr. Benjamin F. Stephenson founded the Grand Army of the Republic on April 6, 1866 in Decatur, Illinois, which would go on to become the largest organization of Union veterans from America's bloodiest conflict; and,

WHEREAS, the Grand Army of the Republic was always active in the State of Illinois, holding their National Encampment in their State four times, and providing ten Commanders-in-Chief for the GAR; and,

PROCLAMATIONS

WHEREAS, members of the Grand Army of the Republic build meeting halls as memorials to their fallen comrades, and three of these Halls still stand in Aurora, Peoria, and Rockford, Illinois as memorials to the men who fought to preserve the Union; and,

WHEREAS, the Sons of Union Veterans of the Civil War are the Congressionally chartered legal heirs and successors of the Grand Army of the Republic, tasked with preserving the memory of the Boys in Blue; and,

WHEREAS, the Auxiliary to the Sons of Union Veterans of the Civil War, the Ladies of the Grand Army of the Republic, the Women's Relief Corp, and the Daughters of Union Veterans of the Civil War 1861-1865 exist with the Sons of Union Veterans of the Civil War as the Allied Orders of the Grand Army of the Republic, sharing common goals and values; and,

WHEREAS, the Allied Orders National encampment is taking place in Springfield, Illinois from August 12-14, 2016, the Sesquicentennial year of the Foundation of the Grand Army of the Republic in the very State of its founding;

THEREFORE, I, Bruce Rauner, Governor of the State of Illinois, do proclaim August 12, 2016, as **ALLIED ORDERS OF THE GRAND ARMY OF THE REPUBLIC DAY** in the State of Illinois, and encourage all citizens to honor and remember the sacrifice of the more than 285,000 Illinois soldiers who served in the Civil War, and the hundreds of thousands of Americans who gave their lives that the life of the Nation might be preserved, and the organizations here listed who perpetuate their memory.

Issued by the Governor May 10, 2016
Filed by the Secretary of State June 2, 2016

2016-155**Complex Regional Pain Syndrome Awareness Day**

WHEREAS, Complex Regional Pain Syndrome (CRPS), also known as Reflex Sympathetic Dystrophy Syndrome (RSDS), is a nerve disorder that causes chronic pain and can strike at any age, most often affecting one of the arms, feet, hands, or legs; and,

WHEREAS, the pain often spreads to include the entire arm or leg, and typical characteristics of CRPS include dramatic changes in the color and temperature of the skin over the affected limb or body part, accompanied by intense burning pain, skin sensitivity, sweating, and swelling; and,

WHEREAS, although CRPS occurs especially after an injury or trauma to a limb, doctors are uncertain what causes it and even though there are different types of treatments, there is no cure; and,

PROCLAMATIONS

WHEREAS, though treatment can relieve painful symptoms, the prognosis varies from person to person; and,

WHEREAS, several institutes of the National Institutes of Health (NIH) are supporters of research relating to CRPS; and,

WHEREAS, the National Institute of Neurological Disorders and Stroke (NINDS), the primary federal supporter of research on the brain and central nervous system, has scientists that are studying new approaches to treat CRPS and intervene more aggressively after traumatic injury to lower the chances of developing the disorder; and,

WHEREAS, this research is encouraging to everyone who hopes CRPS will one day be eliminated; and,

WHEREAS, on November 7, 2016, members of the Complex Regional Pain Syndrome community will celebrate the third annual Color the World Orange Day to spread awareness of this poorly understood pain disorder;

THEREFORE, I, Bruce Rauner, Governor of the State of Illinois, do hereby proclaim November 7, 2016, as **COMPLEX REGIONAL PAIN SYNDROME AWARENESS DAY** in Illinois, to raise awareness about CRPS and in support of the effort to combat this disorder that affects so many throughout the country and our state.

Issued by the Governor May 10, 2016
Filed by the Secretary of State June 2, 2016

2016-156
Men's Health Week

WHEREAS, despite advances in medical technology and research, men continue to live an average of five years less than women, with African-American men having the lowest life expectancy; and,

WHEREAS, recognizing and preventing men's health problems is a family issue, because of its impact on wives, mothers, daughters, and sisters; and,

WHEREAS, educating the public and health care providers about the importance of a healthy lifestyle and early detection of male health problems helps to reduce rates of mortality from disease, improve overall health, and save money; and,

PROCLAMATIONS

WHEREAS, men who are educated about the value of preventative health will be more likely to participate in health screenings; and,

WHEREAS, the Men's Health Network collaborated with Congress to acknowledge the week leading up to Father's Day as "National Men's Health Week", as a special campaign to help educate men and their families about the importance of positive health attitudes and preventative health practices; and,

WHEREAS, Men's Health Week will raise awareness of a broad range of men's health issues, including heart disease, diabetes, prostate, testicular, and colon cancer; and,

WHEREAS, all of the citizens of the State of Illinois are encouraged to recognize the importance of a healthy lifestyle, regular exercise, and medical check-ups;

THEREFORE, I, Bruce Rauner, Governor of the State of Illinois, do hereby proclaim June 13-19, 2016, as **MEN'S HEALTH WEEK** in Illinois, and encourage all our citizens to pursue preventative health practices and early detection efforts.

Issued by the Governor May 10, 2016
Filed by the Secretary of State June 2, 2016

2016-157**¡Vive tu Vida! Get Up! Get Moving! Wellness Day**

WHEREAS, Hispanic communities in Illinois and throughout the United States are faced with many challenges every day, among which are maintaining health and wellness; and,

WHEREAS, with a Hispanic population of nearly 15.8 percent, Illinois recognizes the need to confront the challenges Hispanics face with a proactive strategy to strengthen community alliances and networks; and,

WHEREAS, it is important to ensure the state's Hispanic community receives culturally-proficient and linguistically-appropriate health and human services; and,

WHEREAS, a number of organizations, such as the Chicago Hispanic Health Coalition, and the National Alliance for Hispanic Health, work to ensure the perspective and experience of the Hispanic community is brought to the forefront of health care services and policy; and,

WHEREAS, the Chicago Hispanic Health Coalition empowers individuals, builds coalitions, and supports organizations with the goal of promoting healthy behaviors and reducing the risk of illness and injury; and,

PROCLAMATIONS

WHEREAS, to maximize and coordinate efforts among city and state organizations to promote healthy lifestyle awareness in Chicago's Hispanic communities, the Chicago Hispanic Health Coalition and the Illinois Department of Public Health are joining together with the National Alliance for Hispanic Health to sponsor "¡Vive Tu Vida! Get Up! Get Moving!" the nation's premier annual Hispanic family physical activity and healthy lifestyle event; and,

WHEREAS, thousands of people are expected to attend "¡Vive Tu Vida! Get Up! Get Moving!" events in cities across the country; and,

WHEREAS, these events will feature fun and excitement for the whole family, free health screenings, healthy snacks, prize drawings, as well as activity stations for soccer, tennis, baseball, basketball, dance, aerobics, yoga, and more; and,

WHEREAS, this year, Chicago will host a "¡Vive Tu Vida! Get Up! Get Moving!" event on June 4;

THEREFORE, I, Bruce Rauner, Governor of the State of Illinois, do hereby proclaim June 4, 2016, as **¡VIVE TU VIDA! GET UP! GET MOVING! WELLNESS DAY** in Illinois, and encourage all residents to recognize the need for increased health awareness in the Hispanic community and to support the efforts of those participating in this important event.

Issued by the Governor May 10, 2016

Filed by the Secretary of State June 2, 2016

2016-158**Ron Magers Day**

WHEREAS, Ron Magers, television news anchor and reporter at ABC 7, has been one of Chicago's most respected broadcast journalists for more than three decades; and,

WHEREAS, Ron will retire from broadcast journalism on Wednesday, May 25, 2016, after more than 50 years in the television industry; and,

WHEREAS, Ron began his television career in 1965 in Eugene, Oregon, as a reporter and news anchor; he also worked in Portland, Oregon; San Francisco, California; and Minneapolis, Minnesota; before moving to Chicago in 1981, quickly becoming one of the city's most popular and respected journalists; and,

WHEREAS, Ron joined the ABC 7 news team in 1998, continuing to build his reputation for mastery in handling live breaking news, and for his impeccable news judgement; and,

PROCLAMATIONS

WHEREAS, Ron's love for live television and his talent as a broadcast journalist earned him numerous awards, including seven Chicago Emmy Awards, a Peter Lisagor Award, and a National Press Club citation; Ron is also a member of the American Federation of Television and Radio Artists; and,

WHEREAS, Ron supports many Chicagoland charities, including the Heartland Alliance, Baseball Cancer Charities, Northwestern University Settlement House, Howard Brown Health Care, Greater Chicago Food Depository, the Grant Park Music Festival, and Hubbard Street Dance Chicago, among others; and,

WHEREAS, in his retirement, Ron and his wife Elise plan to spend time doing hobbies they enjoy, including boating, and breeding and racing Thoroughbred horses; and,

THEREFORE, I, Bruce Rauner, Governor of the State of Illinois, do hereby proclaim May 25, 2016, **RON MAGERS DAY** in Illinois, in honor and recognition of Ron's many years of dedicated service to the people of Chicago and Illinois.

Issued by the Governor May 13, 2016

Filed by the Secretary of State June 2, 2016

2016-159**National Scoliosis Awareness Month**

WHEREAS, we must increase the public's awareness of scoliosis and help children, parents, adults, and health care providers understand, recognize, and treat the complexities of spinal deformities such as scoliosis; and,

WHEREAS, scoliosis, an abnormal curvature of the spine with no known cause (idiopathic), is a condition affecting two to three percent of the population, or an estimated 7 million people in the United States. Scoliosis is a condition which strikes without regard to gender, race, age, or economic status; and,

WHEREAS, an estimated one million scoliosis patients utilize health care yearly, with approximately one out of every six children diagnosed with this condition eventually required to receive active medical treatment; and,

WHEREAS, the primary age of onset for scoliosis is between 10 and 15, with females being five times more likely to progress to a spinal curve magnitude that requires treatment; and,

PROCLAMATIONS

WHEREAS, screening programs allow for early detection and for treatment opportunities which may alleviate the worst effects of the condition; and,

WHEREAS, we observe National Scoliosis Awareness Month to renew our commitment to raising awareness of and combating the spinal condition of scoliosis, and to recognize the need for increased research and funding to reduce the pain and suffering it causes;

THEREFORE, I, Bruce Rauner, Governor of the State of Illinois, do hereby proclaim June 2016 as **NATIONAL SCOLIOSIS AWARENESS MONTH**, and pledge to continue to work to both raise awareness and fight scoliosis in the State of Illinois.

Issued by the Governor May 23, 2016

Filed by the Secretary of State June 2, 2016

2016-160**American Eagle Day**

WHEREAS, the bald eagle was designated as the United States of America's National Emblem on June 20, 1782 by the Founding Fathers at the Second Continental Congress; and,

WHEREAS, the bald eagle is unique to North America and represents such American values and attributes as freedom, courage, strength, spirit, justice, quality and excellence; and,

WHEREAS, the bald eagle is the central image used in the Great Seal of the United States and in the logos of many branches of the U.S. Government, including the Presidency, Congress, Defense Department, Treasury Department, Justice Department, State Department, Department of Commerce, and U.S. Postal Service; and,

WHEREAS, the bald eagle's image, meaning and symbolism have played a significant role in the beliefs, traditions, religions, lifestyles and heritage of Americans from all walks of life, including U.S. military servicemen and women, American Indians, Christians, and members of various civic, fraternal, patriotic, veterans, youth, conservation, educational, outdoors, nature, sportsman, wildlife, political and sports organizations; and,

WHEREAS, the bald eagle's image, meaning and symbolism have played a significant role in American art, music, literature, architecture, commerce, education, and culture, as well as on United States stamps, currency, and coinage; and,

WHEREAS, the bald eagle was once endangered and threatened with possible extinction, but is gradually making an encouraging comeback to America's skies; and,

PROCLAMATIONS

WHEREAS, the bald eagle was federally classified as an "endangered species" in the lower 48 states under the Endangered Species Act in 1973, and was upgraded to a less imperiled "threatened" status under that Act in 1995; and,

WHEREAS, the Department of Interior and U.S. Fish and Wildlife Service delisted the Bald eagle from Endangered Species Act protection in 2007, but the bald eagle will continue to be protected under the Bald and Golden Eagle Act of 1940 and the Migratory Bird Treaty Act of 1918; and,

WHEREAS, the recovery of the United States' bald eagle population was largely accomplished due to the vigilant efforts of numerous caring agencies, corporations, organizations, and citizens;

THEREFORE, I, Bruce Rauner, Governor of the State of Illinois, do hereby proclaim June 20, 2016, as **AMERICAN EAGLE DAY** in Illinois, and encourage all citizens to join in support of the majestic bald eagle's continuing recovery and the protection of its precious natural habitat, and in commemorating the living and symbolic presence of our National Bird.

Issued by the Governor May 24, 2016

Filed by the Secretary of State June 2, 2016

2016-161
Rail Safety Week

WHEREAS, 140 crashes occurred at public highway-rail grade crossings, resulting in 80 personal injuries and 31 fatalities in the State of Illinois during 2015; and,

WHEREAS, 41 trespassing incidents occurred in the State of Illinois during 2015, resulting in the deaths of 23 pedestrians and injuring 18 others while trespassing on railroad property right of ways; and,

WHEREAS, Illinois ranked second in the nation in grade-crossing fatalities and fifth in trespass fatalities for 2015; and,

WHEREAS, more than 67 percent of crashes at public-grade crossings occur where active warning devices exist; and,

WHEREAS, educating and informing the public about rail safety, reminding the public that railroad right of ways are private property, enhancing public awareness of the dangers associated with highway-rail grade crossing, ensuring pedestrians and motorists are looking and listening while near railways, and obeying established traffic laws will reduce the number of fatalities and injuries to Illinoisans; and,

PROCLAMATIONS

WHEREAS, the Illinois Association of Chiefs of Police, Illinois Truck Enforcement Association, Illinois State Police, Illinois Department of Transportation, Illinois Commerce Commission, Illinois Operation Lifesaver, Illinois Sheriff's Association, Illinois Railroad Association, all local and railroad law enforcement, first responders and area railroad companies commit to partnering together in an effort to educate Illinois residents on all aspects of railroad safety, to enforce applicable state laws and to support Illinois Rail Safety Week;

WHEREAS, this year, the states of Indiana, Michigan, Minnesota and Wisconsin will be joining Illinois in implementing "Operation Lifesaver", a regional rail safety initiative.

THEREFORE, I, Bruce Rauner, Governor of the State of Illinois, do hereby proclaim September 11-17, 2016, as **RAIL SAFETY WEEK** in Illinois, and encourage all citizens to recognize the importance of rail safety education.

Issued by the Governor May 24, 2016

Filed by the Secretary of State June 2, 2016

2016-162**Juneteenth Day**

WHEREAS, Juneteenth is the oldest known celebration commemorating the ending of slavery in the United States; and,

WHEREAS, it was on June 19, 1865, two-and-a-half years after President Lincoln's Emancipation Proclamation that Union soldiers landed at Galveston, Texas with news that the war had ended and that the enslaved were now free; and,

WHEREAS, as freed slaves left plantations and moved to reunite with family members in other states, they encountered a new set of challenges as free men and women; and,

WHEREAS, recounting the memories of that great day and its festivities in June of 1865 would serve as relief from the growing pressures encountered in their new homes; and,

WHEREAS, the celebration of June 19th was coined "Juneteenth" and as participation grew, it became a time to reassure one another, for praying and for gathering with family; and,

WHEREAS, a range of activities were provided for entertainment at early Juneteenth celebrations, many of which continue today. Rodeos, fishing, barbecuing and baseball are just a few of the typical activities that may be held as part of Juneteenth celebrations; and,

PROCLAMATIONS

WHEREAS, Juneteenth also focuses on education and self-improvement. Guest speakers are often brought in and the elders are called upon to recount the events of the past. Prayer services are often also a major part of the festivities; and,

WHEREAS, over the last few decades, Juneteenth has continued to enjoy a growing and healthy interest from communities and organizations throughout the country – all with the mission to promote and cultivate knowledge and appreciation of African American history and culture; and,

WHEREAS, Juneteenth today celebrates African American freedom while encouraging self-development and respect for all cultures; and,

THEREFORE, I, Bruce Rauner, Governor of the State of Illinois, do hereby proclaim June 19, 2016, as **JUNETEENTH DAY** in Illinois, in remembrance of the important events of June 19, 1865, and encourage all citizens to learn about the important contributions that African Americans have made to our state, and to the nation as a whole.

Issued by the Governor May 25, 2016

Filed by the Secretary of State June 2, 2016

2016-163**General Aviation Appreciation Month**

WHEREAS, general aviation and community airports play an important role in the lives of our citizens, as well as in the operation of our businesses and farms; and,

WHEREAS, the State of Illinois has a significant interest in the continued vitality of general aviation, aerospace, aircraft manufacturing, educational institutions, aviation organizations, community airports and airport operators; and,

WHEREAS, according to the Illinois Department of Transportation's Division of Aeronautics, there are 98 public-use general aviation airports in Illinois, supporting more than 14,000 general aviation pilots and more than 5,600 aircraft; and,

WHEREAS, according to Federal Aviation Administration data, Illinois is home to 96 repair stations, 13 FAA-approved pilot schools, 3,354 flight instructors and 3,119 student pilots; and,

WHEREAS, many communities in Illinois support general aviation and community airports for the continued flow of commerce, aviation education, and travel for tourists and visitors to our state;

PROCLAMATIONS

THEREFORE, I, Bruce Rauner, Governor of the State of Illinois, do hereby proclaim the month of June 2016 as **GENERAL AVIATION APPRECIATION MONTH** in Illinois and encourage all citizens to join in its observance.

Issued by the Governor May 26, 2016
Filed by the Secretary of State June 2, 2016

2016-164
Grandparent Alienation Awareness Day

WHEREAS, strong family relationships constitute the foundation of our community; and,

WHEREAS, alienation behaviors are frequently present in high-conflict divorces, separations, asymmetrical custody arrangements, and in intact marriages, often causing mental and emotional anguish to children; and,

WHEREAS, alienation is a term used to describe any number of behaviors and attitudes on the part of one or both parents designed to interfere, damage, or destroy the relationship between a child and family member; and,

WHEREAS, alienation takes advantage of the innocent and impressionable, as well as the suggestibility and dependency of a child, depriving children of their right to love and be loved by their extended family; and,

WHEREAS, mental health professionals agree that the negative effects of alienation can follow a child into adulthood with tragic consequences; and,

WHEREAS, the recently published Diagnostic and Statistical Manual of Mental Disorders (DSM-5) made several references to the dysfunctional family dynamic of alienation as a form of psychological child abuse; and,

WHEREAS, Grandparent Alienation Awareness Day is intended to increase the knowledge and understanding of this problem to help families, institutions, the legal and mental health community, and leaders to better identify and combat such abusive behavior to children;

THEREFORE, I, Bruce Rauner, Governor of the State of Illinois, do hereby proclaim June 14, 2016, as **GRANDPARENT ALIENATION AWARENESS DAY** in Illinois.

Issued by the Governor May 26, 2016
Filed by the Secretary of State June 2, 2016

PROCLAMATIONS

**2016-165
America's Cup Days**

WHEREAS, the America's Cup is often called the "oldest trophy in international sport", and is known as the most difficult trophy in sport to win; and,

WHEREAS, the America's Cup was named after the schooner America, which beat the best yachts the British could offer and won the Royal Yacht Squadron's 100 Guinea Cup in 1851; and,

WHEREAS, in the more than 160 years since that first race off England, only four nations have won the America's Cup; and,

WHEREAS, Team Oracle USA won the 34th America's Cup in San Francisco bay in 2013, and will defend the trophy in the 35th America's Cup in Bermuda in 2017; and,

WHEREAS, the 35th America's Cup includes the first-ever Louis Vuitton America's Cup World Series, a unique interactive sailing and entertainment experience that makes a stop at Chicago's Navy Pier June 10-12, 2016; and,

WHEREAS, the Louis Vuitton America's Cup World Series Chicago is also a qualifying event for the 2017 America's Cup Finals; and,

WHEREAS, Louis Vuitton America's Cup World Series Chicago event chairman Don Wilson and director Tod Reynolds should be credited for bringing this event to Chicago for the first time in the event's 165-year history;

THEREFORE, I, Bruce Rauner, Governor of the State of Illinois do hereby proclaim June 10-12, 2016, as **AMERICA'S CUP DAYS** in Illinois.

Issued by the Governor May 27, 2016

Filed by the Secretary of State June 2, 2016

**2016-166
Children's Day**

WHEREAS, all children are created equal, and they are endowed with certain unalienable rights; and,

WHEREAS, as the future of Illinois, children are the highest priority of our state; and,

PROCLAMATIONS

WHEREAS, it is especially important that the citizens of our state be aware of the needs of our children; and,

WHEREAS, all citizens of our state should promote a safe and healthy environment for our children; and,

WHEREAS, during the month of June, all citizens of Illinois should unite in aiding to further the cause of hope for our children;

THEREFORE, I, Bruce Rauner, Governor of the State of Illinois, do hereby proclaim June 12, 2016, as **CHILDREN'S DAY** in Illinois, and urge communities of the state to come to together to participate in giving faith, hope, love, and commitment to our children.

Issued by the Governor May 27, 2016
Filed by the Secretary of State June 2, 2016

2016-167
Immigrant Heritage Month

WHEREAS, generations of immigrants from every corner of the globe have built our country's economy and created the unique character of our nation; and,

WHEREAS, immigrants continue to grow businesses, innovate, strengthen our economy, and create American jobs in Illinois; and,

WHEREAS, immigrants have provided the United States with unique social and cultural influence, fundamentally enriching the extraordinary character of our nation; and,

WHEREAS, immigrants have been tireless leaders not only in securing their own rights and access to equal opportunity, but have also campaigned to create a fairer and more just society for all Americans; and,

WHEREAS, despite these countless contributions, the role of immigrants in building and enriching our nation has frequently been overlooked and undervalued throughout our history;

THEREFORE, I, Bruce Rauner, Governor of the State of Illinois, do hereby proclaim June 2016 as **IMMIGRANT HERITAGE MONTH** in Illinois.

Issued by the Governor May 27, 2016
Filed by the Secretary of State June 2, 2016

PROCLAMATIONS

2016-168**Philippine Independence Day**

WHEREAS, one of the most significant dates in the history of the Philippines' is Independence Day, which marks the date of the nation's independence from Spanish rule on June 12, 1898; and,

WHEREAS, in 1898, the Philippine Declaration of Independence was signed, and publicly read by Ambrosio Rianzares Bautista, declaring a free, sovereign, and democratic Philippines; and,

WHEREAS, the Philippines' flag was raised and its national anthem was played for the first time in 1898; and,

WHEREAS, this year marks the 118th anniversary of Philippine Independence, and Illinois is proud that thousands of Filipino Americans call our state home; and,

WHEREAS, the annual June 12 observance of Philippines' Independence Day came into effect after past-President Diosdado Macapagal signed the Republic Act No. 4166 on August 4, 1964; and,

WHEREAS, our state's thriving Filipino American population is well-served by the Consulate General of the Philippines in Chicago, and it is important that we commend the valuable Filipino community organizations across the Land of Lincoln; and,

WHEREAS, the contributions of Filipino Americans to the social, economic, and cultural landscape of this State greatly increase the quality of life for all Illinois residents; and,

WHEREAS, the Philippine Consulate General along with the Filipino American community in Chicago will celebrate the 118th anniversary of Philippine Independence Day on June 12, 2016, with a flag-raising ceremony; and,

WHEREAS, it is appropriate on this occasion for the people of the Land of Lincoln to recognize Filipino Americans;

THEREFORE, I, Bruce Rauner, Governor of the State of Illinois, do hereby proclaim June 12, 2016, as **PHILIPPINE INDEPENDENCE DAY** in Illinois, and join all Filipino American citizens in celebration of this very special day.

Issued by the Governor May 27, 2016

Filed by the Secretary of State June 2, 2016

PROCLAMATIONS

2016-169
Italian National Day

WHEREAS, in 1946, after World War II ended, Italian citizens voted on the future of their government; and,

WHEREAS, Italians voted for a republican form of government over a monarchy; and,

WHEREAS, June 2, 1946 marked the beginning of universal suffrage in Italy; and,

WHEREAS, sixty-nine years later, Italians all across the globe commemorate the birth of their freedom, and remember the great sacrifices that were made to ensure a better quality of life for future generations; and,

WHEREAS, the Italian community in Chicago has long been an essential part of the city's vibrant cultural landscape; and,

WHEREAS, Italian Americans have made significant social, cultural and economic contributions to the growth of Illinois over the years; and,

WHEREAS, the renowned success of Italian Americans can be attributed to the establishment of a republican government;

THEREFORE, I, Bruce Rauner, Governor of the State of Illinois, do hereby proclaim June 2, 2016, as **ITALIAN NATIONAL DAY** in Illinois to commemorate the great sacrifices and contributions of Italians and Italian Americans to Illinois and American society.

Issued by the Governor June 1, 2016

Filed by the Secretary of State June 2, 2016

ILLINOIS ADMINISTRATIVE CODE
Issue Index - With Effective Dates

Rules acted upon in Volume 40, Issue 25 are listed in the Issues Index by Title number, Part number, Volume and Issue. Inquiries about the Issue Index may be directed to the Administrative Code Division at (217) 782-7017/18.

PROPOSED RULES

83 - 730	8257
83 - 731	8264
83 - 736	8270

ADOPTED RULES

77 - 515	6/3/2016	8274
80 - 1600	6/3/2016	8437

PEREMPTORY RULES

80 - 310	6/1/2016	8462
----------	----------------	------

**EXECUTIVE ORDERS AND
PROCLAMATIONS**

16 - 152	5/3/2016	8496
16 - 153	5/3/2016	8496
16 - 154	5/10/2016	8497
16 - 155	5/10/2016	8498
16 - 156	5/10/2016	8499
16 - 157	5/10/2016	8500
16 - 158	5/13/2016	8501
16 - 159	5/23/2016	8502
16 - 160	5/24/2016	8503
16 - 161	5/24/2016	8504
16 - 162	5/25/2016	8505
16 - 163	5/26/2016	8506
16 - 164	5/26/2016	8507
16 - 165	5/27/2016	8508
16 - 166	5/27/2016	8508
16 - 167	5/27/2016	8509
16 - 168	5/27/2016	8510
16 - 169	6/1/2016	8511

REGULATORY AGENDA

14 - 250	8491
86 - 1910	8493

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