

State of Florida

GENERAL RECORDS SCHEDULE GS4 FOR PUBLIC HOSPITALS, HEALTH CARE FACILITIES AND MEDICAL PROVIDERS



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R. 1B-24.003(1)(d), *Florida Administrative Code*
Florida Department of State

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GENERAL RECORDS SCHEDULE

GENERAL INFORMATION AND INSTRUCTIONS

FOREWORD

The **general records schedules** established by the Department of State are intended for use by state, county, city and special district public records custodians. If you are unsure of your organization's status as a "public agency," consult your legal counsel and/or the Florida Attorney General's Office for a legal opinion. The Department of State publishes the following general records schedules:

GS1-SL	State and Local Government Agencies
GS2	Law Enforcement, Correctional Facilities and District Medical Examiners
GS3	Election Records
GS4	Public Hospitals, Health Care Facilities and Medical Providers
GS5	Public Universities and Colleges
GS7	Public Schools Pre-K-12 and Adult and Career Education
GS8	Fire Departments
GS9	State Attorneys
GS11	Clerks of Court
GS12	Property Appraisers
GS13	Tax Collectors
GS14	Public Utilities
GS15	Public Libraries

All Florida public agencies are eligible to use the GS1-SL, which provides retention periods for the most common administrative records, such as routine correspondence and personnel, payroll, financial and legal records. General records schedules GS2 through GS15 are applicable to program records of specific functional areas, such as elections administration, tax collecting or law enforcement, each of which has unique program responsibilities and thus unique records retention requirements. The GS2 through GS15 should be used in conjunction with the GS1-SL to cover as many administrative and program records as possible.

The retention periods set forth in the general records schedules are based on federal and state laws and regulations, general administrative practices and fiscal management principles. Please note that these are **minimum** retention periods; public agencies may retain their records longer at their discretion. In fact, certain accreditation committees may have standards that require longer retention periods. Contact your accrediting organization for more information on their requirements. In addition, federal, state or local laws and regulations regarding recordkeeping and records retention for specific agencies or specific types of records might require a longer retention than indicated in this general schedule. Agencies should be aware of all laws and regulations relating to their records and recordkeeping requirements. However, remember that a public agency is **not** permitted to **reduce** the retention periods stated in a general records schedule.

For additional information on records retention and disposition, please refer to *The Basics of Records Management* handbook, which, along with all Florida general records schedules, is available on the Department of State's Records Management website at info.florida.gov/records-management/.

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I. STATUTORY AUTHORITY

This general records schedule is issued by the Department of State's Division of Library and Information Services in accordance with the statutory provisions of Chapters 119 and 257, *Florida Statutes*. **This schedule covers records created, received or maintained by public hospitals, health care facilities and medical providers.**

Chapter 119, *Florida Statutes*, defines the terms "public records," "custodian of public records" and "agency," as well as the fundamental process by which disposition of public records is authorized under law.

Chapter 257, *Florida Statutes*, establishes the Florida State Archives and the Records and Information Management Program under the direction of the Division of Library and Information Services and specifically provides for a system for the scheduling and disposition of public records. Chapter 257 also authorizes the Division to establish and coordinate standards, procedures and techniques for efficient and economical records creation and recordkeeping, and it requires all agencies to appoint a Records Management Liaison Officer (RMLO).

II. DETERMINING RETENTION REQUIREMENTS

In determining public records retention requirements, four values must be considered to ensure that the records will fulfill their reason for creation and maintenance: administrative, legal, fiscal and historical. These four values have been evaluated in depth to determine the retention requirements of the records listed in this general records schedule.

There are two particular financial factors that may impact the retention period of an agency's records:

A. Audits - The term "audit" is defined by Section 11.45, *Florida Statutes*, as encompassing financial, operational and performance audits. The Florida Auditor General's Office describes these audits as follows:

1. Financial audit means an examination of financial statements in order to express an opinion on the fairness with which they are presented in conformity with generally accepted accounting principles and an examination to determine whether operations are properly conducted in accordance with legal and regulatory requirements. Financial audits must be conducted in accordance with auditing standards generally accepted in the United States and government auditing standards as adopted by the Florida Board of Accountancy. Audit requirements for state financial assistance provided by State of Florida agencies to nonstate entities are established by the Florida Single Audit Act, Section 215.97, *Florida Statutes*. When applicable, the scope of financial audits shall encompass the additional activities necessary to establish compliance with the Single Audit Act Amendments of 1996, 31 U.S.C. ss. 7501-7507, and other applicable federal laws.
2. Operational audit means an audit conducted to evaluate management's performance in establishing and maintaining internal controls, including controls designed to prevent and detect fraud, waste and abuse, and in administering assigned responsibilities in accordance with applicable laws, administrative rules, contracts, grant agreements and other guidelines. Operational audits must be conducted in accordance with government auditing standards. Such audits examine internal controls that are designed and placed in operation to promote and encourage the achievement of management's control objectives in the categories of compliance, economic and efficient operations, reliability of financial

records and reports, and safeguarding of assets, and identify weaknesses in those internal controls.

3. Performance audit means an examination of a program, activity or function of a governmental entity conducted in accordance with applicable government auditing standards or auditing and evaluation standards of other appropriate authoritative bodies. The term includes an examination of issues related to a number of defined criteria.

The Records Management Program does not track or maintain information on which audits apply to which records in which agencies. Different agencies are subject to different types of audits at different times, and each agency is responsible for knowing what audits might be conducted and retaining needed records for that purpose. For instance, some agencies might be subject to the Federal Single Audit Act, while others are not. In general, any records relating to finances or financial transactions might be subject to audit.

Audits may be conducted by the Florida Auditor General, independent public accountants, or other state or federal auditors as well as grant funding agencies and national or statewide professional accreditation or certification groups. Your finance office, your legal office and the Auditor General's Office are good sources of information regarding which specific records your agency should retain for audit purposes.

Because conceivably any record in any agency might be required for audit, we are no longer including the “provided applicable audits have been released” language on selected retention items. Each agency is responsible for ensuring that any and all auditable records are maintained for as long as necessary to meet that agency’s audit requirements.

- B. Grants - Any public agency receiving local, state or federal grant money will need to be familiar with grantor agency requirements.

III. SCHEDULING AND DISPOSITION OF PUBLIC RECORDS

The procedures for scheduling and disposition of public records, which are applicable to all public agencies, consist of two separate but related actions:

- A. Establishing a Records Retention Schedule - A retention schedule describing the records and setting the minimum retention period is required for each record series. A record series, as defined in Rule 1B-24, *Florida Administrative Code*, is “a group of related public records arranged under a single filing arrangement or kept together as a unit (physically or intellectually) because they consist of the same form, relate to the same subject or function, result from the same activity, document a specific type of transaction, or have some other relationship arising from their creation, receipt, or use.” Examples of series that agencies might maintain are Personnel Files, Client Case Files, Project Research Files, Equipment Maintenance and Repair Records, and Procurement Files. Each record series might contain records in a variety of forms and formats that collectively document a particular program, function or activity of the agency.

The records retention schedule officially establishes the *minimum* length of time that the record series must be retained. **This retention applies to the agency’s record (master) copy of the records – those public records specifically designated by the custodian as the official record. The retention period for duplicates – copies of records that are not the official record of an agency – is always “Retain until obsolete, superseded, or administrative value is lost” (“OSA”) unless otherwise specified.**

Therefore, we are no longer including the OSA retention statement for duplicates in each retention item.

1. **General records schedules** establish retention requirements for records documenting administrative and program functions common to several or all government agencies, such as personnel, accounting, purchasing and general administration. General records schedules can cover a significant proportion of an agency's record series. The *General Records Schedule GS1-SL for State and Local Government Agencies* can be used by all state and local agencies in determining their records retention requirements.

Certain agencies can use other general records schedules in conjunction with the GS1-SL. For example, along with using the GS1-SL, public universities and colleges should use the *GS5 for Public Universities and Colleges* for program records unique to their functions and activities. Similarly, along with using the GS1-SL, State Attorneys should use the *GS9 for State Attorneys* and property appraisers should use the *GS12 for Property Appraisers*. Please see the Foreword for a complete list of general records schedules, and contact the Records Management Program to verify which general records schedules are appropriate for use by your agency.

If a similar record series is listed in two general record schedules, the schedule with the longer retention requirement shall take precedence.

REMEMBER: The retention period stated in the applicable schedule is the **minimum** time a record must be maintained. If two or more record series are filed together, the combined file must be retained through the longest retention period of those records.

2. **Individual records schedules** establish retention requirements for records that are unique to particular agencies. These schedules are used for records that are not in a general schedule. Individual records schedules may **only** be used by the agency for which they were established.

To establish an individual records schedule, an agency must submit a Request for Records Retention Schedule, Form LS5E-105REff.2-09, to the Records Management Program for review and approval. This "105" form is available on the Records Management website at info.florida.gov/records-management/forms-and-publications/.

Records become eligible for disposition action once they have met the retention requirements specified in an established retention schedule and any other applicable requirements (e.g., litigation). The individual schedule remains effective until there is a change in series content or until other factors are introduced that would affect the retention period, at which time a new individual records retention schedule should be submitted for approval. If a new general records schedule is later established that requires an equal or longer retention period for the same records, that general records schedule supersedes the individual records schedule. If you have an individual schedule that requires a longer retention, contact the Records Management Program for guidance.

- B. **Final Disposition of Public Records** - Section 257.36(6), *Florida Statutes*, states that "A public record may be destroyed or otherwise disposed of only in accordance with retention schedules established by the division." This means that all records, regardless of access provisions, must be scheduled before disposition can occur (see Sections 119.07-119.0714, *Florida Statutes*, regarding access provisions). Agencies must identify an appropriate general records schedule or individual records schedule for any records being disposed of. If an appropriate retention schedule for the records does not exist, one

must be established by following the procedures listed above for individual records schedules.

Agencies must maintain internal **records disposition documentation**, including retention schedule number, retention schedule item number (including, when needed, the suffix 'a' for the record copy or 'b' for duplicates), record series title, inclusive dates, volume in cubic feet of physical records destroyed (for electronic records, record the number of bytes and/or records and/or files if known, or indicate that the disposed records were in electronic form), and disposition action (manner of disposition) and date. A form titled *Records Disposition Document*, which is recommended for use in documenting records disposition, is available on the Records Management website at info.florida.gov/records-management/forms-and-publications/. Agencies must maintain this documentation as a permanent record but should **not** submit it to the Records Management Program for review or approval.

IV. DISTINGUISHING BETWEEN THE DIFFERENT TYPES OF RETENTION PERIOD REQUIREMENTS

When trying to determine when records are eligible for disposition, agencies must be aware of the different types of retention requirements. For instance, records with a retention of "3 anniversary years" will have a different eligibility date from records with a retention of "3 fiscal years" or "3 calendar years."

A. Anniversary Year - from a specific date

Example: 3 anniversary years

If a record series has a retention of "3 anniversary years," the eligibility date would be 3 years after the ending date of the series.

B. Calendar Year - January 1 through December 31

Example: 3 calendar years

If a record series has a retention of "3 calendar years," the eligibility date would be 3 years after the end of the calendar year of the last record in the series.

C. Fiscal Year - depends on agency type

- State government agencies, school districts - July 1 through June 30
- Local government agencies - October 1 through September 30

Example: 3 fiscal years

If a record series has a retention of "3 fiscal years," the eligibility date would be 3 years after the end of the fiscal year of the last record in the series.

D. Months or Days

Examples: 6 months; 90 days

If a record series has a retention of "6 months," the eligibility date would be 6 months after the ending date of the record series.

If a record series has a retention of "90 days," the eligibility date would be 90 days after the ending date of the record series.

E. Retain until obsolete, superseded, or administrative value is lost (OSA)

With this retention, a record is eligible for disposition whenever it is no longer of any use or value to the agency or when it has been replaced by a more current record. The retention could vary from less than one day to any length of time thereafter.

F. Triggering Event

With this retention, records become eligible for disposition upon or after a specific triggering event.

Examples:

Retain until youth turns age 25.

Retain for life of the structure.

3 anniversary years after final action.

Example: Calculating Eligibility Dates

If the **ending date** for a specific record series is **7/31/2007**, when are these records eligible for disposition under different retention period types?

Retention Period	Start Counting From	Add # of Years	Retain Through
3 anniversary years	7/31/2007	+3	= 7/31/2010
3 fiscal years (local govt.)	9/30/2007	+3	= 9/30/2010
3 fiscal years (school district)	6/30/2008	+3	= 6/30/2011
3 calendar years	12/31/2007	+3	= 12/31/2010

V. ARCHIVAL VALUE

A. State Agencies - The State Archives of Florida identifies records having enduring historical, administrative, legal or fiscal value that may be eligible for permanent preservation. If a record series description indicates that the records "**may have archival value**," the state agency must contact the State Archives of Florida for archival review before disposition of the records. The RMLO or other agency representative should contact the Archives by telephone at 850.245.6750 or by email at recmgt@dos.myflorida.com. The Archives will provide guidance for the transfer of the records to the State Archives or other appropriate disposition of the records. For records indicating both a **Permanent** retention **and** possible archival value, agencies should contact the State Archives after five years for archival review and guidance as to whether, when and how to transfer the records to the Archives.

B. All Other Agencies - When preparing to dispose of records that have met their required retention, carefully consider the potential historical research value of those records. Some records that do not have a permanent retention still might have enduring value to your community as evidence of the interactions between government and citizens and as sources of information about local government, society and culture. For your convenience, we have indicated that "**This series may have archival value**" for series

that are most likely to have such historical or archival value. Not all such records will be determined to be archival; conversely, some records without this statement in the series description might have archival value. Records of historical value to your community should be preserved locally for the benefit of historians and other researchers. Technical assistance in determining archival value is available from State Archives staff at 850.245.6750.

VI. ELECTRONIC RECORDS

Records retention schedules apply to records regardless of the format in which they reside. Therefore, records created or maintained in electronic format must be retained in accordance with the minimum retention requirements presented in these schedules. Printouts of standard correspondence are acceptable in place of the electronic files. Printouts of electronic communications (email, instant messaging, text messaging, multimedia messaging, chat messaging, social networking, or any other current or future electronic messaging technology or device) are acceptable in place of the electronic files, **provided that the printed version contains all date/time stamps and routing information**. However, in the event that an agency is involved in or can reasonably anticipate **litigation** on a particular issue, the agency must maintain in native format any and all related and legally discoverable electronic files.

VII. FACTORS THAT MAY INFLUENCE THE DISPOSITION OF RECORDS

- A. **Litigation** - When a public agency has been notified or can reasonably anticipate that a potential cause of action is pending or underway, that agency should **immediately** place a hold on disposition of **any and all** records related to that cause. Your agency's legal counsel should inform your Records Management Liaison Officer and/or records custodian(s) when that hold can be lifted and when the records are again eligible for disposition.
- B. **Public Records Requests** - According to Section 119.07(1)(h), *Florida Statutes*, the custodian of a public record may not dispose of a record "for a period of 30 days after the date on which a written request to inspect or copy the record was served on or otherwise made to the custodian of public records by the person seeking access to the record. If a civil action is instituted within the 30-day period to enforce the provisions of this section with respect to the requested record, the custodian of public records may not dispose of the record except by order of a court of competent jurisdiction after notice to all affected parties."
- C. **Accreditation Standards** - Some public agencies receive national or statewide accreditation or certification by professional societies, organizations and associations. Examples include the Joint Commission on the Accreditation of Healthcare Organizations, the Commission on Accreditation for Law Enforcement Agencies and COLA (formerly the Commission on Office Laboratory Accreditation). In an effort to enhance the professionalism of their members, these groups may place additional requirements on public agencies beyond those mandated under state or federal law. Agencies may therefore choose to maintain their records for a longer period of time than required by established records retention schedules in order to meet accreditation standards.
- D. **Records in Support of Financial, Operational or Performance Audits** - These records should be retained in accordance with the following guidelines provided by the Florida Office of the Auditor General:

Records must be retained for **at least** three fiscal years (most financial records

must be retained for a minimum of five fiscal years in accordance with guidelines of the Department of Financial Services and the Office of the Auditor General). **If subject to the Federal Single Audit Act (pursuant to 2CFR200.501(a)) or other federal audit or reporting requirements, records must be maintained for the longer of the stated retention period or three years after the release date of the applicable Federal Single Audit Act or completion of other federal audit or reporting requirements.** Finally, if any other audit, litigation, claim, negotiation, or other action involving the records has been started before the expiration of the retention period and the disposition of the records, the records must be retained until completion of the action and resolution of all issues arising from it. However, in no case can such records be disposed of before the three fiscal year minimum.

- E. Federal, state or local laws and regulations regarding recordkeeping and records retention for specific agencies or specific types of records might require a longer retention than indicated in this general schedule. Agencies should be aware of all laws and regulations relating to their records and recordkeeping requirements.

VIII. REFORMATTING STANDARDS AND REQUIREMENTS

Unless otherwise prohibited by law or rule, the record copy of public records as defined by Section 119.011(12), *Florida Statutes*, may be reformatted to microfilm or electronic form as long as the requirements of Rule 1B-26.003 or 1B-26.0021, *Florida Administrative Code*, are met.

- A. Electronic Recordkeeping is defined in Rule 1B-26.003, *Florida Administrative Code*, which provides standards and guidelines for creation and maintenance of record (master) copies of public records in electronic form.
- B. Microfilm Standards are defined in Rule 1B-26.0021, *Florida Administrative Code*, which provides standards for microfilming of public records to ensure that the film, photography methods, processing, handling and storage are in accordance with methods, procedures and specifications designed to protect and preserve such records on microfilm.

IX. RECORDS VOLUME CONVERSION TO CUBIC FOOT MEASUREMENTS

Cassette tapes, 200	1.0 cubic foot
Letter-size file drawer	1.5 cubic feet
Legal-size file drawer	2.0 cubic feet
Letter-size 36" shelf	2.0 cubic feet
Legal-size 36" shelf	2.5 cubic feet
Magnetic Tapes, 12	1.0 cubic foot
3 x 5 cards, ten 12" rows	1.0 cubic foot
3 x 5 cards, five 25" rows	1.0 cubic foot
4 x 6 cards, six 12" rows	1.0 cubic foot
5 x 8 cards, four 12" rows	1.0 cubic foot
16mm microfilm, 100 rolls	1.0 cubic foot
35mm microfilm, 50 rolls	1.0 cubic foot
Map case drawer, 2" x 26" x 38"	1.1 cubic feet
Map case drawer, 2" x 38" x 50"	2.2 cubic feet
Roll storage, 2" x 2" x 38"	0.1 cubic foot
Roll storage, 2" x 2" x 50"	0.2 cubic foot
Roll storage, 4" x 4" x 38"	0.3 cubic foot
Roll storage, 4" x 4" x 50"	0.5 cubic foot
(One roll of microfilm contains approximately 1.0 cubic foot of records.)	

Cubic foot calculation: (Length" x Width" x Height") ÷ 1,728 = cubic feet

ACCREDITATION RECORDS: SURVEY AND INSPECTION REPORT HEALTHCARE FACILITIES (Item #1)

This record series consists of documentation used to demonstrate compliance with professional standards established for healthcare facilities. The series may include, but is not limited to, accreditation survey results, inspection reports by accrediting institutions, notices of corrections, correction reports, and in-house surveys and testing done prior to the actual accreditation survey. Also included in this series are public notices required by accrediting organizations, public hearing transcripts, and any additional supporting documentation materials necessary for the survey, inspection, and correction of deficiencies. This applies to all certifying agencies, whether state, federal, or professional organizations. This series may be used by a specific department or for the hospital as a whole. **This series may have archival value.**

RETENTION:

- a) Record copy. 5 anniversary years after next accreditation report is issued.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

ADMISSION REPORTS: STATISTICAL (Item #2)

This record series consists of statistical admission reports statistical information for patients who were admitted to health care facilities. These reports do not give personal identifying information such as name and address. These reports contain statistical data used to abstract various factors. The series may include, but is not limited to, data may include the number of patients in admitted to or discharged from the facility or a specific particular ward such as maternity or intensive care, the number of patients admitted for each hour of the day, the number of trauma patients in a day, average length of stay, daily number of deaths and post-operative deaths, bed occupancy rate, and patient demographics etc.

RETENTION:

- a) Record copy. 3 fiscal years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Are these reported anywhere? If only used for statistical purposes, propose deleting and referencing GS1-SL item #124, Operational and Statistical Report Records.

RESPIRATORY PROTECTION PROGRAM RECORDS: AIR SAMPLING AND BIOASSAYS (Item #107)

This record series documents air sampling and bioassays conducted to measure the level of air contaminants. The series may include, but is not limited to, identification of potential hazards, estimated exposure levels and evaluations of actual intake levels, consists of the results of air sampling and bioassays as well as surveys conducted in the radiology section which are sufficient enough to identify potential hazards, permit proper equipment selection, estimate exposure levels, and to evaluate actual intake levels. The air sampling, surveys, and bioassays are part of the required Respiratory Protection Program. 10D-91.471 & 10D-91.452, FAC

RETENTION:

- a) Record copy. 1 anniversary year after expiration or termination of license.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

10D-91 no longer exists.

AUDITS: RADIATION PROTECTION PROGRAM (Item #108)

This record series consists of any audits or reviews conducted by the state or federal government, a consultant, or radiology provider on the Radiation Protection Program. The audit or review evaluates the program's content and implementation. Proof of corrective actions may also be included in this series. 10D-91.470, FAC

RETENTION:

- a) Record copy. 3 years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose deleting and referencing GS1-SL item #83, Audits: State/Federal

BIOMEDICAL WASTE RECORDS (Item #96)

This record series documents the shipment and disposal of biomedical waste. consists of training records, which document that staff members were instructed on the proper handling and disposition of biomedical wastes; The series may include, but is not limited to, biomedical waste tracking forms, mail and return receipts, transporter information, and shipment logs. copies of signed biomedical tracking forms generated by the disposing agency and signed by the owner/operator of the destination facility as required by 40 CFR 259.52; exception forms required by biomedical waste producers under 40 CFR 259.55c; original mail receipts generated when an agency transports regulated medical waste by the U.S. Postal Service as well as the return receipt; and the shipment log maintained by the original generating point and any central receiving facilities. Shipment logs contain the date of shipment, the quantity by weight and the category of

waste shipped, the address and location of the central collection point and the original generating point, signatures as required, and the date of receipt by a central receiving point. This log may also contain the name and address of the transporter and the transporter's state permit or license number. The exception form is completed by a generator if they do not receive a completed signed copy of the tracking form from the owner/operator of the destination facility within 45 days after shipment. The exception form is submitted to the EPA Regional Administrator and the appropriate state agency. This form includes a legible copy of the tracking form for which there is no confirmation of delivery and a signed cover letter explaining the generator's efforts in locating the waste and the results of those efforts. 10D-104.003, FAC and 40 CFR 259.54, .55, .60

RETENTION:

- a) Record copy. 3 calendar anniversary years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Remove training records and reference applicable Personnel Records item in GS1-SL.

BIRTH RECORDS/CERTIFICATES

(Item # 6)

This record series consists of vital birth records and certificates filed with state registrar of vital statistics. This series may include any birth record, or amendments thereto, in certificate form or in report form as collected by the county health officer, as well as the penny post cards issued in the 1900s and the birth ledgers of cities created before the Bureau of Vital Statistics. ***This series may have archival value.***

RETENTION:

- a) Record copy. Permanent.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose combining with Death Certificates into new item – Vital Statistics Records.

BIRTH REPORTS

(Item #102)

This record series consists of birth reports submitted by the medical facility to the County Public Health county health department Unit every five days on diskette. The reports contains all necessary information for to the complete completion of the birth certificate including the baby's name, weight, height, time, date, and location of birth, and information on the baby's parents. The record copy is retained by the Office of Vital Statistics for the generation of a birth certificate. Copies of this report maintained by the hospital are duplicates.

RETENTION:

- a) Record copy. 1 anniversary year after birth certificate is issued.
- b) Duplicate. Retain until obsolete, superseded or administrative value is lost.

BLOOD BANK RECORDS

(Item #122)

This record series consists of documents maintained in a blood bank which record the donor information, storage and distribution of the product, compatibility testing, quality control records, transfusion reaction reports and complaints, and general records. This series also includes the logs which indicate on-hand inventory and notices of emergency shortages. General records are described as records of the sterilization of supplies and reagents, responsible personnel, errors and accidents, maintenance of equipment and the physical plant, and the expiration dates of supplies and reagents. Quality control records include: calibration and standardization of equipment, performance checks, periodic check of sterile technique, and periodic tests of the capacity of shipping containers to maintain the proper temperature. Compatibility tests include the results of cross-matching, antibody screenings, and the results of confirmation testing. Storage and distribution records include: the distribution and disposition of the blood product; visual inspection of whole blood and red blood cells during storage and immediately before distribution; storage temperature control and initialed temperature log or recorder chart; and emergency releases of blood including a physician's signature. Donor records include: donor selection, informed consent, medical interview and examination, permanent and temporary deferrals, donor adverse reaction complaints and reports, investigation and follow up, therapeutic bleedings, immunization, and blood collection including phlebotomist's name. This series relates to JCAHCO standard QC5.1.7. **THE RETENTION IS 6 MONTHS AFTER THE PRODUCT'S EXPIRATION DATE; HOWEVER, IF THERE IS NO EXPIRATION DATE, THE RECORDS ARE RETAINED PERMANENTLY.** 21 CFR 606.160, .165, .170, and .151

RETENTION:

- a) Record copy. 186 days after expiration.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose creating two new items for BLOOD BANK RECORDS due to retention requirements for products with expiration dates and products with no expiration dates:

21 CFR 606.160 (d) states "Records shall be retained for such interval beyond the expiration date for the blood or blood component as necessary to facilitate the reporting of any unfavorable clinical reactions. You must retain individual product records no less than 10 years after the records of processing are completed or 6 months after the latest expiration date for the individual product, whichever is the later date. When there is no expiration date, records shall be retained indefinitely."

BLOOD BANK RECORDS: NO PRODUCT EXPIRATION DATE **Item #XXX**

This record series documents the donation, processing and distribution of blood and blood products that have no product expiration date. The series may include, but is not limited to, dates of donations; patient typing records; documentation of reactions; blood product storage, distribution and inspection records; records of errors and accidents; final disposition reports; quality control records; and compatibility testing records. Retention is pursuant to 21 CFR 606.160, Records. See also BLOOD BANK RECORDS: PRODUCT EXPIRATION DATE.

RETENTION: PERMANENT.

BLOOD BANK RECORDS: PRODUCT EXPIRATION DATE **Item #XXX**

This record series documents the donation, processing and distribution of blood and blood products. The series may include, but is not limited to, dates of donations; patient typing records; documentation of reactions; blood product storage, distribution and inspection records; records of errors and accidents; final disposition reports; quality control records; and compatibility testing records. Retention is pursuant to 21 CFR 606.160, Records. See also BLOOD BANK RECORDS: NO PRODUCT EXPIRATION DATE.

RETENTION: 10 anniversary years after the records of processing are completed or 6 months after the latest expiration date for the individual product, whichever is later.

CANCER REGISTRY REPORTS **{Item #10}**

This record series consists of cancer registry reports which were required by the Department of Health and Rehabilitative Services (HRS) in 1972 and discontinued in 1977. These reports are no longer accumulated created but may still be in storage. The reports document such information as identified the type of cancer, its growth and location, the treatments prescribed and their effectiveness, and the age, gender, and race of the patient.

RETENTION:

- a) Record copy. 75 calendar years after last entry; microfilm optional.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

CLINICAL STUDY RECORDS **Item #XXX**

This record series consists of records of clinical studies to develop new and better methods to diagnose, treat and prevent disease by recruiting volunteers for trials using new medicines or treatments. Clinical studies answer specific questions regarding vaccines, new therapies or new ways of using current treatments. The series may include, but is not limited to, reports; narrative descriptions; informed consents and authorizations; physical examination records; laboratory results; diagnostic test reports; progress notes; medication records; physician order forms; and participant's confidential medical information including medical history, physical examination and tests results.

RETENTION: 10 anniversary years after completion of study.

COMPLAINT RECORDS: MAMMOGRAPHY FACILITY **{Item #91}**

This record series consists of the complaints filed by an employees and or patients against a mammography provider and the results of the accrediting body's investigations. The series may include, but is not limited to, witness statements; documentary evidence; notes filed by the person(s) filing the complaint, employees, witnesses, anonymous complainants or others; complete case file history; letters; determinations; final reports; and executive summaries. 21 CFR 900.4 and 95.11 F.S.

RETENTION:

- a) Record copy. 7 anniversary years after resolution investigation.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

COST CONTAINMENT REPORTS **{Item #20}**

This record series consists of Cost Containment and Prior Year Actual Reports submitted by a medical provider to AHCA, formerly called the Hospital Cost Containment Board, in compliance with the Florida Hospital Uniform Reporting System. These reports are required under FAC Rule 59E-5.103.

RETENTION:

- a) Record copy. 5 calendar years
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Rule 59E-5.103 has been repealed. Are these still created or required? What kind of information is provided in the report? If these cost containment reports document agencies efforts to prevent unnecessary spending or reduce expenses, could they fall under item #122, Administrator Records: Agency Director/Program Manager? Or could they fall under GS1-SL item #341, Disbursement Records: Summary?

DEATH CERTIFICATES (Item #22)

This record series consists of death certificates. The record (master) copy should be filed with state registrar of vital statistics or county health officer. The duplicate should be filed in the patient's medical file. **This series may have archival value.**

RETENTION:

- a) Record copy. Permanent; microfilm optional.
- b) Duplicates. Retain as long as the item it relates to.

Propose combining with Birth Records/Certificates into new item – Vital Statistics Records.

DELIVERY ROOM LOGS (Item #23)

This record series consists of a log detailing in chronological order the names of who utilized the delivery room and when. The log then cross references this information with a patient identification number for tracking or billing purposes. These logs are primarily paper based, although a more sophisticated form could exist in a computerized environment.

RETENTION:

- a) Record copy. 10 years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost

Propose deleting and referencing GS1-SL item #365, Receipt/Revenue Records: Detail if used for billing purposes. Are these still used for tracking purposes? If so, are they now part of the Patient Medical Record or the Master Patient Index?

DIETARY RECIPE RECORDS: STANDARDIZED (Item #28)

This record series consists of standardized dietary recipe records used in the preparation of patient meals by the kitchen staff. Recipes records may include a nutritional analysis, ingredients lists, and serving size notation.

RETENTION:

- a) Record copy. Retain until obsolete, superseded or administrative value is lost
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost

Propose combining Dietitian Consulting: Institutions (Item #111), Dietary Receipt Records: Standardized (Item #28) and Menus (Item #54) into new item Food Service Records.

DIETITIAN COUNSULTING: INSTITUTIONS (Item #111)

This record series consists of annual summaries provided by a nutritionist or dietitian to health care facilities and group homes which do not have a professional on staff. These summaries evaluate the menus, sanitation, policies and procedures, and recommend modifications for the food preparation and service department. 10F-6.010, FAC

RETENTION:

- a) Record copy. 2 years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose combining Dietitian Consulting: Institutions (Item #111), Dietary Receipt Records: Standardized (Item #28) and Menus (Item #54) into new item Food Service Records.

FOOD SERVICES RECORDS Item #XXX

This record series documents food services provided at healthcare facilities. The series may include, but is not limited to, menus of meals and snacks offered, recipes used in the preparation of meals, and dietitian consulting summaries and reviews. The series also documents such information as serving sizes, serving times, nutritional analysis and ingredient lists. Records created pursuant to 42 CFR 483.480, Condition of participation: Dietetic services, and Rule 58A-5.020, *Florida Administrative Code*, Food Service Standards.

RETENTION: 2 anniversary years.

Propose combining Dietitian Consulting: Institutions (Item #111), Dietary Receipt Records: Standardized (Item #28) and Menus (Item #54) into new item Food Service Records.

EKG/EEG/FETAL HEART MONITORING STRIPS

(Item #118)

This record series consists of capnography, EEG, EKG, fetal monitoring, pulse oximetry, stress test and treadmill test the actual strips generated by various vital sign monitors and testing devices where a report or interpretation has been recorded in the patient medical record. This series does NOT apply to For strips generated where no report of their content is contained within the patient's medical file. In those cases the strips would take the retention of should be retained as long as the patient medical record.

RETENTION:

- a) Record copy. 30 days after report is filed.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

FINAL TEST REPORTS: PATHOLOGY

(Item # 85)

This record series consists of the legally reproduced copies of each test result and preliminary reports on pathology testing. This series is specific to pathology, histology, and cytology records. Documentation includes all the information recorded on the test requisition plus the specimen's accession number, the date and time the lab received the specimen, the condition and disposition of samples which do not meet the lab's acceptance standards, the records and dates of performance of each step in the patient testing leading to and including the final report. 42 CFR 493.1101

RETENTION:

- a) Record copy. 10 years.

Propose combining Requisitions: Laboratory Tests (Item #95), Final Test Reports: Pathology (Item #85), Patient Testing: Immunohematology Records (Item #84) and Patients Tests: Laboratory Copy (Item #83) into new item Laboratory/Pathology Testing Records.

GUNSHOT WOUND/LIFE-THREATENING INJURY REPORTS: HOSPITAL COPY

(Item #128)

This record series consists of a reports made by any physicians, nurses, or employees thereof, who knowingly treats any person suffering from a gunshot wound, life threatening injury or other wound indicating violence and filed with the county sheriff's department in which treatment is administered, or receives a request for such treatment. This report is made to the sheriff of the county where the request for treatment is placed or care is rendered. The record copy is retained by the medical provider. The sheriff's copy is scheduled in the GS2 for Law Enforcement Agencies. Records created pursuant to Section 790.24, Florida Statutes, Report of medical treatment of certain wounds; penalty for failure to report.

RETENTION:

- a) Record copy. 30 days.
- b) Duplicate. Retain until obsolete, superseded or administrative value is lost.

INCIDENT RECORDS

(Item #40)

This record series consists of a report of an unusual incident which is recorded by a witness to the incident in a formal manner such as a log, event book, incident form, etc. The incident report includes: the time, date, and location of the event; the nature of the incident; the persons involved and names of witnesses; a description of the events which took place; the time police, security, EMS, or the fire department was called and by whom; the supervisor on duty; the types of equipment used and by whom; and remarks on whether follow-up by the next shift is necessary. This series may be used to report security or injury incidents or to note disturbances in the work place such as fire alarms, roof leak, computer and power outages, car alarms, and other events. SEE ALSO "RISK MANAGEMENT REPORTS: INTERNAL"

RETENTION:

- a) Record copy. 7 calendar years after incident.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost

Propose deleting and referring to applicable Patient Medical Record item (if an incident relating to medical treatment/patient care), GS1-SL item #241, INCIDENT REPORT FILES, or item #188, INJURY RECORDS.

INFECTION CONTROL RECORDS PROGRAM: REPORTS

(Item #131)

This record series documents facilities' efforts to identify, report, evaluate, prevent or stop the spread of infections in healthcare settings. The series may include, but is not limited to, consists of surgical infection investigation reports, training course content, and the reviews and evaluations of all septic, isolation, and sanitation techniques used in the medical facility, and, Also included in this series are reports on an employees who may have or have has been exposed to a communicable disease, their work restrictions, and estimated date of reinstatement. These reports are part of the agency's attempt to identify, report, evaluate, and maintain records of infections. 59A-3.215, FAC. SEE ALSO "RISK MANAGEMENT REPORTS: INTERNAL"

RETENTION:

- a) Record copy. 5 calendar years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

INSPECTIONS: RADIOLOGY SECTION (Item #101)

This record series consists of the results of a federal, state, or consulting physicist's inspection of the radiological services section, as well as the records of any actions taken to correct the identified deficiencies. 59A-3-228, FAC

RETENTION:

- a) Record Copy. 2 years after compliance.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose combining Inspections: Radiology Section (Item #101), Inventory: Sealed Radiation Sources (Item #115), Maintenance/Inspection: Radiographic Devices (Item #116), Monitoring Records: Packages of Radioactive Materials (Item #104), Radiation Detection Instrumentation (Item #86), Radiation Equipment: Minor Maintenance (Item #87), Surveys: Radiology (Item #106), Testing: Entry Control Devices (Item #114), Testing: Sealed Sources (Item #105), and Utilization Logs: Radiology (Item #117) into one new item – Radiology Records: Operational.

INVENTORY RECORDS: DRUG (Item #127)

This record series consists of all required inventories pertaining to controlled and non-controlled substances, including drugs destroyed or disposed drugs held by health care providers, including pharmacists and EMS units. The series documents such information as substances received; substances sold, administered, dispensed or disposed; substances placed on or removed from EMS vehicles; and outdated drugs and disposition. This series contains records for controlled substances classifications I, II, III, IV, and V, and applies to practitioners, institutions, and pharmacies. In the case of an EMS unit, inventories of each controlled substance placed on or removed from the vehicle are conducted at the beginning and ending of each shift. A written log with consecutive and permanently numbered pages accompanies the inventory. The log shall specify: the vehicle number; the name of the employee conducting the inventory; the date and time of the inventory; the name, weight, volume or quantity, and expiration date of each substance; the run report number if applicable; each amount administered; the printed name and signature of the administering paramedic or other authorized licensed official; and the printed name and signature of persons witnessing the disposal of unused portions. Pharmacies should maintain an inventory of all controlled substances received which shows the date receipt, the name and address of the sender, and the kind and quantity of controlled substances received. Pharmacies must record all controlled substances sold, administered, dispensed, or otherwise disposed of, including the date of sale, administration, or dispensing. This record should also include the correct name and address of the person to whom dispensed, or the owner and species of animal for which sold, administered, or dispensed. Documentation and inventorying of all outdated drugs, their segregation from all other drugs, and either their return to the manufacturer or distributor or their destruction are also part of this record series. 499.0121 and 893.07, FS, and 21 CFR 1304.04

RETENTION:

- a) Record copy. 2 anniversary years after date of inventory.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

INVENTORY: SEALED RADIATION SOURCES (Item #115)

This record series consists of the results of quarterly physical inventories which account for all sealed sources received or possessed under an appropriate license. This series details the quantities and kinds of radioactive material, the location of sealed sources, the date of the inventory, and the name of the staff member conducting the inventory. 10D-91.508, FAC

RETENTION:

- a) Record copy. 2 years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose combining Inspections: Radiology Section (Item #101), Inventory: Sealed Radiation Sources (Item #115), Maintenance/Inspection: Radiographic Devices (Item #116), Monitoring Records: Packages of Radioactive Materials (Item #104), Radiation Detection Instrumentation (Item #86), Radiation Equipment: Minor Maintenance (Item #87), Surveys: Radiology (Item #106), Testing: Entry Control Devices (Item #114), Testing: Sealed Sources (Item #105), and Utilization Logs: Radiology (Item #117) into one new item – Radiology Records: Operational.

LABORATORY/PATHOLOGY TESTING RECORDS Item #XXX

This record series documents laboratory, pathology, histology and cytology processing, testing and reporting of specimen. The records document such information as the accession, condition and disposition

of each specimen, performance of each step in the testing, test requisitions, test results and final reports. Retention is pursuant to 42 CFR 493.1105, Standard: Retention requirements.
RETENTION: 10 anniversary years after report date.

Propose combining Requisitions: Laboratory Tests (Item #95), Final Test Reports: Pathology (Item #85), Patient Testing: Immunohematology Records (Item #84) and Patients Tests: Laboratory Copy (Item #83) into new item Laboratory/Pathology Testing Records.

42 CFR 493.1105(a)(6)(ii) requires test reports for at least 10 years after the date of reporting.

MAINTENANCE/INSPECTION: RADIOGRAPHIC DEVICES (Item #116)

This record series consists of quarterly inspections and maintenance of radiographic exposure devices, storage containers, and source changers to assure proper functioning of these components. Maintenance is in accordance with the manufacturer's specifications. This series may also show that equipment was removed from service because damage during inspection was noted. This series does not include major repairs, parts replacement, or annual testing. 10D-91.510, FAC

RETENTION:

- a) Record copy. 2 years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose combining Inspections: Radiology Section (Item #101), Inventory: Sealed Radiation Sources (Item #115), Maintenance/Inspection: Radiographic Devices (Item #116), Monitoring Records: Packages of Radioactive Materials (Item #104), Radiation Detection Instrumentation (Item #86), Radiation Equipment: Minor Maintenance (Item #87), Surveys: Radiology (Item #106), Testing: Entry Control Devices (Item #114), Testing: Sealed Sources (Item #105), and Utilization Logs: Radiology (Item #117) into one new item – Radiology Records: Operational.

MAMMOGRAM IMAGES/FILM: SINGLE VISIT (Item #90)

This record series consists of radiographic images of breasts taken at a facility where no additional mammograms of the patient are performed the x-ray film taken to identify breast cancer in women, provided that this is the ONLY mammogram of the patient taken at this facility. This retention is for the actual film not the radiologist's interpretation of film. This series does not include the Theradiologist's interpretation of the images which is covered by part of the applicable Patient Medical Record item. Retention for the films of patients who have had MORE than one mammogram at the facility are located under Item #78 "X-ray Films." This retention period was set by the federal Mammography Quality Standards Act. Retention is pursuant to 21 CFR 900.12(e)(1)(4)(i), Quality standards. See also "X-RAY/IMAGING RECORDS."

RETENTION:

- a) Record copy. 10 anniversary years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

MANUALS, DIRECTIVES, PROCEDURES, POLICIES: HEALTHCARE SUPERSEDED (Item #120)

This record series consists of superseded, out-of-date manuals, directives, procedures and policies, directives, procedures, and publications which have created or impacted medical procedure, policy, or outlining the methods for accomplishing the functions and activities of healthcare facilities operations in a health care facility. These records demonstrate the operational atmosphere and give guidance to medical staff on the care and treatment of a patients. These records are vital to malpractice cases as they establish the conditions under which care was provided. Examples include nursing plans, dietary manuals, and risk management plans. 95.11, FS Retention is pursuant to Section 95.11, Florida Statutes, Limitations other than for the recovery of real property. This series may have archival value.

RETENTION:

- a) Record copy. 7 anniversary years after superseded or obsolete.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

MASTER PATIENT INDEXES (Item #49)

This record series consists of master patient indexes used to identify patients and their medical records. The series may include, but is not limited to, the patient's name, patient identifier number, address, date of birth, date of admission, diagnosis and the date of discharge, where applicable. Some institutions may include the patient's address and the diagnosis as part of this record. This record series may be entered on index cards or a computerized system. This series may have archival value.

RETENTION:

- a) Record copy. 10 anniversary years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

MEASUREMENTS/CALCULATIONS: ENVIRONMENTAL EXPOSURE (Item #123)

This record series consists of the results of measurements and calculations used to evaluate the release of radioactive effluents into the environment. These results may be used to correct environmental damage to a specific location. 10D-91.471 FAC.

RETENTION:

- a) Record copy. 1 year after expiration or termination of facility license.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose combining Measurements/Calculations: Environmental Exposure (Item #123), Planned Special Exposure: Radiology (Item #112), Radiation Monitoring Records: Human Exposure (Item #88), and Radiation Protection Program (Item #124) into one new item – Radiology/Radiation Records: Exposure.

MEDICARE/MEDICAID RECORDS (Item #132)

This records series consists of all financial, administrative and program records associated with Medicare and Medicaid claims, reimbursement, and client activities. 409.907 and .913 F.S.

RETENTION:

- a) Record copy. 5 fiscal years provided all audit issues have been resolved.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

What kind of administrative and program records? Do they document determination of eligibility? Just financial? If this is only financial records, propose deleting and referencing GS1-SL item #365, Receipt/Revenue Records: Detail.

MEDICARE/MEDICAID RECORDS: COUNTY HEALTH DEPARTMENTS (Item #134)

This records series consists of all financial, administrative and program records associated with Medicare and Medicaid claims, reimbursement, and client activities for County Health Departments under the Department of Health. FAC Rule 59G-4-.055(7).

RETENTION:

- a) Record copy. 6 fiscal years provided all audit issues have been resolved.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

What kind of administrative and program records? Do they document determination of eligibility? Just financial? If this is only financial records, propose deleting and referencing GS1-SL item #365, Receipt/Revenue Records: Detail.

MENUS (Item # 54)

This record series consists of the menus of actual food served by a intermediate care facility for the mentally handicapped, elder care facility, hospital, or other healthcare provider with food service capabilities. The menus list the variety of food choices available for a given meal or snack on a given day at a certain time. The dietitian's name, the date, and the average portion size may also be indicated. The meal and snack schedule should note the time and length of food service. 42 CFR 483.480 and 58A-5.020, FAC

RETENTION:

- a) Record copy. 6 months.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose combining Dietitian Consulting: Institutions (Item #111), Dietary Receipt Records: Standardized (Item #28) and Menus (Item #54) into new item Food Service Records.

MINUTES: AIR AMBULANCE SAFETY COMMITTEE (Item #125)

This record series consists of the minutes taken during an air ambulance provider's safety committee meetings. Air medical providers are required by 10D-66.051(19), FAC, to hold quarterly safety committee meetings for the review of safety policies and procedures, unusual occurrences, safety issues, and audit compliance. *This series may have archival value.* See also GS1, "MINUTES: OFFICIAL MEETINGS (TRANSCRIPTS)," "MINUTES: OFFICIAL MEETINGS (AUDIO/VIDEO)," "MINUTES: OFFICIAL MEETINGS (SUPPORTING DOCUMENTS)," and "MINUTES: OTHER MEETINGS."

RETENTION:

- a) Record copy. 2 years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose deleting and referencing applicable GS1-SL Minutes item.

MONITORING RECORDS: PACKAGES OF RADIOACTIVE MATERIALS (Item #104)

This record series consists of the results of calibrations required when a package containing radioactive materials is received by the radiology section. The section is required to monitor the package for radioactive contamination and excessive levels. The monitoring record would record the date and time a package was received, the time and date of calibration, the results and levels of the test, the name of the person who performed the test, as well as the time and date of notification of the carrier and the Department of Health if contamination or excessive levels exist. 10D-91.460 and 10D-91.471, FAC

RETENTION:

- a) Record copy. 3 years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose combining Inspections: Radiology Section (Item #101), Inventory: Sealed Radiation Sources (Item #115), Maintenance/Inspection: Radiographic Devices (Item #116), Monitoring Records: Packages of Radioactive Materials (Item #104), Radiation Detection Instrumentation (Item #86), Radiation Equipment: Minor Maintenance (Item #87), Surveys: Radiology (Item #106), Testing: Entry Control Devices (Item #114), Testing: Sealed Sources (Item #105), and Utilization Logs: Radiology (Item #117) into one new item – Radiology Records: Operational.

ON-SITE INCINERATOR RECORDS (Item #97)

This record series documents the operation of on-site incinerators at healthcare facilities. The records document such information as acceptance of medical waste; date and length of each incineration cycle; and total weight of waste incinerated per cycle. consists of acceptance records, the on-site incinerator form, and the operating log for an on-site incinerator. Acceptance records include documents which record the arrival of regulated medical waste to the on-site incinerator for disposal. Recorded in these documents are the date of acceptance, the state permit or license number of the transporter, the total weight of waste accepted, and the signature of the receiver. The operating log includes the date of each incineration cycle, the length of the cycle, the total weight of waste incinerated per cycle, and an estimate of the weight of regulated medical waste incinerated per cycle. The on-site incinerator form is maintained by the operator and summarizes the information collected in the operating log. It includes the facility name, address, and location; facility type; contact person; waste feed information; and the total number of incinerators at the facility. This report must be certified as required. 40 CFR 259.61 and .62.

RETENTION:

- a) Record copy. 3 calendar years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

OPERATION INDEXES (Item #60)

This record series consists of indexes of surgical operations performed at the facility. These indexes may include in-patient as well as out-patient procedures, the name of surgeon or physician, the patient's name, and the time and date of the surgery. These indexes cross reference the use of the OR against a unique patient identification number for tracking and billing purposes. ***This series may have archival value.***

RETENTION:

- a) Record copy. 10 years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Are these used for tracking and information access purposes? If so, can it be combined with Master Patient Index, or is it a separate record? OR – is this used just for billing purposes? If just for billing, propose deleting and referencing GS1-SL item #365, Receipt/Revenue Records: Detail.

PATIENT MEDICAL RECORDS (Item #80)

This record series documents the medical history, diagnosis, treatment and care consists of the current and complete medical record for every of patients seeking care or service from by a public healthcare provider or institution. Public healthcare providers and or institutions, including public providers of dental care and mental health and drug addiction counseling, multiphase clinics, hospitals, county public health units, medical/dental/nursing schools, EMS providers, and limited care residential facilities. The series may include, but is not limited to, clinical data and medical history, such as demographics, vital signs, diagnoses, medications, treatment plans, progress notes, problems, immunization dates, allergies, radiology images, and laboratory and test results. Records created pursuant to Rule 59A-3, *Florida Administrative Code, Hospital Licensure*. The medical record shall contain information required for the completion of a birth, death, or stillbirth certificate and may contain the following information: identification data; chief complaint or reason for seeking care; present illness; personal and family medical history; physical examination report; provisional and pre-operative diagnosis; clinical laboratory reports; radiology, diagnostic imaging, and ancillary testing reports; consultation reports; requisitions for laboratory tests; medical and surgical treatment notes and reports; evidence of appropriate informed consent; evidence of medication and dosage administered; a copy of the Florida Emergency Medical Services Report if delivered

by ambulance; tissue reports; physician, nurse, and therapist progress notes and reports; principal and secondary diagnoses and procedures when applicable; discharge summary; appropriate social services reports; autopsy findings; individualized treatment plans; clinical assessments of patient's needs; certification of transfer of patient between facilities; routine inquiry form regarding organ donation in the event of death; operative reports and progress notes; postoperative information; referral sources; intake interviews; orientation program documentation; mental status examination and assessments; documentation of seclusion and restraints usage; if applicable a copy the form "Public Baker Act Service Eligibility;" physical, inhalation, speech, and occupational therapy plans, progress notes, and consultations; when applicable, Department of Health or Children and Families' forms for the reporting of child, elder, or domestic violence and trauma reports; anesthesia records; blood donor and transfusion information; organ receipt or tissue transplant records; data on a medical device transplant; bone marrow test reports; dialysis records; diet counseling and restriction notations; interpretations of the EEG, EKG, and fetal heart monitor tracings or if no tracings are reported—the actual tracings are included; infant screening test reports; nuclear medicine reports; x-ray interpretation records; growth charts and allergy history; emergency care rendered prior to arrival at the facility; time police or medical examiner notified; infection notices and follow-up; security notices for violent or unstable patients and accompanying family members; and adverse incident reports. Additional items may be included in the patient medical file on a case by case basis and under the recommendation of a professional or medical standards organization. 59A-3.214, FAC **This series may have archival value. Non-routine patient medical records, such as those documenting a particularly significant public health issue such as a major new health threat or epidemic, may have archival value.**

RETENTION:

- a) Record copy. 7 anniversary years after last entry.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

PATIENT MEDICAL RECORDS: CHILDREN UNDER ONE YEAR OF AGE

{Item #130}

This record series documents the medical history, diagnosis, treatment and care consists of the current and complete medical record for every of patients under one year of age seeking care or service from by a public healthcare provider or institution. Public healthcare providers and or institutions, including public providers of dental care and mental health and drug addiction counseling, multiphase clinics, hospitals, county public health units, medical/ dental/nursing schools, EMS providers, and limited care residential facilities. The series may include, but is not limited to, clinical data and medical history, such as demographics, vital signs, diagnoses, medications, treatment plans, progress notes, problems, immunization dates, allergies, radiology images, and laboratory and test results. Records created pursuant to Rule 59A-3, Florida Administrative Code, Hospital Licensure. The medical record shall contain information required for the completion of a birth, death, or stillbirth certificate and may contain the following information: identification data; chief complaint or reason for seeking care; present illness; personal and family medical history; physical examination report; provisional and pre-operative diagnosis; clinical laboratory reports; radiology, diagnostic imaging, and ancillary testing reports; consultation reports; requisitions for laboratory tests; medical and surgical treatment notes and reports; evidence of appropriate informed consent; evidence of medication and dosage administered; a copy of the Florida Emergency Medical Services Report if delivered by ambulance; tissue reports; physician, nurse, and therapist progress notes and reports; principal and secondary diagnoses and procedures when applicable; discharge summary; appropriate social services reports; autopsy findings; individualized treatment plans; clinical assessments of patient's needs; certification of transfer of patient between facilities; routine inquiry form regarding organ donation in the event of death; operative reports and progress notes; postoperative information; referral sources; intake interviews; orientation program documentation; mental status examination and assessments; documentation of seclusion and restraints usage; if applicable a copy the form "Public Baker Act Service Eligibility;" physical, inhalation, speech, and occupational therapy plans, progress notes, and consultations; when applicable, Department of Health or Children and Families' forms for the reporting of child, elder, or domestic violence and trauma reports; anesthesia records; blood donor and transfusion information; organ receipt or tissue transplant records; data on a medical device transplant; bone marrow test reports; dialysis records; diet counseling and restriction notations; interpretations of the EEG, EKG, and fetal heart monitor tracings or if no tracings are reported—the actual tracings are included; infant screening test reports; nuclear medicine reports; x-ray interpretation records; growth charts and allergy history; emergency care rendered prior to arrival at the facility; time police or medical examiner notified; infection notices and follow-up; security notices for violent or unstable patients and accompanying family members; and adverse incident reports. Additional items may be included in the patient medical file on a case by case basis and under the recommendation of a professional or medical standards organization. s. 95.11(4)B, FS. **This series may have archival value. Non-routine patient medical records, such as those documenting a particularly significant public health issue such as a major new health threat or epidemic, may have archival value.**

RETENTION:

- a) Record copy. Retain until patient's 8th birthday Eighth Birthday.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

PATIENT MEDICAL RECORDS: NURSING HOME MINORS

(Item #133)

This record series documents the medical history, diagnosis, treatment and care consists of the current and complete medical record for every of patients seeking care or service from by a nursing home provider. The series may include, but is not limited to, clinical data and medical history, such as demographics, vital signs, diagnoses, medications, treatment plans, progress notes, problems, immunization dates, allergies, radiology images, and laboratory and test results. Records created pursuant to Rule 59A-3, *Florida Administrative Code*, Hospital Licensure. This record series consists of the complete medical record for every patient seeking care or service from a nursing home provider. The medical record shall contain information required for the completion of a birth, death, or stillbirth certificate and may contain the following information: identification data; chief complaint or reason for seeking care; present illness; personal and family medical history; physical examination report; provisional and pre-operative diagnosis; clinical laboratory reports; radiology, diagnostic imaging, and ancillary testing reports; consultation reports; requisitions for laboratory tests; medical and surgical treatment notes and reports; evidence of appropriate informed consent; evidence of medication and dosage administered; a copy of the Florida Emergency Medical Services Report if delivered by ambulance; tissue reports; physician, nurse, and therapist progress notes and reports; principal and secondary diagnoses and procedures when applicable; discharge summary; appropriate social services reports; autopsy findings; individualized treatment plans; clinical assessments of patient's needs; certification of transfer of patient between facilities; routine inquiry form regarding organ donation in the event of death; operative reports and progress notes; postoperative information; referral sources; intake interviews; orientation program documentation; mental status examination and assessments; documentation of seclusion and restraints usage; if applicable a copy the form "Public Baker Act Service Eligibility;" physical, inhalation, speech, and occupational therapy plans; progress notes, and consultations; when applicable, Department of Health or Children and Families' forms for the reporting of child, elder, or domestic violence and trauma reports; anesthesia records; blood donor and transfusion information; organ receipt or tissue transplant records; data on a medical device transplant; bone marrow test reports; dialysis records; diet counseling and restriction notations; interpretations of the EEG, EKG, and fetal heart monitor tracings or if no tracings are reported—the actual tracings are included; infant screening test reports; nuclear medicine reports; x-ray interpretation records; growth charts and allergy history; emergency care rendered prior to arrival at the facility; time police or medical examiner notified; infection notices and follow-up; security notices for violent or unstable patients and accompanying family members; and adverse incident reports. Additional items may be included in the patient medical file on a case by case basis and under the recommendation of a professional or medical standards organization. 59A-4.118, FAC and s. 95.11, FS. **This series may have archival value. Non-routine patient medical records, such as those documenting a particularly significant public health issue such as a major new health threat or epidemic, may have archival value.**

RETENTION:

- a) Record copy. Retain until patient's 24th birthday years of age or 7 anniversary years after last entry, whichever is later longer.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

PATIENT RECORDS: PHARMACY

(Item #129)

This record series consists of a patient record system maintained by all pharmacies for patients to whom new or refill prescriptions are dispensed. This series includes the patient's full name, address, telephone number, age or date of birth, gender, a list of all new or refill prescriptions from previous providers, and any comments on patient's therapy. Allergies, drug reactions, idiosyncrasies, chronic conditions, disease states, and notes on medical devices and existing conditions may also be recorded. This record may be maintained in hard copy or computerized formats. 59X-27.800, 59X-28.140, 59X-28.150, FAC.

RETENTION:

- a) Record copy. 2 years after last entry.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose combining with PRESCRIPTION RECORDS into new Pharmacy Patient and Prescription Records.

PATIENT TESTING: IMMUNOHEMATOLOGY RECORDS

(Item # 84)

This record series consists of the documents which record each step in the processing, testing, and reporting of patient specimens to assure the accuracy of the testing. Documentation includes all the information recorded on the test requisition plus the accession number of the specimen, the date and time of the specimen's receipt by the lab, the condition and disposition of the specimens which do not meet the lab's acceptance standards, and the records and dates of performance of each step in the patient testing leading to and including the final report. This record series is specific to immunohematology and histocompatibility records. 42 CFR 493.1101.

RETENTION:

- a) Record copy. 5 years.

~~b) Duplicates. Retain until obsolete, superseded or administrative value is lost.~~

Propose combining Requisitions: Laboratory Tests (Item #95), Final Test Reports: Pathology (Item #85), Patient Testing: Immunohematology Records (Item #84) and Patient Tests: Laboratory Copy (Item #83) into new item Laboratory/Pathology Testing Records.

PATIENT TESTS: LABORATORY COPY (Item # 83)

This record series consists of the documents which record each step in the processing, testing, and reporting of patient specimens to assure the accuracy of testing. Documentation includes all the information recorded on the test requisition plus the accession number of the specimen, the date and time of the lab's receipt of the specimen, the condition and disposition of the specimens which do not meet the lab's acceptance criteria, and the records and dates of performance of each step of the patient testing leading to and including the final report. This series also documents the loan or referral of slides to another laboratory and is relevant to JCAHCO standard QC4.6. This retention does not apply to pathology and immunohematology testing. 42 CFR 493.1101.

RETENTION:

a) Record copy. 2 years.

~~b) Duplicates. Retain until obsolete, superseded or administrative value is lost.~~

Propose combining Requisitions: Laboratory Tests (Item #95), Final Test Reports: Pathology (Item #85), Patient Testing: Immunohematology Records (Item #84) and Patient Tests: Laboratory Copy (Item #83) into new item Laboratory/Pathology Testing Records.

PERFORMANCE REPORTS: PROFICIENCY TESTING FACILITY (Item # 94)

This record series consists of reports issued on each laboratory's performances for the individual Medicare, Medicaid, and CLIA-licensed specialty or sub-specialty of service after a proficiency test is performed. Duplicate copies of these reports are also sent to Health and Human Services, the laboratory which was tested, and the state survey agency. 42 CFR 493.903.

RETENTION:

a) Record copy. 5 years.

~~b) Duplicates. Retain until obsolete, superseded or administrative value is lost.~~

Propose combining with Proficiency Testing: Laboratories (item #93).

PHARMACY PATIENT AND PRESCRIPTION RECORDS Item #XXX

This records series documents patients that have been dispensed medicine or substances by a pharmacy. The records document such information as patients' full name, address, telephone number, age, date of birth and gender; name of prescribing practitioner; the medicine or substance prescribed and quantity, strength and directions for its use; prescription number; initials of the pharmacist; date prescriptions filled; and comments on patients' therapy, allergies, drug reactions, idiosyncrasies, chronic conditions and disease state. The series may also include written prescriptions and lists of all new or refilled prescriptions. Retention pursuant to Rule 64B16-27.800(3), Pharmacy Practice, Requirement for Patient Records.

RETENTION: 2 anniversary years after last entry.

PLANNED SPECIAL EXPOSURE: RADIOLOGY (Item #112)

This record series consists of records on each planned special exposure. These records may include, but are not limited to, the following: the exceptional circumstances requiring the exposure; the name of the official who authorized the exposure and a copy of the signed order; which actions were necessary; why the actions were necessary; what precautions were taken to assure that doses were maintained in accordance with standard; what individual and collective doses were expected to result in; and the dose actually received during exposure. 10D-91.474, FAC.

RETENTION:

a) Record copy. 1 year after termination or expiration of license.

~~b) Duplicates. Retain until obsolete, superseded or administrative value is lost.~~

Propose combining Measurements/Calculations: Environmental Exposure (Item #123), Planned Special Exposure: Radiology (Item #112), Radiation Monitoring Records: Human Exposure (Item #88), and Radiation Protection Program (Item #124) into one new item – Radiology/Radiation Records: Exposure.

PRESCRIPTION RECORDS (Item #64)

This record series consists of a written prescription which is retained by the pharmacist in the pharmacy from which it is filled. The prescription includes: the full name and address of the patient; the full name and

address of the prescribing practitioner and his federal controlled substance registry number; the name of the substance prescribed, its quantity and strength and the directions for its use; the prescription number; and the initials of the pharmacist and the date filled. s. 893.04, FS and 59X-28.140, FAC

RETENTION:

- a) Record copy. 2 years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose combining with PATIENT RECORDS: PHARMACY into new Pharmacy Patient and Prescription Records item.

PROCESSING RECORDS: BLOOD BANK (Item #121)

This record series consists of blood bank records which monitor the process by which blood products are made available for use. Processing records include: blood processing, including the results and interpretation of all tests and re-tests; component preparation, including all relevant dates and times; separation and pooling of recovered plasma; the centrifugation and pooling of source plasma; and the labeling of the product including the initials of the processor. 21 CFR 606.151

RETENTION:

- a) Record copy. 5 years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose combining with Blood Bank Records (Item #122).

PROCEDURES: SPECIMEN TESTING Item #XXX

This record series consists of procedures outlining the object of specimen testing, the correct use of equipment and the methodology for taking the test. The series may include, but is not limited to, requirements for specimen collection and processing; step by step performance of the procedures; remedial action for failed instrument operation; criteria for specimen storage; and course of action for inoperable test system. Retention is pursuant to Rule 59A-6.022, *Florida Administrative Code*, Standards of Performance.

RETENTION: 2 anniversary years after discontinuance of policy.

PROFICIENCY TESTING: LABORATORIES (Item #93)

This record series consists of documents the proficiency tests used by laboratories to verify the accuracy and reliability of its testing. The series documents such information as step by step proficiency testing, sample preparation and handling, steps taken in the testing of samples, instrument printouts, proficiency testing program results, laboratory performance evaluations and corrective actions. documents which attest to the handling, preparation, processing, examination, and each step in the testing and reporting of results for all proficiency testing samples, including a copy of the proficiency testing program report forms used to record the test results. This series also features all documents which reflect the necessary training and technical assistance appropriate to correcting the problems associated with proficiency testing failures. 42 CFR 493.801 and .823 Retention is pursuant to 42 CFR 493.903, Administrative responsibilities.

RETENTION:

- a) Record copy. 5 anniversary 2 years after event.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

QUALITY CONTROL RECORDS: IMMUNOHEMATOLOGY (Item #82)

This record series documents quality control testing of immunohematology samples in an effort to detect, reduce and correct deficiencies in laboratory internal analytical processes. The series may include, but is not limited to, control graphs and charts, cumulative summaries, corrective actions, testing logs and attestations that the quality control samples were tested in the same manner as regular patient samples. Records created pursuant to 42 CFR 493, Laboratory Requirements. See also "QUALITY CONTROL RECORDS: LABORATORIES." consists of all documentation which attests to the quality control requirements specified in 42 CFR 93.1203 through 493.1285. Included in this series are all records which document that the quality control samples were tested in the same exact manner as the regular patient samples. This series is only for the quality control records of immunohematology samples. 42 CFR 493.1221 and 21 CFR 606.

RETENTION:

- a) Record copy. 5 anniversary years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

QUALITY CONTROL RECORDS: LABORATORIES (Item #81)

This record series documents quality control testing of laboratory samples in an effort to detect, reduce and correct deficiencies in laboratory internal analytical processes. The series may include, but is not limited to,

control graphs and charts, cumulative summaries, corrective actions, testing logs and attestations that the quality control samples were tested in the same manner as regular patient samples. Records created pursuant to 42 CFR 493, Laboratory Requirements. See also "QUALITY CONTROL RECORDS: IMMUNOHEMATOLOGY." consists of all documentation which attests to the quality control requirements specified in 42 CFR 93.1203 through 493.1285. Included in this series are the records of each step in the processing and testing of the quality control samples to assure that the quality control samples are tested in the same exact manner as the regular patient samples. This series does not apply to testing of immunohematology samples. 42 CFR 493.1221.

RETENTION:

- a) Record copy. 2 anniversary years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

QUALITY ASSURANCE RECORDS CONTROL SURVEY: MAMMOGRAPHY FACILITY

(Item #92)

This record series documents mammography facilities' efforts to "ensure the safety, reliability, clarity, and accuracy of mammography services performed at the facility" as required by 21 CFR 900.12, Quality standards. The series may include, but is not limited to, quality control surveys, equipment evaluations and performance tests. consists of the reports of the surveys conducted annually to assure that the facility meets specified quality control and equipment standards. 21 CFR 900.12.

RETENTION:

- a) Record copy. 1 calendar year or until the next annual inspection, whichever is later.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

RADIATION DETECTION INSTRUMENTATION

(Item #86)

This record series consists of documents which record the dates and times of the calibration of radiation detection instruments as well as the name of the individual performing the calibration. These are the instruments which measure radiation levels in the environment, on humans, and objects. This series also includes any repair to the instrumentation including the date and time of inspection, the problem located, the out of service dates, and the date of its return. 59A-3.228, FAC.

RETENTION:

- a) Record copy. 3 years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose combining Inspections: Radiology Section (Item #101), Inventory: Sealed Radiation Sources (Item #115), Maintenance/Inspection: Radiographic Devices (Item #116), Monitoring Records: Packages of Radioactive Materials (Item #104), Radiation Detection Instrumentation (Item #86), Radiation Equipment: Minor Maintenance (Item #87), Surveys: Radiology (Item #106), Testing: Entry Control Devices (Item #114), Testing: Sealed Sources (Item #105), and Utilization Logs: Radiology (Item #117) into one new item – Radiology Records: Operational.

RADIATION EQUIPMENT: MINOR MAINTENANCE

(Item #87)

This record series consists of documentation of all minor maintenance, daily function checks, and instrument calibration performed in accordance with the manufacturer's instructions on the testing equipment operated by a testing facility, hospital, or clinic. This series does not cover major repairs, parts replacement, or annual maintenance. This series is equivalent to JCAHCO standard EC1.6. 59A-6.022, FAC.

RETENTION:

- a) Record copy. 2 years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose combining Inspections: Radiology Section (Item #101), Inventory: Sealed Radiation Sources (Item #115), Maintenance/Inspection: Radiographic Devices (Item #116), Monitoring Records: Packages of Radioactive Materials (Item #104), Radiation Detection Instrumentation (Item #86), Radiation Equipment: Minor Maintenance (Item #87), Surveys: Radiology (Item #106), Testing: Entry Control Devices (Item #114), Testing: Sealed Sources (Item #105), and Utilization Logs: Radiology (Item #117) into one new item – Radiology Records: Operational.

RADIATION MONITORING RECORDS: HUMAN EXPOSURE

(Item #88)

This record series consists of documents which record the annual doses received by individuals for whom monitoring is required as specified in 10D-91.446, FAC, and the doses received during planned special exposures, accidents, and emergency conditions. Eligible persons include adults and minors who receive in excess of their limitations in a single year and individuals entering a high or very high radiation area. When applicable, these records should contain: the deep dose equivalent to the whole body, eye dose equivalent, shallow dose equivalent to the skin and extremities, the estimated intake of radionuclides; the committed effective dose equivalent assigned to the intake of radionuclides; the specific information used to

calculate the committed dose; the total effective dose; and the total of the deep dose and committed dose to the organ receiving the highest total dose. This series also includes documents which record the radiation dose to an embryo or fetus and the expectant mother. These documents note the name of the mother, the date of treatment, the organ receiving the highest dose, and the name of the staff member performing the therapy. The Declaration of Pregnancy may be filed separately from the dosage records and contains a formal acknowledgment by the mother that she is expecting. The form gives an estimated conception date and is designed to alert the staff to pregnancy. This series also includes the results of measurements and calculations used to determine individual intakes of radioactive materials and used in the assessment of the internal dose. Surveys of radiation for the purpose of determining an individual's dose from external sources are also included. These surveys are used in the assessment of individual dose equivalents in the absence of or in combination with individual monitoring data. 10D-91.446, 10D-91.471, 10D-91.475, 10D-91.518 and 59A-3.228, FAC.

RETENTION:

- a) Record copy. 1 year after the termination or expiration of license.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose combining Measurements/Calculations: Environmental Exposure (Item #123), Planned Special Exposure: Radiology (Item #112), Radiation Monitoring Records: Human Exposure (Item #88), and Radiation Protection Program (Item #124) into one new item – Radiology/Radiation Records: Exposure.

RADIATION PROTECTION PROGRAM

(Item #124)

This record series consists of the written provisions of a radiation protection program designed to prevent unnecessary radiological exposure to humans and the environment. This series relates to JCAHCO standard QC13.1. 10D-91.470, FAC.

RETENTION:

- a) Record copy. 1 year after termination or expiration of license.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose combining Measurements/Calculations: Environmental Exposure (Item #123), Planned Special Exposure: Radiology (Item #112), Radiation Monitoring Records: Human Exposure (Item #88), and Radiation Protection Program (Item #124) into one new item – Radiology/Radiation Records: Exposure.

RADIOACTIVE WASTE DISPOSAL RECORDS: RADIOACTIVE WASTE

(Item #89)

This record series consists of documents which record the disposal of radioactive waste and waste by-products by the radiology section. The series may include, but is not limited to, These records may include the date and method of disposal, the name and address of the waste hauler, the amount disposed of, and the name of the staff handling the disposal or transfer process. 10D-91.477 and 59A-3.228, FAC. Records created pursuant to Rule 64E-5.340, Florida Administrative Code, Records of Waste Disposal or Transfer.

RETENTION:

- a) Record copy. 1 anniversary year after the termination or expiration of license.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Rules listed no longer exists.

RADIOACTIVE WASTE DISPOSAL RECORDS: NON-SEALED SOURCE RADIOACTIVE MATERIAL (Item #113)

This record series consists of reports which documents the disposal of any non-sealed source radioactive material which is not a sealed source and has a with a physical half-life of less than 120 90 days. The series may include, but is not limited to, This report contains the date of disposal, the date the material was placed in storage, the radionuclides disposed of, the model and serial number of the survey instrument used, the background dose rate, the container's surface radiation dose rate, and the name of the individual performing the disposal. 10D-91.465, 10D-91.477, and 10D-91.732, FAC. Retention is pursuant to Rule 64E-5.331, Florida Administrative Code, Disposal of Specific Wastes.

RETENTION:

- a) Record copy. 3 anniversary years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Rules listed no longer exists.

RADIOLOGY RECORDS: OPERATIONAL

Item #XXX

This record series documents the operational activities of radiology facilities. The series documents such information as sealed sources received or possessed; radioactive material calibrations and monitoring; radiation detection instrumentation calibrations; daily function checks; maintenance repairs; radiation surveys; tests for entry control devices to secured radiation areas; tests of sealed sources of radiation; utilization logs of sealed sources and storage containers; maintenance reports; record of equipment removed from service; and inspector reports and documentation of corrective actions.

RETENTION: 3 anniversary years after date of record.

Propose combining Inspections: Radiology Section (Item #101), Inventory: Sealed Radiation Sources (Item #115), Maintenance/Inspection: Radiographic Devices (Item #116), Monitoring Records: Packages of Radioactive Materials (Item #104), Radiation Detection Instrumentation (Item #86), Radiation Equipment: Minor Maintenance (Item #87), Surveys: Radiology (Item #106), Testing: Entry Control Devices (Item #114), Testing: Sealed Sources (Item #105), and Utilization Logs: Radiology (Item #117) into one new item – Radiology Records: Operational.

RADIOLOGY/RADIATION RECORDS: EXPOSURE Item XXX

This record series documents facilities' efforts to monitor radiological exposure to humans and the environment. The series may include, but is not limited to, measurements and calculations used to evaluate the release of radioactive effluents into the environment, planned special exposures, accident and emergency exposures and radiation protection provisions.

RETENTION: 1 anniversary year after expiration or termination of facility license.

Propose combining Measurements/Calculations: Environmental Exposure (Item #123), Planned Special Exposure: Radiology (Item #112), Radiation Monitoring Records: Human Exposure (Item #88), and Radiation Protection Program (Item #124) into one new item – Radiology/Radiation Records: Exposure.

REQUISITIONS: LABORATORY TESTS (Item #95)

This record series consists of all requisitions authorizing a laboratory to perform tests on a sample. These requisitions may be in an electronic or written format. Included in a requisition are the patient's name or identification number, the name or identifier of who ordered the test, the date and time of the specimen collection, the source of the specimen, the patient's gender and age or date of birth, and pertinent clinical information. For pap smears the requisition also requires the last date of menstruation, history of abnormal smears, treatment of biopsy, and risk factors for cervical cancer. The record copy is retained by a public laboratory. Duplicates may be in the Patient Medical Record. 42 CFR 493.1101.

RETENTION:

a) Record copy. 2 years.

b) Duplicates. Retain as long as the item it relates to.

Are the requisitions needed as long as the tests/reports to show the lab had authorization to perform the tests? If so, then propose combining Requisitions: Laboratory Tests (Item #95), Final Test Reports: Pathology (Item #85), Patient Testing: Immunohematology Records (Item #84) and Patient Tests: Laboratory Copy (Item #83) into new item Laboratory/Pathology Testing Records.

RESIDENT CONTRACTS: ASSISTED LIVING FACILITIES (Item #109)

This record series consists of contracts signed by the resident or resident's guardian which place the resident in the care of the facility. The contract would contain provisions specifically setting forth the services and accommodations to be provided by the facility to the including extended congregate care services, limited mental health or nursing services. The contract will also list the basic daily, weekly, monthly, and annual charges or rates and any extra services provided and their fees. Payment procedures, rate increase policies, notices of religious affiliations, and written bed hold policies and termination agreements are also part of the contract. 58A-5.024 FAC.

RETENTION:

a) Record copy. 5 fiscal years after completion of contract provided applicable audits have been resolved.

b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose deleting and referencing GS1-SL item #65, CONTRACTS/LEASES/AGREEMENTS: NON-CAPITAL IMPROVEMENT.

RESIDENT RECORDS: ASSISTED LIVING FACILITIES (Item # 110)

This record series consists of documentation relating to documents the care and contractual obligations of assisted living facilities for the facility to the residents. The series may include, but is not limited to, included in this series are documents appointment of appointing the resident's guardians, establishing a power-of-

attorney, demographic data, therapeutic diets, and a healthcare provider's name and address. Medical records are maintained separately and take the retention period of the patient medical record. 58A-5.024, FAC. This series may have archival value.

RETENTION:

- a) Record copy. 1 anniversary year after departure or death.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

RISK MANAGEMENT RECORDS: INTERNAL

(Item #69)

This record series consists of internal risk management records including documents healthcare facilities' implementation and oversight of an internal risk management program. The series may include, but is not limited to, records documenting the education and training of all non-physician employees; analyses of frequency and causes of adverse incidents to patients; an analyses analysis of patient grievances that relate to patient care and the quality of medical services; reviews of incident reports; and meeting minutes of the risk management committee. This record series does not cover the hospital's copy copies of adverse incident reports, which are required to be sent to the Agency for Health Care Administration or the required and annual incident summary reports. Adverse incident reports should also be filed in the applicable PATIENT MEDICAL RECORDS series. Records created pursuant to Section s. 95.11 and 395.0197, FS Florida Statutes, Internal risk management program.

RETENTION:

- a) Record copy. 7 calendar years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

RUN REPORTS: EMERGENCY

(Item #70)

This record series documents consists of a report on patients who have been revived, or attempted to be revived, by the administration of drugs, both intercardiac and intravenously, and by using counter shock treatment as well as all other patients who receive accepted service from an Emergency Medical Technicians (EMT), Emergency Medical Services (EMS), or Air-Medical Provider, or a paramedics. The records document such information as treatment and administration of drugs; Run reports will include each patient's name, home address, age or date of birth, sex and race; call identification number, unit number of responding vehicles; transporting vehicle, if applicable; location of scene or incident; location of patient; and destination of each calls. The record copy of the run report is held by the service provider and a duplicate is sent to the Dept. of Health, formerly known as the HRS EMS Office. 10D-66.060, FAC and s. 95.11, FS See also General Records Schedule GS8 for Fire/Rescue Departments, item #39 "RUN REPORTS: NON-EMERGENCY" in the GS8.

RETENTION:

- a) Record copy. 7 anniversary years after last entry.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

STAFFING RECORDS SCHEDULES: MEDICAL PERSONNEL

(Item #126)

This record series consists of work schedules for documents the work shifts of medical staff personnel including the nursing staff nurses, physicians, medical aides, and support staff who provide medical treatment. The series also includes work shifts for physicians "on call." including phlebotomists. These schedules may be maintained on a daily, weekly, monthly or bimonthly basis. The record copy is located in the administrator's office for the particular department or with the individual in charge of staffing. Duplicates may be found throughout the agency.

RETENTION:

- a) Record copy. 7 anniversary years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

SURVEYS: RADIOLOGY

(Item #106)

This record series consists of surveys which are necessary to evaluate radiation levels, concentrations or quantities of radioactive materials, and potential radioactive hazards that could be present. This series also includes surveys of physical radiation for the purpose of determining whether each sealed source is in its shielded position prior to securing the radiographic device, storage container, or source changes in a storage area. The entire device is surveyed including the source guide tube. 10D-91.445 and 10D-91.471, FAC

RETENTION:

- a) Record copy. 3 years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose combining Inspections: Radiology Section (Item #101), Inventory: Sealed Radiation Sources (Item #115), Maintenance/Inspection: Radiographic Devices (Item #116), Monitoring Records: Packages of Radioactive Materials (Item #104), Radiation Detection Instrumentation (Item #86), Radiation Equipment: Minor Maintenance (Item #87), Surveys: Radiology (Item #106),

Testing: Entry Control Devices (Item #114), Testing: Sealed Sources (Item #105), and Utilization Logs: Radiology (Item #117) into one new item – Radiology Records: Operational.

TEST PROCEDURES: DISCONTINUED (Item #103)

This record series consists of a copy of each test procedure with the dates of its initial use and discontinuance. The procedure may explain, but is not limited to, the methodology of the test, the results sought, the positions who perform the test, possible side effects, and any necessary equipment. 59A-6.022, FAC and s. 95.11, F.S.

RETENTION:

- a) Record copy. 4 years after discontinued.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Unclear of the type of testing this relates to. Propose deleting and referencing DIRECTIVES/PROCEDURES/POLICIES: HEALTHCARE and new item PROCEDURES: SPECIMEN TESTING

TESTING: ENTRY CONTROL DEVICES (Item #114)

This record series consists of documents which record the testing of the entry control devices to secured areas, housing high levels of radiation. These records must include the date, time and results of each test. Testing shall be conducted prior to initial operation and a schedule of periodic testing for the entry control and warning systems will be followed by the radiology section. 10D-91.449 and 10D-91.478, FAC

RETENTION:

- a) Record copy. 3 years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose combining Inspections: Radiology Section (Item #101), Inventory: Sealed Radiation Sources (Item #115), Maintenance/Inspection: Radiographic Devices (Item #116), Monitoring Records: Packages of Radioactive Materials (Item #104), Radiation Detection Instrumentation (Item #86), Radiation Equipment: Minor Maintenance (Item #87), Surveys: Radiology (Item #106), Testing: Entry Control Devices (Item #114), Testing: Sealed Sources (Item #105), and Utilization Logs: Radiology (Item #117) into one new item – Radiology Records: Operational.

TESTING: SEALED SOURCES (Item #105)

This record series consists of documentation on the testing of sealed sources of radiation by the radiology department for leaks or contamination. These records would contain the date and time of the test, the name of who performed the test, the sources tested, the results of the test, the levels of radiation found, and the actions taken by staff. 10D-91.472, FAC

RETENTION:

- a) Record copy. 3 years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose combining Inspections: Radiology Section (Item #101), Inventory: Sealed Radiation Sources (Item #115), Maintenance/Inspection: Radiographic Devices (Item #116), Monitoring Records: Packages of Radioactive Materials (Item #104), Radiation Detection Instrumentation (Item #86), Radiation Equipment: Minor Maintenance (Item #87), Surveys: Radiology (Item #106), Testing: Entry Control Devices (Item #114), Testing: Sealed Sources (Item #105), and Utilization Logs: Radiology (Item #117) into one new item – Radiology Records: Operational.

ORGAN/TISSUE TRACKING RECORDS SYSTEM (Item #99)

This record series consists of all documents in the centralized tracking system which records the receipt and disposition of all organs and tissue transplanted within the hospital. The records document such information as At a minimum, the system will include the following records: the organ or tissue type; the donor identification id number; the name and license number of the procurement or distribution facility which supplied the tissue; or organ; recipient name and identification id number; name of transplanting doctor; date the organ or tissue was received by the hospital; and the date of the transplant. This information may be provided quarterly to an organ or tissue procurement service. 59A-3.214, FAC This series may have archival value. Records created pursuant to Rule 59A-3.270, Florida Administrative Code, Health Information Management. This series may have archival value.

RETENTION:

- a) Record copy. Permanent. 25 anniversary years after known death date of candidate/recipient or 100 anniversary years after registration date, whichever comes first.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Changed retention based on US Department of Health & Human Services requirement to maintain their OPTN/SRTR Data System for 25 years beyond the known death of the candidate or the organ recipient based on System of Record Notice 09-15-0055.

TRAINING & LICENSE RECORDS: RADIOLOGY (Item #100)

This record series consists of the credentials, licenses, and certifications of each person providing diagnostic and therapeutic radiation, imaging, and nuclear medicine services including formal training, on the job education, and continuing educational credits. 59A-3.228, FAC and s. 95.11, FS

RETENTION:

- a) Record copy. 7 years after separation or termination of employment.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose deleting and referencing applicable Personnel Records item in the GS1-SL.

UTILIZATION LOGS: RADIOLOGY (Item #117)

This record series consists of current logs which show for each source of radiation a detailed description of the make and model number for the sources or the storage container in which the sealed source is located, the identity of the radiographer to whom the source is assigned, and the locations and dates of its use. 10D-91.509 and 59A-3.228, FAC

RETENTION:

- a) Record copy. 2 years.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Propose combining Inspections: Radiology Section (Item #101), Inventory: Sealed Radiation Sources (Item #115), Maintenance/Inspection: Radiographic Devices (Item #116), Monitoring Records: Packages of Radioactive Materials (Item #104), Radiation Detection Instrumentation (Item #86), Radiation Equipment: Minor Maintenance (Item #87), Surveys: Radiology (Item #106), Testing: Entry Control Devices (Item #114), Testing: Sealed Sources (Item #105), and Utilization Logs: Radiology (Item #117) into one new item – Radiology Records: Operational.

VITAL STATISTICS RECORDS Item #XXX

This record series consists of the provider's or facility's official records of births, deaths and fetal deaths. The series may include, but is not limited to, birth certificates, death certificates, fetal death certificates and any supporting documentation. Records created pursuant to Rule 64V-1, Vital Records and Associated Activities.

RETENTION: Permanent

X-RAY/IMAGING RECORDS FILMS (Item #78)

This record series consists of x-ray images, x-ray films, mammogram images, scans and other images produced for screening or diagnostic procedures. The series includes such information as the name of the patient, the type of examination, dates of the exam and the technician performing the service. See also "MAMMOGRAM IMAGES: SINGLE VISIT." This record series consists of developed x-ray film which may have been interpreted by a radiologist. Interpretations of these films may be found in the Patient Medical Record. Mammograms of returning patients are included in this series. Mammograms of one-time visitors are located in Item #90, Mammograms.

RETENTION:

- a) Record copy. 7 anniversary years after last entry.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

X-RAY/IMAGING LOGS SYSTEM MAINTENANCE RECORDS (Item #98)

This record series documents the operation and maintenance of x-ray systems. The series may include, but is not limited to, tube rating charts and cooling curves; record of surveys, calibrations, maintenance, modifications from the original schematics and drawings performed on the x-ray machine along with the names of persons who performed the service; correspondence relating to the x-ray systems; and logs containing the patient's name, the type of examination and the dates the examinations were performed. consists of log for each x-ray device which records the name of the patient, the type of examination, the dates of the exam, and the technician performing the service. When the patient or film must be provided with human auxiliary support, the name of the human holder shall be recorded as well. 10D-91.603 and 59A-3.228, FAC Records created pursuant to Rule 64E-5.502, Florida Administrative Code, General Requirements.

RETENTION:

- a) Record copy. 7 anniversary years after last entry.
- b) Duplicates. Retain until obsolete, superseded or administrative value is lost.

Cross-Reference

CROSS-REFERENCE

A

ADVERSE INCIDENT REPORTS

use applicable PATIENT MEDICAL RECORDS

AIR SAMPLING AND BIOASSAYS

use RESPIRATORY PROTECTION PROGRAM RECORDS: AIR SAMPLING

AUDITS: RADIATION PROTECTION PROGRAM

use General Records Schedule GS1-SL for State and Local Government Agencies, Item #83, AUDITS:
STATE/FEDERAL

AMBULANCE RECORDS (GENERAL)

use INVENTORY RECORDS: DRUGS (item #127)

or RUN REPORTS: EMERGENCY (item #70)

or SEE ALSO General Records Schedule GS8 for Fire/Rescue Departments, ITEM item #39, RUN
REPORTS: NON-EMERGENCY

MINUTES: AIR AMBLUANCE SAFETY COMMITTEE (item #125)

ANESTHESIA RECORDS

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

APPOINTMENT BOOKS: CLINIC

use General Records Schedule GS1-SL for State and Local Government Agencies, item #89,
CALENDARS (GS1, item #89)

AUTOPSY RECORDS

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

B

BIRTH RECORDS/CERTIFICATES

use VITAL STATISTICS RECORDS

BLOOD BANK (GENERAL)

BLOOD BANK RECORDS (item #122)

PROCESSING RECORDS (item #121)

BLOOD BANK RECORDS

use BLOOD BANK RECORDS: NO PRODUCT EXPIRATION DATE

or BLOOD BANK RECORDS: PRODUCT EXPIRATION DATE

BLOOD DONOR HISTORY RECORDS

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

BLOOD USAGE RECORDS: TRANSFUSIONS

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

BONE MARROW TEST REPORTS

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

C

CENSUS RECORDS: REPORTS (ANNUAL) (MONTHLY) (DAILY)

use General Records Schedule GS1-SL for State and Local Government Agencies, Item #124,

Operational and Statistical Report Records

ADMISSIONS REPORTS: STATISTICAL (item # 2)

CHILD ABUSE REPORTS: HOSPITAL COPY

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

CLINICAL PATHOLOGY LOGS

use LABORATORY/PATHOLOGY TESTING RECORDS
FINAL TEST REPORTS: PATHOLOGY (item #85)

CLINICAL PATHOLOGY REPORTS: PATIENT

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

CLINICAL PATHOLOGY REPORTS: OUTPATIENT

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

CODE 15 REPORTS

use applicable PATIENT MEDICAL RECORDS

COMMUNICATIONS TAPE RECORDINGS: EMERGENCY MEDICAL SERVICES

use General Records Schedule GS1-SL for State and Local Government Agencies, Item #377, 911
RECORDS: LOGS
or General Records Schedule GS1-SL for State and Local Government Agencies, Item #335,
COMMUNICATIONS AUDIO RECORDINGS
RADIO LOGS: COMMUNICATIONS (GS8, item 33)

COMMUNICABLE DISEASE REPORTS: HOSPITAL COPY

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

COST CONTAINMENT REPORTS

use General Records Schedule GS1-SL for State and Local Government Agencies, Item #334,
CORRESPONDENCE AND MEMORANDUM: PROGRAM AND POLICY DEVELOPMENT
or General Records Schedule GS1-SL for State and Local Government Agencies, Item #122,
ADMINISTRATOR RECORDS: AGENCY DIRECTOR/PROGRAM MANAGER

CYTOLOGY REPORTS

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

D

DEATH CERTIFICATES

use VITAL STATISTICS RECORDS

DELIVERY ROOM LOGS

use General Records Schedule GS1-SL for State and Local Government Agencies, Item #3,
ADMINISTRATIVE SUPPORT RECORDS
or General Records Schedule GS1-SL for State and Local Government Agencies, Item #124,
OPERATION AND STATISTICAL REPORT RECORDS
or General Records Schedule GS1-SL for State and Local Government Agencies, Item #365,
RECEIPT/REVENUE RECORDS: DETAIL

DIALYSIS RECORDS

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

DIET COUNSELING RECORDS

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

DIET RECORDS: INDIVIDUAL

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

DIETITIAN COUNSULTING: INSTITUTIONS

use FOOD SERVICE RECORDS

DIETARY RECIPE RECORDS: STANDARDIZED

use FOOD SERVICE RECORDS

DRUG RECORDS: PATIENT

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

DRUG RECORDS: REQUISITIONING/DISPENSING

use INVENTORY RECORDS: DRUG (item # 127)

E

EKG/EEG/FETAL HEART MONITOR STRIPS

use MONITORING STRIPS

ELECTROCARDIOGRAM TRACINGS

use EKG/EEG/FETAL HEART MONITORING STRIPS (item #118)
or applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

ELECTROENCEPHALOGRAM TRACINGS

use EKG/EEG/FETAL HEART MONITORING STRIPS (item #118)
or applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

F

FETAL HEART MONITOR STRIPS

use EKG/EEG/FETAL HEART MONITORING STRIPS (item #118)
or applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

FINAL TEST REPORTS: PATHOLOGY

use LABORATORY/PATHOLOGY TESTING RECORDS

GUNSHOT WOUND REPORTS: HOSPITAL COPY

use GUNSHOT WOUND/LIFE-THREATENING INJURY REPORTS

H

HEALTH EXAMINATION RECORDS: FOOD HANDLERS

use General Records Schedule GS1-SL for State and Local Government Agencies, Item #212,

MEDICAL RECORDS

HEALTH EXAMINATION RECORDS: ROUTINE PERSONNEL (GS1, item # 212)

I

INCIDENT RECORDS

use General Records Schedule GS1-SL for State and Local Government Agencies, Item #241,

INCIDENT REPORT FILES

or General Records Schedule GS1-SL for State and Local Government Agencies, Item #188, INJURY
RECORDS

INCIDENT REPORTS: SUMMARY AND REVIEW

use General Records Schedule GS1-SL for State and Local Government Agencies, Item #241,

INCIDENT REPORT FILES

or General Records Schedule GS1-SL for State and Local Government Agencies, Item #188, INJURY
RECORDS

RISK MANAGEMENT RECORDS: INTERNAL (item #69)

INCINERATOR RECORDS

use ON-SITE INCINERATOR RECORDS (item #97)

INFANT SCREENING TEST REPORTS (QUARTERLY)

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

INFECTION CONTROL PROGRAM: REPORTS

use INFECTION CONTROL RECORDS

INHALATION THERAPY RECORDS

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

IMMUNIZATION RECORDS

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

INSPECTIONS: RADIOLOGY SECTION

use RADIOLOGY RECORDS: OPERATIONAL

*****CROSS-REFERENCE*****

INVENTORY RECORDS: DRUGS

INVENTORY RECORDS: DRUG (item #127)

INVENTORY: SEALED RADIATION SOURCES

use RADIOLOGY RECORDS OPERATIONAL

L

LABORATORY LOGS

use LABORATORY/PATHOLOGY TESTING RECORDS

PATIENT TESTS: LABORATORY (item # 83)

LABORATORY QUALITY CONTROL RECORDS

use QUALITY CONTROL RECORDS: LABORATORY TESTING

QUALITY CONTROL RECORDS: LABORATORIES (item # 81)

LABORATORY RECORDS (GENERAL)

use LABORATORY/PATHOLOGY TESTING RECORDS

PATIENT TESTING: IMMUNOHEMATOLOGY (item #84)

PATIENT TEST: LABORATORY COPY (item #83)

FINAL TEST REPORT: PATHOLOGY (item #85)

PERFORMANCE REPORT: PROFICIENCY TESTING FACILITY (item #94)

PROFICIENCY TESTS: LABORATORY (item #93)

QUALITY CONTROL RECORDS: IMMUNOHEMATOLOGY (item #82)

QUALITY CONTROL RECORDS (item #81)

REQUISITION: LABORATORY TESTS (item #95)

TEST PROCEDURES: DISCONTINUED (item #103)

LABORATORY TEST REPORTS

PATIENT TESTS: LABORATORY COPY (item #83)

M

MAINTENANCE/INSPECTION: RADIOGRAPHIC DEVICES

use RADIOLOGY RECORDS OPERATIONAL

MAMMOGRAPHY

use COMPLAINT RECORDS: MAMMOGRAPHY FACILITY (item #91)

or MAMMOGRAM IMAGES: SINGLE VISIT (item #90)

or QUALITY ASSURANCE RECORDS: CONTROL RECORDS: MAMMOGRAPHY FACILITY (item #92)

or X-RAY/IMAGING RECORDS FILMS (item #78)

MANUALS, DIRECTIVES, PROCEDURES, POLICIES: SUPERSEDED

DIRECTIVES/PROCEDURES/POLICIES: HEALTHCARE

MEDICAL RECORDS: (PATIENT) EMERGENCY ROOM

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

MEDICAL RECORDS: (PATIENT) INPATIENT

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

MEDICAL RECORDS: (PATIENT) OUTPATIENT/CLINIC

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

MEDICARE/MEDICAID RECORDS

use General Records Schedule GS1-SL for State and Local Government Agencies, Item #365.

RECEIPT/REVENUE RECORDS: DETAIL

MEDICARE/MEDICAID RECORDS: COUNTY HEALTH DEPARTMENTS

use General Records Schedule GS1-SL for State and Local Government Agencies, Item #365.

RECEIPT/REVENUE RECORDS: DETAIL

MENUS

use FOOD SERVICE RECORDS

MINUTES: AIR AMBULANCE SAFETY COMMITTEE

use General Records Schedule GS1-SL for State and Local Government Agencies, Item #32,

MINUTES: OFFICIAL MINUTES

or General Records Schedule GS1-SL for State and Local Government Agencies, Item #424,

MINUTES: OFFICIAL MEETINGS (SPECIAL DISTRICTS/AGENCY SUPPORT ORGANIZATIONS/NON-POLICY ADVISORY BOARDS)

MONITORING RECORDS: PACKAGES OF RADIOACTIVE MATERIALS

use RADIOLOGY RECORDS OPERATIONAL

N

NUCLEAR MEDICINE SERVICES RECORDS

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

NURSING CARE PLANS: DAILY

use STAFFING RECORDS SCHEDULES: MEDICAL PERSONNEL (item #126)

NURSING PLANS: DEPARTMENTAL

use DIRECTIVES/PROCEDURES/POLICIES: HEALTHCARE

MANUALS, DIRECTIVES, POLICIES, PLANS: SUPERSEDED (item #120)

O

OCCUPATIONAL THERAPY RECORDS

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

OPERATION INDEXES

use applicable PATIENT MEDICAL RECORDS

or General Records Schedule GS1-SL for State and Local Government Agencies, Item #365,

RECEIPT/REVENUE RECORDS: DETAIL

or General Records Schedule GS1-SL for State and Local Government Agencies, Item #124,

OPERATIONAL AND STATISTICAL REPORT RECORDS

or General Records Schedule GS1-SL for State and Local Government Agencies, Item #122,

ADMINISTRATOR RECORDS: AGENCY DIRECTOR/PROGRAM MANAGER

or General Records Schedule GS1-SL for State and Local Government Agencies, Item #3,

ADMINISTRATIVE SUPPORT RECORDS

P

PATHOLOGY REPORTS: SURGICAL TISSUE

use LABORATORY/PATHOLOGY TESTING RECORDS

FINAL TEST REPORTS: PATHOLOGY (item #85)

PATIENT RECORDS: PHARMACY

use PHARMACY PATIENT AND PRESCRIPTION RECORDS

PATIENT TESTING: IMMUNOHEMATOLOGY RECORDS

use LABORATORY/PATHOLOGY TESTING RECORDS

PATIENT TESTS: LABORATORY COPY

use LABORATORY/PATHOLOGY TESTING RECORDS

PHARMACY RECORDS

use INVENTORY RECORDS: DRUG (item #127)

PATIENT RECORD: PHARMACY (item #129)

use PHARMACY PATIENT AND PRESCRIPTION RECORDS

PRESCRIPTIONS (item #64)

PERFORMANCE REPORTS: PROFICIENCY TESTING FACILITY

use PROFICIENCY TESTING: LABORATORIES

PHYSICAL THERAPY RECORDS

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

PLANNED SPECIAL EXPOSURE: RADIOLOGY

use RADIOLOGY/RADIATION RECORDS: EXPOSURE

PRESCRIPTION RECORDS

use PHARMACY PATIENT AND PRESCRIPTION RECORDS

PROCESSING RECORDS: BLOOD BANK

use BLOOD BANK RECORDS: NO PRODUCT EXPIRATION DATE
or BLOOD BANK RECORDS: PRODUCT EXPIRATION DATE

PSYCHIATRIC REPORTS

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

QUALITY CONTROL SURVEY: MAMMOGRAPHY FACILITY

use QUALITY ASSURANCE RECORDS: MAMMOGRAPHY FACILITY

RADIATION DETECTION INSTRUMENTATION

use RADIOLOGY RECORDS OPERATIONAL

RADIATION EQUIPMENT: MINOR MAINTENANCE

use RADIOLOGY RECORDS OPERATIONAL

RADIATION EXPOSURE RECORDS: PERSONNEL

use RADIOLOGY/RADIATION RECORDS: EXPOSURE
or applicable *General Records Schedule GS1-SL for State and Local Government Agencies*
PERSONNEL RECORDS item

RADIATION MONITORING RECORDS: HUMAN EXPOSURE (item # 88)

RADIATION MONITORING RECORDS: EQUIPMENT

use RADIOLOGY RECORDS OPERATIONAL
MAINTENANCE INSPECTION: RADIOGRAPHIC DEVICES (item # 116)

RADIATION MONITORING RECORDS: HUMAN EXPOSURE

use RADIOLOGY/RADIATION RECORDS: EXPOSURE

RADIATION PROTECTION PROGRAM

use RADIOLOGY/RADIATION RECORDS: EXPOSURE

RADIATION PROTECTION PROGRAM RECORDS

use RADIOLOGY/RADIATION RECORDS: EXPOSURE
or *General Records Schedule GS1-SL for State and Local Government Agencies*, Item #83, AUDITS:
STATE/FEDERAL
AUDITS: RADIATION PROTECTION PROGRAM (item #108)

RADIOACTIVE MATERIALS RECORDS

use DISPOSAL RECORDS: RADIOACTIVE WASTE
RADIOACTIVE WASTE DISPOSAL RECORDS (items #89, 113)
or DISPOSAL RECORDS: NON-SEALED SOURCE RADIOACTIVE MATERIAL

RADIOLOGY RECORDS (GENERAL)

INSPECTIONS (item #101)
INVENTORY: SEALED SOURCES (item #115)
MAINTENANCE/INSPECTION: RADIOGRAPHIC DEVICES (item #116)
MEASUREMENTS/CALCULATIONS: ENVIRONMENTAL EXPOSURE (item #123)
MONITORING RECORDS (item #104)
PLANNED SPECIAL EXPOSURE (item #112)
RADIATION DETECTION INSTRUMENTATION (item #86)
RADIATION EQUIPMENT: MINOR MAINTENANCE (item #87)
RADIATION MONITORING RECORDS (item #88)
RADIATION PROTECTION PROGRAM (item #124)
RADIOACTIVE WASTE DISPOSAL (items #89, 113)
SURVEYS: RADIOLOGY (item #106)
TESTING: ENTRY CONTROL DEVICES (item #114)

*****CROSS-REFERENCE*****

TESTING: SEALED SOURCES (item #105)
RAINING AND LICENSES: RADIOLOGISTS (item #100)
UTILIZATION LOGS: RADIOLOGY (item #117)

REQUISITIONS: LABORATORY TESTS
use LABORATORY/PATHOLOGY TESTING RECORDS

RESIDENT CONTRACTS: ASSISTED LIVING FACILITIES
use General Records Schedule GS1-SL for State and Local Government Agencies, Item #65.
CONTRACTS/LEASES/AGREEMENTS: NON-CAPITAL IMPROVEMENT

RESIDENT RECORDS: ASSISTED LIVING FACILITIES
use General Records Schedule GS1-SL for State and Local Government Agencies, Item #65.
CONTRACTS/LEASES/AGREEMENTS: NON-CAPITAL IMPROVEMENT

RESPIRATORY PROTECTION PROGRAM RECORDS
AIR SAMPLING AND BIOASSAYS (item #107)

RISK MANAGEMENT RECORDS: INTERNAL
use General Records Schedule GS1-SL for State and Local Government Agencies, Item #122.
ADMINISTRATOR RECORDS: AGENCY DIRECTOR/PROGRAM MANAGER
or General Records Schedule GS1-SL for State and Local Government Agencies, Item #338.
CORRESPONDENCE AND MEMORANDA: PROGRAM AND POLICY DEVELOPMENT
or General Records Schedule GS1-SL for State and Local Government Agencies, Item #291.
PROJECT FILES: OPERATIONAL

RISK MANAGEMENT
INCIDENT RECORDS (item #40)
INFECTION CONTROL PROGRAM: REPORTS (item #131)
RISK MANAGEMENT RECORDS: INTERNAL (item #69)

S
SOCIAL SERVICES CASE FILES
use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

SPECIMEN LOGS: PATHOLOGY
use LABORATORY/PATHOLOGY TESTING RECORDS
FINAL TEST REPORTS: PATHOLOGY (item # 85)

SPEECH THERAPY RECORDS
use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

SURGICAL INFECTION INVESTIGATION REPORTS
use INFECTION CONTROL RECORDS
INFECTION CONTROL PROGRAM: REPORTS (item # 4)

SURVEYS: RADIOLOGY
use RADIOLOGY RECORDS

TEST PROCEDURES: DISCONTINUED
use DIRECTIVES/PROCEDURES/POLICIES: HEALTHCARE
or PROCEDURES: SPECIMEN TESTING

TESTING: ENTRY CONTROL DEVICES
use RADIOLOGY RECORDS: OPERATIONAL

TESTING: SEALED SOURCES
use RADIOLOGY RECORDS: OPERATIONAL

TISSUE TRACKING SYSTEM
use ORGAN/TISSUE TRACKING RECORDS

TRAINING & LICENSE RECORDS: RADIOLOGY

General Records Schedule GS4 Public Hospitals, Health Care Facilities and Medical Providers
CROSS-REFERENCE

use applicable *General Records Schedule GS1-SL for State and Local Government Agencies*
PERSONNEL RECORDS item

U

UTILIZATION LOGS: RADIOLOGY

use RADIOLOGY RECORDS: OPERATIONAL

UTILIZATION REVIEW PLANS

use DIRECTIVES/PROCEDURES/POLICIES: HEALTHCARE

~~MANUALS, DIRECTIVES, POLICIES, PLANS: SUPERSEDED (item #120)~~

X

X-RAY FILMS

use X-RAY/IMAGING RECORDS

X-RAY INTERPRETATION REPORTS

use applicable PATIENT MEDICAL RECORD (items #80, 130, 133)

X-RAY LOGS

use X-RAY/IMAGING SYSTEM MAINTENANCE RECORDS

ALPHABETICAL LISTING

ACCREDITATION RECORDS: HEALTHCARE FACILITIES	Item #1
BIOMEDICAL WASTE RECORDS	Item #96
BIRTH REPORTS	Item #102
BLOOD BANK RECORDS: NO PRODUCT EXPIRATION DATE	Item #XXX
BLOOD BANK RECORDS: PRODUCT EXPIRATION DATE	Item #XXX
CANCER REGISTRY REPORTS	Item #10
CLINICAL STUDY RECORDS	Item #XXX
COMPLAINT RECORDS: MAMMOGRAPHY FACILITY	Item #91
DIRECTIVES/PROCEDURES/POLICIES: HEALTHCARE	Item #120
DISPOSAL RECORDS: NON-SEALED SOURCE RADIOACTIVE MATERIAL	Item #113
DISPOSAL RECORDS: RADIOACTIVE WASTE	Item #89
FOOD SERVICES RECORDS	Item #XXX
GUNSHOT WOUND/LIFE-THREATENING INJURY REPORTS	Item #128
IMAGING RECORDS	Item #78
INFECTION CONTROL RECORDS	Item #131
INVENTORY RECORDS: DRUG	Item #127
LABORATORY/PATHOLOGY TESTING RECORDS	Item #XXX
MAMMOGRAM IMAGES: SINGLE VISIT	Item #90
MASTER PATIENT INDEXES	Item #49
MONITORING STRIPS	Item #118
ON-SITE INCINERATOR RECORDS	Item #97
ORGAN/TISSUE TRACKING RECORDS	Item #99
PATIENT MEDICAL RECORDS	Item #80
PATIENT MEDICAL RECORDS: CHILDREN UNDER ONE YEAR OF AGE	Item #130
PATIENT MEDICAL RECORDS: NURSING HOME MINORS	Item #133
PHARMACY PATIENT AND PRESCRIPTION RECORDS	Item #XXX
PROCEDURES: SPECIMEN TESTING	Item #XXX
PROFICIENCY TESTING: LABORATORIES	Item #93
QUALITY CONTROL RECORDS: IMMUNOHEMATOLOGY	Item #82
QUALITY CONTROL RECORDS: LABORATORIES	Item #81
QUALITY ASSURANCE RECORDS: MAMMOGRAPHY FACILITY	Item #92
RADIOLOGY RECORDS: OPERATIONAL	Item #XXX
RADIOLOGY/RADIATION RECORDS: EXPOSURE	Item #XXX
RESIDENT RECORDS: ASSISTED LIVING FACILITIES	Item # 110
RESPIRATORY PROTECTION PROGRAM RECORDS: AIR SAMPLING	Item #107
RISK MANAGEMENT RECORDS: INTERNAL	Item #69
RUN REPORTS: EMERGENCY	Item #70
STAFFING RECORDS: MEDICAL PERSONNEL	Item #126
VITAL STATISTICS RECORDS	Item #XXX
X-RAY/IMAGING RECORDS	Item #78
X-RAY/IMAGING SYSTEM MAINTENANCE RECORDS	Item #98

NUMERICAL LISTING

ACCREDITATION RECORDS: HEALTHCARE FACILITIES	Item #1
CANCER REGISTRY REPORTS	Item #10
MASTER PATIENT INDEXES	Item #49
RISK MANAGEMENT RECORDS: INTERNAL	Item #69
RUN REPORTS: EMERGENCY	Item #70
X-RAY/IMAGING RECORDS	Item #78
PATIENT MEDICAL RECORDS	Item #80
QUALITY CONTROL RECORDS: IMMUNOHEMATOLOGY	Item #82
QUALITY CONTROL RECORDS: LABORATORIES	Item #81
DISPOSAL RECORDS: RADIOACTIVE WASTE	Item #89
MAMMOGRAM IMAGES: SINGLE VISIT	Item #90
COMPLAINT RECORDS: MAMMOGRAPHY FACILITY	Item #91
QUALITY ASSURANCE RECORDS: MAMMOGRAPHY FACILITY	Item #92
PROFICIENCY TESTING: LABORATORIES	Item #93
BIOMEDICAL WASTE RECORDS	Item #96
ON-SITE INCINERATOR RECORDS	Item #97
X-RAY/IMAGING SYSTEM MAINTENANCE RECORDS	Item #98
ORGAN/TISSUE TRACKING RECORDS	Item #99
BIRTH REPORTS	Item #102
RESPIRATORY PROTECTION PROGRAM RECORDS: AIR SAMPLING	Item #107
RESIDENT RECORDS: ASSISTED LIVING FACILITIES	Item # 110
DISPOSAL RECORDS: NON-SEALED SOURCE RADIOACTIVE MATERIAL	Item #113
MONITORING STRIPS	Item #118
DIRECTIVES/PROCEDURES/POLICIES: HEALTHCARE	Item #120
STAFFING RECORDS: MEDICAL PERSONNEL	Item #126
INVENTORY RECORDS: DRUG	Item #127
GUNSHOT WOUND/LIFE-THREATENING INJURY REPORTS	Item #128
PATIENT MEDICAL RECORDS: CHILDREN UNDER ONE YEAR OF AGE	Item #130
INFECTION CONTROL RECORDS	Item #131
PATIENT MEDICAL RECORDS: NURSING HOME MINORS	Item #133
BLOOD BANK RECORDS: NO PRODUCT EXPIRATION DATE	Item #XXX
BLOOD BANK RECORDS: PRODUCT EXPIRATION DATE	Item #XXX
CLINICAL STUDY RECORDS	Item #XXX
FOOD SERVICES RECORDS	Item #XXX
LABORATORY/PATHOLOGY TESTING RECORDS	Item #XXX
PHARMACY PATIENT AND PRESCRIPTION RECORDS	Item #XXX
PROCEDURES: SPECIMEN TESTING	Item #XXX
RADIOLOGY RECORDS: OPERATIONAL	Item #XXX
RADIOLOGY/RADIATION RECORDS: EXPOSURE	Item #XXX
VITAL STATISTICS RECORDS	Item #XXX
X-RAY/IMAGING RECORDS	Item #XXX