NORTH CAROLINA MEDICAL BOARD

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President-Elect

Pascal O. Udekwu, MD
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2013 ANNUAL REPORT

August 11, 2014

The Honorable Elaine Marshall, Secretary of State
By email to: Ms. Linda Wise Lwise@sosnc.com;
and pubs@sosnc.com

The Honorable Roy Cooper, Attorney General
By email to: ncago@ncdoj.gov

Ms. Melissa Lovell, Office of the Attorney General
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By email to: Mr. Donald Crooke Donald.crooke@osbm.nc.gov)

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By email to: lauren.lemons@osc.nc.gov

The Hon. Beth Wood, NC State Auditor
Beth_Wood@ncauditor.net

And: two paper copies to:
Office of the State Auditor
20602 Mail Service Center
Raleigh, NC 27699-0601

Dear All:

The North Carolina Medical Board is filing this report in compliance with N.C.Gen.Stat.§ 93B-2.

Section 93B-2. Annual reports required; contents; open to inspection; sanction for failure to report.

(a): No later than October 31 of each year, each occupational licensing board shall file with the Secretary of State, the Attorney General, and the Joint Regulatory Reform Committee an annual report containing all of the following information:

1.The address of the board, and the names of its members and officers:

The NCMB is located at 1203 Front Street, Raleigh, NC 27609. Its mailing address is: P.O. Box 20007, Raleigh NC 27619.

The following twelve persons are current members and/or officers of the Medical Board:

Paul S. Camnitz, MD, President
Cheryl L. Walker-McGill, MD, President-Elect
Pascal O. Udekwu, Secretary-Treasurer
Thelma C. Lennon, Public Member
Eleanor E. Greene, MD, Board Member
Subhash C. Gumber, MD, Board Member
Michael J. Arnold, Public Member
H. Dianne Meelheim, FNP-BC, Board Member
Debra A. Bolick, MD, Board Member
A.Wayne Holloman, Public Member
Timothy E. Lietz, MD, Board Member
Barbara E. Walker, DO, Board Member

2. The number of persons who applied to the board for examination. NONE (not applicable). Pursuant to N.C.G.S. 90-10.1, the NCMB accepts licensing examinations administered by: the National Board of Medical Examiners (NBME) or its successor; the United States Medical Licensing Examination (USMLE) or its successor; or the Federation Licensing Examination (FLEX) or its successor. The NCMB may also administer or accept other State Board licensing examinations or other examinations the Board deems equivalent to the examinations described in subdivisions (1) through (3) of N.C.Gen.Stat.§ 90-10.1, pursuant to rules adopted by the Board.

3. *The number of persons who were refused examination.* NONE (not applicable.)

4. *The number who took the examination.* NONE (not applicable).

5. *The number to whom initial licenses were issued.* 2,024 MDs (Medical Doctors); 214 DOs (Doctors of Osteopathy) (total physician licenses: 2,238); 870 Resident Training Licenses; 513 PAs (Physician Assistants); 23 LPs (Licensed Perfusionists); and 0 AAs (Anesthesiology Assistants). The NCMB maintains a registry of polysomnographic technicians ("sleep techs") but does not license them. In 2013, the NCMB registered 822 sleep techs in North Carolina.

6. *The number who applied for license or approval by reciprocity or comity*. NONE (not applicable).

7. *The number who were granted licenses or approvals by reciprocity or comity*. NONE (not applicable).

7a. *The number of official complaints received involving licensed and unlicensed activities.* The Board received 1,304 complaints from patients or the public in 2013.

7b. *The number of disciplinary actions* taken against licensees, or other actions taken against nonlicensees, including injunctive relief.*
The Medical Board took 195 prejudicial actions* against licensees or NPs with NCMB approval. Please note that some individuals had more than one action for the year.

**prejudicial action includes: revocation, suspension, surrender or mandatory relinquishment of a license, loss of privileges afforded by that license, probation, limitation or restriction of license or of license privileges, letters of reprimand or warning, and/or fines.*

This does not include private letters of concern sent to licensees. If private letters of concern are added to the prejudicial actions, the total number of cases "closed with disciplinary action" equals 793.

8. *The number of licenses or approvals suspended or revoked.* Thirty-four licenses or approvals were suspended. One physician license was revoked.

9. *The number of licenses or approvals terminated for any reason other than failure to pay a required renewal fee*.
In 2013, the NC Medical Board revoked the license of 1 physician; suspended the licenses of 34 licensees; summarily suspended one licensee; and accepted the surrender of 18 licenses.

10. *The substance of any anticipated request by the occupational licensing board to the General Assembly to amend statutes related to the occupational licensing board*.

The NCMB will seek amendment of the Medical Practice Act, NCGS §90-1 et. seq., to achieve the objectives set forth in the attached memo.

11.*The substance of any anticipated change in the rules adopted by the occupational licensing board or the substance of any anticipated adoption of new rules by the occupational licensing board.*

Please see the attached edition of rules currently in the administrative rulemaking process. Also, the North Carolina Medical Board will be undergoing the statutorily-mandated self-audit of all of its administrative rules in early 2015, and that process may lead to rule repeals, amendments or adoptions.

N.C.Gen.Stat.§ 93B-2. (b*)* *Each occupational licensing board shall file with the Secretary of State, the Attorney General, the Office of State Budget and Management, and the Joint Legislative Administrative Procedure Oversight Committee a financial report that includes the source and amount of all funds credited to the occupational licensing board and the purpose and amount of all funds disbursed by the occupational licensing board during the previous 12-month period.*

A financial report that includes the source and amount of all funds credited to the Medical Board and the purpose and amount of all funds disbursed by the Medical Board is attached. This Independent Auditors' Report was created by Koonce, Wooten & Haywood, LLP, CPAs, and is titled: "North Carolina Medical Board Financial Statements For the Years Ended October 31, 2013 and 2012.

If you have any questions, please do not hesitate to contact me.

Very truly yours,

R David Henderson

R. David Henderson
Executive Director

NORTH CAROLINA MEDICAL BOARD

PROPOSED LEGISLATIVE CHANGES FOR 2015 SESSION OF THE NORTH CAROLINA GENERAL ASSEMBLY

Attachment to 2013 Annual Report filed pursuant to N.C.Gen.Stat.§ 93B-2

G.S. 90-2: This change limits a Board member to serving two complete three-year terms in their lifetime.

G.S. 90-3: This change permits the Board to share investigative information with the Review Panel in case applicants omit or misstate relevant information on their application or during their interview. This change also requires the Review Panel to publish the names of applicants and the names of nominees on its website. Finally, this change makes it clear that certain information received by the Review Panel in connection with an application is confidential and may be discussed in a closed session. This change strikes the appropriate balance between transparency and public participation on the one hand and, on the other hand, a thorough application and interview process.

G.S. 90-5.2: This change permits the Board to share information with its licensees via e-mail and share licensee e-mail addresses with others so long as it is in connection with public health or practice of medicine issues.

G.S. 90-13.1 and 90-13.2: The Board has not requested or received a fee increase in approximately nine years. This fee increase will ensure the continued effective and efficient operations of the Board and preserve fee funded, self-regulation of the medical profession at no cost to the taxpayer.

G.S. 90-14: This change permits the Board to serve orders for assessment or examination and orders following a hearing directly to the licensee with a copy to the licensee's attorney. This will ensure that licensees receive important communications from the Board in a timely manner.

G.S. 90-14: Presently, Chapter 90 is unclear about the discovery process in contested cases before the Board. This change makes clear that, once charges have been issued, the Board and respondent may engage in discovery pursuant to the North Carolina Rules of Civil Procedure. Moreover, this change provides additional protections to the licensee and creates an affirmative obligation on the Board to turn over certain information.

G.S. 90-14.13: Removes the requirement of hospitals to report suspensions for delinquent medical records. Experience has shown that the issue of delinquent medical records is best handled at the local level by hospitals.

G.S. 90-21.22: This change rewrites the North Carolina Physician Health Program (PHP) enabling statute to, among other things, update the language and make it clear that participants are entitled to a summary of PHP's assessment. The change also makes clear that PHP must report immediately to the Board detailed information about any licensee of the Board who constitutes an imminent danger to patient safety or care.

21 NCAC 32B .1350 is amended as published in 28:22 NCR pages 2725 - 2727 as follows:

21 NCAC 32B .1350 REINSTATEMENT OF PHYSICIAN LICENSE

(a) Reinstatement is for a physician who has held a North Carolina License, but whose license either has been inactive for more than one year, or whose license became inactive as a result of disciplinary action (revocation or suspension) taken by the Board. It also applies to a physician who has surrendered a license prior to charges being filed by the Board.

(b) All applicants for reinstatement shall:

(1) submit a completed application, attesting under oath or affirmation that information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;

(2) submit documentation of a legal name change, if applicable;

(3) supply a certified copy of applicant's birth certificate if the applicant was born in the United States or a certified copy of a valid and unexpired US passport. If the applicant does not possess proof of U.S. citizenship, the applicant must provide information about applicant's immigration and work status which the Board will use to verify applicant's ability to work lawfully in the United States;

(4) If a graduate of a medical school other than those approved by LCME, AOA, COCA or CACMS, shall furnish an original ECFMG certification status report of a currently valid certification of the ECFMG. The ECFMG certification status report requirement shall be waived if:

(A) the applicant has passed the ECFMG examination and successfully completed an approved Fifth Pathway program (original ECFMG score transcript from the ECFMG required); or

(B) the applicant has been licensed in another state on the basis of a written examination before the establishment of the ECFMG in 1958;

(5) submit the AMA Physician Profile; and, if applicant is an osteopathic physician, also submit the AOA Physician Profile;

(6) submit a NPDB/HIPDB report dated within 60 days of the application's submission;

(7) submit a FSMB Board Action Data Bank report;

(8) submit documentation of CME obtained in the last three years, upon request;

(9) submit two completed fingerprint cards supplied by the Board;

(10) submit a signed consent form allowing a search of local, state, and national files to disclose any criminal record;

(11) provide two original references from persons with no family or material relationship to the applicant. These references must be:

(A) from physicians who have observed the applicant's work in a clinical environment within the past three years;

(B) on forms supplied by the Board;

(C) dated within six months of submission of the application; and

(D) bearing the original signature of the author;

(12) pay to the Board a non-refundable fee pursuant to G.S. 90-13.1(a), plus the cost of a criminal background check; and

(13) upon request, supply any additional information the Board deems necessary to evaluate the applicant's qualifications.

(c) In addition to the requirements of Paragraph (b) of this Rule, the applicant shall submit proof that the applicant has:

(1) within the past 10 years taken and passed either:

(A) an exam listed in G.S. 90-10.1 (a state board licensing examination; NBME; NBOME; USMLE; FLEX; COMLEX; or MCCQE or their successors);

(B) SPEX (with a score of 75 or higher); or

(C) COMVEX (with a score of 75 or higher);

(2) within the past ten years:

(A) obtained certification or recertification of CAQ by a specialty board recognized by the ABMS, CCFP, FRCP, FRCS or AOA; or

(B) met requirements for ABMS MOC (maintenance or certification) or AOA OCC (Osteopathic continuous Certification);

(3) within the past 10 years completed GME approved by ACGME, CFPC, RCPSC or AOA; or

(4) within the past three years completed CME as required by 21 NCAC 32R .0101(a), .0101(b), and .0102.

(d) All reports must be submitted directly to the Board from the primary source, when possible.

(e) An applicant shall be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character if the Board needs more information to complete the application.

(f) An application must be complete within one year of submission. If not, the applicant shall be charged another application fee plus the cost of another criminal background check.

(g) Notwithstanding the above provisions of this rule, the licensure requirements established by rule at the time the applicant first received his or her equivalent North Carolina license shall apply.

History Note: *Authority G.S. 90-8.1; 90-9.1; 90-10.1; 90-13.1;*
Eff. August 1, 2010;
Amended Eff. September 1, 2014; November 1, 2013; November 1, 2011.

21 NCAC 32B .1360 is amended as published in 28:22 NCR pages 2725 - 2727 as follows:

21 NCAC 32B .1360 REACTIVATION OF PHYSICIAN LICENSE

(a) Reactivation applies to a physician who has held a physician license in North Carolina, and whose license has been inactive for up to one year except as set out in Rule .1704(e) of this Subchapter. Reactivation is not available to a physician whose license became inactive either while under investigation by the Board or because of disciplinary action by the Board.

(b) In order to reactivate a Physician License, an applicant shall:

(1) submit a completed application, attesting under oath that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;

(2) supply a certified copy of applicant's birth certificate if the applicant was born in the United States or a certified copy of a valid and unexpired US passport. If the applicant does not possess proof of U.S. citizenship, the applicant must provide information about applicant's immigration and work status which the Board will use to verify applicant's ability to work lawfully in the United States; (Note: there may be some applicants who are not present in the US and who do not plan to practice physically in the US. Those applicants shall submit a statement to that effect);

(3) submit a FSMB Board Action Data Bank report;

(4) submit documentation of CME obtained in the last three years;

(5) submit two completed fingerprint record cards supplied by the Board;

(6) submit a signed consent form allowing search of local, state, and national files for any criminal record;

(7) pay to the Board the relevant, non-refundable fee, plus the cost of a criminal background check; and

(8) upon request, supply any additional information the Board deems necessary to evaluate the applicant's competence and character.

(c) An applicant may be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character.

(d) Notwithstanding the above provisions of this rule, the licensure requirements established by rule at the time the applicant first received his or her equivalent North Carolina license shall apply.

History Note: *Authority G.S. 90-8.1; 90-9.1; 90-12.1A; 90-13.1; 90-14(a)(11a);*
Eff. August 1, 2010.

21 NCAC 32B .1402 is amended as published in 28:22 NCR pages 2725 - 2727 as follows:

21 NCAC 32B .1402 APPLICATION FOR RESIDENT'S TRAINING LICENSE

(a) In order to obtain a Resident's Training License, an applicant shall:

(1) submit a completed application, attesting under oath or affirmation that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;

(2) submit documentation of a legal name change, if applicable;

(3) submit a photograph, two inches by two inches, affixed to the oath or affirmation which has been attested to by a notary public;

(4) submit proof on the Board's Medical Education Certification form that the applicant has completed at least 130 weeks of medical education.

(5) If a graduate of a medical school other than those approved by LCME, AOA, COCA or CACMS, furnish an original ECFMG certification status report of a currently valid certification of the ECFMG. The ECFMG certification status report requirement shall be waived if:

(A) the applicant has passed the ECFMG examination and successfully completed an approved Fifth Pathway program (original ECFMG score transcript from the ECFMG required); or

(B) the applicant has been licensed in another state on the basis of a written examination before the establishment of the ECFMG in 1958;

(6) submit an appointment letter from the program director of the GME program or his appointed agent verifying the applicant's appointment and commencement date;

(7) submit two completed fingerprint record cards supplied by the Board;

(8) submit a signed consent form allowing a search of local, state, and national files for any criminal record;

(9) pay a non-refundable fee pursuant to G.S. 90-13.1(b), plus the cost of a criminal background check;

(10) provide proof that the applicant has taken and ~~passed:~~ passed within three attempts:

(A) the COMLEX ~~Level 1~~ Level 1, ~~within three attempts~~ and each component of COMLEX Level 2 (cognitive evaluation and performance evaluation) ~~within three attempts;~~ and if taken, COMLEX Level 3; or

(B) the USMLE Step 1 ~~within three attempts~~ and each component of the USMLE Step 2 (Clinical Knowledge and Clinical ~~Skills)~~ ~~within three attempts;~~ Skills); and if taken USMLE Step 3; and

(11) upon request, supply any additional information the Board deems necessary to evaluate the applicant's competence and character.

(b) An applicant shall be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character, if the Board needs more information to complete the application.

(c) If the applicant previously held a North Carolina residency training license, the licensure requirements established by rule at the time the applicant first received his or her North Carolina residency training license shall apply.

History Note: *Authority G.S. 90-8.1; 90-12.01; 90-13.1;*
Eff. August 1, 2010;
Amended Eff. September 1, 2014; November 1, 2013; August 1, 2012; November 1, 2011.

21 NCAC 32U .0101 is amended with changes as published in 28:21 NCR pages 2586 - 2590 as follows:

21 NCAC 32U .0101 ADMINISTRATION OF VACCINES BY PHARMACISTS

(a) An Immunizing Pharmacist shall administer only those vaccines or immunizations permitted by G..S. 90-85.15B and shall do so subject to all requirements of that statute and this Rule. ~~Purpose. The purpose of this Rule is to provide standards for pharmacists engaged in the administration of influenza, pneumococcal and zoster vaccines as authorized in G.S. 90-85.3(r) of the North Carolina Pharmacy Practice Act.~~

(b) ~~Definitions.~~ The following words and terms, when used in this Rule, have the following meanings: ~~meanings, unless the context indicates otherwise.~~

(1) ~~"ACPE" means Accreditation Council for Pharmacy Education.~~

~~(2)~~ "Administer" means the direct application of a drug to the body of a patient by injection, inhalation, ingestion, or other means by:

(A) an Immunizing Pharmacist or a Pharmacy Intern [~~pharmacy intern~~] who is under the direct, in-person supervision of an Immunizing Pharmacist; ~~a pharmacist, an authorized agent under the pharmacist's supervision, or other person authorized by law;~~ or

(B) the patient at the direction of either an Immunizing Pharmacist or a health care provider authorized by North Carolina law to prescribe the vaccine. ~~a physician or pharmacist.~~

(2) "Immunizing Pharmacist" shall have the meaning provided in G..S. 90-85.3(i1).

(3) "Pharmacy Intern" [~~intern"~~] shall have the meaning provided in 21 NCAC 46 .1317(28).~~"Antibody" means a protein in the blood that is produced in response to stimulation by a specific antigen. Antibodies help destroy the antigen that produced them. Antibodies against an antigen usually equate to immunity to that antigen.~~

(4) "Physician" means a currently licensed M.D. or D.O. with the North Carolina Medical Board who is responsible for the [~~on-going, continuous~~] supervision of the Immunizing Pharmacist pursuant to the Written Protocol between the Immunizing Pharmacist and the [~~physician~~] Physician. ~~"Antigen" means a substance recognized by the body as being foreign; it results in the production of specific antibodies directed against it.~~

~~(5)~~ ~~"Board" means the North Carolina Board of Pharmacy.~~

~~(6)~~ ~~"Confidential record" means any health-related record that contains information that identifies an individual and that is maintained by a pharmacy or pharmacist such as a patient medication record, prescription drug order, or medication order.~~

~~(7)~~ ~~"Immunization" means the act of inducing antibody formation, thus leading to immunity.~~

~~(8)~~ ~~"Medical Practice Act" means G.S. 90-1, et seq.~~

~~(9)~~ ~~"Physician" means a currently licensed M.D. or D.O. with the North Carolina Medical Board who is responsible for the on-going, continuous supervision of the pharmacist pursuant to written protocols between the pharmacist and the physician.~~

~~(10) "Vaccination" means the act of administering any antigen in order to induce immunity; is not synonymous with immunization since vaccination does not imply success.~~

~~(11) "Vaccine" means a specially prepared antigen, which upon administration to a person may result in immunity.~~

(5) RESERVED

(6) RESERVED

(7) RESERVED

(8) RESERVED

(9) RESERVED

(10) RESERVED

(11) RESERVED

(12) "Written Protocol" is a document ~~means a physician's written order, standing medical order, or other order or protocol. A written protocol must be~~ prepared, ~~signed~~ signed, and dated by the ~~physician~~ Physician and Immunizing Pharmacist that shall ~~pharmacist and~~ contain the following:

(A) the name of the Physician ~~individual physician authorized to prescribe drugs and~~ responsible for authorizing the Written Protocol; ~~written protocol;~~

(B) the name of the Immunizing Pharmacist ~~individual pharmacist~~ authorized to administer vaccines;

(C) the immunizations or vaccinations that may be administered by the Immunizing Pharmacist; ~~pharmacist;~~

(D) the screening questionnaires and safety procedures that shall at least include the then-current minimum standard screening questionnaire and safety procedures adopted by the Medical Board, the Board of [~~Nursing~~] Nursing, and the Board of Pharmacy pursuant to S.L. 2013-246, [~~s. 6.~~] s. 6 and available at the North Carolina Medical Board's office and on its website (www.ncmedboard.org).

~~(D)~~(E) the procedures to follow, including any drugs required by the Immunizing Pharmacist ~~pharmacist~~ for treatment of the patient, in the event of an emergency or ~~severe~~ adverse ~~reaction~~ event following vaccine administration;

~~(E)~~(F) the reporting requirements by the Immunizing Pharmacist ~~pharmacist~~ to the Physician, ~~physician issuing the written protocol,~~ including content and time frame; and

~~(F)~~(G) the locations at which the Immunizing Pharmacist ~~pharmacist~~ may administer immunizations or vaccinations. ~~vaccinations; and~~

~~(G) the requirement for annual review of the protocols by the physician and pharmacist.~~

The Physician and the Immunizing Pharmacist [~~must~~] shall review the Written Protocol at least annually and revise it if necessary.

~~(c) Policies and Procedures.~~

~~(1) Pharmacists must follow a written protocol as specified in Subparagraph (b)(12) of this Rule for administration of influenza, pneumococcal and zoster vaccines and the treatment of severe adverse events following administration.~~

~~(2) The pharmacist administering vaccines must maintain written policies and procedures for handling and disposal of used or contaminated equipment and supplies.~~

~~(3) The pharmacist or pharmacist's agent must give the appropriate, most current vaccine information regarding the purpose, risks, benefits, and contraindications of the vaccine to the patient or legal representative with each dose of vaccine. The pharmacist must ensure that the patient or legal representative is available and has read, or has had read to him or her, the information provided and has had his or her questions answered prior to administering the vaccine.~~

~~(4) The pharmacist must report adverse events to the primary care provider as identified by the patient.~~

~~(5) The pharmacist shall not administer vaccines to patients under 18 years of age.~~

~~(6) The pharmacist shall not administer the pneumococcal or zoster vaccines to a patient unless the pharmacist first consults with the patient's primary care provider. The pharmacist shall document in the patient's profile the primary care provider's order to administer the pneumococcal or zoster vaccines. If the patient does not have a primary care provider, the pharmacist shall not administer the pneumococcal or zoster vaccines to the patient.~~

~~(7) The pharmacist shall report all vaccines administered to the patient's primary care provider and report all vaccines administered to all entities as required by law, including any State registries which may be implemented in the future.~~

~~(d) Pharmacist requirements. Pharmacists who enter into a written protocol with a physician to administer vaccines shall:~~

~~(1) hold a current provider level cardiopulmonary resuscitation (CPR) certification issued by the American Heart Association or the American Red Cross or an equivalent certification organization;~~

~~(2) successfully complete a certificate program in the administration of vaccines accredited by the Centers for Disease Control, the ACPE or a health authority or professional body approved by the Board as having a certificate program similar to the programs accredited by either the Centers for Disease Control or the ACPE;~~

~~(3) maintain documentation of:~~

~~(A) completion of the initial course specified in Subparagraph (2) of this Paragraph;~~

~~(B) three hours of continuing education every two years beginning January 1, 2006, which are designed to maintain competency in the disease states, drugs, and administration of vaccines;~~

~~(C) current certification specified in Subparagraph (1) of this Paragraph;~~

~~(D) original written physician protocol;~~

~~(E) annual review and revision of original written protocol with physician;~~

~~(F) any problems or complications reported; and~~

~~(G) items specified in Paragraph (g) of this Rule.~~

(c) ~~A pharmacist~~ An Immunizing Pharmacist who, because of physical disability, is unable to obtain a current provider level CPR certification may administer vaccines in the presence of a pharmacy technician or pharmacist who holds a current provider level CPR certification.

(d) With each dose of vaccine, either the Immunizing Pharmacist or a Pharmacy Intern shall [~~pharmacy intern must~~] give the [~~appropriate,~~] most current vaccine information regarding the purpose, risks, benefits, and contraindications of the vaccine to the patient or legal representative. The Immunizing Pharmacist or Pharmacy Intern [~~pharmacy intern~~] must ensure that the patient or legal representative has the opportunity to read, or to have read to him or her, the information provided and to have any questions answered prior to administration of the vaccine.

(e) ~~Supervising Physician responsibilities. Pharmacists who administer vaccines shall enter into a written protocol with a supervising physician who agrees~~ The Physician shall [~~must~~] agree to meet the following requirements:

(1) be responsible for the formulation or approval ~~and periodic review~~ of the Written Protocol ~~physician's order, standing medical order, standing delegation order, or other order or written protocol~~ and ~~periodically~~ review the Written Protocol ~~order or protocol~~ and the services provided to patients ~~a patient~~ under the Written [~~Protocol;~~] Protocol, as set out in subsection (b)(12) of this Rule; ~~order or protocol;~~

(2) be accessible to the Immunizing Pharmacist ~~pharmacist administering the vaccines~~ or be available through direct telecommunication for consultation, assistance, direction, and provide back-up coverage; and

(3) ~~review written protocol with pharmacist at least annually and revise if necessary; and~~

~~(4)~~ receive a periodic status reports from the Immunizing Pharmacist, ~~report on the patient,~~ including any problems ~~problem~~ or complications ~~complication~~ encountered.

(f) ~~Drugs.~~ The following requirements pertain to drugs administered by an Immunizing Pharmacist: ~~a pharmacist:~~

(1) Drugs administered by an Immunizing Pharmacist ~~a pharmacist~~ under the provisions of this Rule shall be in the legal possession of:

(A) a pharmacy, which shall be the pharmacy responsible for drug accountability, including the maintenance of records of administration of the immunization or vaccination; or

(B) the Physician, ~~a physician,~~ who shall be responsible for drug accountability, including the maintenance of records of administration of the immunization or vaccination;

(2) Drugs shall be transported and stored at the proper temperatures indicated for each drug;

(3) ~~Pharmacists,~~ Immunizing Pharmacists, while engaged in the administration of vaccines under the Written Protocol, ~~written protocol,~~ shall have in their custody and control the vaccines identified in the Written Protocol ~~written protocol~~ and any other drugs listed in the Written Protocol ~~written protocol~~ to treat adverse events; ~~reactions;~~ and

(4) After administering vaccines at a location other than a pharmacy, the Immunizing Pharmacist ~~pharmacist~~ shall return all unused prescription medications to the pharmacy or ~~physician~~ Physician responsible for the drugs.

(g) Record Keeping and Reporting.

(1) ~~A pharmacist who administers any vaccine~~ An Immunizing Pharmacist shall maintain the following information, readily retrievable, in the pharmacy records regarding each administration:

(A) ~~The~~ the name, address, and date of birth of the patient;

(B) ~~The~~ the date of the administration;

(C) ~~The~~ the administration site of injection (e.g., right arm, left leg, right upper arm);

(D) ~~Route~~ route of administration of the vaccine;

(E) ~~The~~ the name, manufacturer, lot number, and expiration date of the vaccine;

(F) ~~Dose~~ dose administered;

(G) ~~The~~ the name and address of the patient's primary health care provider, as identified by the patient; and

(H) ~~The~~ the name or identifiable initials of the Immunizing Pharmacist. ~~administering pharmacist.~~

(2) ~~A pharmacist who administers vaccines~~ An Immunizing Pharmacist shall document the annual review with the Physician ~~physician~~ of the Written Protocol as required in this Rule. ~~written protocol in the records of the pharmacy that is in possession of the vaccines administered.~~

(3) An Immunizing Pharmacist shall [~~must~~] report adverse events associated with administration of a vaccine to either the prescriber, when administering a vaccine pursuant to G..S. 90-85.15B(a), or the patient's primary care provider, if the patient identifies one, when administering a vaccine pursuant to G.S. 90-85.15B(b).

(h) The Immunizing Pharmacist shall [~~must~~] maintain written policies and procedures for handling and disposal of used or contaminated equipment and supplies.

~~(h) Confidentiality.~~

~~(1) The pharmacist shall comply with the privacy provisions of the federal Health Insurance Portability and Accountability Act of 1996 and any rules adopted pursuant to this act.~~

~~(2) The pharmacist shall comply with any other confidentiality provisions of federal or state laws.~~

History Note: *Authority G.S. 90-85.3(r); 90-85.15B;*
Emergency Adoption Eff. September 10, 2004;
Temporary Adoption Eff. December 29, 2004;
Eff. November 1, 2005;
Amended Eff. February 1, 2008;
Emergency Amendment Eff. October 9, 2009;
Temporary Amendment Eff. December 29, 2009;

Temporary Amendment Expired on October 12, 2010.

Amended Eff. September 1, 2014; March 1, 2012.

21 NCAC 32V .0102 is proposed to be amended as follows:

21 NCAC 32V .0102 DEFINITIONS

The following definitions apply to this Subchapter:

(1) Approved educational program – Any program within the United States which, at the time of the Applicant's attendance, was approved by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the Accreditation Committee for Perfusion Education (AC-PE), or any Canadian educational program recognized by the Conjoint Committee on Accreditation of the Canadian Medical Association ~~(CMA).~~ (CMA); or any program, attended by Applicant, that was subsequently approved by CAAHEP, ACPE or CME within seven years of the Applicant's graduation.

(2) Board – The entity referred to in G.S. 90-682(5) and its agents.

(3) Committee – The entity referred to in G.S. 90-682(2) and its agents.

(4) Provisional licensed perfusionist - The person who is authorized to practice perfusion pursuant to 90-698.

(5) Registering - Renewing the license by paying the biennial fee and complying with Rule .0104 of this Subchapter.

(6) Supervising - Overseeing the activities of, and accepting the responsibility for, the perfusion services rendered by a provisional licensed perfusionist. Supervision shall be continuous but, except as otherwise provided in the rules of this Subchapter, shall not be construed as requiring the physical presence of the supervising perfusionist at the time and place that the services are rendered. Supervision shall not mean direct, on-site supervision at all times, but shall mean that the supervising perfusionist shall be readily available for consultation and assistance whenever the provisional licensee is performing or providing perfusion services.

(7) "Supervising Perfusionist" means a perfusionist licensed by the Committee and who serves as a primary supervising perfusionist or as a back-up supervising perfusionist.

(a) The "Primary Supervising Perfusionist" is the perfusionist who, by signing the designation of supervising perfusionist form provided by the Committee, accepts responsibility for the provisional licensed perfusionist medical activities and professional conduct at all times, whether the perfusionist is personally providing supervision or the supervision is being provided by a Back-up Supervising Perfusionist.

(b) The "Back-up Supervising Perfusionist" means the perfusionist who accepts the responsibility for supervision of the provisional licensed perfusionist's activities in the absence of the Primary Supervising Perfusionist. The Back-up Supervising Perfusionist is responsible for the activities of the provisional licensed perfusionist only when providing supervision.

History Note: *Authority G.S. 90-681; 90-682; 90-685(1)(3);*
Eff. September 1, 2007.

Amended Eff. September 1, 2014.

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NORTH CAROLINA MEDICAL BOARD

Financial Statements

October 31, 2013 and 2012

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NORTH CAROLINA MEDICAL BOARD
Management's Discussion and Analysis
October 31, 2013

As management of the North Carolina Medical Board (the Board), we offer this discussion and analysis of the financial position for the fiscal year ended October 31, 2013. This discussion and analysis is designed to provide an overview of the Board's activities that have a financial impact and to present the change in the Board's financial position. This discussion should be read along with the financial statements and notes to the financial statements.

Financial Highlights

Net assets are an indicator of the financial health of the Board. Assets exceeded liabilities by $2,418,828 and $2,869,799 as of October 31, 2013 and 2012, respectively.

Condensed Statement of Net Position

	October 31,	
	2013	2012
Current Assets	$ 2,581,509	$ 2,796,004
Noncurrent Asset	2,375,085	2,205,236
Capital Assets	2,032,764	2,374,686
Total Assets	6,989,358	7,375,926
Current Liabilities	4,570,530	4,506,127
Invested in Capital Assets	2,032,764	2,374,686
Unrestricted Net Position	386,064	495,113
Total Net Position	$ 2,418,828	$ 2,869,799

The following table summarizes the revenues and expenses for the Board for the fiscal years ending October 31, 2013 and 2012:

Condensed Statement of Revenues, Expenses and Changes in Net Assets

	For the Years Ended October 31,	
	2013	2012
Operating Revenues	$ 8,247,253	$ 8,223,234
Non-Operating Revenues	229,565	264,910
Total Revenues	8,476,818	8,488,144
Operating Expenses	8,927,789	8,906,160
Change in Net Position	(450,971)	(418,016)
Beginning Net Position	2,869,799	3,287,815
Ending Net Position	$ 2,418,828	$ 2,869,799

Operating revenues increased by $24,019. The primary reason for the increase in operating revenues was an increase in registration fees due to an increase in the number of licenses approved or renewed. However, the increase in registration fees was offset by a decrease in civil penalties collected. Operating expenses increased by $21,629 during the year. The primary reason for the increase in operating expenses was an increase in employee wages due to merit increases and staff additions. However, the increase in wages and benefits was offset by a decrease in civil penalties remitted. Non-Operating revenues decreased by $35,345. The primary reason for the decrease in non-operating revenues was a decrease in unrealized gains on investments.

NORTH CAROLINA MEDICAL BOARD
Management's Discussion and Analysis
October 31, 2013

Overview of Financial Statements

This discussion and analysis is an introduction to the Board's basic financial statements, which comprise the following components: 1) Statement of Net Position, 2) Statement of Revenues, Expenses, and Changes in Net Position, 3) Statement of Cash Flows, and 4) Notes to Financial Statements. These financial statements are prepared in accordance with Governmental Accounting Standards Board (GASB) principles.

Financial Statements

The financial statements present information about the Board using accounting methods similar to those used by private businesses. The major difference being that the focus of governmental reporting is fiscal and operational accountability to assure that sufficient resources are available to cover cost of providing services over the long term as opposed to the market-driven focus reported in the private sector.

The Statement of Net Position presents assets, liabilities, and net position.

The Statement of Revenues, Expenses, and Changes in Net Position presents the activities that show the change in net position. Operating revenues are received primarily from initial and renewal of licensing fees. Non-operating revenue is derived from earnings on investments and gains (losses) on sales of fixed assets. Operating expenses are used to acquire goods and services in return for the operating revenues in order to carry out the mission of the Board.

The Statement of Cash Flows presents information on how changes in the Statement of Net Position and Statement of Revenues, Expenses, and Changes in Net Position affects cash. The Statement of Cash Flows is useful in analyzing the short-term viability of the Board; i.e. its ability to meet its financial obligations.

Capital Assets

Net capital assets decreased by $341,922 during the year ended October 31, 2013. The decrease was due primarily to depreciation expense being offset by routine equipment purchases. The following is a summary of capital assets, net of depreciation:

	For the Years Ended October 31,	
	2013	2012
Land	$ 177,000	$ 177,000
Building and Improvements	1,448,946	1,533,425
Office Furniture and Equipment	406,818	664,261
	$ 2,032,764	$ 2,374,686

Contacting the Board's Management

This financial report is designed to provide a general overview of the Board's finances and to demonstrate the Board's accountability for the funds it receives and expends. If you have any questions about this report or need additional information, contact:

R. David Henderson, Executive Director
North Carolina Medical Board
P. O. Box 20007
Raleigh, NC 27619-0007

KWH
Koonce, Wooten & Haywood, LLP
CERTIFIED PUBLIC ACCOUNTANTS

To the Board of Directors
North Carolina Medical Board
Raleigh, North Carolina

INDEPENDENT AUDITOR'S REPORT

We have audited the accompanying financial statements of North Carolina Medical Board as of October 31, 2013, and the related notes to the financial statements, which collectively comprise the Board's financial statements as listed in the table of contents. The financial statements of North Carolina Medical Board as of October 31, 2012 were audited by other auditors whose report dated January 14, 2013, expressed an unmodified opinion on those statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinions

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the North Carolina Medical Board, as of October 31, 2013, and the changes in financial position and cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

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Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis on pages 1 through 2 be presented to supplement the financial statements. Such information, although not a part of the financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the financial statements, and other knowledge we obtained during our audit of the financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Koonce, Wooten & Haywood, L.L.P.

Raleigh, North Carolina
January 16, 2014

NORTH CAROLINA MEDICAL BOARD
Statements of Net Position
October 31, 2013 and 2012

	2013	2012
ASSETS:		
CURRENT ASSETS:		
Cash and Cash Equivalents	$ 259,085	$ 201,359
Accounts Receivable	47,865	
Investments	2,245,213	2,486,297
Prepaid Expenses	29,346	108,348
Total Current Assets	2,581,509	2,796,004
CAPITAL ASSETS:		
Land	177,000	177,000
Building and Improvements	2,313,020	2,313,020
Office Furniture and Equipment	3,144,261	3,110,104
Total	5,634,281	5,600,124
Less Accumulated Depreciation	3,601,517	3,225,438
Total Capital Assets	2,032,764	2,374,686
OTHER ASSETS:		
Investments	2,375,085	2,205,236
Total Assets	$ 6,989,358	$ 7,375,926
LIABILITIES:		
CURRENT LIABILITIES:		
Accounts Payable	$ 189,073	$ 170,292
Payroll Liabilities		112,132
Compensated Absences	305,479	288,602
Unearned Lease Incentive	8,068	19,028
Unearned License Revenue	4,067,910	3,916,073
Total Current Liabilities	4,570,530	4,506,127
NET POSITION:		
Invested in Capital Assets	$ 2,032,764	$ 2,374,686
Unrestricted	386,064	495,113
Total Net Position	$ 2,418,828	$ 2,869,799

The accompanying notes are an integral part of the financial statements.

NORTH CAROLINA MEDICAL BOARD
Statements of Revenues, Expenses, and Changes in Net Position
For the Years Ended October 31, 2013 and 2012

	2013	2012
OPERATING REVENUES:		
Physicians' Fees	$ 6,723,288	$ 6,543,347
Corporations' Fees	141,480	136,848
Residents' Fees	409,847	397,650
Physician Assistants' Fees	566,200	529,000
Nurse Practitioners' Fees	228,375	210,967
Other Licensee Fees	67,175	51,750
Datalink and Roster Reports	40,388	51,822
Civil Penalties Collected	70,500	301,850
Total Operating Revenues	8,247,253	8,223,234
OPERATING EXPENSES:		
Employee Wages and Benefits	5,868,945	5,572,315
Physician Health Program	779,668	780,959
Office Expenses	434,398	421,886
Depreciation	461,922	528,571
Postage and Printing	73,619	117,340
Automotive, Travel, and Meal Expenses	215,539	238,452
Board Per Diem Expense	152,206	171,219
Maintenance and Computer Support	522,097	387,193
Consulting	248,397	162,520
Legal and Accounting	46,621	167,139
Dues and Publications	39,976	44,498
Civil Penalties Remitted	70,500	301,850
Other	13,901	12,218
Total Operating Expenses	8,927,789	8,906,160
OPERATING LOSS	(680,536)	(682,926)
NON-OPERATING REVENUES:		
Gain on Disposal of Assets	800	2,243
Investment Income	228,765	262,667
Total Non-Operating Revenues	229,565	264,910
CHANGE IN NET POSITION	(450,971)	(418,016)
NET POSITION--Beginning of Year	2,869,799	3,287,815
NET POSITION--End of Year	$ 2,418,828	$ 2,869,799

The accompanying notes are an integral part of the financial statements.

NORTH CAROLINA MEDICAL BOARD
Statements of Cash Flows
For the Years Ended October 31, 2013 and 2012

	2013	2012
CASH FLOWS FROM OPERATING ACTIVITIES:		
Cash Received from Registrations	$ 8,240,337	$ 8,021,578
Cash Payments to Employees	(5,964,200)	(5,455,678)
Cash Payments to Physicians Health Program	(778,773)	(790,513)
Cash Payments for Office Operations	(1,731,326)	(2,023,164)
Cash Received for Other Operating Revenues	110,888	353,673
Net Cash Provided (Used) by Operating Activities	(123,074)	105,896
CASH FLOWS FROM INVESTING ACTIVITIES:		
Proceeds from Sale of Fixed Assets	800	2,280
Purchases of Fixed Assets	(120,000)	(265,093)
Purchases of Investments	(1,730,964)	(821,753)
Proceeds from Sale of Investments	2,030,964	1,071,754
Net Cash Provided (Used) by Investing Activities	180,800	(12,812)
NET INCREASE IN CASH	57,726	93,084
CASH--Beginning of Year	201,359	108,275
CASH--End of Year	$ 259,085	$ 201,359
RECONCILIATION OF OPERATING LOSS TO		
NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES:		
Operating Loss	$ (680,536)	$ (682,926)
Adjustments to Reconcile Operating Loss to		
Net Cash Provided (Used) by Operating Activities:		
Depreciation	461,922	528,571
Changes in Assets and Liabilities:		
Accounts Receivable	(47,865)	
Prepaid Expenses	79,002	(41,558)
Accounts Payable	18,781	39,872
Payroll Liabilities	(112,132)	112,132
Compensated Absences	16,877	4,505
Unearned Lease Incentive	(10,960)	(6,716)
Unearned License Revenue	151,837	152,016
Net Cash Provided (Used) by Operating Activities	$ (123,074)	$ 105,896
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION:		
Noncash Investing Activities:		
Reinvested Interest and Dividends, net of fees	$ 123,562	$ 127,407

The accompanying notes are an integral part of the financial statements.

NORTH CAROLINA MEDICAL BOARD
Notes to Financial Statements
October 31, 2013 and 2012

1. Summary of Significant Accounting Policies

A. Organization:

The North Carolina Medical Board (the Board) is an occupational licensing board and is authorized by Chapter 90 of the NC General Statutes. The Board exists to regulate the practice of medicine for the benefit and protection of the people of the State of North Carolina. The Board is involved in licensing, monitoring, education, and rehabilitation of physicians, physicians' assistants, and other health care professionals.

B. Reporting Entity:

The Board is considered an agency of the State of North Carolina and along with other state licensing boards is reported as an enterprise fund within the State's Comprehensive Annual Financial Report (CAFR).

C. Basis of Presentation:

The accompanying financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America. The Governmental Accounting Standards Board (GASB) is the accepted standard setting body for establishing governmental accounting principles and reporting standards.

All activities of the Board are accounted for within a single proprietary fund. Proprietary funds are used to account for operations that are financed and operated in a manner where the intent of the governing body is that the cost of is that the cost of carrying out the legislatively-delegated function for the benefit of the general public be financed or recovered primarily through user charges.

D. Basis of Accounting:

In accordance with *Governmental Accounting Standards Statement 34*, the Board presents a Statement of Net Position; a Statement of Revenues, Expenses, and Changes in Net Position; and a Statement of Cash Flows. These statements reflect entity-wide operations of the Board. The Board has no fiduciary funds or component units. The financial statements report all activities of the North Carolina Medical Board using the current financial resource measurement focus and the full accrual basis of accounting. Revenue from individual health care professional licensees is recognized over the license period. Individuals are licensed by the Board annually upon registering within 30 days of their birthday. Corporations are licensed annually and the revenue is recognized over the license period. Operating revenues and expenses consist of those revenues and expenses that result from the ongoing principal operations of the Board. Other revenues and expenses are classified as non-operating in the financial statements.

E. Cash and Cash Equivalents:

For purposes of the statements of cash flows, the Board considers cash to include cash in banks and short-term investments with original maturities of three months or less.

F. Investments:

The Board reports investments at fair value as required by *Governmental Accounting Standards Statement 31*. Fair value is based on readily available published values. Money market funds invested through brokerage accounts or bank investment management firms are considered investments.

G. Capital Assets:

Capital assets are recorded at original cost using a capitalization threshold of $5,000. Depreciation on furniture and office equipment is computed using the straight-line method over the estimated useful lives of the individual assets, ranging from three to seven years. Depreciation on the building and building improvements is computed using the straight-line method over the estimated useful life of the building, which is estimated at

NORTH CAROLINA MEDICAL BOARD
Notes to Financial Statements
October 31, 2013 and 2012

1. Summary of Significant Accounting Policies (Continued)

30 years. Expenditures for repairs and maintenance are charged to expense as incurred. The cost and related accumulated depreciation associated with capital assets are removed from the accounts upon retirement or other disposition, and any resulting gain or loss is reflected as a non-operating item.

H. Long-Lived Assets:

Long-lived assets to be held and used are reviewed for impairment whenever events or changes in circumstances indicate that the related carrying amount may not be recoverable. When required, impairment losses on assets to be held and used are recognized based on the excess of the asset's carrying amount over the fair value of the asset. Long-lived assets to be disposed of are reported at the lower of carrying amount or fair value less cost to sell.

I. Compensated Absences:

Vacation is accrued as earned and payable. Board policy provides for a maximum accumulation of unused vacation leave of 480 hours, which can be carried forward at the end of each fiscal year. Unused vacation in excess of 480 hours may be transferred to sick leave. Upon termination of employment, the employee is paid for vacation earned but not taken up to a maximum of 240 hours. The liability is adjusted annually for the change in accrued vacation pay, and the change is reflected in the statement of revenues, expenses, and changes in net position. Accrued vacation totaled $305,479 and $288,602 at October 31, 2013 and 2012, respectively.

The Board's sick leave policy provides for an unlimited accumulation of earned sick leave. Since the Board has no obligation to compensate an employee for the accumulated sick leave until it is taken, no accrual for sick leave has been made.

J. Unearned Revenue:

Unearned revenue consists of license fees collected and recognized as revenue over the time periods to which the fees relate.

K. Net Position:

Net position is classified as invested in capital assets, net of related debt; restricted; and unrestricted. Restricted net position represents constraints on resources that are either externally imposed by creditors, grantors, contributors, or laws or regulations of other governments or imposed by law through state statute. The Board currently has no restricted net position.

L. Accounting Estimates:

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reported period. Actual results could differ from those estimates.

M. Subsequent Events:

Management of the Board evaluated subsequent events through January 16, 2014, which is the date the financial statements were available to be issued. They discovered no subsequent events that should be disclosed.

NORTH CAROLINA MEDICAL BOARD
Notes to Financial Statements
October 31, 2013 and 2012

2. Deposits

All deposits of the Board are maintained in financial institutions located in the State of North Carolina. Amounts in excess of monthly operating expenses are transferred to a managed investment account.

3. Investments

As of October 31, 2013 and 2012, the Board had the following investments:

	Fair Value	
	2013	2012
Corporate Bonds	$ 1,978,384	$ 1,348,362
Government Bonds	876,874	1,088,915
Bond Mutual Funds	569,169	1,254,468
Equity Securities	1,060,572	938,082
	4,484,999	4,629,827
Money Market	135,299	61,706
	$ 4,620,298	$ 4,691,533

The Board's investments are subject to interest, credit, and custodial risk.

Interest Rate Risk – As a means of limiting its exposure to fair value losses arising from rising interest rates and to protect principal, the Board's investment policy seeks to maintain an asset allocation that allows for required cash flows while maintaining a high quality, diverse asset allocation.

The maturities of the Board's corporate and government bonds as of October 31, 2013 were:

1-3 years	$ 1,467,619
3-7 years	1,331,956
7+ years	55,683
	$ 2,855,258

Credit Risk – The Board has authorized the investment manager discretion to buy and sell securities; however, the investment allocation guidelines are governed by the Board's investment policy. The investment policy permits a portfolio of 10% - 25% equity investments, 75% - 90% fixed income investments, and a maximum of 10% cash equivalents.

The investment policy provisions permit the holding of current bonds held with Standard & Poor's credit ratings of AAA to BB-; however, future bond purchases are restricted to securities with an A rating or better.

NORTH CAROLINA MEDICAL BOARD
Notes to Financial Statements
October 31, 2013 and 2012

3. Investments (Continued)

At October 31, 2013, the Board's portfolio had the following credit ratings:

Credit Rating	Investment Amount
AA+	$ 569,340
AA	55,682
AA-	336,624
A+	206,473
A	737,359
A-	206,643
BBB+	206,001
BBB	229,601
Not Rated	569,169

In addition, the Board held government bonds with a fair value of $307,535, which are not rated but are fully guaranteed by the United States.

Custodial Credit Risk – Custodial credit risk is the risk that in the event of the failure of the counter party, the Board will not be able to recover the value of its investments or collateral securities that are in the possession of an outside party.

The Board maintains cash accounts at a commercial bank. Accounts maintained at commercial banks are insured, in the aggregate per depositor, by the Federal Deposit Insurance Corporation (FDIC) up to $250,000 per bank. The Board had FDIC uninsured cash balances of $47,213 at October 31, 2013. The Board did not have any FDIC uninsured cash balances at October 31, 2012.

The Board also maintains securities and cash and cash equivalents in a bank investment management firm (Firm). The Firm carries bankers' professional liability insurance with limits up to $15 million to cover inadvertent actions taken by bank personnel on behalf of fiduciary accounts. In addition, the Firm carries a financial institution bond policy covering criminal activities, employee dishonesty, and electronic and computer crime. At October 31, 2013, the FDIC limits of protection were $250,000 for cash and cash equivalents held with the Firm and the Board had no uninsured cash and cash equivalents.

Investment income is composed of the following at October 31:

	2013	2012
Interest and Dividends	$ 156,742	$ 160,781
Unrealized and Realized Gains	105,203	135,260
Investment Fees	(33,180)	(33,374)
	$ 228,765	$ 262,667

NORTH CAROLINA MEDICAL BOARD
Notes to Financial Statements
October 31, 2013 and 2012

4. Capital Assets

Changes in capital assets for the year ended October 31, 2013 were as follows:

	October 31, 2012	Increases	Decreases	October 31, 2013
Capital Assets Not Being Depreciated:				
Land	$ 177,000	$	$	$ 177,000
Capital Assets Being Depreciated:				
Building and Improvements	2,313,020			2,313,020
Office Furniture and Equipment	3,110,104	120,000	(85,843)	3,144,261
Total Capital Assets Being Depreciated	5,423,124	120,000	(85,843)	5,457,281
Less Accumulated Depreciation for:				
Building and Improvements	779,595	84,479		864,074
Office Furniture and Equipment	2,445,843	377,443	(85,843)	2,737,443
Total Accumulated Depreciation	3,225,438	461,922	(85,843)	3,601,517
Total Capital Assets Being Depreciated	2,197,686	(341,922)		1,855,764
Capital Assets, net	$ 2,374,686	$ (341,922)	$ 0	$ 2,032,764

Changes in capital assets for the year ended October 31, 2012 were as follows:

	October 31, 2011	Increases	Decreases	October 31, 2012
Capital Assets Not Being Depreciated:				
Land	$ 177,000	$	$	$ 177,000
Capital Assets Being Depreciated:				
Building and Improvements	2,284,807	28,213		2,313,000
Office Furniture and Equipment	3,076,761	236,880	(203,537)	3,110,104
Total Capital Assets Being Depreciated	5,361,568	265,093	(203,537)	5,423,124
Less Accumulated Depreciation for:				
Building and Improvements	698,074	81,521		779,595
Office Furniture and Equipment	2,202,292	447,050	(203,499)	2,445,843
Total Accumulated Depreciation	2,900,366	528,571	(203,499)	3,225,438
Total Capital Assets Being Depreciated	2,461,202	(263,478)	(38)	2,197,686
Capital Assets, net	$ 2,638,202	$ (263,478)	$ (38)	$ 2,374,686

NORTH CAROLINA MEDICAL BOARD
Notes to Financial Statements
October 31, 2013 and 2012

5. Pension Plan

The Board has a contributory pension plan covering all full-time employees who have met certain age and length of service requirements. There was one employee hired prior to 1983 who is covered by the Teachers' and State Employees' Retirement System of North Carolina. Under this plan, employees are required to defer 6% of their salary and the Board contributes a percentage of salary as set by the General Assembly of the State of North Carolina. This percentage for the years ended October 31, 2013 and 2012 was 14.23% and 13.12%, respectively.

Employees hired after 1982 are covered under a 401(k) plan administered by John Hancock which allows all employees an elective deferral of their salary. The Board makes a matching contribution of up to 6% of an employee's salary.

In November 2009, the Board adopted a 457 plan administered by Qualified Retirement Plan Services, Inc. The plan allows all employees to elect a deferral.

Total pension costs for the years ended October 31, 2013 and 2012 were $257,341 and $270,457, respectively. Employee contributions for the years ended October 31, 2013 and 2012 were $578,091 and $505,788, respectively.

6. Lease Obligations and Deferred Lease Incentive

The Board is committed on various long-term leases for equipment and storage. These operating leases expire at various times over the next three years. Rent expense for these leases for the years ended October 31, 2013 and 2012 was $31,850 and $52,270, respectively.

Future minimum lease commitments required as of October 31, 2013 are summarized as follows:

Years Ending October 31	
2014	$ 49,209
2015	34,388
2016	15,290
2017	9,593
2018	3,198
	$ 111,678

In 2010, the Board replaced two leased copiers with two copiers from another company. The new company gave the Board $35,258 as compensation for obligations under the older copier leases. The Board deferred the revenue and recognized the $35,258 on a straight-line basis over the remaining life of the new lease. In 2013, the Board replaced the leased copier with a copier from another company. The new company gave the Board $16,137 as compensation to pay off the obligation under the old copier lease. The Board is applying the payments on the old copier against the deferred lease incentive liability. The old copier lease is expected to be paid off entirely in April 2014. At October 31, 2013 and 2012, the Board had $8,068 and $19,208, respectively, of deferred income related to these lease incentives.

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7. Compensated Absences

Changes to accrued vacation are as follows:

	2013	2012
Beginning Accrued Vacation	$ 288,602	$ 284,097
Vacation Earned	340,077	315,148
Vacation Used	(323,200)	(310,643)
Ending Accrued Vacation	$ 305,479	$ 288,602

8. Commitments

Effective January 1, 1994, the Board entered into an agreement with the North Carolina Medical Society to constitute a revised peer review agreement for the purpose of conducting an impaired physician program. This program is administered by North Carolina Physicians Health Program, Inc. (NCPHP), an affiliate of the North Carolina Medical Society. The program has been established for the identification of impaired physicians and physicians' assistants and to provide avenues for treatment programs and rehabilitation of impaired physicians. Expenditures made pursuant to the NCPHP program were $779,668 and $780,959 for the years ended October 31, 2013 and 2012, respectively.

9. Risk Management

Tort claims of Board members up to $1,000,000 are self-insured by the State under the authority of the State Tort Claims Act. Additional coverage is provided to the Board under the State's public officers' and employees' liability insurance contract with a private insurance company. The Board also protects itself from exposures to loss through the purchase of commercial insurance.

10. Reclassification

Certain amounts for 2012 have been reclassified to conform with the 2013 financial statement presentation. Such reclassifications have no effect on changes in net position or cash flows as previously reported.