CHAPTER 24
Health and Safety

ARTICLE 1
Public Health

24-1-1. Short title.

Chapter 24, Article 1 NMSA 1978 may be cited as the "Public Health Act".

History: 1953 Comp., § 12-34-1, enacted by Laws 1973, ch. 359, § 1; 2004, ch. 44, § 1; 2004, ch. 50, § 1.

ANNOTATIONS

2004 amendments. — Laws 2004, ch. 44, § 1 and Laws 2004, ch. 50, § 1 enact identical amendments to Section 24-1-1 NMSA 1978, effective May 19, 2004. The 2004 amendments include all of Chapter 24, Article 1 as the Public Health Act.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 39 Am. Jur. 2d Health § 1 et seq.

39A C.J.S. Health and Environment § 1 et seq.

24-1-2. Definitions.

As used in the Public Health Act [24-1-1 NMSA 1978]:

A. "department" or "division" means the children, youth and families department as to child care centers, residential treatment centers that serve persons up to twenty-one years of age, community mental health centers that serve only persons up to twenty-one years of age and day treatment centers that serve persons up to twenty-one years of age, and the department of health as to all other health facilities;

B. "director" means the secretary;

C. "person", when used without further qualification, means an individual or any other form of entity recognized by law;

D. "health facility" means a public hospital, profit or nonprofit private hospital, general or special hospital, outpatient facility, maternity home or shelter, adult daycare facility, nursing home, intermediate care facility, boarding home not under the control of an institution of higher learning, child care center, shelter care home, diagnostic and treatment center, rehabilitation center, infirmary, community mental health center that serves both children and adults or adults only, residential treatment center that serves

persons up to twenty-one years of age, community mental health center that serves only persons up to twenty-one years of age and day treatment center that serves persons up to twenty-one years of age or a health service organization operating as a free-standing hospice or a home health agency. The designation of these entities as health facilities is only for the purposes of definition in the Public Health Act [24-1-1 NMSA 1978] and does not imply that a free-standing hospice or a home health agency is considered a health facility for the purposes of other provisions of state or federal laws. "Health facility" also includes those facilities that, by federal regulation, must be licensed by the state to obtain or maintain full or partial, permanent or temporary federal funding. It does not include the offices and treatment rooms of licensed private practitioners; and

E. "secretary" means the secretary of children, youth and families as to child care centers and facilities and the secretary of health as to all other health facilities.

History: 1953 Comp., § 12-34-2, enacted by Laws 1973, ch. 359, § 2; 1977, ch. 253, § 39; 1979, ch. 25, § 1; 1981, ch. 171, § 10; 1983, ch. 112, § 1; 1987, ch. 27, § 1; 1996, ch. 35, § 1; 1999, ch. 165, § 1; 2003, ch. 284, § 1.

ANNOTATIONS

Cross references. — For creation of the department of health, see 9-7-4 NMSA 1978.

For criminal records screening for caregivers employed by care providers, see 29-17-2 to 29-17-5 NMSA 1978.

The 1996 amendment, effective May 15, 1996, rewrote Subsections A and B; in Subsection D, deleted "sanitarium" preceding "maternity" and "asylum" preceding "nursing" in the first sentence and substituted "entities as health facilities" for "services as a health facility" in the second sentence; and added Subsection E.

The 1999 amendment, effective June 18, 1999, inserted "community mental health center" following "infirmary" in Subsection D.

The 2003 amendment, effective June 20, 2003, substituted "residential treatment centers that serve persons up to twenty-one years of age, community mental health centers that serve only persons up to twenty-one years of age and day treatment centers that serve persons up to twenty-one years of age" for "and facilities" following "child care centers" in Subsection A; in Subsection D, inserted "that serves both children and adults or adults only, residential treatment center that serves persons up to twenty-one years of age, community mental health center that serves only persons up to twenty-one years of age and day treatment center that serves persons up to twenty-one years of age" following "mental health center", and substituted "that" for "which" following "includes those facilities".

24-1-3. Powers and authority of department.

The department has authority to:

A. receive such grants, subsidies, donations, allotments or bequests as may be offered to the state by the federal government or any department thereof or by any public or private foundation or individuals;

B. supervise the health and hygiene of the people of the state;

C. investigate, control and abate the causes of disease, especially epidemics, sources of mortality and other conditions of public health;

D. establish, maintain and enforce isolation and quarantine;

E. close any public place and forbid gatherings of people when necessary for the protection of the public health;

F. establish programs and adopt rules to prevent infant mortality, birth defects and morbidity;

G. prescribe the duties of public health nurses and school nurses;

H. provide educational programs and disseminate information on public health;

I. maintain and enforce rules for the licensure of health facilities;

J. bring action in court for the enforcement of health laws and rules and orders issued by the department;

K. enter into agreements with other states to carry out the powers and duties of the department;

L. cooperate and enter into contracts or agreements with the federal government or any other person to carry out the powers and duties of the department;

M. maintain and enforce rules for the control of communicable diseases deemed to be dangerous to public health;

N. maintain and enforce rules for immunization against diseases deemed to be dangerous to the public health;

O. maintain and enforce such rules as may be necessary to carry out the provisions of the Public Health Act [24-1-1 NMSA 1978] and to publish the rules;

P. supervise state public health activities, operate a dental public health program and operate state laboratories for the investigation of public health matters;

Q. sue and, with the consent of the legislature, be sued;

R. regulate the practice of midwifery;

S. administer legislation enacted pursuant to Title VI of the Public Health Service Act, as amended and supplemented;

T. inspect such premises or vehicles as necessary to ascertain the existence or nonexistence of conditions dangerous to public health or safety;

U. request and inspect, while maintaining federal and state confidentiality requirements, copies of:

(1) medical and clinical records reasonably required for the department's quality assurance and quality improvement activities; and

(2) all medical and clinical records pertaining to the individual whose death is the subject of inquiry by the department's mortality review activities; and

V. do all other things necessary to carry out its duties.

History: 1953 Comp., § 12-34-3, enacted by Laws 1973, ch. 359, § 3; 1975, ch. 183, § 2; 2001, ch. 119, § 2.

ANNOTATIONS

Cross references. — For department of health generally, *see* Chapter 9, Article 7 NMSA 1978.

For Title VI of the Public Health Service Act, *see* 42 U.S.C. § 291 et seq.

The 2001 amendment, effective June 15, 2001, substituted "rules" for "regulations" throughout the section; and added Subsection U, redesignating former Subsection U as Subsection V.

Statutes delegating power to enact and enforce health regulations are to be liberally construed in order to effectuate the purpose of their enactment. 1957-58 Op. Att'y Gen. No. 58-230.

The health and social services department's (now department of health's) licensing power as delegated by the legislature in this article should be liberally construed to allow the department to prescribe, maintain and enforce necessary or desirable regulations to promote the psychological and physical well-being of children attending licensed child care centers. Included within the scope of the department's authority is the prescription, maintenance and enforcement of minimum standards for the care given children in licensed child care centers, provided such standards bear a

reasonable relation to the public health and are reasonably adapted to prevent some existing or anticipated menace. 1976 Op. Att'y Gen. No. 76-37.

Isolation of person afflicted with contagious disease. — Under a general delegation of the power to take measures necessary to prevent the spread of contagious disease, health officers have the power to provide for the isolation of persons afflicted with such a disease. 1959-60 Op. Att'y Gen. No. 60-174.

Licensed nurse need not also have midwife license. — A family nurse practitioner authorized by the board of nursing to perform services constituting midwifery need not, as well, have a midwife license from the health services division (now department of health). 1981 Op. Att'y Gen. No. 81-7.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 39 Am. Jur. 2d Health § 37 et seq.

Physical examination or test, health regulation requiring submission to, as to violation of constitutional rights, 25 A.L.R.2d 1407.

Constitutional rights of owner as against destruction of building by public authorities, 14 A.L.R.2d 73.

Validity of regulations as to plumbers and plumbing, 22 A.L.R.2d 816.

Propriety of state or local government health officer's warrantless search - post-Camara cases, 53 A.L.R.4th 1168.

39A C.J.S. Health and Environment §§ 3 to 54.

24-1-4. Creation of health districts; appointment of health officers; powers and duties of health officers.

A. The director shall establish health districts and may modify and create new ones as he deems necessary.

B. The director shall appoint one district health officer for each health district. The director may appoint assistants to the district health officer when he deems necessary.

C. The director shall establish the powers and duties of the district health officers.

D. All school health personnel, except physical education personnel, are under the direct supervision and control of the district health officer in their district. They shall make such reports relating to public health as the district health officer in their district requires.

History: 1953 Comp., § 12-34-4, enacted by Laws 1973, ch. 359, § 4.

ANNOTATIONS

Cross references. — For district health officers generally, *see* 24-4-1 to 24-4-3 NMSA 1978.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 39 Am. Jur. 2d Health § 16 et seq.

Personal liability of health officer, 24 A.L.R. 798.

39A C.J.S. Health and Environment §§ 3 to 17.

24-1-4.1. Certified nurse-midwives; prescriptive, distributing and administering authority.

A. Certified nurse-midwives who have fulfilled requirements for prescriptive authority may prescribe in accordance with rules, regulations, guidelines and formularies for individual certified nurse-midwives promulgated by the department of health.

B. As used in this section, "prescriptive authority" means the ability of the certified nurse-midwife to practice independently, serve as a primary care provider and as necessary collaborate with licensed medical doctors or osteopathic physicians. Certified nurse-midwives who have fulfilled requirements for prescribing drugs may prescribe, distribute and administer to their patients dangerous drugs, including controlled substances included in Schedules II through V [30-31-7 to 30-31-10 NMSA 1978] of the Controlled Substances Act [30-31-1 NMSA 1978], that have been prepared, packaged or fabricated by a licensed pharmacist or doses of drugs that have been prepackaged by a pharmaceutical manufacturer in accordance with the Pharmacy Act [61-11-1 NMSA 1978] and New Mexico Drug, Device and Cosmetic Act [26-1-1 NMSA 1978].

History: Laws 1997, ch. 253, § 1.

ANNOTATIONS

Cross references. — For Insurance Code provisions relating to freedom of choice of hospital and practitioner, *see* 59A-22-32 NMSA 1978.

For qualifications and scope of practice of certifed nurse practitioners, *see* 61-3-23.2 NMSA 1978.

24-1-5. Licensure of health facilities; hearings; appeals.

A. A health facility shall not be operated without a license issued by the department. If a health facility is found to be operating without a license, in order to protect human health or safety, the secretary may issue a cease-and-desist order. The health facility may request a hearing that shall be held in the manner provided in this section. The department may also proceed pursuant to the Health Facility Receivership Act.

B. The department is authorized to make inspections and investigations and to prescribe rules it deems necessary or desirable to promote the health, safety and welfare of persons using health facilities.

C. Except as provided in Subsection F of this section, upon receipt of an application for a license to operate a health facility, the department shall promptly inspect the health facility to determine if it is in compliance with all rules of the department. Applications for hospital licenses shall include evidence that the bylaws or rules of the hospital apply equally to osteopathic and medical physicians. The department shall consolidate the applications and inspections for a hospital that also operates as a hospital-based primary care clinic.

D. Upon inspection of a health facility, if the department finds a violation of its rules, the department may deny the application for a license, whether initial or renewal, or it may issue a temporary license. A temporary license shall not be issued for a period exceeding one hundred twenty days, nor shall more than two consecutive temporary licenses be issued.

E. A one-year nontransferable license shall be issued to any health facility complying with all rules of the department. The license shall be renewable for successive one-year periods, upon filing of a renewal application, if the department is satisfied that the health facility is in compliance with all rules of the department or, if not in compliance with a rule, has been granted a waiver or variance of that rule by the department pursuant to procedures, conditions and guidelines adopted by rule of the department. Licenses shall be posted in a conspicuous place on the licensed premises, except that child care centers that receive no state or federal funds may apply for and receive from the department a waiver from the requirement that a license be posted or kept on the licensed premises.

F. A health facility that has been inspected and licensed by the department and that has received certification for participation in federal reimbursement programs and that has been fully accredited by the joint commission on accreditation of health care organizations or the American osteopathic association shall be granted a license renewal based on that accreditation. Health facilities receiving less than full accreditation by the joint commission on the accreditation of health care organizations or by the American osteopathic association may be granted a license renewal based on that accreditation. License renewals shall be issued upon application submitted by the health facility upon forms prescribed by the department. This subsection does not limit in any way the department's various duties and responsibilities under other provisions of the Public Health Act [24-1-1 NMSA 1978] or under any other subsection of this section, including any of the department's responsibilities for the health and safety of the public.

G. The department may charge a reasonable fee not to exceed twelve dollars ($12.00) per bed for an inpatient health facility or three hundred dollars ($300) for any other health facility for each license application, whether initial or renewal, of an annual license or the second consecutive issuance of a temporary license. Fees collected shall

not be refundable. All fees collected pursuant to licensure applications shall be deposited with the state treasurer for credit in a designated department recurring account for use in health facility licensure and certification operations.

H. The department may revoke or suspend the license of a health facility or may impose on a health facility an intermediate sanction and a civil monetary penalty provided in Section 24-1-5.2 NMSA 1978 after notice and an opportunity for a hearing before a hearing officer designated by the department to hear the matter and, except for child care centers and facilities, may proceed pursuant to the Health Facility Receivership Act [24-1E-1 NMSA 1978] upon a determination that the health facility is not in compliance with any rule of the department. If immediate action is required to protect human health and safety, the secretary may suspend a license or impose an intermediate sanction pending a hearing, provided the hearing is held within five working days of the suspension or imposition of the sanction, unless waived by the licensee, and, except for child care centers and facilities, may proceed ex parte pursuant to the Health Facility Receivership Act.

I. The department shall schedule a hearing pursuant to Subsection H of this section if the department receives a request for a hearing from a licensee:

(1) within ten working days after receipt by the licensee of notice of suspension, revocation, imposition of an intermediate sanction or civil monetary penalty or denial of an initial or renewal application;

(2) within four working days after receipt by the licensee of an emergency suspension order or emergency intermediate sanction imposition and notice of hearing if the licensee wishes to waive the early hearing scheduled and request a hearing at a later date; or

(3) within five working days after receipt of a cease-and-desist order.

The department shall also provide timely notice to the licensee of the date, time and place of the hearing, identity of the hearing officer, subject matter of the hearing and alleged violations.

J. A hearing held pursuant to provisions of this section shall be conducted in accordance with adjudicatory hearing rules and procedures adopted by rule of the department. The licensee has the right to be represented by counsel, to present all relevant evidence by means of witnesses and books, papers, documents, records, files and other evidence and to examine all opposing witnesses who appear on any matter relevant to the issues. The hearing officer has the power to administer oaths on request of any party and issue subpoenas and subpoenas duces tecum prior to or after the commencement of the hearing to compel discovery and the attendance of witnesses and the production of relevant books, papers, documents, records, files and other evidence. Documents or records pertaining to abuse, neglect or exploitation of a resident, client or patient of a health facility or other documents, records or files in the

custody of the human services department or the office of the state long-term care ombudsman at the aging and long-term services department that are relevant to the alleged violations are discoverable and admissible as evidence in any hearing.

K. Any party may appeal the final decision of the department pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

L. A complaint about a health facility received by the department pursuant to this section shall be promptly investigated and appropriate action shall be taken if substantiated. The department shall develop a health facilities protocol in conjunction with the human services department, the protective services division of the children, youth and families department, the office of the state long-term care ombudsman and other appropriate agencies to ensure the health, safety and rights of individuals in health facilities. The health facilities protocol shall require:

(1) cross-reference among agencies pursuant to this subsection of an allegation of abuse, neglect or exploitation;

(2) an investigation, within the strict priority time frames established by each protocol member's rules, of an allegation or referral of abuse, neglect or exploitation after the department has made a good cause determination that abuse, neglect or exploitation occurred;

(3) an agency to share its investigative information and findings with other agencies, unless otherwise prohibited by law; and

(4) require the receiving agency to accept the information provided pursuant to Paragraph (3) of this subsection as potential evidence to initiate and conduct investigations.

M. A complaint received by the department pursuant to this section shall not be disclosed publicly in a manner as to identify any individuals or health facilities if upon investigation the complaint is unsubstantiated.

N. Notwithstanding any other provision of this section, when there are reasonable grounds to believe that a child is in imminent danger of abuse or neglect while in the care of a child care facility, whether or not licensed, or upon the receipt of a report pursuant to Section 32A-4-3 NMSA 1978, the department shall consult with the owner or operator of the child care facility. Upon a finding of probable cause, the department shall give the owner or operator notice of its intent to suspend operation of the child care facility and provide an opportunity for a hearing to be held within three working days, unless waived by the owner or operator. Within seven working days from the day of notice, the secretary shall make a decision, and, if it is determined that any child is in imminent danger of abuse or neglect in the child care facility, the secretary may suspend operation of the child care facility for a period not in excess of fifteen days. Prior to the date of the hearing, the department shall make a reasonable effort to notify

the parents of children in the child care facility of the notice and opportunity for hearing given to the owner or operator.

O. Nothing contained in this section or in the Public Health Act [24-1-1 NMSA 1978] shall authorize either the secretary or the department to make any inspection or investigation or to prescribe any rules concerning group homes as defined in Section 9-8-13 NMSA 1978 except as are reasonably necessary or desirable to promote the health and safety of persons using group homes.

History: 1953 Comp., § 12-34-5, enacted by Laws 1973, ch. 359, § 5; 1975, ch. 183, § 3; 1979, ch. 33, § 1; 1983, ch. 185, § 1; 1987, ch. 31, § 2; 1989, ch. 138, § 1; 1990, ch. 105, § 1; 1996, ch. 35, § 2; 1997, ch. 113, § 1; 1998, ch. 55, § 32; 1999, ch. 265, § 34; 2003, ch. 120, § 1; 2005, ch. 53, § 1.

ANNOTATIONS

Cross references. — For inspections generally, *see* 24-1-16 to 24-1-19 NMSA 1978.

For confidentiality of files and records generally, *see* 24-1-20 NMSA 1978.

For abandonment or abuse of a child, *see* 30-6-1 NMSA 1978.

The 1990 amendment, effective July 1, 1990, substituted "in this section" for "in Subsection H of this section" at the end of the third sentence in Subsection A; added the language beginning "or if not in compliance" at the end of the second sentence in Subsection E; in Subsection H, inserted "or may impose on any health facility after January 1, 1991, any intermediate sanction or civil monetary penalty provided in Section 24-1-5.2 NMSA 1978" in the first sentence, inserted "or impose any intermediate sanction" and "or imposition of the sanction" in the second sentence, transferred the former third sentence and made it the beginning of the third sentence of present Subsection J and transferred the former fourth sentence to make it the first sentence of present Subsection K; added present Subsection I; added the first and second sentences, the language beginning "prior to or after the commencement" at the end of the third sentence and the fourth sentence of present Subsection J; added the second sentence of present Subsection K; added Subsection L; designated former Subsections I to K as present Subsections M to O; and substituted "any individuals" for "other individuals" in present Subsection M.

The 1996 amendment, effective May 15, 1996, in Subsection A, substituted "secretary" for "director" in the second sentence and added the last sentence; in Subsection G, substituted "the second consecutive issuance" for "renewal"; in Subsection H, in the first sentence, deleted "after January 1, 1991" following the second occurrence of "facility" and added the exception near the middle of the sentence, and added the exception at the end of the second sentence; in Subsection N, deleted "health" preceding "facility" four times, substituted "32A-4-3" for "32-1-15" in the first sentence, and inserted "child-

care" in the third and fourth sentences; in Subsection O, deleted "of health and environment" following "secretary"; and made stylistic changes throughout the section.

The 1997 amendment, effective June 20, 1997, added the the third sentence to Subsection C and made minor stylistic changes throughout the section.

The 1998 amendment, effective September 1, 1998, in the section heading, inserted "; Hearings; Appeals"; in Subsection C, substituted "rules" for "regulations" in two places; in Subsection D, substituted "rules" for "regulations" and "the department" for "it"; in Subsection E, substituted "rules" for "regulations" in two places, and substituted "rule" for "regulation" in three places; rewrote Subsection K; and made minor stylistic changes throughout the section.

The 1999 amendment, effective July 1, 1999, substituted "Section 39-3-1.1" for "Section 12-8A-1" in Subsection K.

The 2003 amendment, effective June 20, 2003, in Subsection A, substituted "A" for "No" at the beginning, inserted "not" preceding "be operated without"; in Subsection F, inserted "health" preceding "facility upon forms"; rewrote Subsection L; substituted "A complaint" for "Complaints" at the beginning of Subsection M; and substituted "when" for "where" preceding "there are reasonable grounds" in Subsection N.

The 2005 amendment, effective July 1, 2005, amends Subsection G to increase the maximum fees that may be charged for initial and renewal license applications from $3.00 to $12.00 per bed and from $100 to $300 per facility and to provide that all fees shall be credited to a “recurring account” for use in health facility licensure and certification operations.

Applicability. — Laws 1990, ch. 105, § 5 makes the provisions of the act authorizing imposition of intermediate sanctions and civil monetary penalties apply to health facility licensing regulation violations occurring on or after January 1, 1991.

Child care center operated by church. — The statutory requirement of obtaining a license to operate a child care center did not violate the right of a church, which operated a child care center in which corporal punishment was allowed, to freely exercise religion. Health Servs. Div. v. Temple Baptist Church, 112 N.M. 262, 814 P.2d 130 (Ct. App. 1991).

Am. Jur. 2d, A.L.R. and C.J.S. references. — 40 Am. Jur. 2d Hospitals and Asylums § 5 et seq.

Validity, construction, and effect of statute requiring consultation with, or approval of, local governmental unit prior to locating group home, halfway house, or similar community residence for the mentally ill, 51 A.L.R.4th 1096.

Licensing and regulation of nursing or rest homes, 53 A.L.R.4th 689.

Propriety of state or local government health officer's warrantless search - post-Camara cases, 53 A.L.R.4th 1168.

Tort liability of private nursery school or day-care center, or employee thereof, for injury to child while attending facility, 58 A.L.R.4th 240.

Criminal liability under statutes penalizing abuse or neglect of the institutionalized infirm, 60 A.L.R.4th 1153.

Governmental liability for negligence in licensing, regulating, or supervising private day-care home in which child is injured, 68 A.L.R.4th 266.

41 C.J.S. Hospitals § 3 et seq.

24-1-5.1. Repealed.

ANNOTATIONS

Repeals. — Laws 1990, ch. 105, § 4 repeals 24-1-5.1 NMSA 1978, as enacted by Laws 1981, ch. 171, § 11, relating to health and safety certification of foster homes, effective July 1, 1990. For provisions of former section, *see* New Mexico One Source of Law DVD.

24-1-5.2. Health facilities; intermediate sanctions; civil penalty.

A. Upon a determination that a health facility is not in compliance with any licensing requirement of the department, the department, subject to the provisions of this section and Section 24-1-5 NMSA 1978, may:

(1) impose any intermediate sanction established by rule, including but not limited to:

(a) a directed plan of correction;

(b) facility monitors;

(c) denial of payment for new medicaid admissions to the facility;

(d) temporary management or receivership; and

(e) restricted admissions;

(2) assess a civil monetary penalty, with interest, for each day the facility is or was out of compliance. Civil monetary penalties shall not exceed a total of five thousand dollars ($5,000) per day. Penalties and interest amounts assessed under this paragraph and recovered on behalf of the state shall be remitted to the department in a recurring

account in the state treasury for the sole purpose of funding the nonreimbursed cost of facility monitors, temporary management and health facility receiverships. The civil monetary penalties contained in this paragraph are cumulative and may be imposed in addition to any other fines or penalties provided by law; and

(3) with respect to health facilities other than childcare centers or facilities, proceed pursuant to the Health Facility Receivership Act [24-1E-1 NMSA 1978].

B. The secretary shall adopt and promulgate rules specifying the criteria for imposition of any intermediate sanction and civil monetary penalty. The criteria shall provide for more severe sanctions for a violation that results in any abuse, neglect or exploitation of residents, clients or patients as defined in the rules or that places one or more residents, clients or patients of a health facility at substantial risk of serious physical or mental harm.

C. The provisions of this section for intermediate sanctions and civil monetary penalties shall apply to certified nursing facilities except when a federal agency has imposed the same remedies, sanctions or penalties for the same or similar violations.

D. Rules adopted by the department shall permit sanctions pursuant to Paragraphs (1) and (2) of Subsection A of this section for a specific violation in a certified nursing facility if:

(1) the state statute or rule is not duplicated by a federal certification rule; or

(2) the department determines intermediate sanctions are necessary if sanctions permitted pursuant to Paragraphs (1) and (2) of Subsection A of this section do not duplicate a sanction imposed under the authority of 42 U.S.C. 1395 or 1396 for a particular deficiency.

E. A health facility is liable for the reasonable costs of a directed plan of correction, facility monitors, temporary management or receivership imposed pursuant to this section and Section 24-1-5 NMSA 1978. The department may take all necessary and appropriate legal action to recover these costs from a health facility. All money recovered from a health facility pursuant to this subsection shall be paid into the general fund.

History: 1978 Comp., § 24-1-5.2, enacted by Laws 1990, ch. 105, § 2; 1996, ch. 35, § 3; 2005, ch. 53, § 2.

ANNOTATIONS

Cross references. — For Statewide Health Care Act, *see* 27-10-1 NMSA 1978.

The 1996 amendment, effective May 15, 1996, in Subsection A, deleted "after January 1, 1994" following "that" in the introductory language and added Paragraph (3); in

Subsection B, deleted "of health and environment" following "secretary" and substituted "and civil" for "including the amount of" and "penalty" for "penalties and the type and extent of intermediate sanctions"; in Subsection D, inserted "or receivership" in the first sentence; and made stylistic changes throughout the section.

The 2005 amendment, effective July 1, 2005, provides that penalties and interest amounts be remitted to the department to be used solely for funding the non-reimbursed cost of facility monitors, temporary management and health facility receiverships; provides that the provision for intermediate sanctions and monetary penalties shall apply to certified nursing facilities, except when a federal agency has already taken action; and provides that department rules shall permit sanctions for violations in a certified nursing facility if the state statute or the rule imposing the sanction is not duplicated by federal law or rule.

Applicability. — Laws 1990, ch. 105, § 5 makes the provisions of the act authorizing imposition of intermediate sanctions and civil monetary penalties apply to health facility licensing regulation violations occurring on or after January 1, 1991.

24-1-5.3. Repealed.

ANNOTATIONS

Repeals. — Laws 1990, ch. 97, § 3, as amended by Laws 1993, ch. 84, § 3 and Laws 1995, ch. 88, § 2 repeal 24-1-5.3 NMSA 1978, as amended by Laws 1993, ch. 84, § 1 and 1995, ch. 88, § 1, effective July 1, 1995 and July 1, 1997, respectively. For provisions of former section, *see* New Mexico One Source of Law DVD.

Compiler's notes. — Laws 1997, ch. 217, § 1 amended this section effective June 20, 1997 by, in Subsection B, adding "Except as provided in Subsection C of this section for transfers" at the beginning of the introductory language, substituting "July 1, 1999" for "July 1, 1997" at the beginning of Paragraph (1) and substituting "presented to the first session of the 44th legislature" for "begun implementation of" near the middle of Paragraph (1); and adding Subsection C relating to transferring beds from currently licensed facilities to other facilities and redesignating former Subsection C as Subsection D. Laws 1995, Chapter 88, Section 2 repealed Section 24-1-5.3 NMSA 1978 effective July 1, 1997 and therefore the June 20, 1997 amendments have not been published.

24-1-5.4. Plan of growth; requirements; reporting.

No later than January 1, 1999 the human services department and the department of health shall develop a plan with approval of the first session of the forty-fourth legislature to control growth of intermediate care facilities for the mentally retarded and clarify the role of intermediate care facilities for the mentally retarded in the developmental disabilities care system. The plan shall include fiscal, geographical, service and access criteria necessary to provide for the needs of individuals in need of

such facilities and shall be in accordance with the freedom of choice provisions of Title XIX of the Social Security Act. The departments shall present a joint report and legislative recommendations on growth of intermediate care facilities for the mentally retarded to the interim legislative health and human services committee no later than October 1, 1998.

History: Laws 1997, ch. 217, § 2.

ANNOTATIONS

Cross references. — For Title XIX of the federal Social Security Act, *see* 42 U.S.C. § 1396 et seq.

24-1-5.5. Repealed.

ANNOTATIONS

Repeals. — Laws 1998 (1st S.S.), ch. 1, § 2 repeals 24-1-5.5 NMSA 1978, as enacted by Laws 1998 (1st S.S.), ch. 1, § 1, relating to a licensure moratorium for intermediate care facilities for the mentally retarded, effective July 1, 2000. For provisions of the former section, *see* New Mexico One Source of Law DVD.

24-1-5.6. Northern New Mexico substance abuse treatment pilot project.

A. The department of health shall establish the northern New Mexico substance abuse treatment pilot project.

B. The northern New Mexico substance abuse treatment pilot project shall provide substance abuse treatment in Rio Arriba and Santa Fe counties.

C. Currently accepted treatment practices shall be used in the northern New Mexico substance abuse treatment pilot program [project].

D. The department of health shall seek federal funding to support and supplement the northern New Mexico substance abuse treatment pilot project.

E. The department of health shall report to the legislature annually by December 1 on the progress of the northern New Mexico substance abuse treatment pilot project.

F. The department of health shall coordinate with the human services department to determine whether any patient who participates in the northern New Mexico substance abuse treatment pilot project is eligible to receive temporary assistance for needy families pursuant to the New Mexico Works Act [27-2B-1 NMSA 1978].

History: Laws 1999 (1st S.S.), ch. 8, § 1.

ANNOTATIONS

Bracketed material. — The bracketed word "project" in Subsection C was inserted by the compiler. It was not enacted by the legislature and is not part of the law.

24-1-5.7. Methadone clinics; regulation by the department of health.

A. The federal government requires the state to approve the establishment of all new methadone clinics. In an effort to maintain compliance with the federal requirement, the department of health shall regulate the establishment and continuance of methadone clinics in New Mexico in accordance with its powers and duties as the state's public health agency and drug abuse agency.

B. In regulating methadone clinics, the department of health shall perform an assessment of the need for clinics and develop clinical and administrative standards as required by federal law. The department may consider other factors it deems necessary to ensure the provision of drug abuse treatment services and the protection of the health and safety of New Mexico citizens.

C. For the purposes of this section, "methadone clinic" means a public or private facility that dispenses methadone for the detoxification treatment or maintenance treatment of narcotic addicts.

History: Laws 2003, ch. 190, § 1.

ANNOTATIONS

Effective dates. — Laws 2003, ch.190, § 2 makes the act effective on July 1, 2003.

24-1-5.8. Legislative findings; licensing requirements for certain hospitals.

A. The legislature finds that:

(1) acute care general hospitals throughout New Mexico operate emergency departments and provide vital emergency medical services to patients requiring immediate medical care; and

(2) federal and state laws require hospitals that operate an emergency department to provide certain emergency services and care to any person, regardless of that person's ability to pay. Accordingly, these hospitals encounter significant financial losses when treating uninsured or underinsured patients.

B. As used in this section:

(1) "limited service hospital" means a hospital that limits admissions according to medical or surgical specialty, type of disease or medical condition, or a hospital that limits its inpatient hospital services to surgical services or invasive diagnostic and treatment procedures; provided, however, that a "limited service hospital" does not include:

(a) a hospital licensed by the department as a special hospital;

(b) an eleemosynary hospital that does not bill patients for services provided; or

(c) a hospital that has been granted a license prior to January 1, 2003;

(2) "department" means the department of health; and

(3) "low-income patient" means a patient whose family or household income does not exceed two hundred percent of the federal poverty level.

C. The department shall issue a license to an acute-care or general hospital or a limited services hospital that agrees to:

(1) continuously maintain and operate an emergency department that provides emergency medical services as determined by the department;

(2) participate in the medicaid, medicare and county indigent care programs;

(3) require a physician owner to disclose a financial interest in the hospital before referring a patient to the hospital;

(4) comply with the same quality standards applied to other hospitals;

(5) provide emergency services and general health care to nonpaying patients and low-income reimbursed patients in the same proportion as the patients are treated in acute-care general hospitals in the local community, as determined by the department in consultation with a statewide hospital organization, the government of the county in which the facilities are located and the affected hospitals; provided that:

(a) a hospital may appeal the determination of the department pursuant to Section 39-3-1.1 NMSA 1978; and

(b) the annual cost of the care required to be provided pursuant to this paragraph shall not exceed an amount equal to five percent of the hospital's annual revenue; and

(6) require a health care provider to disclose a financial interest before referring a patient to the hospital.

History: Laws 2003, ch. 426, § 1.

ANNOTATIONS

Emergency clauses. — Laws 2003, ch. 426, § 2 makes the act effective immediately, approved April 8, 2003.

24-1-5.9. Reporting requirements.

A. A hospital, a long-term care facility or a primary care clinic shall provide information sufficient for the secretary to make a reasonable assessment based on clear and convincing evidence of its financial viability, sustainability and potential impact on health care access. Information provided to the secretary pursuant to this section shall remain confidential, is exempt from the Inspection of Public Records Act [14-3-1 NMSA 1978], unless disclosure or use is mandated by the state or federal law, and shall not be used as a basis for suspension, revocation or issuance of a license. The hospital, long-term care facility or primary care clinic shall provide this information to the secretary at least sixty days before the anticipated effective date of a proposed licensure, closure, disposition or acquisition of the hospital, the long-term care facility or the primary care clinic or its essential services.

B. The secretary shall issue a notice of finding to the facility within sixty days of receiving information from the facility.

C. For the purposes of this section:

(1) "hospital" means a facility providing emergency or urgent care, inpatient medical care and nursing care for acute illness, injury, surgery or obstetrics. "Hospital" includes a facility licensed by the department as a critical access hospital, general hospital, long-term acute care hospital, psychiatric hospital, rehabilitation hospital, limited services hospital and special hospital;

(2) "long-term care facility" means a nursing home licensed by the department to provide intermediate or skilled nursing care; and

(3) "primary care clinic" means a community-based clinic that provides the first level of basic or general health care for an individual's health needs, including diagnostic and treatment services and, if integrated into the clinic's service array, mental health services.

History: Laws 2004, ch. 44, § 2 and Laws 2004, ch. 50, § 2.

ANNOTATIONS

Duplicate laws. — Laws 2004, ch. 44, § 2 and Laws 2004, ch. 50, § 2 enact identical new sections of the Public Health Act, effective May 19, 2004. Both have been compiled as Section 24-1-5.9 NMSA 1978. *See* 12-1-8 NMSA 1978.

24-1-5.10. Federal participation required; exception.

A. Except as provided in Subsection B of this section, all programs, clinics, hospitals and other health-related centers and entities, including those identified by the human services department pursuant to Paragraph (3) of Subsection A of Section 27-2-12.13 NMSA 1978, that are eligible under Section 340B of the federal Public Health Service Act, including hospitals and clinics licensed under the state Public Health Act [24-1-1 NMSA 1978], shall participate in that Section 340B federal prescription drug price discount program.

B. If an entity described in Subsection A of this section can demonstrate to the satisfaction of the department of health that the prescription drug price discount it receives other than through the Section 340B program results in greater savings to the state, the entity may be granted an exception to the requirements of this section.

History: Laws 2004, ch. 47, § 1.

ANNOTATIONS

24-1-6. Tests required for newborn infants.

A. The department shall adopt screening tests for the detection of congenital diseases that shall be given to every newborn infant, except that, after being informed of the reasons for the tests, the parents or guardians of the newborn child may waive the requirements for the tests in writing. The screening tests shall include at a minimum:

(1) 3-methylcrotonyl-CoA deficiency;

(2) 3-OH 3-CH3 glutaric aciduria;

(3) argininosuccinic acidemia;

(4) mitochondrial acetoacetyl-CoA thiolase deficiency;

(5) biotinidase deficiency;

(6) carnitine uptake defect;

(7) citrullinemia;

(8) congenital adrenal hyperplasia;

(9) congenital hypothyroidism;

(10) cystic fibrosis;

(11) galactosemia;

(12) glutaric acidemia type I;

(13) Hb S/beta-thalassemia;

(14) hearing deficiency;

(15) homocystinuria;

(16) isovaleric academia;

(17) long-chain L-3-OH acyl-CoA dehydrogenase deficiency;

(18) maple syrup urine disease;

(19) medium chain acyl-CoA dehydrogenase deficiency;

(20) methylmalonic acidemia;

(21) multiple carboxylase deficiency;

(22) phenylketonuria;

(23) proponic acidemia;

(24) sickle cell anemia;

(25) trifunctional protein deficiency;

(26) tyrosinemia type I; and

(27) very long-chain acyl-CoA dehydrogenase deficiency.

B. In determining which other congenital diseases to screen for, the secretary shall consider the recommendations of the New Mexico pediatrics society of the American academy of pediatrics.

C. The department shall institute and carry on such laboratory services or may contract with another agency or entity to provide such services as are necessary to detect the presence of congenital diseases.

D. The department shall, as necessary, carry on an educational program among physicians, hospitals, public health nurses and the public concerning congenital diseases.

E. The department shall require that all hospitals or institutions having facilities for childbirth perform or have performed screening tests for congenital diseases on all newborn infants except if the parents or guardians of a child object to the tests in writing.

History: 1953 Comp., § 12-34-6, enacted by Laws 1973, ch. 359, § 6; 1975, ch. 254, § 1; 1978, ch. 83, § 1; 1981, ch. 95, § 1; 2005, ch. 134, § 1.

ANNOTATIONS

Cross references. — For education and testing with respect to sickle cell trait and sickle cell anemia, *see* 24-3-1 NMSA 1978.

The 2005 amendment, effective June 17, 2005, requires the health department to adopt screening tests for the diseases listed in Subsection A(1) through (27).

Compiler's note. — Laws 2005, ch. 134,§ 2 provides that the provisions of Laws 2005, ch. 134, § 1 shall become effective upon appropriation to expand screening tests for newborn infants for detection of congenital diseases contained in Senate Bill 190 or similar legislation in the first session of the forty-seventh legislature becoming law. Laws 2005, ch. 34, § 7, effective June 17, 2005, appropriate $85,000 to the department of health in Subsection G(32) to expand screening tests for newborn infants for detection of congenital diseases.

24-1-6.1. Newborn hearing testing required; department of health.

By July 1, 2001, the department of health shall adopt rules to require that infants born in health facilities licensed by the department shall be screened for hearing sensitivity prior to being discharged. The rules shall also require the testing of newborns brought to licensed health facilities after birth who have not received a hearing sensitivity screening and notification to the parents of all screened infants of the results of the hearing sensitivity screening. Nothing in this section shall be construed to require screening for hearing sensitivity of a newborn infant if the infant's parents object to the screening on the grounds that it conflicts with their religious beliefs.

History: Laws 2001, ch. 82, § 1.

ANNOTATIONS

Emergency clauses. — Laws 2001, ch. 82, § 2 makes the act effective immediately, approved April 2, 2001.

24-1-7. Sexually transmitted diseases; reports of cases.

A. Every physician who makes a diagnosis of or treats or prescribes for a case of a sexually transmitted disease, every superintendent or manager of a clinic, dispensary or charitable or penal institution in which there is a case of a sexually transmitted disease and every laboratory performing a positive laboratory test for a sexually transmitted disease shall report the case immediately, in writing, on a form supplied by the department to the district health officer in the district in which they are located.

B. All district health officers shall make weekly reports to the department on forms supplied by the department of all cases of a sexually transmitted disease reported to them during the preceding week.

History: 1953 Comp., § 12-34-7, enacted by Laws 1973, ch. 359, § 7; 1993, ch. 341, § 1.

ANNOTATIONS

The 1993 amendment, effective July 1, 1993, substituted "sexually transmitted" for "venereal" in the section heading and "a sexually transmitted" for "venereal" throughout the section, and made a stylistic change in Subsection A.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 39 Am. Jur. 2d Health § 62.

Requiring submission to physical examination or test as violation of constitutional rights, 25 A.L.R.2d 1407.

Tort liability for infliction of venereal disease, 40 A.L.R.4th 1089.

24-1-8. Communication regarding sexually transmitted diseases.

If any attending physician knows or has good reason to suspect that a person having a sexually transmitted disease may conduct himself so as to expose other persons to infection, he shall notify the district health officer of the name and address of the diseased person and the facts of the case.

History: 1953 Comp., § 12-34-8, enacted by Laws 1973, ch. 359, § 8; 1993, ch. 341, § 2.

ANNOTATIONS

The 1993 amendment, effective July 1, 1993, rewrote the section heading and substituted "sexually transmitted" for "venereal" near the middle of the section.

24-1-9. Capacity to consent to examination and treatment for a sexually transmitted disease.

Any person regardless of age has the capacity to consent to an examination and treatment by a licensed physician for any sexually transmitted disease.

History: 1953 Comp., § 12-34-9, enacted by Laws 1973, ch. 359, § 9; 1993, ch. 341, § 3.

ANNOTATIONS

The 1993 amendment, effective July 1, 1993, substituted "a sexually transmitted" for "venereal" in the section heading and "sexually transmitted" for "venereal" near the end of the section.

Law reviews. — For article, "Treating Children Under the New Mexico Mental Health and Developmental Disabilities Code," see 10 N.M. L. Rev. 279 (1980).

24-1-9.1. Sexually transmitted diseases; testing of persons convicted of certain criminal offenses.

A. A test designed to identify any sexually transmitted disease may be performed on an offender convicted pursuant to state law of any criminal offense:

(1) involving contact between the penis and the vulva;

(2) involving contact between the penis and anus;

(3) involving contact between the mouth and penis;

(4) involving contact between the mouth and vulva;

(5) involving contact between the mouth and anus; or

(6) when the court determines from the facts of the case that there was a transmission or likelihood of transmission of bodily fluids from the offender to the victim of the criminal offense.

B. When consent to perform a test on an offender cannot be obtained, the victim of a criminal offense described in Subsection A of this section may petition the court to order that a test be performed on the offender. When the victim of the criminal offense is a minor or an incompetent, the parent or legal guardian of the victim may petition the court to order that a test be performed on the offender. The court shall order and the test shall be administered to the offender within ten days after the petition is filed by the

victim, his parent or guardian. The results of the test shall be disclosed only to the offender and to the victim or the victim's parent or legal guardian.

History: 1978 Comp., § 24-1-9.1, enacted by Laws 1993, ch. 341, § 4.

24-1-9.2. Sexually transmitted diseases; testing of persons formally charged for allegedly committing certain criminal offenses.

A. A test designed to identify any sexually transmitted disease may be performed on a person, upon the filing of a complaint, information or an indictment alleging that the person committed a state criminal offense:

(1) involving contact between the penis and the vulva;

(2) involving contact between the penis and anus;

(3) involving contact between the mouth and penis;

(4) involving contact between the mouth and vulva; or

(5) involving contact between the mouth and anus.

B. If consent to perform a test on an alleged offender cannot be obtained, the victim of the alleged criminal offense described in Subsection A of this section may petition the court, through the prosecuting office or personally, to order that a test be performed on the alleged offender; provided that the same test is first performed on the victim of the alleged criminal offense. The test may be performed on the alleged offender regardless of the result of the test performed on the victim of the alleged criminal offense. If the victim of the alleged criminal offense is a minor or incompetent, the parent or legal guardian of the victim of the alleged criminal offense may petition the court to order that a test be performed on the alleged offender.

C. The court may issue an order based on a finding of good cause after a hearing at which both the victim of the alleged criminal offense and the alleged offender have the right to be present. During the hearing, only affidavits, counter affidavits and medical reports regarding the facts that support or rebut the issuance of an order shall be admissible. The hearing shall be conducted within seventy-two hours after the victim petitions the court for the order. The petition and all proceedings in connection therewith shall be under seal. The court shall issue an order and the test shall be administered to the alleged offender within ten days after the petition is filed by the victim of the alleged criminal offense, his parent or guardian.

D. The results of the test shall be disclosed only to the alleged offender and to the victim of the alleged criminal offense or the victim's parent or legal guardian. When the victim of the alleged criminal offense or the alleged offender has a positive test result,

both the alleged offender and the victim of the alleged criminal offense shall be provided with counseling.

E. A prosecuting attorney may not use in a criminal proceeding arising out of the alleged criminal offense the fact that a test was administered to the alleged offender or the results of the test.

F. The provisions of this section shall not affect the rights and remedies available to the victim of the alleged criminal offense and the alleged offender in any civil action.

G. The administration of a test to an alleged offender pursuant to the provisions of this section shall not preclude the subsequent administration of another test pursuant to the provisions of Section 24-1-9.1 NMSA 1978.

History: 1978 Comp., § 24-1-9.2, enacted by Laws 1996, ch. 80, § 1.

ANNOTATIONS

Cross references. — For informed consent for testing of persons charged with committing certain criminal offsenses, *see* 24-2B-5.2 NMSA 1978.

24-1-9.3. Sexually transmitted diseases; mandatory counseling.

No positive test result for a sexually transmitted disease shall be revealed to the person upon whom the test was performed without the person performing the test or the health facility at which the test was performed providing or referring that person for individual counseling about:

A. the meaning of the test results;

B. the possible need for additional testing;

C. the availability of appropriate health care services, including mental health care, social and support services; and

D. the benefits of locating and counseling any individual by whom the infected person may have been exposed to the sexually transmitted disease and any individual whom the infected person may have exposed to the sexually transmitted disease.

History: 1978 Comp., § 24-1-9.3, enacted by Laws 1996, ch. 80, § 2.

24-1-9.4. Sexually transmitted diseases; confidentiality.

Except as provided in Section 24-1-9.2 NMSA 1978, no person or the person's agents or employees who require or administer a test for sexually transmitted diseases

shall disclose the identity of any person upon whom a test is performed or the result of such a test in a manner that permits identification of the subject of the test, except to the following persons:

A. the subject of the test or the subject's legally authorized representative, guardian or legal custodian;

B. any person designated in a legally effective release of the test results executed prior to or after the test by the subject of the test or the subject's legally authorized representative;

C. an authorized agent, a credentialed or privileged physician or employee of a health facility or health care provider if the health care facility or health care provider itself is authorized to obtain the test results, the agent or employee provides patient care or handles or processes specimens of body fluids or tissues and the agent or employee has a need to know such information;

D. the department of health and the centers for disease control and prevention of the United States public health service in accordance with reporting requirements for a diagnosed case of a sexually transmitted disease;

E. a health facility or health care provider that procures, processes, distributes or uses:

(1) a human body part from a deceased person, with respect to medical information regarding that person;

(2) semen for the purpose of artificial insemination;

(3) blood or blood products for transfusion or injection; or

(4) human body parts for transplant with respect to medical information regarding the donor or recipient;

F. health facility staff committees or accreditation or oversight review organizations that are conducting program monitoring, program evaluation or service reviews, as long as any identity remains confidential;

G. authorized medical or epidemiological researchers who may not further disclose any identifying characteristics or information; and

H. for purposes of application or reapplication for insurance coverage, an insurer or reinsurer upon whose request the test was performed.

History: 1978 Comp., § 24-1-9.4, enacted by Laws 1996, ch. 80, § 3.

24-1-9.5. Sexually transmitted diseases; disclosure statement.

No person to whom the results of a test for sexually transmitted diseases have been disclosed may disclose the test results to another person, except as authorized in Sections 24-1-9.4 and 24-1-9.6 NMSA 1978. Whenever disclosure is made, it shall be accompanied by a statement in writing that includes the following or substantially similar language:

"This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A person who makes an unauthorized disclosure of this information is guilty of a petty misdemeanor and shall be sentenced to imprisonment in the county jail for a definite term not to exceed six months or the payment of a fine of not more than five hundred dollars ($500), or both."

History: 1978 Comp., § 24-1-9.5, enacted by Laws 1996, ch. 80, § 4.

24-1-9.6. Sexually transmitted diseases; disclosure.

A victim of an alleged criminal offense who receives information pursuant to Section 24-1-9.2 NMSA 1978 may disclose the test results as is reasonably necessary to protect his health and safety or the health and safety of his family or sexual partner.

History: 1978 Comp., § 24-1-9.6, enacted by Laws 1996, ch. 80, § 5.

24-1-9.7. Penalty.

A person who makes an unauthorized disclosure of the results of a test designed to identify a sexually transmitted disease is guilty of a petty misdemeanor and shall be sentenced to imprisonment in the county jail for a definite term not to exceed six months or the payment of a fine of not more than five hundred dollars ($500), or both.

History: 1978 Comp., § 24-1-9.7, enacted by Laws 1996, ch. 80, § 6.

24-1-10. Pregnancy; serological test for syphilis.

A. Every physician examining a pregnant woman for conditions relating to her pregnancy during the period of gestation or at delivery or both shall take or cause to be taken a sample of blood of such woman at the time of first examination.

B. All such blood samples shall be submitted to the state public health laboratory for a standard serological test for syphilis.

C. The standard serological test shall be a test for syphilis approved by the director of the department. Such serological tests shall be made on request without charge by the department.

History: 1953 Comp., § 12-34-10, enacted by Laws 1973, ch. 359, § 10.

ANNOTATIONS

Cross references. — For consent to examination and diagnosis for pregnancy, *see* 24-1-13 NMSA 1978.

24-1-11. Reporting of blood tests.

In reporting every birth and stillbirth, physicians and others required to make such reports shall state on the certificate whether a blood test for syphilis has been made upon a specimen of blood taken from the mother of the child for which a birth or stillbirth certificate is filed and the approximate date when the specimen was taken.

History: 1953 Comp., § 12-34-11, enacted by Laws 1973, ch. 359, § 11.

24-1-12. Health certificates; filing.

A. Any person who operates or is employed in a health facility shall, upon becoming employed or engaged in such occupation, present to the employer or, if self-employed, file at the place of business a health certificate from a licensed physician stating the person is free from communicable diseases in a transmissible state dangerous to the public health as defined by regulation of the health services division of the health and environment department [department of health]. The certificate shall be obtained not more than ninety days prior to the date of employment.

B. All certificates shall be kept on file and be subject to inspection by the licensing authority.

History: 1953 Comp., § 12-34-12, enacted by Laws 1973, ch. 359, § 12; 1981, ch. 46, § 1.

ANNOTATIONS

Bracketed material. — The bracketed reference relating to the department of health was inserted by the compiler, as Laws 1991, ch. 25, § 16 repeals former 9-7-4 NMSA 1978, relating to the health and environment department and enacts a new 9-7-4 NMSA 1978 creating the department of health. Section 9-7-5 NMSA 1978, as amended by Laws 1991, ch. 25, § 17 makes the secretary of health the administrative head of the department. The bracketed material was not enacted by the legislature and is not part of the law.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 39 Am. Jur. 2d Health § 56 et seq.

39A C.J.S. Health and Environment §§ 38, 39.

24-1-13. Pregnancy; capacity to consent to examination and diagnosis.

Any person, regardless of age, has the capacity to consent to an examination and diagnosis by a licensed physician for pregnancy.

History: 1953 Comp., § 12-34-13, enacted by Laws 1973, ch. 359, § 13.

ANNOTATIONS

Cross references. — For standard serological test for syphilis for pregnant women, *see* 24-1-10 NMSA 1978.

Am. Jur. 2d, A.L.R. and C.J.S. references. — Liability for incorrectly diagnosing existence or nature of pregnancy, 2 A.L.R.5th 769.

24-1-13.1. Pregnancy; prenatal, delivery and postnatal treatment to a female minor; capacity to consent.

A health care provider shall have the authority, within the limits of his license, to provide prenatal, delivery and postnatal care to a female minor. A female minor shall have the capacity to consent to prenatal, delivery and postnatal care by a licensed health care provider.

History: Laws 2001, ch. 314, § 1 and Laws 2001, ch. 327, § 1.

ANNOTATIONS

Cross references. — For age of majority, *see* 28-6-1 NMSA 1978.

Duplicate laws. — Laws 2001, ch. 314, § 1 and Laws 2001, ch. 327, § 1 enact identical new sections of the law, effective June 15, 2001. Both have been compiled as 24-1-13.1 NMSA 1978.

24-1-14. [Sterilization;] special qualifications prohibited.

No hospital which permits any operation that results in sterilization to be performed therein or medical staff of such hospital shall require any person upon whom a sterilization operation is to be performed to meet any special qualifications which are not imposed on individuals seeking other types of operations in the hospital.

History: 1953 Comp., § 12-34-14, enacted by Laws 1973, ch. 359, § 14.

ANNOTATIONS

Law reviews. — For comment, "Voluntary Sterilization in New Mexico: Who Must Consent?" see 7 N.M. L. Rev. 121 (1976-77).

Am. Jur. 2d, A.L.R. and C.J.S. references. — 39 Am. Jur. 2d Health § 74.

Legality of voluntary nontherapeutic sterilization, 35 A.L.R.3d 1444.

When statute of limitations begins to run against malpractice action in connection with sterilization or birth control procedures, 93 A.L.R.3d 218.

24-1-15. Reporting of contagious diseases.

A. When a physician or other person knows that a person is infected with a threatening communicable disease, he shall promptly notify a public health official or his authorized agent.

B. A public health official who has knowledge that a person is infected with a threatening communicable disease and has refused voluntary treatment, detention or observation shall petition the court for an order to detain the person who is infected with the threatening communicable disease until the person is no longer a contagious threat to the public or the person voluntarily complies with the appropriate treatment and contagion precautions.

C. The petition shall be made under oath or shall be accompanied by a sworn affidavit setting out specific facts showing that the person is infected with a threatening communicable disease.

D. The petition shall state that the person to be detained:

(1) is actively infectious with a threatening communicable disease or presents a substantial likelihood of having a threatening communicable disease based on credible medical evidence;

(2) poses a substantial likelihood of transmission of the threatening communicable disease to others because of inadequate separation from others; and

(3) after being advised of his condition and the risks posed thereby, has refused voluntary treatment.

E. Upon the filing of a petition the court shall:

(1) immediately grant ex parte a temporary order of protection to isolate the person infected with the threatening communicable disease if there is probable cause from the specific facts shown by the affidavit or by the petition to give the judge reason to believe that the person infected with a threatening communicable disease poses a substantial threat to the public health and safety;

(2) cause the temporary order of protection, notice of hearing and an advisement of the terms of the temporary protective order, including his right to representation and re-petition for termination of any protective order that removes and detains the infected person, to be immediately served on the allegedly infected person; and

(3) within five days after the granting of the temporary order of protection, hold an evidentiary hearing to determine if the court shall continue the order.

F. A person held pursuant to a temporary protective order as set forth in Subsection E of this section shall be:

(1) entitled to representation by counsel at the evidentiary hearing and at all hearings thereafter for the duration of the period of removal and detention; and

(2) permitted to communicate on any matter, including his removal and detention, with persons by telephone, or other reasonably available means, that do not expose other persons to the risk of infection for the duration of the period of removal and detention.

G. Counsel may be retained by the person held or shall be appointed by the court if the court determines that the person held cannot afford legal representation or if the court determines that appointment of counsel is required in the interest of justice.

H. At the evidentiary hearing the court shall review the circumstances surrounding the temporary order and, if the petitioner can show by clear and convincing evidence that the person being held has not voluntarily complied or will not voluntarily comply with appropriate treatment and contagion precautions, the court may continue the detention of the person infected with a threatening communicable disease. The court shall order regular review of the order to detain by providing the person being held with a subsequent hearing within ninety days of the temporary order's issuance and every ninety days thereafter. The detention order shall be terminated and the person shall be released if:

(1) the person being held is certified by a public health official to pose no further risk of infecting others;

(2) at a hearing, the petitioner, whose burden of proof continues under a clear and convincing standard, can no longer show that the person being held is infected with

a threatening communicable disease and that he will not comply with appropriate treatment and contagion precautions voluntarily; or

(3) exceptional circumstances exist warranting the termination of the temporary protective order.

I. The provisions of this section do not permit the forcible administration of medications.

J. The proceedings shall be recorded stenographically, electronically, mechanically or by other appropriate means. The proceedings shall be closed to the general public and the records shall be sealed from public inspection.

K. A person who in good faith reports another person infected with a threatening communicable disease shall not be held liable for civil damages as a result of the report; provided that the person reported as being infected with a threatening communicable disease shall have the right to sue for damages sustained as a result of negligent or intentional reporting of inaccurate information or the disclosure of information to an unauthorized person.

L. For purposes of this section:

(1) "court" means the district court of the judicial district where the person who is alleged to be infected with a threatening communicable disease resides or is found;

(2) "public health official" means a district health officer, the director of the public health division of the department of health, a chief medical officer or a person designated by the secretary of health to carry out the duties provided in this section; and

(3) "threatening communicable disease" means a disease that causes death or great bodily harm, passes from one person to another and for which there is no means by which the public reasonably can avoid the risk of contracting the disease.

History: 1953 Comp., § 12-34-15, enacted by Laws 1973, ch. 359, § 15; 1999, ch. 159, § 1; 2002, ch. 74, § 1.

ANNOTATIONS

The 1999 amendment, effective June 18, 1999, substituted "a public health official" for "the district health officer" in Subsection A and rewrote Subsection B which read: "Any health authority receiving notice that any person is infected with disease dangerous to the public health shall secure his voluntary isolation or, if such person refuses to submit to isolation, he shall file a complaint with any magistrate or district court judge having jurisdiction over the infected person. The complaint shall state the facts as related, under oath, by the health authority or the facts according to his information and belief. Any magistrate or district court judge having jurisdiction may, upon proper complaint,

issue a warrant directed to an officer authorized to serve arrest warrants requiring such officer, under the direction of the complaining health authority, to isolate the person".

The 2002 amendment, effective May 15, 2002, substituted "infected with a threatening communicable disease" for "sick with any disease dangerous to the public health" in Subsection A; deleted "and treat" following "detain" in Subsection B, and deleted similar references to treatment throughout the section; added new Subsections G, J, and K, and redesignated former Subsections G, H and I as Subsections H, I and L, respectively; and rewrote present Subsection H, shifting the burden of proof to the petitioner rather than the detainee.

Power to compel hospitalization of persons infected with dangerous disease. — 1959-60 Op. Att'y Gen. No. 60-8.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 39 Am. Jur. 2d Health § 52.

AIDS infection as affecting right to attend public school, 60 A.L.R.4th 15.

Liability of doctor or other health practitioner to third party contracting contagious disease from doctor's patient, 3 A.L.R.5th 370.

39A C.J.S. Health and Environment § 19.

24-1-16. Inspection definitions.

As used in Sections 16 through 19 [24-1-16 to 24-1-19 NMSA 1978] of the Public Health Act:

A. "inspectorial search" means an entry into and examination of premises or vehicles, for the purpose of ascertaining the existence or nonexistence of conditions dangerous to health or safety or otherwise relevant to the public interest, in accordance with inspection requirements prescribed by fire, housing, sanitation, welfare, zoning or other laws or ordinances duly enacted for the promotion of public well-being;

B. "inspection officer" means an official authorized by law to conduct inspectorial searches; and

C. "inspection order" means an order issued by a magistrate or other competent official authorizing an inspectorial search.

History: 1953 Comp., § 12-34-16, enacted by Laws 1973, ch. 359, § 16.

ANNOTATIONS

Cross references. — For constitutional provision relating to searches and seizures, *see* N.M. Const., art. II, § 10.

24-1-17. Inspectorial search by consent.

A. Within the scope of his authority with respect to the places to be inspected and the purpose for which inspection is to be carried out, an inspection officer may conduct an inspectorial search, with the voluntary consent of an occupant or custodian of the premises or vehicles to be inspected, who reasonably appears to the inspection officer to be in control of the places to be inspected or otherwise authorized to give such consent.

B. Before requesting consent for an inspectorial search, the inspection officer shall inform the person to whom the request is directed of the authority under and purposes for which the inspection is to be made and shall, upon demand, exhibit a badge or document evidencing his authority to make such inspections.

C. Inspections undertaken pursuant to this section shall be carried out with due regard for the convenience and privacy of the occupants, and during the daytime unless, because of the nature of the premises, the convenience of the occupants or other circumstances, there is a reasonable basis for carrying out the inspection at night.

D. Except in accordance with the provisions of the subsequent subsection adequate notice of the time and purpose of an inspection shall be sent to the occupants or custodians of premises or vehicles to be inspected not less than seven days before the inspection is undertaken.

E. The notice required by the preceding subsection may be dispensed with if, because of the nature of the inspection to be undertaken, the conduct of the occupants, or other circumstances, there is a reasonable basis for belief that such notice would obstruct, or seriously diminish the utility, of the inspection in question.

History: 1953 Comp., § 12-34-17, enacted by Laws 1973, ch. 359, § 17.

ANNOTATIONS

Cross references. — For constitutional provision relating to searches and seizures, *see* N.M. Const., art. II, § 10.

Am. Jur. 2d, A.L.R. and C.J.S. references. — Propriety of state or local government health officer's warrantless search - post-Camara cases, 53 A.L.R.4th 1168.

24-1-18. Inspection searches.

A. Upon sufficient showing that consent to an inspectorial search has been refused or is otherwise unobtainable within a reasonable period of time, an inspection officer may make application for an inspection order. Such application shall be made to a district court judge having jurisdiction over the premises or vehicle to be searched or an administrative official authorized by statute or ordinance to issue inspection orders.

B. The application shall be granted and the inspection order issued upon a sufficient showing that inspection in the area in which the premises or vehicles in question are located, or inspection of the particular premises or vehicles, is in accordance with reasonable legislative or administrative standards, and that the circumstances of the particular inspection for which application is made are otherwise reasonable. The issuing authority shall make and keep a record of the proceedings on the application, and enter thereon his finding in accordance with the requirements of this section.

C. The inspection officer executing the order shall, if the premises or vehicle in question are unoccupied at the time of execution, be authorized to use such force as is reasonably necessary to effect entry and make the inspection.

D. The officer conducting the search shall, if authorized by the issuing authority on proper showing, be accompanied by one or more law enforcement officers authorized to serve search warrants who shall assist the inspection officer in executing the order at his direction.

E. After execution of the order or after unsuccessful efforts to execute the order, as the case may be, the inspection officer shall return the order to the issuing authority with a sworn report of the circumstances of execution or failure thereof.

History: 1953 Comp., § 12-34-18, enacted by Laws 1973, ch. 359, § 18.

ANNOTATIONS

Cross references. — For constitutional provision relating to searches and seizures, *see* N.M. Const., art. II, § 10.

24-1-19. Emergency inspectorial searches.

A. Whenever it reasonably appears to an inspection officer that there may be a condition, arising under the laws he is authorized to enforce and imminently dangerous to health and safety, the detection or correction of which requires immediate access, without prior notice, to premises for purposes of inspectorial search, and if consent to such search is refused or cannot be promptly obtained, the inspection officer may make an emergency inspectorial search of the premises without an inspection order.

B. Upon completion of the emergency inspectorial search, the inspection officer shall make prompt report of the circumstances to the judicial or administrative authority to whom application for an inspection order would otherwise have been made.

History: 1953 Comp., § 12-34-19, enacted by Laws 1973, ch. 359, § 19.

ANNOTATIONS

Cross references. — For constitutional provision relating to searches and seizures, *see* N.M. Const., art. II, § 10.

Am. Jur. 2d, A.L.R. and C.J.S. references. — Propriety of state or local government health officer's warrantless search - post-Camara cases, 53 A.L.R.4th 1168.

24-1-20. Records confidential.

A. The files and records of the department giving identifying information about individuals who have received or are receiving from the department treatment, diagnostic services or preventive care for diseases, disabilities or physical injuries, are confidential and are not open to inspection except where permitted by rule of the department, as provided in Subsection C of this section and to the secretary of health and environment [secretary of health] or to an employee of the health and environment department [department of health] authorized by the secretary to obtain such information, but the information shall only be revealed for use in connection with a governmental function of the secretary or the authorized employee. Both the secretary and the employees are subject to the penalty contained in Subsection F of this section if they release or use the information in violation of this section.

B. All information voluntarily provided to the director or his agent in connection with studies designated by him as medical research and approved by the secretary of health and environment [secretary of health], either conducted by or under the authority of the director for the purpose of reducing the morbidity or mortality from any cause or condition of health, is confidential and shall be used only for the purposes of medical research. The information shall not be admissible as evidence in any action of any kind in any court or before any administrative proceeding or other action.

C. The human services department and the office of the state long-term care ombudsman shall have prompt access to all files and records in the possession of the licensing and certification bureau of the department that are related to any health facility investigation. Officers and employees of those agencies with such access are subject to the penalty in Subsection F of this section if they release or use the information in violation of this section.

D. The files and records of the department are subject to subpoena for use in any pending cause in any administrative proceeding or in any of the courts of the state, unless otherwise provided by law.

E. No person supplying information to the department for use in a research project or any cooperating person in a research project shall be subject to any action for damages or other relief as a result of that activity.

F. Any person who discloses confidential information in violation of this section is guilty of a petty misdemeanor.

History: 1953 Comp., § 12-34-20, enacted by Laws 1973, ch. 359, § 20; 1975, ch. 324, § 1; 1977, ch. 253, § 41; 1990, ch. 105, § 3.

ANNOTATIONS

Cross references. — For Health Information System Act, *see* 24-14A-1 NMSA 1978.

For sentencing for misdemeanors, *see* Chapter 31, Article 19 NMSA 1978.

Bracketed material. — The bracketed reference relating to the department of health was inserted by the compiler, as Laws 1991, ch. 25, § 16 repeals former 9-7-4 NMSA 1978, relating to the health and environment department and enacts a new 9-7-4 NMSA 1978 creating the department of health. Section 9-7-5 NMSA 1978, as amended by Laws 1991, ch. 25, § 17 makes the secretary of health the administrative head of the department. The bracketed material was not enacted by the legislature and is not part of the law.

The 1990 amendment, effective July 1, 1990, in Subsection A, in the first sentence, deleted "including information from other sources" following "records of the department" and inserted "as provided in Subsection C of this section," in the second sentence, substituted "Subsection F of this section" for "this section", added present Subsection C, redesignated former Subsections C to E as present Subsections D to F, substituted "in any administrative proceeding or in any of the courts" for "in any of the courts" in present Subsection D, and made stylistic changes in Subsections A, B and present D.

Applicability. — Laws 1990, ch. 105, § 5 makes the provisions of the act authorizing imposition of intermediate sanctions and civil monetary penalties apply to health facility licensing regulation violations occurring on or after January 1, 1991.

Am. Jur. 2d, A.L.R. and C.J.S. references. — Public health record as subject of privilege, 136 A.L.R. 856.

24-1-21. Penalties.

Any person violating any of the provisions of the Public Health Act [24-1-1 NMSA 1978] or any order, rule or regulation adopted pursuant to the provisions of the Public Health Act is guilty of a petty misdemeanor and shall be punished by a fine not to exceed one hundred dollars ($100) or imprisonment in the county jail for a definite term not to exceed six months or both such fine and imprisonment in the discretion of the court. Each day of a continuing violation of Subsection A of Section 24-1-5 NMSA 1978 after conviction shall be considered a separate offense. The department also may enforce its rules and orders by any appropriate civil action. The attorney general shall represent the department.

History: 1953 Comp., § 12-34-22, enacted by Laws 1973, ch. 359, § 22; 1975, ch. 183, § 4; 1983, ch. 185, § 2.

ANNOTATIONS

Am. Jur. 2d, A.L.R. and C.J.S. references. — 39 Am. Jur. 2d Health § 84 et seq.

39A C.J.S. Health and Environment §§ 48-52.

24-1-22. Scientific laboratory division; testing methods; certification.

A. The scientific laboratory division of the department of health is authorized to promulgate and approve satisfactory techniques or methods to test persons believed to be operating a motor vehicle or a motorboat under the influence of drugs or alcohol and to issue certification for test operators and their instructors that shall be subject to termination or revocation at the discretion of the scientific laboratory division. The scientific laboratory division is further authorized to establish or approve quality control measures for alcohol breath testing and to establish or approve standards of training necessary to ensure the qualifications of individuals conducting these analyses or collections.

B. The scientific laboratory division shall establish criteria and specifications for equipment, training, quality control, testing methodology, blood-breath relationships and the certification of operators, instructors and collectors of breath samples.

C. All laboratories analyzing breath, blood or urine samples pursuant to the provisions of the Implied Consent Act [66-8-105 NMSA 1978] and the Boating While Intoxicated Act [66-13-1 NMSA 1978] shall be certified by the scientific laboratory division. The certification shall be granted in accordance with the rules and regulations of the scientific laboratory division and shall be subject to termination or revocation for cause.

History: Laws 1981, ch. 165, § 1; 2003, ch. 241, § 14.

ANNOTATIONS

Cross references. — For provision creating the department of health, *see* 9-7-4 NMSA 1978.

For provisions authorizing the performance of a blood-alcohol test, *see* 66-8-103, 66-8-104 and 66-8-109 NMSA 1978.

Bracketed material. — The bracketed reference relating to the department of health was inserted by the compiler, as Laws 1991, ch. 25, § 16 repeals former 9-7-4 NMSA 1978, relating to the health and environment department and enacts a new 9-7-4 NMSA 1978 creating the department of health. Section 9-7-5 NMSA 1978, as amended by Laws 1991, ch. 25, § 17 makes the secretary of health the administrative head of the

department. The bracketed material was not enacted by the legislature and is not part of the law.

The 2003 amendment, effective July 1, 2003, in Subsection A, substituted "department of health" for "department of health and environment"; and inserted "or a motorboat" following "motor vehicle"; and in Subsection C, inserted "and the Boating While Intoxicated Act" following "Implied Consent Act".

Failure to observe defendant for twenty minutes. — A breath alcohol test taken after the defendant was continuously observed for only fifteen minutes was not admissible in her criminal case for driving while intoxicated, because it did not comply with a Department of Health regulation requiring breath samples to be collected only after the subject has been under continuous observation for at least 20 minutes prior to collection of the first breath sample. State v. Gardner, 1998-NMCA-160, 126 N.M. 125, 967 P.2d 465, cert. denied, 126 N.M. 107, 967 P.2d 447 (1998).

Legislature did not intend to create a statutory right when it enacted this section, or to make compliance with regulations promulgated under this section mandatory. State v. Watkins, 104 N.M. 561, 724 P.2d 769 (Ct. App.), writ dismissed, 104 N.M. 522, 724 P.2d 231 (1986).

Am. Jur. 2d, A.L.R. and C.J.S. references. — Authentication of blood sample taken from human body for purposes of determining blood alcohol content, 76 A.L.R.5th 1.

Authentication of blood sample taken from human body for purposes other than determining blood alcohol content, 77 A.L.R.5th 201.

Authentication of organic nonblood specimen taken from human body for purposes of analysis, 78 A.L.R.5th 1.

24-1-23. Disclosure by medicare health care providers; limitation on charges to recipient of services.

A. As used in this section:

(1) "health care provider" means any person who provides health care services the charges for which either he or the recipient of the services is eligible for payment or reimbursement of under provisions of the federal medicare program; and

(2) "recipient" means a person who is eligible under the federal medicare program provisions for reimbursement to him or payment on his behalf for charges for health care services.

B. A health care provider shall disclose to a recipient before providing services the provider's policy regarding whether or not the provider accepts assignment of medicare benefits.

History: Laws 1987, ch. 157, § 1.

24-1-24. Brain injury services fund created.

A. There is created in the state treasury the "brain injury services fund". The fund shall be invested in accordance with the provisions of Section 6-10-10 NMSA 1978, and all income earned on the fund shall be credited to the fund.

B. The brain injury services fund shall be used to institute and maintain a statewide brain injury services program designed to increase the independence of persons with traumatic brain injuries.

C. The department of health shall adopt all rules, regulations and policies necessary to administer a statewide brain injury services program. The department of health shall coordinate with and seek advice from the brain injury advisory council to ensure that the statewide brain injury services program is appropriate for persons with traumatic brain injuries.

D. All money credited to the brain injury services fund shall be appropriated to the department of health for the purpose of carrying out the provisions of this section and shall not revert to the general fund.

History: Laws 1997, ch. 242, § 7 and Laws 1997, ch. 247, § 4.

ANNOTATIONS

Duplicate law. — Laws 1997, ch. 242, § 7 and Laws 1997, ch. 247, § 4 enact identical provisions of law; both have been compiled as 24-1-24 NMSA 1978.

24-1-25. Holly Gonzales experimental treatment fund created.

A. The "Holly Gonzales experimental treatment fund" is created in the state treasury.

B. The Holly Gonzales experimental treatment fund shall be administered by the secretary of health. The money in the fund shall be used solely for the purpose of paying for the costs of federal drug administration approved experimental treatments or procedures for children with catastrophic, debilitating or terminal illnesses. An attending physician of a patient seeking coverage of a treatment or procedure from the fund shall certify to the secretary of health that conventional treatments or procedures cannot control or cure the illness, the expected outcome for the patient is death and the experimental treatment or procedure has a reasonable chance of either curing or controlling the illness for an extended period of time. The patient shall provide documentation from his medical insurer that the experimental treatment is not included in the policy covering the patient.

C. The patient shall submit receipts to the secretary of health for payment from the Holly Gonzales experimental treatment fund for the direct expenses of the experimental treatment or procedure and for associated expenses necessarily incurred in obtaining the treatment or procedure.

D. Disbursements from the Holly Gonzales experimental treatment fund shall be by warrant drawn by the secretary of finance and administration pursuant to vouchers signed by the secretary of health.

History: Laws 2001, ch. 333, § 1.

ANNOTATIONS

Emergency clauses. — Laws 2001, ch. 333, § 3 makes the act effective immediately, approved April 5, 2001.

24-1-26. Repealed.

History: Laws 2003, ch. 59, § 1; 2004, ch. 46, § 18.

ANNOTATIONS

Repeals. — Laws 2004, ch. 46, § 18 repeals 24-1-26 NMSA 1978, concerning the interagency behavioral health coordinating committee, enacted by Laws 2003, ch. 59, § 1, effective May 19, 2004. For provisions of former section, *see* New Mexico One Source of Law DVD.

24-1-27. Purpose.

The purpose of creating a single interagency behavioral health purchasing collaborative is to develop a statewide system of behavioral health care that promotes the behavioral health and well-being of children, individuals and families; encourages a seamless system of care that is accessible and continuously available; and emphasizes prevention and early intervention, resiliency, recovery and rehabilitation.

History: Laws 2004, ch. 46, § 1.

ANNOTATIONS

24-1-28. Behavioral health planning council created; powers and duties; membership.

There is created the "behavioral health planning council".

A. The council shall consist of the following members, all of whom shall be appointed by and serve at the pleasure of the governor:

(1) consumers of behavioral health services and consumers of substance abuse services, as follows:

(a) adults with serious mental illness;

(b) seniors;

(c) family members of adults with serious mental illness and of children with serious emotional or neurobiological disorders; and

(d) persons with co-occurring disorders;

(2) Native American representatives from a pueblo, an Apache tribe, the Navajo Nation and an urban Native American population;

(3) providers;

(4) state agency representation from agencies responsible for:

(a) adult mental health and substance abuse;

(b) children's mental health and substance abuse;

(c) education;

(d) vocational rehabilitation;

(e) criminal justice;

(f) juvenile justice;

(g) housing;

(h) medicaid and social services;

(i) health policy planning;

(j) developmental disabilities planning; and

(k) disabilities issues and advocacy;

(5) such other members as the governor may appoint to ensure appropriate cultural and geographic representation; and

(6) advocates.

B. Providers and state agency representatives together may not constitute more than forty-nine percent of the council membership.

C. The council shall:

(1) advocate for adults, children and adolescents with serious mental illness or severe emotional, neurobiological and behavioral disorders, as well as those with mental illness or emotional problems, including substance abuse and co-occurring disorders;

(2) report annually to the governor and the legislature on the adequacy and allocation of mental health services throughout the state;

(3) encourage and support the development of a comprehensive, integrated, community-based behavioral health system of care, including mental health and substance abuse services, and services for persons with co-occurring disorders;

(4) advise state agencies responsible for behavioral health services for children and adults, as those agencies are charged in Section 9-7-6.4 NMSA 1978;

(5) meet regularly and at the call of the chair, who shall be selected by the council membership from among its members;

(6) establish subcommittees, to meet at least quarterly, as follows:

(a) a medicaid subcommittee, chaired by the secretary of human services or a designee, which may also serve as a subcommittee of the medicaid advisory committee;

(b) a child and adolescent subcommittee, chaired by the secretary of children, youth and families or a designee;

(c) an adult subcommittee, chaired by the secretary of health or a designee;

(d) a substance abuse subcommittee, chaired by the secretary of health or a designee, which shall include DWI issues and shall include representation from local DWI councils;

(e) a Native American subcommittee, chaired by the secretary of Indian affairs or a designee; and

(f) other subcommittees as may be established by the chair of the council to address specific issues. All subcommittees may include nonvoting members

appointed by the chair for purposes of providing expertise necessary to the charge of the respective subcommittee;

(7) review and make recommendations for the comprehensive mental health state block grant and the substance abuse block grant applications, the state plan for medicaid services and any other plan or application for federal or foundation funding for behavioral health services; and

(8) replace the governor's mental health planning council and act in accordance with Public Law 102-321 of the federal Public Health Service Act.

History: Laws 2004, ch. 46, § 2; 2005, ch. 7, § 1.

ANNOTATIONS

The 2005 amendment, effective June 17, 2005, eliminates the requirement that Native American appointees to the behavioral health planning council be consumers of behavioral health services and consumers of substance abuse services and provides for the creation a Native American subcommittee of the council.

24-1-29. Commission created; members; duties.

A. There is created the "governor's HIV and AIDS policy commission", consisting of twenty-three members as follows:

(1) the secretary of health or the secretary's designee;

(2) the secretary of human services or the secretary's designee;

(3) the secretary of public education or the secretary's designee;

(4) the chief medical officer of the corrections department or the officer's designee;

(5) the chair of the department of health's medical advisory committee;

(6) the executive director of the New Mexico medical insurance pool or the director's designee;

(7) a representative from each of the six health management alliance organizations, appointed by the governor;

(8) six consumers reflecting the diversity of the HIV and AIDS populations in New Mexico, including Native Americans and other people of color, appointed by the governor; and

(9) five public members who have expertise in HIV and AIDS services, prevention, program administration, financial management and other categories of expertise required under federal planning requirements, appointed by the governor.

B. The governor shall appoint the chair of the commission. Members appointed by the governor shall serve for terms of three years, except that the initial term of seven members shall be two years. Vacancies of the appointed members shall be filled by appointment by the governor for the remainder of the unexpired term. Appointed members shall receive per diem and mileage as provided in the Per Diem and Mileage Act [10-8-1 NMSA 1978] but shall receive no other compensation, perquisite or allowance. The commission shall be administratively attached to the department, which shall provide administrative services to the commission.

C. The commission shall:

(1) review and make recommendations on department HIV and AIDS policies;

(2) study and make recommendations to the department on all factors affecting the availability, quality and accessibility of health services for persons with HIV and AIDS, including:

(a) review and consult with the department's medical advisory committee regarding the HIV and AIDS drug formulary and policies of selection, utilization and provision of those drugs; and

(b) review policies and practices of each state agency with responsibilities to persons with HIV and AIDS, including statutes and rules governing these responsibilities;

(3) serve as a planning and advisory group to the department's HIV and AIDS services program;

(4) annually provide its evaluation and recommendations to the department for inclusion in the department's annual report, including recommendations for administrative and legislative changes, for resource allocation by the department and for funding;

(5) provide information on HIV and AIDS programs and issues as requested by the executive and legislative branches of government;

(6) advocate for improved and expanded services for persons living with HIV and AIDS; and

(7) establish task forces as it deems necessary.

D. For purposes of this section:

(1) "commission" means the governor's HIV and AIDS policy commission;

(2) "department" means the department of health;

(3) "HIV and AIDS" means human immunodeficiency virus and acquired immune deficiency syndrome; and

(4) "consumers" means people living with HIV and AIDS.

History: Laws 2005, ch. 5, § 1.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 5 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective June 17, 2005, 90 days after adjournment of the legislature.

Compiler's note. — Although this section has been compiled within the Public Health Act [24-1-1 NMSA 1978], it was not enacted as a section of that act.

24-1-30. Hand washing facilities; requirement.

Portable hand washing facilities shall be provided with at least one hand wash facility to every one-to-ten portable toilets in public locations where portable toilets are required by law or ordinance. The facilities shall be in close proximity to the toilets.

History: Laws 2005, ch. 190, § 1.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 190 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective June 17, 2005, 90 days after adjournment of the legislature.

ARTICLE 1A
Rural Primary Health Care

24-1A-1. Short title.

This act [24-1A-1 to 24-1A-3, 24-1A-4 NMSA 1978] may be cited as the "Rural Primary Health Care Act".

History: Laws 1981, ch. 295, § 1.

24-1A-2. Purpose of act.

The purpose of the Rural Primary Health Care Act [24-1A-1 NMSA 1978] is to recruit and retain health care personnel and assist in the provision of primary health care services through eligible programs in underserved areas of the state in order to better serve the health needs of the public.

History: Laws 1981, ch. 295, § 2; 1983, ch. 236, § 1.

24-1A-3. Definitions.

As used in the Rural Primary Health Care Act [24-1A-1 NMSA 1978]:

A. "health care underserved areas" means a geographic area in which it has been determined by the department of health, through the use of indices and other standards set by the department, that sufficient primary health care is not being provided to the citizens of that area;

B. "eligible programs" means nonprofit community-based entities that provide or commit to provide primary health care services for residents of health care underserved areas and includes rural health facilities and those serving primarily low-income populations;

C. "department" means the department of health; and

D. "primary health care" means the first level of basic or general health care for an individual's health needs, including diagnostic and treatment services.

History: Laws 1981, ch. 295, § 3; 1983, ch. 236, § 2; 1996, ch. 29, § 2.

ANNOTATIONS

The 1996 amendment, effective May 15, 1996, substituted "department of health" for "health and environment department" in Subsections A and C, and substituted "that provide or commit to provide" for "established to provide" and "health facilities" for "health clinics" in Subsection B.

24-1A-3.1. Department; technical and financial assistance.

To the extent funds are made available for the purposes of the Rural Primary Health Care Act [24-1A-1 NMSA 1978], the department is authorized to:

A. provide for a program to recruit and retain health care personnel in health care underserved areas;

B. develop plans for and coordinate the efforts of other public and private entities assisting in the provision of primary health care services through eligible programs;

C. provide for technical assistance to eligible programs in the areas of administrative and financial management, clinical services, outreach and planning;

D. provide for distribution of financial assistance to eligible programs that have applied for and demonstrated a need for assistance in order to sustain a minimum level of delivery of primary health care services; and

E. provide a program for enabling the development of new primary care health care services or facilities, and that program:

(1) shall give preference to communities that have few or no community-based primary care services;

(2) may require in-kind support from local communities where primary care health care services or facilities are established;

(3) may require primary care health care services or facilities to assure provision of health care to the medically indigent; and

(4) shall permit the implementation of innovative and creative uses of local or statewide health care resources, or both, other than those listed in Paragraphs (2) and (3) of this subsection.

History: 1978 Comp., § 24-1A-3.1, enacted by Laws 1983, ch. 236, § 3; 1991, ch. 212, § 18; 1996, ch. 29, § 3.

ANNOTATIONS

The 1991 amendment, effective July 1, 1991, added Subsection E.

The 1996 amendment, effective May 15, 1996, made stylistic changes in Subsection D; and in Subsection E, substituted "provide" for "institute" and "services" for "centers" in the introductory language, and substituted "services" for "centers" in Paragraphs (2) and (3).

24-1A-4. Rules and regulations.

Subject to the State Rules Act [14-4-1 NMSA 1978], the department shall adopt rules and regulations for recruiting health care personnel in health care underserved areas, and shall establish a formula for distribution of financial assistance to eligible programs which shall take into account the relative needs of applicants for assistance, provided that funds may not be expended for land or facility acquisition or debt amortization and further provided that a local match of ten percent shall be required from each local recipient for each request for assistance.

History: Laws 1981, ch. 295, § 4; 1983, ch. 236, § 4.

ARTICLE 1B
County Maternal and Child Health Plan

24-1B-1. Short title.

This act [24-1B-1 to 24-1B-7 NMSA 1978] may be cited as the "County Maternal and Child Health Plan Act".

History: Laws 1991, ch. 113, § 1.

24-1B-2. Purpose of act.

The purpose of the County Maternal and Child Health Plan Act [24-1B-1 NMSA 1978] is to encourage the development of comprehensive, community-based maternal and child health services to meet the needs of childbearing women and their families and thereby improve the long-term health of New Mexicans across the state.

History: Laws 1991, ch. 113, § 2.

24-1B-3. Definitions.

As used in the County Maternal and Child Health Plan Act [24-1B-1 NMSA 1978]:

A. "board" means the board of county commissioners in a county;

B. "department" means the health and environment department [department of health]; and

C. "planning council" means the county maternal and child health planning council.

History: Laws 1991, ch. 113, § 3.

ANNOTATIONS

Bracketed material. — The bracketed reference relating to the department of health was inserted by the compiler, as Laws 1991, ch. 25, § 16 repeals former 9-7-4 NMSA 1978, relating to the health and environment department and enacts a new 9-7-4 NMSA 1978 creating the department of health. Section 9-7-5 NMSA 1978, as amended by Laws 1991, ch. 25, § 17 makes the secretary of health the administrative head of the department. The bracketed material was not enacted by the legislature and is not part of the law.

24-1B-4. Planning council created; membership.

A. The board may create a county maternal and child health planning council, and it may appoint members for terms designated by the board. The members of the planning council shall be selected to represent a broad spectrum of interests that may include county officials, community-based program providers, childbearing and parenting families, local school administrators, local political leaders, employees of the income support office, employees of the county field health office, maternal and child health care providers, obstetricians, family physicians, nurses, mid-level providers and hospital administrators.

B. Members of the planning council shall elect from among themselves a chairman for a term designated by the board. The planning council shall meet at the call of the chairman.

C. Planning council members shall not be paid, but they may receive per diem and mileage expenses paid by the county as provided in the Per Diem and Mileage Act [10-8-1 NMSA 1978].

History: Laws 1991, ch. 113, § 4.

24-1B-5. County maternal and child health plans.

A. The board or its designee with the advice of the planning council may prepare a county maternal and child health plan. The plan shall have the approval of the planning council and the board before it may be submitted by the board to the department for approval.

B. Two or more boards may agree among themselves to establish a multicounty maternal and child health plan.

C. Each county maternal and child health plan shall include:

(1) a county needs assessment that identifies and quantifies:

(a) those populations that are unable to obtain adequate maternal and child health services;

(b) the major factors that affect accessibility to local maternal and child health services;

(c) the gaps in locally available maternal and child health services; and

(d) the extent to which county residents use maternal and child health services available in other counties;

(2) a county inventory that identifies existing public and private providers, services and maternal and child health plans, medicaid and other governmental and

charitable resources, program duplications and the county's current monetary contributions to maternal and child health programs; and

(3) recommendations on how to improve and fund maternal and child health in the county based upon the county's needs assessment and inventory of existing services and resources. In its recommendations, the county shall include proposals to eliminate duplications of services, improve access and initiate new services as needed. The county shall also include conclusions about the need to rely on services available in other counties and on the level of charitable, federal, state and county funding and in-kind contributions that are required to implement its plan fully.

D. The recommendations contained in the county maternal and child health plan may be based on the development of comprehensive maternal and child health services. Development of the maternal and child health plan may include a consideration of:

(1) teen pregnancy;

(2) family planning;

(3) prenatal care;

(4) financing of perinatal care for persons not eligible for medicaid;

(5) proposals to expand provider capacity;

(6) outreach, information, referral, risk assessment and case management for both pregnant women and their children;

(7) perinatal health education projects;

(8) home visiting and social support groups;

(9) projects that reduce poor pregnancy and child outcomes;

(10) projects that enhance utilization of well-child care;

(11) projects that remove transportation barriers from perinatal services; and

(12) projects that coordinate local community services, including those services provided by the county's state public health office.

E. The plan shall be updated at the request of the board or the department if the plan as implemented is not achieving the stated goals or if the needs of the local population have changed.

History: Laws 1991, ch. 113, § 5.

24-1B-6. County maternal and child health funds.

A. The department shall contract for maternal and child health services in a county to implement the county's maternal and child health plan after the plan has been approved by the department.

B. As a condition of the department contracting for county maternal and child health services in a county, after an opportunity for county input the county may be required to contribute to the implementation of its department-approved county maternal and child health plan based on the relative wealth of the county as measured by the population of the county, the per-capita income of the county, the gross receipts tax base and the average property value in the county.

C. The department shall contract for maternal and child health services to implement a county's maternal and child health plan based upon:

(1) the amount of funds appropriated for the purpose of carrying out the provisions of the County Maternal and Child Health Plan Act [24-1B-1 NMSA 1978];

(2) the county's need for services as measured by:

(a) maternal and child health indicators;

(b) the teen pregnancy rate; and

(c) maternal and child health provider availability and shortages; and

(3) the county's demonstration that the services in its county maternal and child health plan fit into the comprehensive outline of community-based maternal and child health services described in Subsection D of Section 5 [24-1B-5 NMSA 1978] of the County Maternal and Child Health Plan Act.

D. Nothing in this act shall prohibit the department from contracting for those categories of maternal and child health services that it contracted for prior to the effective date of the County Maternal and Child Health Care Act or that it deems essential for public health.

History: Laws 1991, ch. 113, § 6.

24-1B-7. Department; powers and duties.

A. The department shall review, evaluate, and approve or reject county maternal and child health plans and it may require that a county update its county maternal and child health plan.

B. The department is authorized to contract for maternal and child health services to implement county maternal and child health plans subject to the availability of appropriations for that purpose.

C. The department shall monitor and evaluate the contracts funded by the department and assess whether maternal and child health conditions are improving.

D. The department shall provide technical assistance and training to assist each county as needed in developing its maternal and child health plan.

E. The department may gather information necessary to evaluate the effectiveness of services it contracts for through the provisions of the County Maternal and Child Health Plan Act [24-1B-1 NMSA 1978].

F. The department shall adopt all rules and regulations necessary to carry out the purposes of the County Maternal and Child Health Plan Act including:

(1) the procedures and format for applying for department approval of a county maternal and child health plan;

(2) the format for county maternal and child health plans;

(3) the criteria to review, evaluate and approve or reject county maternal and child health plans;

(4) the procedures and format for requesting that the department procure services under a department-approved county maternal and child health plan;

(5) the formula used to determine a county's required contribution to implement its maternal and child health plan;

(6) a procedure that determines a county's need for maternal and child health services;

(7) the procedure to determine the distribution of state funds appropriated to implement county maternal and child health plans;

(8) the procedures for gathering and reporting programmatic and financial information necessary to evaluate the effectiveness of maternal and child health services that the department contracts for through the provisions of the County Maternal and Child Health Plan Act; and

(9) definitions that set an acceptable minimum standard for the services provided.

History: Laws 1991, ch. 113, § 7.

ARTICLE 1C
Primary Care Capital Funding

24-1C-1. Short title.

Chapter 24, Article 1C NMSA 1978 may be cited as the "Primary Care Capital Funding Act".

History: Laws 1994, ch. 62, § 7; 1997, ch. 230, § 1.

ANNOTATIONS

The 1997 amendment, effective June 20, 1997, substituted "Chapter 24, Article 1C NMSA 1978" for "Sections 7 through 16 of this act".

24-1C-2. Purpose.

The purpose of the Primary Care Capital Funding Act [24-1C-1 NMSA 1978] is to provide funding for capital projects to eligible entities in order to increase health care services in rural and other health care underserved areas in the state.

History: Laws 1994, ch. 62, § 8.

24-1C-3. Definitions.

As used in the Primary Care Capital Funding Act [24-1C-1 NMSA 1978]:

A. "authority" means the New Mexico finance authority;

B. "capital project" means repair, renovation or construction of a facility; purchase of land; acquisition of capital equipment of a long-term nature; or acquisition of capital equipment to be used in the delivery of primary care, telehealth or hospice services;

C. "department" means the department of health;

D. "eligible entity" means:

(1) a community-based nonprofit primary care clinic or hospice that operates in a rural or other health care underserved area of the state, is a 501(c)(3) nonprofit corporation for federal income tax purposes and is eligible for funding pursuant to the Rural Primary Health Care Act;

(2) a school-based health center that operates in a public school district and that meets department requirements or that is funded by the federal department of health and human services; or

(3) a telehealth site that is operated by an eligible entity pursuant to Paragraphs (1) and (2) of this subsection;

E. "fund" means the primary care capital fund; and

F. "primary care" means the first level of basic or general health care for an individual's health needs, including diagnostic and treatment services and including services delivered at a primary care clinic, telehealth site or a school-based health center; "primary care" includes the provision of mental health services if those services are integrated into the eligible entity's service array.

History: Laws 1994, ch. 62, § 9; 2000, ch. 75, § 1; 2005, ch. 54, § 1.

ANNOTATIONS

The 2000 amendment, effective May 17, 2000, in Subsection B, extended the definition of "capital project" to include the acquisition of long-term capital equipment.

The 2005 amendment, effective June 17, 2005, defines "capital project" to include the acquisition of capital equipment to deliver primary care, telehealth or hospice services; modifies the definition of "eligible entity" to include community-based non-profit clinics and hospices regardless of the value of their assets if they are eligible for funding under the act, school-based health centers and telehealth sites operated by an eligible entity and defines "primary care" to include services delivered at a primary heal care clinic, telehealth site or school-based health center.

Compiler's notes. — The reference to "501(c)(3)" in Subsection D refers to 26 U.S.C. § 501(c)(3).

24-1C-4. Primary care capital fund; creation.

A. The "primary care capital fund" is created as a revolving fund in the state treasury. The fund shall consist of appropriations, loan repayments, gifts, grants, donations and interest earned on investment of the fund. A separate account shall be maintained for appropriations, loan repayments, gifts, grants, donations and interest earned on investment of the account for loans to school-based health centers and telehealth sites. Money in the fund shall not revert at the end of a fiscal year.

B. The fund shall be administered by the authority. Administrative costs of the authority or department shall not be paid from the fund. Money in the fund shall be expended only on warrants drawn by the secretary of finance and administration

pursuant to vouchers signed by the director of the authority or his authorized representative.

History: Laws 1994, ch. 62, § 10; 2005, ch. 54, § 2.

ANNOTATIONS

The 2005 amendment, effective June 17, 2005, requires that a separate account be maintained for funds for loans to school-based health centers and telehealth sites.

24-1C-5. Regulations.

A. Prior to September 15, 1994, the department, in conjunction with the authority, shall adopt regulations to administer and implement the provisions of the Primary Care Capital Funding Act [24-1C-1 NMSA 1978], including providing for:

(1) the determination of rural or other health care underserved areas of the state in which eligible entities may receive loans or contracts for services from the fund;

(2) procedures and forms for applying for loans or contracts for services for capital projects;

(3) documentation required to be provided by the applicant to justify the need for the capital project;

(4) documentation required to be provided by the applicant to demonstrate that the applicant is an eligible entity;

(5) procedures for review, evaluation and approval of loans and contracts for services, including the programmatic, organizational and financial information necessary to review, evaluate and approve an application;

(6) evaluation of the ability and competence of an applicant to provide efficiently and adequately for the completion of a proposed capital project;

(7) approval of loan and contract for services applications, including provisions that accord priority attention to areas with the greatest need for primary care services;

(8) fair geographic distribution of loans and contracts for services;

(9) requirements for repayment of loans, including payment schedules, interest rates, loan terms and other requirements;

(10) ensuring the state's interest in any capital project by the filing of a lien equal to the total of the state's financial participation in the project; and

(11) such other requirements deemed necessary by the department to ensure that the state receives the primary care services for which the legislature appropriates money and that protects the state's interest in a capital project.

B. Regulations adopted by the department shall become effective when filed in accordance with the provisions of the State Rules Act [14-4-1 NMSA 1978].

History: Laws 1994, ch. 62, § 11.

ANNOTATIONS

Cross references. — For Indigent Hospital and County Health Care Act, *see* 27-5-1 NMSA 1978.

24-1C-6. Department; authority; powers and duties.

A. The department and the authority shall administer the loan programs and contracts for services established pursuant to the provisions of the Primary Care Capital Funding Act [24-1C-1 NMSA 1978]. The department and authority shall:

(1) enter into joint powers agreements with each other or other appropriate public agencies to carry out the provisions of that act; and

(2) apply to any appropriate federal, state or local governmental agency or private organization for grants and gifts to carry out the provisions of that act or to fund allied community-based health care programs.

B. The department or authority may, instead of a loan, contract for services with an eligible entity to provide free or reduced fee primary care services for sick and medically indigent persons as reasonably adequate legal consideration for money from the fund to the entity so it may acquire or construct a capital project to provide the services.

C. The department and authority may:

(1) make and enter into contracts and agreements necessary to carry out their powers and duties pursuant to the provisions of the Primary Care Capital Funding Act; and

(2) do all things necessary or appropriate to carry out the provisions of the Primary Care Capital Funding Act.

D. The authority is responsible for all financial duties of the programs, including:

(1) administering the fund;

(2) accounting for all money received, controlled or disbursed for capital projects in accordance with the provisions of the Primary Care Capital Funding Act;

(3) evaluating and approving loans and contracts for services, including determining financial capacity of an eligible entity;

(4) enforcing contract provisions of loans and contracts for services, including the ability to sue to recover money or property owed the state;

(5) determining interest rates and other financial aspects of a loan and relevant terms of a contract for services; and

(6) performing other duties in accordance with the provisions of the Primary Care Capital Funding Act, regulations promulgated pursuant to that act or joint powers agreements entered into with the department.

E. The department is responsible for the following duties:

(1) defining sick and medically indigent persons for purposes of the Primary Care Capital Funding Act;

(2) establishing priorities for loans and contracts for services;

(3) determining the appropriateness of the capital project;

(4) evaluating the capability of an applicant to provide and maintain primary care or hospice services;

(5) selecting recipients of loans and persons with whom to contract for services;

(6) determining that capital projects comply with all state and federal licensing and procurement requirements; and

(7) contracting with an eligible entity to provide primary care services without charge or at a reduced fee for sick and medically indigent persons as defined by the department.

F. The authority may make a loan to an eligible entity to acquire, construct, renovate or otherwise improve a capital project, provided there is a finding:

(1) by the department that the project will provide primary care services to sick and medically indigent persons as defined by the department; and

(2) by the authority that there is adequate protection, including loan guarantees, real property liens, title insurance, security interests in or pledges of

accounts and other assets, loan covenants and warranties or restrictions on other encumbrances and pledges for the state funds extended for the loan.

G. The authority may make a loan to a school-based health center that operates in a public school district or to a telehealth site for a capital project; provided, however, that the loan shall not exceed the amount in the account reserved for school-based health center or telehealth site funding.

History: Laws 1994, ch. 62, § 12; 1997, ch. 230, § 2; 2005, ch. 54, § 3.

ANNOTATIONS

Cross references. — For Indigent Hospital and County Health Care Act, *see* 27-5-1 NMSA 1978.

The 1997 amendment, effective June 20, 1997, substituted "the following duties" for "programmatic duties, including" at the end of the introductory language of Subsection E, inserted "and procurement" in Paragraph E(6), inserted "renovate or otherwise improve" in the introductory language of Subsection F, and rewrote Paragraph F(2).

The 2005 amendment, effective June 17, 2005, authorizes loans to a school-based health center or telehealth site for a capital project in an amount that does not exceed the amount in the account for school-based health center or telehealth site funding.

24-1C-7, 24-1C-8. Repealed.

ANNOTATIONS

Repeals. — Laws 1997, ch. 230, § 4 repeals 24-1C-7 and 24-1C-8 NMSA 1978, as enacted by Laws 1994, ch. 62, §§ 13 and 14, relating to land acquisition and ranking of liens on capital projects, effective June 20, 1997. For provisions of former sections, *see* New Mexico One Source of Law DVD.

24-1C-9. Eligible entity; change in status.

If an eligible entity that has received a loan or contract for services for a capital project ceases to maintain its nonprofit status or ceases to deliver primary care services at the site of the capital project for twelve consecutive months, the state may pursue the remedies provided in the loan agreement or contract for services or as provided by law.

History: Laws 1994, ch. 62, § 15; 1997, ch. 230, § 3.

ANNOTATIONS

The 1997 amendment, effective June 20, 1997, substituted "may pursue the remedies provided in the loan agreement or contract for services as provided by law" at the end of

the section for language relating to the state having specific remedies at its option, subject to other liens having preference.

24-1C-10. Report.

The department and the authority shall report jointly to the governor and the legislature by December 1 of each year on the primary care capital funding program.

History: Laws 1994, ch. 62, § 16.

ARTICLE 1D
Health Services Corps

24-1D-1. Short title.

This act [24-1D-1 to 24-1D-10 NMSA 1978] may be cited as the "Health Service Corps Act".

History: Laws 1994, ch. 63, § 1.

24-1D-2. Definitions.

As used in the Health Service Corps Act [24-1D-1 NMSA 1978]:

A. "corps" means the New Mexico health service corps;

B. "department" means the department of health;

C. "health professional" means a physician, physician assistant, nurse practitioner, nurse-midwife, emergency medical technician-paramedic, dentist or dental hygienist;

D. "physician" means a medical doctor or doctor of osteopathic medicine;

E. "physician assistant" means a physician assistant or osteopathic physician assistant; and

F. "practice site" means a public health clinic or public or private nonprofit primary care clinic that is located in a state-designated medically underserved area or that serves a high-needs population and that uses a sliding fee scale approved by the department.

History: Laws 1994, ch. 63, § 2; 2003, ch. 393, § 1.

ANNOTATIONS

The 2003 amendment, effective June 20, 2003, in Subsection C, deleted "or" following "nurse-midwife" and inserted "dentist or dental hygienist" at the end of Subsection C.

24-1D-3. New Mexico health service corps; staff; department powers and duties.

A. The "New Mexico health service corps" is created in the department to recruit and place health professionals in rural and other medically underserved areas. The secretary of health may employ a medical director to head the corps. The medical director may employ support staff and employ or contract with health professional staff. Employees are subject to the provisions of the Personnel Act [10-9-1 NMSA 1978].

B. The corps has the power to:

(1) enter into contracts to carry out the provisions of the Health Service Corps Act [24-1D-1 NMSA 1978] and sue for enforcement of those contracts; and

(2) adopt and file, in accordance with the State Rules Act [14-4-1 NMSA 1978], rules and regulations to carry out the provisions of the Health Service Corps Act.

C. The corps shall:

(1) recruit health professionals as employees or contractors of the corps;

(2) determine physician specialties to be recruited, with a focus on family practice physicians;

(3) establish criteria and procedures for the acceptance of applications and selection of recipients for commitment stipends;

(4) establish criteria and procedures for evaluating and qualifying corps health professionals;

(5) determine and maintain a list of eligible communities and practice sites;

(6) determine the need for health professionals at each practice site and assign staff as needed on a priority basis;

(7) provide support for health professionals at practice sites;

(8) work closely with the commission on higher education and the educational assistance foundation to coordinate the use of health professionals who have practice obligations pursuant to the Medical Student Loan for Service Act [21-22-1 NMSA 1978], the Osteopathic Medical Student Loan for Service Act [21-22A-1 NMSA 1978] or the Nursing Student Loan for Service Act [21-22B-1 NMSA 1978];

(9) work with the university of New Mexico school of medicine, college of nursing, the emergency medical services academy and any other entity to identify students or residents who qualify for the corps; and

(10) establish accounting and auditing procedures to account for all money paid to health professionals or received from communities and practice sites.

History: Laws 1994, ch. 63, § 3.

24-1D-4. Corps sites; local assistance; reimbursements.

The corps may require a community or practice site to pay the costs associated with providing corps health professionals in the community. The corps may allow in-kind contributions as partial or complete payment. The corps may negotiate with the community on the amount of money or in-kind services that shall be paid to the state. Money paid to the state shall be deposited in the general fund. Payback requirements and in-kind contributions shall be determined and negotiated based on formulas adopted pursuant to regulations.

History: Laws 1994, ch. 63, § 4.

24-1D-5. Corps service; commitment stipends.

A. The corps may provide commitment stipends to potential health professionals who agree to serve in the corps for at least two years. Commitment stipends shall be determined by the department within available revenue.

B. Nothing in the Health Service Corps Act [24-1D-1 NMSA 1978] prohibits the corps from hiring health professionals who have not received commitment stipends.

History: Laws 1994, ch. 63, § 5.

24-1D-6. Evaluations prior to corps service; stipend payback.

A. All corps health professionals shall be licensed or certified to practice in New Mexico. If the corps determines that a person does not meet the corps' standards for service, that person shall not serve as a corps health professional.

B. Prior to service, the corps shall evaluate every student and resident to whom commitment stipends have been paid. Evaluations shall continue during service. Evaluations shall include grades; licensing test scores; recommendations of professors, professional mentors and co-workers; and other factors the corps determines by regulation to be pertinent to ensuring the provision of quality health care through the corps.

C. If a person to whom a commitment stipend has been paid does not qualify for service, he shall pay back the total stipend on terms and conditions set forth in the contract with the corps. If a person to whom a commitment stipend has been paid is serving in the corps and he is deemed unsatisfactory, he shall pay back the amount of stipend determined by formula to be owed pursuant to terms and conditions set forth in the contract with the corps.

D. If a person to whom a commitment stipend has been paid qualifies for service, he may pay back the stipend through service in a community specified by the department under conditions approved by the department even if he is not an employee or contractor of the corps.

History: Laws 1994, ch. 63, § 6.

24-1D-7. Corps service for educational loan-for-service programs.

Service in the corps may be used to satisfy service requirements pursuant to the provisions of state educational loan-for-service programs.

History: Laws 1994, ch. 63, § 7.

24-1D-8. Administrative assistance.

The corps may contract with other agencies to assist it in paying stipends and collecting money owed pursuant to contract provisions or penalties.

History: Laws 1994, ch. 63, § 8.

24-1D-9. Legal counsel.

The office of general counsel of the department of health shall provide legal services to the corps. The general form of stipend contracts entered into pursuant to the provisions of the Health Service Corps Act [24-1D-1 NMSA 1978] shall be approved by a special assistant attorney general employed by the department of health and signed by the resident or student and the medical director or his authorized representative on behalf of the state. The corps is vested with full and complete authority and power to sue in its own name for any balance due the state from a resident or student on a contract. Money paid pursuant to contract shall be deposited in the general fund.

History: Laws 1994, ch. 63, § 9.

24-1D-10. Failure to serve; penalty.

If a health professional whom the corps deems qualified to serve does not serve or serves only a portion of his service obligation, he is subject to a penalty of three times

the amount of the total commitment stipend, plus eighteen percent interest per year. The corps shall provide by regulation for mitigating circumstances, the assessment of the penalty and payback schedules.

History: Laws 1994, ch. 63, § 10.

ARTICLE 1E
Health Facility Receiverships

24-1E-1. Short title.

Chapter 24, Article 1E NMSA 1978 may be cited as the "Health Facility Receivership Act".

History: 1978 Comp., § 24-1E-1, enacted by Laws 1996, ch. 35, § 4; 2001, ch. 225, § 1.

ANNOTATIONS

The 2001 amendment, effective June 15, 2001, substituted "Chapter 24, Article 1E NMSA 1978" for "Sections 24-1E-1 through 24-1E-6".

24-1E-2. Definitions.

As used in the Health Facility Receivership Act [24-1E-1 NMSA 1978]:

A. "department" means the department of health;

B. "health facility" means:

(1) a health facility as defined in Subsection D of Section 24-1-2 NMSA 1978 other than a child-care center or facility, whether or not licensed by the state of New Mexico; or

(2) a community-based program providing services funded, directly or indirectly, in whole or in part, by the home and community-based medicaid waiver program or by developmental disabilities, traumatic brain injury or other medical disabilities programs;

C. "person" includes a natural person and any other form of entity recognized by law;

D. "receiver" means the secretary, upon appointment pursuant to the Health Facility Receivership Act; and

E. "secretary" means the secretary of health.

History: 1978 Comp., § 24-1E-2, enacted by Laws 1996, ch. 35, § 5; 2001, ch. 225, § 2.

ANNOTATIONS

The 2001 amendment, effective June 15, 2001, added the Paragraph (1) designation in Subsection B, and in that paragraph, substituted "state of New Mexico; or" for "department"; and added Paragraph B(2).

24-1E-3. Health facility receiverships authorized; venue.

A. The secretary may file a verified petition in the district court seeking appointment as receiver of a health facility if the facility:

(1) is being operated without a valid license from the division;

(2) will be closed within sixty days and adequate arrangements to relocate its residents have not been submitted to and approved by the secretary;

(3) has been abandoned, its residents have been abandoned or such abandonment is imminent; or

(4) presents a situation, physical condition, practice or method of operation that the secretary finds presents an imminent danger of death or significant mental or physical harm to its residents or other persons.

B. The proceedings shall be governed by, and the receiver's powers and duties shall be as specified in, the Receivership Act [44-8-1 NMSA 1978], supplemented as provided in the Health Facility Receivership Act [24-1E-1 NMSA 1978].

C. Venue shall be laid in the district court for Santa Fe county or any other county in which the health facility or any of its satellite facilities is located.

D. Service of process shall be made in any manner provided by the Rules of Civil Procedure for the District Courts. If personal service cannot practicably or promptly be made as so provided, service may be made by delivery of the summons with the petition attached to any person in charge of the health facility at the time service is made.

E. The health facility shall file a responsive pleading within ten days after the date service is made or within such time as directed by the district court.

History: 1978 Comp., § 24-1E-3, enacted by Laws 1996, ch. 35, § 6.

ANNOTATIONS

Cross references. — For application for appointment of a receiver, *see* 44-8-5 NMSA 1978.

24-1E-3.1. Rulemaking.

No later than December 31, 2001, the secretary shall promulgate rules to implement the provisions of the Health Facility Receivership Act [24-1E-1 NMSA 1978].

As a minimum, the rules shall establish:

A. conditions under which a petition for a health facility receivership may be filed;

B. the duties, authority and responsibilities of the deputy receiver and the health facility;

C. the specific authority of the deputy receiver to impose financial conditions and requirements on the health facility;

D. minimum qualifications for deputy receivers; and

E. provisions that will be requested for inclusion in district court orders entered pursuant to the Health Facility Receivership Act .

History: Laws 2001, ch. 225, § 4.

ANNOTATIONS

24-1E-4. Hearing on petition.

A. Except in the case of an ex parte hearing under the Receivership Act [44-8-1 NMSA 1978], the district court shall hold a hearing on the petition within ten days after the petition is filed or as soon thereafter as practicable. The health facility shall be given notice of the hearing at least five days before the hearing date.

B. In the case of an ex parte hearing under the Receivership Act, the district court may enter an order appointing the secretary as temporary receiver, with all the rights and responsibilities of a receiver, for ten days or until a hearing can be held on the petition.

C. Following hearing, the district court shall appoint the secretary as receiver if it finds that any of the conditions of Subsection A of Section 24-1E-3 NMSA 1978 exists.

D. Following any regular or ex parte hearing, the district court may appoint a qualified person, experienced in health facility management, to act as deputy receiver. The person appointed as deputy receiver shall be free of conflict of interest with the health facility that is in receivership.

E. The receiver's bond shall be deemed satisfied by his bond under the Surety Bond Act [10-2-3 NMSA 1978]. If a deputy receiver is not a public employee covered under the Surety Bond Act, he shall obtain a fidelity and performance bond in an amount determined by the court. The cost of the bond shall be paid from the receivership estate.

History: 1978 Comp., § 24-1E-4, enacted by Laws 1996, ch. 35, § 7; 2001, ch. 225, § 3.

ANNOTATIONS

The 2001 amendment, effective June 15, 2001, inserted the last sentence of Subsection D.

24-1E-5. Receiver's powers and duties.

A. In addition to the receiver's powers and duties under the Receivership Act [44-8-1 NMSA 1978], the secretary as receiver and any deputy receiver under the Health Facility Receivership Act [24-1E-1 NMSA 1978] shall, except as the district court may otherwise order:

(1) perform all acts that are necessary to:

(a) correct or remedy each condition on which the receiver's appointment was based;

(b) ensure adequate care for each resident or other person in the health facility;

(c) bring the facility into compliance with all applicable state and federal laws, rules and regulations; and

(d) manage and operate the health facility, including closing down, expanding or initiating new operations, hiring and firing officers and employees, contracting for necessary services, personnel, supplies, equipment, facilities and all other appropriate things, purchasing, selling, marshaling, and otherwise managing its property and assets, paying the facility's obligations, borrowing money and property and giving security for these and expending funds of the facility;

(2) give notice of establishment of the receivership to interested persons, and publish notice in a newspaper of general circulation in each county in which the health care facility and any of its satellite facilities is located;

(3) if residents are to be discharged or transferred, discuss the options for alternative placement with any resident or the guardian of that resident, as applicable, and arrange to transfer the resident's records and personal property to the alternative placement facility; and

(4) with the court's approval, void any lease, mortgage, secured transaction, contract or transfer of money or property made within one year prior to the filing of the petition if made without fair consideration, including excessive interest rate, or made with actual intent to hinder, delay or defraud either future or existing creditors.

B. A deputy receiver shall have the same powers and duties as the receiver, unless the court orders otherwise.

History: 1978 Comp., § 24-1E-5, enacted by Laws 1996, ch. 35, § 8.

24-1E-6. Termination of receivership.

The receivership shall terminate when the conditions that led to its establishment, and any other conditions that constitute grounds for establishment of a receivership, have ceased to exist. If the health facility is insolvent or otherwise financially distressed, the receivership shall terminate upon filing of federal bankruptcy proceedings, unless the district court orders otherwise.

History: 1978 Comp., § 24-1E-6, enacted by Laws 1996, ch. 35, § 9.

24-1E-7. Facility may seek modification or termination.

A health facility under receivership may petition the court at any time for modification or termination of the order of receivership.

History: Laws 2001, ch. 225, § 5.

ANNOTATIONS

ARTICLE 1F
Billy Griego HIV and AIDS Act

24-1F-1. Short title.

This act may be cited as the "Billy Griego HIV and AIDS Act".

History: Laws 2005, ch. 6, § 1.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 6 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective June 17, 2005, 90 days after adjournment of the legislature.

Compiler's note. — Although this section has been compiled within the Public Health Act [24-1-1 NMSA 1978], it was not enacted as a section of that act.

24-1F-2. Purpose.

The purpose of the Billy Griego HIV and AIDS Act [24-1F-1 NMSA 1978] is to ensure that consumers are the focus of the funding and services provided and their consideration is to be the determining factor in all the state's human immunodeficiency virus and acquired immune deficiency syndrome programs.

History: Laws 2005, ch. 6, § 2.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 6 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective June 17, 2005, 90 days after adjournment of the legislature.

Compiler's note. — Although this section has been compiled within the Public Health Act [24-1-1 NMSA 1978], it was not enacted as a section of that act.

24-1F-3. Department of health; duties.

The department of health shall serve as the state's human immunodeficiency virus and acquired immune deficiency syndrome service coordinator among all state agencies, providing direct and contract education and prevention and treatment services for eligible persons, subject to the availability of funds. The department shall serve as the state contract administrator for federal Ryan White services funding as well as for all federal centers for disease control and prevention human immunodeficiency virus and acquired immune deficiency syndrome programs. Services shall include prevention, clinical services, a drug assistance and insurance assistance program to eligible individuals and programs appropriate for Native Americans, including traditional medicine services. Services shall be delivered in a consumer-oriented model. The department of health shall include a quality assurance component in all services and shall ensure that all clients are educated about their rights and responsibilities and the department's grievance procedures.

History: Laws 2005, ch. 6, § 3.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 6 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective June 17, 2005, 90 days after adjournment of the legislature.

Cross references. — For the Ryan White Care Act, *see* 42 U.S.C.A. Sections 300ff-11 *et seq*.

Compiler's note. — Although this section has been compiled within the Public Health Act [24-1-1 NMSA 1978], it was not enacted as a section of that act.

24-1F-4. Medical advisory committee created; membership; duties.

A. There is created at the department of health a "medical advisory committee" to consist of seven members, chaired by the department's chief medical officer or the officer's designee. Committee membership shall consist of four physicians and two consumers with current experience in the treatment of human immunodeficiency virus and acquired immune deficiency syndrome.

B. The committee shall review the department of health's human immunodeficiency virus and acquired immune deficiency syndrome drug formulary and policies regarding selection, utilization and provision of those drugs and recommend changes as appropriate to the department of health and report its recommendations to the governor's HIV and AIDS policy commission.

History: Laws 2005, ch. 6, § 4.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 6 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective June 17, 2005, 90 days after adjournment of the legislature.

Compiler's note. — Although this section has been compiled within the Public Health Act [24-1-1 NMSA 1978], it was not enacted as a section of that act.

24-1F-5. Independent constituent service program; duties.

An independent "constituent services program" is created. The program shall review all fiscal matters and record and review all complaints and requests for services that come to its attention about public programs and services for persons living with the human immunodeficiency virus and acquired immune deficiency syndrome statewide. The program shall make an annual report to the department of health by November 1 of each year on its activities and recommendations.

History: Laws 2005, ch. 6, § 5.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 6 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective June 17, 2005, 90 days after adjournment of the legislature.

Compiler's note. — Although this section has been compiled within the Public Health Act [24-1-1 NMSA 1978], it was not enacted as a section of that act.

24-1F-6. Annual report; policies and procedures.

A. The department of health shall provide an annual report on activities and expenditures conducted pursuant to the Billy Griego HIV and AIDS Act [24-1F-1 NMSA 1978]. The report shall be submitted no later than December 15 to the legislature and the governor.

B. The department of health shall develop and annually review policies and procedures pertaining to the Billy Griego HIV and AIDS Act.

History: Laws 2005, ch. 6, § 6.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 6 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective June 17, 2005, 90 days after adjournment of the legislature.

Compiler's note. — Although this section has been compiled within the Public Health Act [24-1-1 NMSA 1978], it was not enacted as a section of that act.

ARTICLE 1G
New Mexico Telehealth Commission Act

24-1G-1. Short title.

This act may be cited as the "New Mexico Telehealth Commission Act".

History: Laws 2005, ch. 55, § 1.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 55 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective June 17, 2005, 90 days after adjournment of the legislature.

24-1G-2. Purpose.

The purpose of creating a telehealth commission is to encourage a single, coordinated statewide effort to create a telehealth system that:

A. provides and supports health care delivery, diagnosis, consultation, treatment, transfer of medical data and education when distance separates a patient and a health care provider; multiple health care providers involved in patient care; and health care providers and educational or professional activities;

B. addresses the problems of provider distribution in medically underserved areas of the state;

C. strengthens the health infrastructure;

D. attracts and retains health care providers in rural areas; and

E. helps reduce costs associated with health care and make health care more affordable.

History: Laws 2005, ch. 55, § 2.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 55 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective June 17, 2005, 90 days after adjournment of the legislature.

24-1G-3. Definitions.

As used in the New Mexico Telehealth Commission Act [24-1G-1 NMSA 1978]:

A. "commission" means the New Mexico telehealth commission; and

B. "telehealth" means the use of electronic information, imaging and communication technologies, including interactive audio, video, data communications as well as store-and-forward technologies, to provide and support health care delivery, diagnosis, consultation, treatment, transfer of medical data and education when distance separates the patient and the health care provider.

History: Laws 2005, ch. 55, § 3.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 55 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective June 17, 2005, 90 days after adjournment of the legislature.

24-1G-4. Telehealth commission created; powers and duties; membership.

A. The "New Mexico telehealth commission" is created. The commission is administratively attached to the department of health, which shall work in conjunction with the New Mexico health policy commission, in accordance with the Executive Reorganization Act [9-1-1 NMSA 1978].

B. The commission shall consist of no more than twenty-five members with members, one-third of whom shall be from rural areas, chosen from the following categories, all of whom shall be appointed by and serve at the pleasure of the governor:

(1) health care facilities;

(2) health care practitioners;

(3) health care workforce educators;

(4) telehealth technology experts;

(5) the telecommunications industry;

(6) the business community;

(7) health care insurance providers or other health care payers;

(8) Indian nations, tribes and pueblos;

(9) legislators;

(10) state agencies responsible for:

(a) telecommunications;

(b) public health;

(c) medicaid and social services;

(d) workforce development;

(e) children's health and social services;

(f) services for the elderly and disabled;

(g) criminal justice;

(h) health policy and planning; and

(i) education; and

(11) other members as the governor may appoint to ensure appropriate cultural and geographic representation and the interests of the public.

C. The commission shall:

(1) identify how telehealth can be used to increase access to care and implement state comprehensive health plans;

(2) identify barriers to telehealth utilization and expansion, including payment, infrastructure, training and workforce availability;

(3) inventory the state's telehealth assets, map available telecommunications infrastructure and examine the financial impact of failing to develop the state's telehealth capacities;

(4) coordinate public and private sector initiatives to enhance networking, portal development and connectivity and to expand telehealth and telecommunications capacity;

(5) establish such subcommittees as the commission deems necessary to fulfill its purpose, powers and duties or to address specific telehealth issues;

(6) identify specific actions to increase collaborative efforts and public-private partnerships to increase the use of telehealth for health care access development, patient outcome improvement, patient and workforce education and health care practitioner recruitment and development;

(7) develop and disseminate specific telehealth standards and guidelines to ensure quality of care, positive health outcomes, appropriate use of technology and protection of privacy and confidentiality;

(8) review and comment on initiatives, projects or grant applications to ensure telehealth standards and guidelines are met and maximum collaboration and cooperation across the state is encouraged;

(9) meet at least once each quarter at the call of the chair or vice chair, who shall be designated by the governor from among the membership; and

(10) report annually to the governor and the legislature on the state of the telehealth system and the adequacy and allocation of telehealth services throughout the state, providing the governor and the legislature with specific recommendations for improving telehealth and related service systems.

D. A majority of the members of the commission constitutes a quorum for the transaction of business.

History: Laws 2005, ch. 55, § 4.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 55 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective June 17, 2005, 90 days after adjournment of the legislature.

ANNOTATIONS

Cross reference. — For the department of health, *see* Section 9-7-4 NMSA 1978. For the New Mexico health policy commission, *see* Section 9-7-11.2 NMSA 1978.

ARTICLE 2
Crippled Children Services

24-2-1. Authority to conduct crippled children services.

The health services division of the health and environment department [department of health] has authority to establish, administer and supervise activities to crippled children and children suffering from conditions which lead to crippling. The health services division also may supervise the administration of those services to crippled children which are not administered directly by it.

History: 1978 Comp., § 24-2-1, enacted by Laws 1977, ch. 253, § 40.

ANNOTATIONS

Bracketed material. — The bracketed reference relating to the department of health was inserted by the compiler, as Laws 1991, ch. 25, § 16 repeals former 9-7-4 NMSA 1978, relating to the health and environment department and enacts a new 9-7-4 NMSA 1978 creating the department of health. Section 9-7-5 NMSA 1978, as amended by Laws 1991, ch. 25, § 17 makes the secretary of health the administrative head of the department. The bracketed material was not enacted by the legislature and is not part of the law.

ARTICLE 2A
Hemophilia Program

24-2A-1. Short title.

This act [24-2A-1 to 24-2A-3 NMSA 1978] may be cited as the "Theodore R. Montoya Memorial Hemophilia Program Act".

History: Laws 1980, ch. 26, § 1.

24-2A-2. Definitions.

As used in the Theodore R. Montoya Memorial Hemophilia Program Act [24-2A-1 NMSA 1978]:

A. "blood products" means certain components or factors obtained from whole blood which when periodically administered to persons suffering from hemophilia result in relief or control of the disease;

B. "eligible patient" means a person suffering from hemophilia whose case has been evaluated and accepted for provision of services by the hemophilia program established by the school;

C. "fund" means the hemophilia fund;

D. "hemophilia" means a genetic disease in which uncontrolled bleeding from otherwise minor causes may result in death or disability;

E. "hemophilia program" means the New Mexico comprehensive hemophilia diagnostic and treatment program established by the school to provide comprehensive clinical evaluation of patients suffering from hemophilia, out-patient blood product usage, counseling services to families of persons suffering from hemophilia and outreach to the public;

F. "provider" means any blood service or laboratory furnishing blood products to the school and its program administration for eligible patients;

G. "university" means the university of New Mexico; and

H. "secretary" means the secretary of health and environment [secretary of health].

History: Laws 1980, ch. 26, § 2.

ANNOTATIONS

Bracketed material. — The bracketed reference relating to the department of health was inserted by the compiler, as Laws 1991, ch. 25, § 16 repeals former 9-7-4 NMSA 1978, relating to the health and environment department and enacts a new 9-7-4 NMSA 1978 creating the department of health. Section 9-7-5 NMSA 1978, as amended by Laws 1991, ch. 25, § 17 makes the secretary of health the administrative head of the department. The bracketed material was not enacted by the legislature and is not part of the law.

24-2A-3. Hemophilia fund created; use; calculation of costs.

A. There is created in the state treasury the "hemophilia fund".

B. The fund shall be administered by the university and shall be used solely to provide hemophilia program services to eligible patients. The university may expend and distribute funds to:

(1) the university of New Mexico school of medicine for the costs of clinical evaluation, to include at least one visit per eligible patient per year;

(2) providers for the costs of blood products for each eligible patient, all as approved by the university of New Mexico school of medicine, to the extent not covered by insurance, medicaid or medicare;

(3) the university of New Mexico school of medicine for hemophilia program support, including nursing coordination, social services to patients and families and outreach for public education; and

(4) the university of New Mexico school of medicine for purchase of insurance or medicare coverage for patients who are eligible for coverage but have insufficient financial resources to pay the premiums.

History: Laws 1980, ch. 26, § 3; 2001, ch. 308, § 1.

ANNOTATIONS

The 2001 amendment, effective June 15, 2001, inserted the university of New Mexico school of medicine throughout the section and added Paragraph B(4).

ARTICLE 2B
Human Immunodeficiency Virus Tests

24-2B-1. Short title.

Chapter 24, Article 2B NMSA 1978 may be cited as the "Human Immunodeficiency Virus Test Act".

History: Laws 1989, ch. 227, § 1; 1993, ch. 107, § 1.

ANNOTATIONS

The 1993 amendment, effective July 1, 1993, substituted "Chapter 24, Article 2B NMSA 1978" for "This act".

Am. Jur. 2d, A.L.R. and C.J.S. references. — Child custody and visitation rights of person infected with AIDS, 86 A.L.R.4th 211.

Transmission or risk of transmission of human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) as basis for prosecution or sentencing in criminal or military discipline case, 13 A.L.R.5th 628.

Validity and propriety under circumstances, of court-ordered HIV testing, 87 A.L.R.5th 631.

The Propriety, under ERISA (29 USCS § 1001 et seq.) and the Americans With Disabilities Act (42 USCS § 12101 et seq.), of Capping Health Insurance Coverage for HIV-Related Claims, 131 A.L.R. Fed. 191.

24-2B-2. Informed consent.

No person shall perform a test designed to identify the human immunodeficiency virus or its antigen or antibody without first obtaining the informed consent of the person upon whom the test is performed, except as provided in Section 24-2B-5, 24-2B-5.1, 24-2B-5.2 or 24-2B-5.3 NMSA 1978. Informed consent shall be preceded by an explanation of the test, including its purpose, potential uses and limitations and the meaning of its results. Consent need not be in writing if there is documentation in the medical record that the test has been explained and the consent has been obtained.

History: Laws 1989, ch. 227, § 2; 1993, ch. 107, § 2; 1996, ch. 80, § 7; 2000, ch. 36, § 1.

ANNOTATIONS

The 1993 amendment, effective June 18, 1993, substituted "24-2B-5 or 24-2B-5.1 NMSA 1978" for "6 of the Human Immunodeficiency Virus Test Act" in the first sentence.

The 1996 amendment, effective July 1, 1996, inserted "or 24-2B-5.2 NMSA 1978" following "24-2B-5.1" and made a stylistic change in the first sentence.

The 2000 amendment, effective May 17, 2000, inserted "or 24-2B-5.3" in the first sentence.

Am. Jur. 2d, A.L.R. and C.J.S. references. — Damage action for HIV testing without consent of person tested, 77 A.L.R.5th 541.

24-2B-3. Substituted consent.

Informed consent shall be obtained from a legal guardian or other person authorized by law when the person is not competent. A minor shall have the capacity to give informed consent to have the human immunodeficiency virus test performed on himself.

History: Laws 1989, ch. 227, § 3.

24-2B-4. Mandatory counseling.

No positive test result shall be revealed to the person upon whom the test was performed without the person performing the test or the health facility at which the test was performed providing or referring that person for individual counseling about:

A. the meaning of the test results;

B. the possible need for additional testing;

C. the availability of appropriate health care services, including mental health care, social and support services; and

D. the benefits of locating and counseling any individual by whom the infected person may have been exposed to the human immunodeficiency virus and any individual whom the infected person may have exposed to the human immunodeficiency virus.

History: Laws 1989, ch. 227, § 4.

24-2B-5. Informed consent not required.

Informed consent for testing is not required and the provisions of Section 24-2B-2 NMSA 1978 do not apply for:

A. a health care provider or health facility performing a test on the donor or recipient when the health care provider or health facility procures, processes, distributes or uses a human body part, including tissue and blood or blood products, donated for a purpose specified under the Uniform Anatomical Gift Act [24-6A-1 NMSA 1978] or for transplant recipients or semen provided for the purpose of artificial insemination and such test is necessary to assure medical acceptability of a recipient or such gift or semen for the purposes intended;

B. the performance of a test in bona fide medical emergencies when the subject of the test is unable to grant or withhold consent and the test results are

necessary for medical diagnostic purposes to provide appropriate emergency care or treatment, except that post-test counseling or referral for counseling shall nonetheless be required when the individual is able to receive that post-test counseling. Necessary treatment shall not be withheld pending test results;

C. the performance of a test for the purpose of research if the testing is performed in a manner by which the identity of the test subject is not known and may not be retrieved by the researcher;

D. the performance of a test done in a setting where the identity of the test subject is not known, such as in public health testing programs and sexually transmitted disease clinics; or

E. the performance of a prenatal test to determine if the human immunodeficiency virus or its antigen is present in a pregnant woman; provided that the woman, or her authorized representative, after having been informed of the option to decline the human immunodeficiency virus test, may choose to not have the human immunodeficiency virus test performed as a part of the routine prenatal testing if she or her authorized representative provides a written statement as follows:

"I am aware that a test to identify the human immunodeficiency virus or its antigen or antibody is a part of routine prenatal testing. However, I voluntarily and knowingly choose to not have the human immunodeficiency virus test performed.

____

(Name of patient or authorized representative, signature and date).".

History: Laws 1989, ch. 227, § 5; 2000, ch. 36, § 2; 2003, ch. 342, § 1.

ANNOTATIONS

The 2000 amendment, effective May 17, 2000, substituted "Section 24-2B-2 NMSA 1978" for "Section 1 of the Human Immunodeficiency Virus Test Act" in the preliminary language of the section, deleted former Subsection D, concerning the testing of health care workers, and redesignated former Subsection E as Subsection D.

The 2003 amendment, effective June 20, 2003, added Subsection E.

24-2B-5.1. Informed consent not required; testing of persons convicted of certain criminal offenses; responsibility to administer and pay for test.

A. A test designed to identify the human immunodeficiency virus or its antigen or antibody may be performed, without his consent, on an offender convicted pursuant to state law of any criminal offense:

(1) involving contact between the penis and vulva;

(2) involving contact between the penis and anus;

(3) involving contact between the mouth and penis;

(4) involving contact between the mouth and vulva;

(5) involving contact between the mouth and anus; or

(6) when the court determines from the facts of the case that there was a transmission or likelihood of transmission of blood, semen or vaginal secretions from the offender to the victim.

B. When consent to perform a test on an offender cannot be obtained pursuant to the provisions of Section 24-2B-2 or 24-2B-3 NMSA 1978, the victim of a criminal offense described in Subsection A of this section may petition the court to order that a test be performed on the offender. The petition and all proceedings in connection therewith shall be under seal. When the victim of the criminal offense is a minor or incompetent, the parent or legal guardian of the victim may petition the court to order that a test be performed on the offender. The court shall order and the test shall be administered to the offender within ten days after the petition is filed by the victim, his parent or guardian. The results of the test shall be disclosed only to the offender and to the victim or the victim's parent or legal guardian. When the offender has a positive test result, both the offender and victim shall be provided with counseling, as described in Section 24-2B-4 NMSA 1978.

C. When the offender is sentenced to imprisonment in a state corrections facility, the court's order shall direct the department of health to be responsible for the administration of and payment for the test and the lawful distribution of the test results.

D. When the offender is convicted of a misdemeanor or petty misdemeanor offense or is convicted of a felony offense that is suspended or deferred, the court's order shall direct the department of health to be responsible for the administration of and payment for the test and the lawful distribution of the test results.

E. When the offender is a minor adjudicated as a delinquent child pursuant to the provisions of the Children's Code [32A-1-1 NMSA 1978] and the court transfers legal custody of the minor to the children, youth and families department, the court's order shall direct the children, youth and families department to be responsible for the administration of and payment for the test and the lawful distribution of the test results.

F. When the offender is a minor adjudicated as a delinquent child pursuant to the provisions of the Children's Code and the court does not transfer legal custody of the minor to the children, youth and families department, the court's order shall direct the department of health to be responsible for the administration of and payment for the test and the lawful distribution of the test results.

History: 1978 Comp., § 24-2B-5.1, enacted by Laws 1993, ch. 107, § 3.

ANNOTATIONS

Severability clauses. — Laws 1993, ch. 107, § 4 provides for the severability of the act if any part or application thereof is held invalid.

24-2B-5.2. Informed consent not required; testing of persons formally charged for allegedly committing certain criminal offenses; responsibility to administer and pay for test.

A. A test designed to identify the human immunodeficiency virus or its antigen or antibody may be performed, without his consent, on a person upon the filing of a complaint, information or an indictment alleging that the person committed a state criminal offense:

(1) involving contact between the penis and the vulva;

(2) involving contact between the penis and anus;

(3) involving contact between the mouth and penis;

(4) involving contact between the mouth and vulva; or

(5) involving contact between the mouth and anus.

B. If consent to perform a test on an alleged offender cannot be obtained pursuant to the provisions of Section 24-2B-2 or 24-2B-3 NMSA 1978, the victim of the alleged criminal offense described in Subsection A of this section may petition the court, through the prosecuting office or personally, to order that a test be performed on the alleged offender; provided that the same test is first performed on the victim of the alleged criminal offense. The test may be performed on the alleged offender regardless of the result of the test performed on the victim of the alleged offense. If the victim of the alleged criminal offense is a minor or incompetent, the parent or legal guardian of the victim of the alleged criminal offense may petition the court to order that a test be performed on the alleged offender.

C. The court may issue an order based on a finding of good cause after a hearing at which both the victim of the alleged criminal offense and the alleged offender have the right to be present. During the hearing, only affidavits, counter affidavits and medical

reports regarding the facts that support or rebut the issuance of an order shall be admissible. The hearing shall be conducted within seventy-two hours after the victim of the alleged criminal offense petitions the court for the order. The petition and all proceedings in connection therewith shall be under seal. The court shall issue the order and the test shall be administered to the alleged offender within ten days after the petition is filed by the victim of the alleged offense, his parent or guardian.

D. The results of the test shall be disclosed only to the alleged offender and to the victim of the alleged criminal offense or the victim's parent or legal guardian. When the victim of the alleged criminal offense or the alleged offender has a positive test result, both the alleged offender and the victim of the alleged criminal offense shall be provided with counseling, as described in Section 24-2B-4 NMSA 1978.

E. The court's order shall direct the department of health to be responsible for the administration of and payment for the test and the lawful distribution of the test results.

F. A prosecuting attorney may not use in a criminal proceeding arising out of the alleged criminal offense the fact that a test was administered to the alleged offender, or the results of the test.

G. The provisions of this section shall not affect the rights and remedies available to the victim of the alleged criminal offense and alleged offender in any civil action.

H. The administration of a test to an alleged offender pursuant to the provisions of this section shall not preclude the subsequent administration of another test pursuant to the provisions of Section 24-2B-5.1 NMSA 1978.

History: 1978 Comp., § 24-2B-5.2, enacted by Laws 1996, ch. 80, § 8.

ANNOTATIONS

Cross references. — For testing for sexually transmitted diseases of persons charged with committing certain criminal offenses, *see* 24-1-9.2 NMSA 1978.

24-2B-5.3. Informed consent not required; testing of persons who are source individuals.

A. As used in this section:

(1) "exposed individual" means a health care provider, first responder or other person, including an employee, volunteer or independent contracted agent of a health care provider or law enforcement agency, while acting within the scope of his employment; or a person who, while receiving services from a health care provider, is significantly exposed to the blood or other potentially infectious material of another person, when the exposure is proximately the result of the activity of the exposed individual or receipt of health care services from the source individual;

(2) "significantly exposed" means direct contact with blood or other potentially infectious material of a source individual in a manner that is capable of transmitting the human immunodeficiency virus; and

(3) "source individual" means a person whose blood or other potentially infectious material may have been or has been the source of a significant exposure.

B. A test designed to identify the human immunodeficiency virus or its antigen or antibody may be performed without the consent of a source individual when an exposed individual is significantly exposed.

C. If consent to perform a test on a source individual cannot be obtained pursuant to the provisions of Section 24-2B-2 or 24-2B-3 NMSA 1978, the exposed individual may petition the court to order that a test be performed on the source individual; provided that the same test shall first be performed on the exposed individual. The test may be performed on the source individual regardless of the result of the test performed on the exposed individual. If the exposed individual is a minor or incompetent, the parent or guardian may petition the court to order that a test be performed on the source individual.

D. The court may issue an order based on a finding of good cause after a hearing at which both the source individual and the exposed individual have the right to be present. The hearing shall be conducted within seventy-two hours after the petition is filed. The petition and all proceedings in connection with the petition shall be under seal. The test shall be administered on the source individual within three days after the order for testing is entered.

E. The results of the test shall be disclosed only to the source individual and the exposed or the exposed individual's parent or guardian. When the source individual or the exposed individual has a positive test result, both shall be provided with counseling as provided in Section 24-2B-4 NMSA 1978.

History: 1978 Comp., § 24-2B-5.3, enacted by Laws 2000, ch. 36, § 3.

ANNOTATIONS

24-2B-6. Confidentiality.

No person or the person's agents or employees who require or administer the test shall disclose the identity of any person upon whom a test is performed or the result of such a test in a manner which permits identification of the subject of the test, except to the following persons:

A. the subject of the test or the subject's legally authorized representative, guardian or legal custodian;

B. any person designated in a legally effective release of the test results executed prior to or after the test by the subject of the test or the subject's legally authorized representative;

C. an authorized agent, a credentialed or privileged physician or employee of a health facility or health care provider if the health care facility or health care provider itself is authorized to obtain the test results, the agent or employee provides patient care or handles or processes specimens of body fluids or tissues and the agent or employee has a need to know such information;

D. the department of health in accordance with reporting requirements established by regulation;

E. a health facility or health care provider which procures, processes, distributes or uses:

(1) a human body part from a deceased person, with respect to medical information regarding that person;

(2) semen provided prior to the effective date of the Human Immunodeficiency Virus Test Act for the purpose of artificial insemination;

(3) blood or blood products for transfusion or injection; or

(4) human body parts for transplant with respect to medical information regarding the donor or recipient;

F. health facility staff committees or accreditation or oversight review organizations which are conducting program monitoring, program evaluation or service reviews, so long as any identity remains confidential;

G. authorized medical or epidemiological researchers who may not further disclose any identifying characteristics or information; and

H. for purposes of application or reapplication for insurance coverage, an insurer or reinsurer upon whose request the test was performed.

History: Laws 1989, ch. 227, § 6; 1997, ch. 214, § 1.

ANNOTATIONS

The 1997 amendment, effective June 20, 1997, rewrote Subsection D.

Am. Jur. 2d, A.L.R. and C.J.S. references. — State statutes or regulations expressly governing disclosure of fact that person has tested positive for human

immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), 12 A.L.R.5th 149.

24-2B-7. Disclosure statement.

No person to whom the results of a test have been disclosed may disclose the test results to another person except as authorized by the Human Immunodeficiency Virus Test Act [24-2B–1 NMSA 1978]. Whenever disclosure is made pursuant to that act, it shall be accompanied by a statement in writing that includes the following or substantially similar language: "This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A person who makes an unauthorized disclosure of this information is guilty of a petty misdemeanor and shall be sentenced to imprisonment in the county jail for a definite term not to exceed six months or the payment of a fine of not more than five hundred dollars ($500), or both."

History: Laws 1989, ch. 227, § 7; 1996, ch. 80, § 9.

ANNOTATIONS

The 1996 amendment, effective July 1, 1996, added the second sentence to the quoted language and made a stylistic change in the second sentence.

24-2B-8. Disclosure.

Nothing in the Human Immunodeficiency Virus Test Act [this article] shall be construed to prevent a person who has been tested from disclosing in any way to any other person his own test results. Any victim of an alleged criminal offense who receives information pursuant to Section 24-2B-5.2 NMSA 1978 may disclose the test results as is reasonably necessary to protect his health and safety or the health and safety of his family or sexual partner.

History: Laws 1989, ch. 227, § 8; 1996, ch. 80, § 10.

ANNOTATIONS

The 1996 amendment, effective July 1, 1996, substituted "Disclosure" for "Self-disclosure" in the section head and added the last sentence.

24-2B-9. Penalty.

A person who makes an unauthorized disclosure of the results of a test designed to identify the human immunodeficiency virus or its antigen or antibody is guilty of a petty misdemeanor and shall be sentenced to imprisonment in the county jail for a definite

term not to exceed six months or the payment of a fine of not more than five hundred dollars ($500), or both.

History: 1978 Comp., § 24-2B-9, enacted by Laws 1996, ch. 80, § 11.

ARTICLE 2C
Harm Reduction

24-2C-1. Short title.

Sections 1 through 6 [24-2C-1 to 24-2C-6 NMSA 1978] of this act may be cited as the "Harm Reduction Act".

History: Laws 1997, ch. 256, § 1.

24-2C-2. Purpose.

The purpose of the Harm Reduction Act [24-2C-1 NMSA 1978] is to:

A. prevent the transmission of the human immunodeficiency virus, hepatitis B and C viruses and other blood-borne diseases; and

B. encourage intravenous drug users to seek substance abuse treatment and ensure that participants receive individual counseling and education to decrease the risk of transmission of blood-borne diseases.

History: Laws 1997, ch. 256, § 2.

24-2C-3. Definitions.

As used in the Harm Reduction Act [24-2C-1 NMSA 1978]:

A. "department" means the department of health;

B. "participant" or "client" means an intravenous drug user who exchanges a used hypodermic syringe, needle or other object used to inject controlled substances or controlled substance analogs into the human body for a sterile hypodermic syringe and needle in compliance with the procedures of the program; and

C. "program" means a harm reduction program for the purpose of sterile hypodermic syringe and needle exchange.

History: Laws 1997, ch. 256, § 3.

24-2C-4. Program created; department responsibilities.

A. The department shall:

(1) establish and administer a harm reduction program for the purpose of sterile hypodermic syringe and needle exchange;

(2) compile data to assist in planning and evaluating efforts to combat the spread of blood-borne diseases; and

(3) make an annual report, including legislative recommendations, to the legislative health and human services committee by October 1 each year.

B. Within thirty days of the effective date of the Harm Reduction Act [24-2C-1 NMSA 1978], the department shall appoint an advisory committee, to include representation from:

(1) the office of the attorney general;

(2) the New Mexico state police division of the department of public safety;

(3) the human immunodeficiency virus sexually transmitted disease bureau of the department;

(4) the director of the epidemiology division of the department or his designee;

(5) a medical officer of the public health division of the department; and

(6) other persons or representatives as chosen by the secretary of health to ensure a thorough and unbiased evaluation of the program established under the Harm Reduction Act.

C. The advisory committee shall:

(1) develop policies and procedures for evaluation of the harm reduction program;

(2) develop criteria for data collection and program evaluation; and

(3) meet as necessary to analyze data and monitor and produce a report on the harm reduction program.

D. The department may contract with private providers to operate the program.

History: Laws 1997, ch. 256, § 4.

24-2C-5. Program.

The program shall provide:

A. sterile hypodermic syringes and needles in exchange for used hypodermic syringes, needles or other objects used to inject controlled substances or controlled substance analogs into the human body;

B. education to participants on the transmission of the human immunodeficiency virus, hepatitis B and C and prevention measures; and

C. referral to substance abuse treatment services for participants.

History: Laws 1997, ch. 256, § 5.

24-2C-6. Immunity from criminal liability.

Exchange or possession of hypodermic syringes and needles in compliance with the procedures of the program shall not constitute a violation of the Controlled Substances Act [30-31-1 NMSA 1978] for a participant in the program, an employee of the department administering the program or a private provider whom the department contracts with to operate the program.

History: Laws 1997, ch. 256, § 6.

ARTICLE 2D
Pain Relief

24-2D-1. Short title.

This act [24-2D-1 to 24-2D-6 NMSA 1978] may be cited as the "Pain Relief Act".

History: Laws 1999, ch. 126, § 1.

ANNOTATIONS

24-2D-2. Definitions.

As used in the Pain Relief Act [24-2D-1 NMSA 1978]:

A. "accepted guideline" means a care or practice guideline for pain management developed by a national joint commission on accreditation of health care organizations; the American pain society; an American geriatrics society; the agency for health care research and quality; a national cancer pain initiative or any other nationally

recognized clinical or professional association; or a specialty society or government-sponsored agency that has developed practice or care guidelines based on original research or on review of existing research and expert opinion whose guidelines have been accepted by the New Mexico medical board and by other boards of health care providers with prescriptive authority;

B. "board" means the licensing board of a health care provider;

C. "clinical expert" means a person who by reason of specialized education or substantial relevant experience in pain management has knowledge regarding current standards, practices and guidelines;

D. "disciplinary action" means a formal action taken by a board against a health care provider, upon a finding of probable cause that the health care provider has engaged in conduct that violates the provider's respective board's practice act;

E. "health care provider" means a person licensed or otherwise authorized by law to provide health care in the ordinary course of business or practice of the person's profession and to have prescriptive authority within the limits of the person's license;

F. "pain" means a condition of bodily sensation of serious physical discomfort that requires the services of a health care provider to alleviate, including discomfort that is persistent and chronic in duration; and

G. "therapeutic purpose" means the use of pharmaceutical and non-pharmaceutical medical treatment that conforms substantially to accepted guidelines for pain management.

History: Laws 1999, ch. 126, § 2; 2005, ch. 140, § 1.

ANNOTATIONS

The 2005 amendment, effective June 17, 2005, defines “accepted guideline” in Subsection A to include a guideline developed by a national joint commission on accreditation of health care organizations and other boards of health care providers with prescriptive authority; defines “disciplinary action” in Subsection D, to mean a violation of the health care provider’s respective board’s practice act; deletes the definition of “intractable pain” in former Subsection F and adds a definition of “pain” in subsection to mean a condition of bodily sensation of serious physical discomfort that requires health care provider service to alleviate.

24-2D-3. Disciplinary action; evidentiary requirements.

A. A health care provider who prescribes, dispenses or administers medical treatment for the purpose of relieving pain and who can demonstrate by reference to an accepted guideline that the provider's practice substantially complies with that guideline

and with the standards of practice identified in Section 24-2D-4 NMSA 1978 shall not be disciplined pursuant to board action or criminal prosecution, unless the showing of substantial compliance with an accepted guideline by the health care provider is rebutted by clinical expert testimony. If no currently accepted guidelines are available, then rules issued by the board may serve the function of such guidelines for purposes of the Pain Relief Act [24-2D-1 NMSA 1978]. The board rules shall conform to the intent of that act. Guidelines established primarily for purposes of coverage, payment or reimbursement do not qualify as an "accepted guideline" when offered to limit treatment options otherwise covered within the Pain Relief Act.

B. In the event that a disciplinary action or criminal prosecution is pursued, the board or prosecutor shall produce clinical expert testimony supporting the finding or charge of violation of disciplinary standards or other legal requirements on the part of the health care provider. A showing of substantial compliance with an accepted guideline shall only be rebutted by clinical expert testimony.

C. The provisions of this section apply to health care providers in the treatment of pain, regardless of a patient's prior or current chemical dependency or addiction. Each board shall adopt rules establishing standards and procedures for the application of the Pain Relief Act, including the care and treatment of chemically dependent individuals.

D. In an action brought by a board against a health care provider based on treatment of a patient for pain, the board shall consider the totality of the circumstances and shall not use as the sole basis of the action:

(1) a patient's age;

(2) a patient's diagnosis;

(3) a patient's prognosis;

(4) a patient's history of drug abuse;

(5) the absence of consultation with a pain specialist; or

(6) the quantity of medication prescribed or dispensed.

History: Laws 1999, ch. 126, § 3; 2005, ch. 140, § 2.

ANNOTATIONS

The 2005 amendment, effective June 17, 2005, adds Subsection D to provide that in an action brought by the board against a health care provider based on treatment of a patient for pain, the board shall not base its decision solely on the factors listed in Subsection D(1) through 6).

24-2D-4. Disciplinary action; prohibitions.

Nothing in the Pain Relief Act [24-2D-1 NMSA 1978] shall prohibit discipline or prosecution of a health care provider for:

A. failing to maintain complete, accurate and current records documenting the physical examination and medical history of the patient, the basis for the clinical diagnosis of the patient and the treatment plan for the patient;

B. writing false or fictitious prescriptions for controlled substances scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 or Sections 26-1-23 and 30-31-18 NMSA 1978;

C. prescribing, administering or dispensing pharmaceuticals in violation of the provisions of the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 or Sections 26-1-23 and 30-31-18 NMSA 1978; or

D. diverting medications prescribed for a patient to the provider's personal use or to other persons.

History: Laws 1999, ch. 126, § 4.

ANNOTATIONS

Cross references. — For the federal Comprehensive Drug Abuse Prevention and Control Act of 1970, *see* 21 U.S.C. § 801 et seq.

24-2D-5. Notification.

The board shall make reasonable efforts to notify health care providers under its jurisdiction of the existence of the Pain Relief Act [24-2D-1 NMSA 1978] and inform any health care provider investigated in relation to the provider's practices in the management of pain of the existence of that act.

History: Laws 1999, ch. 126, § 5.

ANNOTATIONS

24-2D-5.1. Pain management continuing education.

A board shall encourage pain management continuing education for all health care providers who have prescriptive authority and who treat patients with pain.

History: Laws 2005, ch. 140, § 4.

ANNOTATIONS

24-2D-5.2. Pain management advisory council created; duties.

A. The "pain management advisory council" is created and shall be administratively attached to the department of health. Members of the council shall be appointed by the governor to consist of one representative each from the New Mexico medical board, the board of nursing, the board of pharmacy, the board of osteopathic medical examiners, the board of acupuncture and oriental medicine, the university of New Mexico health sciences center, a statewide medical association, a statewide association of pharmacists, a statewide association of nurse practitioners, a statewide association of certified registered nurse anesthetists and a statewide association of osteopathic physicians; one person who is a consumer health care advocate; and three persons who have no direct ties or pecuniary interest in the health care fields.

B. The council shall meet at least quarterly to review current pain management practices in New Mexico and national pain management standards and educational efforts for both consumers and professionals and shall recommend pain management guidelines for each health care profession licensed in New Mexico with prescriptive authority to its respective board. Members who are not public employees shall receive per diem and mileage as provided in the Per Diem and Mileage Act [10-8-1 NMSA 978]. Public employee members shall receive mileage from their respective employers for attendance at council meetings.

History: Laws 2005, ch. 140, § 3.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 140 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective June 17, 2005, 90 days after adjournment of the legislature.

24-2D-6. Scope of act.

Nothing in the Pain Relief Act [24-2D-1 NMSA 1978] shall be construed as expanding the authorized scope of practice of health care providers.

History: Laws 1999, ch. 126, § 6.

ANNOTATIONS

ARTICLE 2E
Testing for Viral Hepatitis

24-2E-1. Testing of persons for hepatitis; consent not required.

A. As used in this section:

(1) "exposed individual" means a health care provider or first responder, including an employee, volunteer or independent contracted agent of a health care provider or law enforcement agency, while acting within the scope of his employment, who is significantly exposed to the blood or other potentially infectious material of another person, when the exposure is proximately the result of the activity of the exposed individual acting within the scope of his employment;

(2) "significantly exposed" means direct contact with blood or other potentially infectious material of a source individual in a manner that is capable of transmitting viral hepatitis; and

(3) "source individual" means a person identified as at-risk for or believed to have viral hepatitis, whose blood or other potentially infectious material may have been or has been the source of a significant exposure.

B. A test designed to identify the viral hepatitis, its antigens or antibodies may be performed without the consent of a source individual when an exposed individual is significantly exposed.

C. If consent to perform a test on a source individual cannot be obtained on a voluntary basis, the exposed individual may petition the court to order that a test be performed on the source individual; provided that the same test shall first be performed on the exposed individual. The test may be performed on the source individual regardless of the result of the test performed on the exposed individual. If the exposed individual is a minor or incompetent, the parent or guardian may petition the court to order that a test be performed on the source individual.

D. The court may issue an order based on a finding of good cause after a hearing at which both the source individual and the exposed individual have the right to be present. The hearing shall be conducted within twenty-four hours after the petition is filed. The petition and all proceedings in connection with the petition shall be under seal. The test shall be administered on the source individual within twenty-four hours after the order for testing is entered.

E. Pursuant to rules adopted by the department of health, the results of the test shall be disclosed only to the source individual, to the exposed individual or, in the case of a minor, to the exposed individual's parent or guardian and to the infectious disease bureau of the public health division of the department of health.

History: Laws 2001, ch. 136, § 1.

ANNOTATIONS

24-2E-2. Confidentiality.

No person or the person's agents or employees who require or administer a test for viral hepatitis shall disclose the identity of any person upon whom a test is performed or the result of such a test in a manner that permits identification of the subject of the test, except to the following persons:

A. the subject of the test or the subject's legally authorized representative, guardian or legal custodian;

B. any person designated in a legally effective release of the test results executed prior to or after the test by the subject of the test or the subject's legally authorized representative;

C. an authorized agent, a credentialed or privileged physician or employee of a health facility or health care provider if the health care facility or health care provider itself is authorized to obtain the test results, the agent or employee provides patient care or handles or processes specimens of body fluids or tissues and the agent or employee has a need to know such information;

D. the department of health in accordance with reporting requirements established by rule;

E. a health facility or health care provider that procures, processes, distributes or uses:

(1) a human body part from a deceased person, with respect to medical information regarding that person;

(2) semen provided prior to the effective date of this 2001 act for the purpose of artificial insemination;

(3) blood or blood products for transfusion or injection; or

(4) human body parts for transplant with respect to medical information regarding the donor or recipient;

F. health facility staff committees or accreditation or oversight review organizations that are conducting program monitoring, program evaluation or service reviews, so long as any identity remains confidential;

G. authorized medical or epidemiological researchers who may not further disclose any identifying characteristics or information; and

H. for purposes of application or reapplication for insurance coverage, an insurer or reinsurer upon whose request the test was performed.

History: Laws 2001, ch. 136, § 2.

ANNOTATIONS

Compiler's notes. — The phrase "the effective date of this 2001 act" in Paragraph E(2) refers to the effective date of Laws 2001, ch. 136 which is June 15, 2001.

24-2E-3. Penalties.

No person to whom the results of a viral hepatitis test have been disclosed may disclose the test results to another person except as authorized in this 2001 act. A person who makes an unauthorized disclosure of this information is guilty of a petty misdemeanor and shall be sentenced to imprisonment in the county jail for a definite term not to exceed six months or the payment of a fine of not more than five hundred dollars ($500) or both.

History: Laws 2001, ch. 136, § 3.

ANNOTATIONS

Compiler's notes. — The phrase "this 2001 act" in the first sentence refers to Laws 2001, ch. 136, codified as 24-2E-1 to 24-2E-3 NMSA 1978.

ARTICLE 3
Sickle Cell Trait and Sickle Cell Anemia

24-3-1. Sickle cell trait and sickle cell anemia; education; diagnosis.

A. The health services division of the health and environment department [department of health] shall provide by regulation procedures to establish, maintain, promote and effectuate a program designed to educate the general public and public and private school students regarding the nature and inheritance of sickle cell trait and sickle cell anemia. The division shall consult and advise the state board of education concerning development and use of informational and educational materials relating to sickle cell trait and sickle cell anemia.

B. The health services division of the health and environment department [department of health] shall provide by regulation for diagnosis of sickle cell trait and sickle cell anemia. Regulations shall provide for, among other things:

(1) the making available to all physicians by the health services division [department of health] of current information concerning the nature, effects, diagnosis and treatment of sickle cell trait and sickle cell anemia;

(2) the testing of all school-age children who may be susceptible to sickle cell trait and sickle cell anemia, at least once, as a part of the school health program; and

(3) the making available without cost to any person unable to afford the services of a physician, tests to diagnose sickle cell trait and sickle cell anemia.

History: 1953 Comp., § 12-3-45, enacted by Laws 1973, ch. 300, § 1; 1977, ch. 253, § 25.

ANNOTATIONS

Cross references. — For education and testing relating to phenylketonuria, *see* 24-1-6 NMSA 1978.

For state board of education, *see* Chapter 22, Article 2 NMSA 1978.

Bracketed material. — The bracketed reference relating to the department of health was inserted by the compiler, as Laws 1991, ch. 25, § 16 repeals former 9-7-4 NMSA 1978, relating to the health and environment department and enacts a new 9-7-4 NMSA 1978 creating the department of health. Section 9-7-5 NMSA 1978, as amended by Laws 1991, ch. 25, § 17 makes the secretary of health the administrative head of the department. The bracketed material was not enacted by the legislature and is not part of the law.

ARTICLE 3A
Certificates of Need for New Health Services

(Repealed by Laws 1981, ch. 300, § 9.)

24-3A-1 to 24-3A-13. Repealed.

ANNOTATIONS

Repeals. — Laws 1981, ch. 300, § 9 repeals 24-3A-1 to 24-3A-13 NMSA 1978, as enacted by Laws 1978, Chapter 104 and amended by Laws 1981, Chapter 300, the Certificate of Need Act, effective July 1, 1983.

ARTICLE 3B
Department of Health Education

24-3B-1. Short title.

Chapter 24, Article 3B NMSA 1978 may be cited as the "Department of Health Education Act".

History: 1978 Comp., § 24-3B-1, enacted by Laws 1978, ch. 211, § 1; 1991, ch. 25, § 27.

ANNOTATIONS

The 1991 amendment, effective March 29, 1991, rewrote this section, which read "The provisions of Sections 1 through 4 may be cited as the 'Health and Environment Department Education Act' ".

24-3B-2. Definitions.

As used in the Department of Health Education Act [24-3B-1 NMSA 1978]:

A. "department" means the department of health;

B. "educational appraisal and review committee" means the educational appraisal and review committee as defined in the special education regulations of the state board of education;

C. "evaluated school-age resident" means a school-age resident who has been evaluated by the department according to the state board of education special education regulations;

D. "fund" means the department of health education fund;

E. "institution-bound resident" means an evaluated school-age resident who is not enrolled in a public school;

F. "referred school-age resident" means an evaluated school-age resident who has been referred to a school district for enrollment;

G. "school-age resident" means a school-age person as defined in Section 22-1-2 NMSA 1978 who is a client as defined in Section 43-1-3 NMSA 1978 in a state institution under the authority of the secretary; and

H. "secretary" means the secretary of health.

History: 1978 Comp., § 24-3B-2, enacted by Laws 1978, ch. 211, § 2; 1991, ch. 25, § 28.

ANNOTATIONS

Cross references. — For state board of education, Chapter 22, Article 2 NMSA 1978.

The 1991 amendment, effective March 29, 1991, added the section heading and substituted "Department of Health Education Act" for "Health and Environment Department Education Act" in the introductory phrase, "department of health" for "health and environment department as created under the Health and Environment Department Act" in Subsection A, "department of health" for "health and environment department" in

Subsection D, "22-1-2 NMSA 1978" for "77-1-2 NMSA 1953" and "43-1-3 NMSA 1978" for "34-2A-2 NMSA 1953" in Subsection G and "health" for "the department" in Subsection H.

24-3B-3. Education of school age residents.

A. All school age residents shall be evaluated by the department for purposes of educational placement according to the special education regulations of the state board of education.

B. Any evaluated school age resident not recommended for placement in a public school by the department or as a result of the appeal process shall be provided an educational program by the institution in which he is a school age resident. All such educational programs shall be in accordance with the special education regulations of the state board of education.

C. The department shall refer any evaluated school age resident who has been recommended for placement in a public school to a school district for enrollment.

D. The educational appraisal and review committee of a school district shall evaluate and recommend placement of all referred school age residents according to the placement process as provided in the special education regulations of the state board of education. A school district shall enroll all referred school age residents who have been recommended for placement in a public school by the educational appraisal and review committee of the school district.

E. The department may appeal any recommendation to not place a referred school age resident in a public school only if such recommendation is made by the educational appraisal and review committee of the school district where the institution, in which the referred school age resident is a client, is located. The appeal process shall be as provided in the special education regulations of the state board of education. Any referred school age resident who has been recommended for placement in a public school as a result of the appeal process shall be enrolled in the school district where the institution, in which the referred school age resident is a client, is located, as provided in Paragraph (2), Subsection C of Section 22-12-4 NMSA 1978.

F. All school age residents who are enrolled in a public school shall be counted in the special education membership of the school district.

G. Transportation for all school age residents enrolled in a public school shall be provided to and from the institution in which they are clients and the public school in which they are enrolled. Such transportation shall be provided in accordance with Section 22-8-2 and Sections 22-16-1 through 22-16-10 NMSA 1978.

History: 1978 Comp., § 24-3B-2 enacted by Laws 1978, ch. 211, § 3.

ANNOTATIONS

Cross references. — For state board of education, *see* Chapter 22, Article 2 NMSA 1978.

24-3B-4. Fund created; use; calculation.

A. There is created the "health and environment department education fund" in the state treasury.

B. The fund shall be used solely to provide educational services to institution-bound residents of the state institutions under the authority of the secretary.

C. The secretary shall distribute the fund to institutions under his authority within limits established by law.

D. The secretary shall determine the allocation to each institution from the fund according to the annual program cost of that institution as calculated on September 15 of the fiscal year.

E. The annual program cost for each institution shall be determined by the following calculation:

number of		dollar value		annual
institution-bound	x 3.9 x	per	=	program
residents		program unit		cost

F. The dollar value per program unit shall be the same as the dollar value per program unit as established by the legislature for the state equalization guarantee.

G. Each director of each state institution under the authority of the secretary shall submit annually, on or before October 15, to the secretary an estimate for the succeeding fiscal year of the number of institution-bound residents and any other information necessary to calculate annual program cost.

H. The secretary shall submit annually, on or before November 15, to the department of finance and administration the recommendations of the department regarding the fund for the succeeding fiscal year, for inclusion in the executive budget document.

History: 1978 Comp., § 24-3B-4, enacted by Laws 1978, ch. 211, § 4.

ANNOTATIONS

Cross references. — For state equalization guarantee distributions, *see* 22-8-25 NMSA 1978.

ARTICLE 4
District Health Officers

24-4-1. District health officer; compensation; private practice prohibited; exception.

Each district health officer shall receive the salary prescribed for such position by the state personnel board. The salary shall constitute full authority for the district health officers and they shall receive no other salary payment or fees from any other public source. No district health officer shall engage in the private practice of medicine, maintain an office for the practice of medicine, nor accept nor receive any fee, gratuity or emolument of any form for rendering medical or surgical service to any citizen of this state, except that permission for such practice may be given by the secretary of the health and environment department [secretary of health] in any district, the board of which has declared an emergency to exist.

History: Laws 1935, ch. 131, § 6; 1941 Comp., § 71-206; Laws 1947, ch. 172, § 4; 1953 Comp., § 12-2-6; Laws 1957, ch. 174, § 3; 1973, ch. 4, § 8; 1977, ch. 253, § 17; 1980, ch. 81, § 1.

ANNOTATIONS

Cross references. — For appointment and establishment of powers and duties of district health officers and assistants, *see* 24-1-4 NMSA 1978.

For state personnel board, *see* 10-9-8 NMSA 1978.

Bracketed material. — The bracketed reference relating to the department of health was inserted by the compiler, as Laws 1991, ch. 25, § 16 repeals former 9-7-4 NMSA 1978, relating to the health and environment department and enacts a new 9-7-4 NMSA 1978 creating the department of health. Section 9-7-5 NMSA 1978, as amended by Laws 1991, ch. 25, § 17 makes the secretary of health the administrative head of the department. The bracketed material was not enacted by the legislature and is not part of the law.

Section prohibits district health officers from engaging in the practice of medicine except in conjunction with their duties as health officers. 1953-54 Op. Att'y Gen. No. 5753.

Acceptance of payment for services. — Where the board has not declared a state of emergency to exist in the district, the district health officer may not accept payment for his services since such would constitute the private practice of medicine and the receipt

of a "fee, gratuity or emolument" for rendering medical or surgical services. 1957-58 Op. Att'y Gen. No. 57-117.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 39 Am. Jur. 2d Health § 8 et seq.

39A C.J.S. Health and Environment §§ 9 to 15.

24-4-2. Offices of county health department and district health officer; expenses.

The board of county commissioners of each county in such health districts shall provide suitable quarters for the county health department and the district health officer, including office space for the district health officer and administrative staff, office space for physician personnel, clinic space for patients and waiting space for patients, their friends and families. The boards of county commissioners shall make proper provision for all office and other expense, including utilities and maintenance, incurred in enforcing the health laws and regulations within the counties wherein such expense is incurred. The board of county commissioners of each county in such health districts may, upon adoption of a resolution approved by the department of finance and administration, deposit such county funds as are hereby provided with the state treasurer to the credit of the health and environment department [department of health] for such purposes as are herein provided at such times as such funds are available; provided the depositing of such funds with the state treasurer be upon a voucher approved by the board of county commissioners subject to all statutes and regulations covering the disbursement of county funds excepting that such funds may be so deposited prior to said payments being due and payable, provided further that no such deposits shall be in excess of any line item of the approved county health budget.

History: Laws 1935, ch. 131, § 7; 1941 Comp., § 71-207; 1953 Comp., § 12-2-7; Laws 1957, ch. 174, § 4; 1977, ch. 24, § 134; 1977, ch. 253, § 18; 1980, ch. 81, § 2.

ANNOTATIONS

Cross references. — For state treasurer, *see* N.M. Const., art. V, § 1 and 8-6-1 NMSA 1978.

Bracketed material. — The bracketed reference relating to the department of health was inserted by the compiler, as Laws 1991, ch. 25, § 16 repeals former 9-7-4 NMSA 1978, relating to the health and environment department and enacts a new 9-7-4 NMSA 1978 creating the department of health. Section 9-7-5 NMSA 1978, as amended by Laws 1991, ch. 25, § 17 makes the secretary of health the administrative head of the department. The bracketed material was not enacted by the legislature and is not part of the law.

24-4-3. Additional health officers; state personnel board rules govern appointment and dismissal.

Whenever, in the opinion of the director of the health services division of the health and environment department [secretary of health], conditions require the employment of persons in addition to the district health officer to properly execute the health laws and regulations in any county, the board of county commissioners of such county, with the approval of the director of the health services division [secretary of health], may employ such additional persons as the director shall designate, and their compensation and expenses shall be paid from the county general fund upon vouchers drawn by the district health officer. The board of county commissioners of such county may, upon adoption of a resolution approved by the secretary of finance and administration, deposit such county funds as are hereby provided with the state treasurer to the credit of the health and environment department [department of health] for such purposes as are herein provided at such time as such funds are available. The depositing of such funds with the state treasurer shall be upon a voucher approved by the board of county commissioners subject to all statutes and regulations covering the disbursement of county funds except that such funds may be so deposited prior to disbursement being due and payable. No such deposits shall be in excess of the approved budget for this purpose. The appointment and dismissal of all persons employed hereunder shall be governed by the rules promulgated under the Personnel Act [10-9-1 NMSA 1978] by the personnel board.

History: Laws 1919, ch. 85, § 36, added by 1920 (S.S.), ch. 2, § 1 (36); 1921, ch. 143, § 1 (36); 1929, ch. 55, § 1 (36); C.S. 1929, § 110-331; Laws 1941, ch. 97, § 1; 1941 Comp., § 71-211; 1953 Comp., § 12-2-11; Laws 1957, ch. 174, § 5; 1973, ch. 4, § 9; 1977, ch. 247, § 135; 1977, ch. 253, § 19; 1983, ch. 301, § 71.

ANNOTATIONS

Cross references. — For state personnel board, *see* 10-9-8 NMSA 1978.

Bracketed material. — The bracketed reference relating to the department of health was inserted by the compiler, as Laws 1991, ch. 25, § 16 repeals former 9-7-4 NMSA 1978, relating to the health and environment department and enacts a new 9-7-4 NMSA 1978 creating the department of health. Section 9-7-5 NMSA 1978, as amended by Laws 1991, ch. 25, § 17 makes the secretary of health the administrative head of the department. The bracketed material was not enacted by the legislature and is not part of the law.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 39A C.J.S. Health and Environment § 11.

ARTICLE 5
Immunization

24-5-1. Immunization regulations.

The public health division of the department of health shall, after consultation with the state board of education, promulgate rules and regulations governing the immunization against diseases deemed to be dangerous to the public health, to be required of children attending public, private, home or parochial schools in the state. The immunizations required and the manner and frequency of their administration shall conform to recommendations of the advisory committee on immunization practices of the United States department of health and human services and the American academy of pediatrics. The public health division shall supervise and secure the enforcement of the required immunization program.

History: 1953 Comp., § 12-3-4.1, enacted by Laws 1959, ch. 329, § 1; 1977, ch. 253, § 20; 1985, ch. 21, § 5; 1998, ch. 26, § 1.

ANNOTATIONS

Cross references. — For department of health, *see* 9-7-4 NMSA 1978.

For state board of education, see 22-2-1 NMSA 1978 et seq.

Bracketed material. — The bracketed reference relating to the department of health was inserted by the compiler, as Laws 1991, ch. 25, § 16 repeals former 9-7-4 NMSA 1978, relating to the health and environment department and enacts a new 9-7-4 NMSA 1978 creating the department of health. Section 9-7-5 NMSA 1978, as amended by Laws 1991, ch. 25, § 17 makes the secretary of health the administrative head of the department. The bracketed material was not enacted by the legislature and is not part of the law.

The 1998 amendment, effective May 20, 1998, in the first sentence, substituted "public health" for "health services", deleted "health and environment" following "division of the", and inserted "of health" near the beginning; substituted the language beginning with "recommendations of the advisory committee" for "recognized standard medical practice in the state" in the second sentence; and substituted "public health" for "health services" in the last sentence.

Claim for defective design of vaccine. — The Public Health Service Act, 42 U.S.C. § 201 et seq., and the Federal Food, Drug and Cosmetic Act, 21 U.S.C. § 301 et seq., and the regulations promulgated thereunder, do not impliedly preempt a state common-law products liability claim for defective design of a pertussis vaccine. MacGillivray v. Lederle Lab. Div., 667 F. Supp. 743 (D.N.M. 1987).

Am. Jur. 2d, A.L.R. and C.J.S. references. — 39 Am. Jur. 2d Health § 27; 68 Am. Jur. 2d Schools §§ 277 to 280.

Products liability: Pertussis vaccine manufacturers, 57 A.L.R.4th 911, 98 A.L.R. Fed. 124.

AIDS infection as affecting right to attend public school, 60 A.L.R.4th 15.

Power of court or other public agency to order vaccination over parental religious objection, 94 A.L.R.5th 613.

39A C.J.S. Health and Environment §§ 18, 22; 79 C.J.S. Schools and School Districts §§ 452, 453.

24-5-1.1. Short title.

Chapter 24, Article 5 NMSA 1978 may be cited as the "Immunization Act".

History: Laws 2004, ch. 45, § 1.

ANNOTATIONS

24-5-2. Unlawful to enroll in school unimmunized; unlawful to refuse to permit immunization.

It is unlawful for any student to enroll in school unless he has been immunized, as required under the rules and regulations of the health services division of the health and environment department [department of health], and can provide satisfactory evidence of such immunization. Provided that, if he produces satisfactory evidence of having begun the process of immunization, he may enroll and attend school as long as the immunization process is being accomplished in the prescribed manner. It is unlawful for any parent to refuse or neglect to have his child immunized, as required by this section, unless the child is properly exempted.

History: 1953 Comp., § 12-3-4.2, enacted by Laws 1959, ch. 329, § 2; 1975, ch. 25, § 1; 1977, ch. 253, § 21.

ANNOTATIONS

Bracketed material. — The bracketed reference relating to the department of health was inserted by the compiler, as Laws 1991, ch. 25, § 16 repeals former 9-7-4 NMSA 1978, relating to the health and environment department and enacts a new 9-7-4 NMSA 1978 creating the department of health. Section 9-7-5 NMSA 1978, as amended by Laws 1991, ch. 25, § 17 makes the secretary of health the administrative head of the department. The bracketed material was not enacted by the legislature and is not part of the law.

24-5-3. Exemption from immunization.

A. Any minor child through his parent or guardian may file with the health authority charged with the duty of enforcing the immunization laws:

(1) a certificate of a duly licensed physician stating that the physical condition of the child is such that immunization would seriously endanger the life or health of the child; or

(2) affidavits or written affirmation from an officer of a recognized religious denomination that such child's parents or guardians are bona fide members of a denomination whose religious teaching requires reliance upon prayer or spiritual means alone for healing; or

(3) affidavits or written affirmation from his parent or legal guardian that his religious beliefs, held either individually or jointly with others, do not permit the administration of vaccine or other immunizing agent.

B. Upon filing and approval of such certificate, affidavits or affirmation, the child is exempt from the legal requirement of immunization for a period not to exceed nine months on the basis of any one certificate, affidavits or affirmation.

History: 1953 Comp., § 12-3-4.3, enacted by Laws 1959, ch. 329, § 3; 1979, ch. 42, § 1.

ANNOTATIONS

Section is controlling as to children attending public, private or parochial schools. 1961-62 Op. Att'y Gen. No. 62-5.

Chiropractors do not qualify as physicians for the purposes intended by this section. 1959-60 Op. Att'y Gen. No. 59-96.

24-5-4. Superintendent; duty to report.

It is the duty of each school superintendent, whether of a public, private or parochial school, to cause to be prepared a record showing the required immunization status of every child enrolled in or attending a school under his jurisdiction. These records must be kept current and available to the public health authorities. The name of any parent or guardian who neglects or refuses to permit his child to be immunized against diseases as required by rules and regulations promulgated hereunder shall be reported by the school superintendent to the director of the health services division of the health and environment department [department of health].

History: 1953 Comp., § 12-3-4.4, enacted by Laws 1959, ch. 329, § 4; 1975, ch. 25, § 2; 1977, ch. 253, § 22.

ANNOTATIONS

Bracketed material. — The bracketed reference relating to the department of health was inserted by the compiler, as Laws 1991, ch. 25, § 16 repeals former 9-7-4 NMSA 1978, relating to the health and environment department and enacts a new 9-7-4 NMSA 1978 creating the department of health. Section 9-7-5 NMSA 1978, as amended by Laws 1991, ch. 25, § 17 makes the secretary of health the administrative head of the department. The bracketed material was not enacted by the legislature and is not part of the law.

24-5-5. Who may immunize; who must pay.

The immunization required by Chapter 24, Article 5 NMSA 1978 may be done by any health care provider who holds a license or certificate pursuant to state law that authorizes him to immunize. If the parents are unable to pay, the immunization shall be provided by the public health division of the department of health. The department shall undertake every effort to obtain federal funding to implement the department's immunization program. No public health employee may receive any fee for immunization service if the service is compensated for by the public health division. Local school boards may contribute toward the cost of materials and supplies for immunizations.

History: 1953 Comp., § 12-3-4.5, enacted by Laws 1959, ch. 329, § 5; 1977, ch. 253, § 23; 1998, ch. 26, § 2.

ANNOTATIONS

The 1998 amendment, effective May 20, 1998, inserted "by Chapter 24, Article 5 NMSA 1978" in the first sentence; in the second sentence, substituted "public health" for "health services", deleted "health and environment" following "division of the", and inserted "of health" following "department"; added the third sentence; and substituted "public health" for "health services" in the fourth sentence.

24-5-6. Penalty.

Violation of any provisions relating to the immunization of school children is a misdemeanor.

History: 1953 Comp., § 12-3-4.6, enacted by Laws 1959, ch. 329, § 6.

ANNOTATIONS

Cross references. — For sentencing for misdemeanors, *see* 31-19-1 NMSA 1978.

24-5-7. Immunization registry; creation.

The department of health, in conjunction with the human services department, shall establish and maintain a state immunization registry. The registry shall be a single

repository of accurate, complete and current immunization records to aid, coordinate and promote effective and cost-efficient disease prevention and control efforts.

History: Laws 2004, ch. 45, § 2.

ANNOTATIONS

24-5-8. Reporting.

Physicians, nurses, pharmacists and other health care providers may report on immunization to the immunization registry unless the patient, or the patient's guardian if the patient is a minor, refuses to allow reporting of this information.

History: Laws 2004, ch. 45, § 3; 2005, ch. 45, §1.

ANNOTATIONS

The 2005 amendment, effective June 17, 2005, permits pharmacists to report on immunization to the immunization registry unless the patient or minor patient’s guardian refuses to allow the reporting of the immunization.

24-5-9. Access.

Access to the information in the immunization registry shall be limited to primary care physicians, nurses, pharmacists, managed care organizations, school nurses and other appropriate health care providers or public health entities as determined by the secretary of health; provided that a managed care organization shall be entitled to access information only for its enrollees.

History: Laws 2004, ch. 45, § 4; 2005, ch. 45, §2.

ANNOTATIONS

The 2005 amendment, effective June 17, 2005, adds pharmacists to the list of those persons who have access to information in the immunization registry.

24-5-10. Use.

The information contained in the immunization registry shall be used for the following purposes:

A. to ensure that the registrants receive all recommended immunizations in a timely manner by providing access to the registrant's immunization record;

B. to improve immunization rates by facilitating notice to registrants of overdue or upcoming immunizations; and

C. to control communicable diseases by assisting in the identification of individuals who require immediate immunization in the event of a disease outbreak.

History: Laws 2004, ch. 45, § 5.

ANNOTATIONS

24-5-11. Rules.

The secretary of health shall adopt rules for the immunization registry pursuant to the Immunization Act [24-5-1 NMSA 1978] concerning the following:

A. the implementation and maintenance of the registry;

B. requirements for content and submission of reports of immunization to the registry;

C. procedures for the patient, or the patient's parent or guardian if the patient is a minor, to decline to participate in the registry;

D. procedures for the registrant, or the registrant's parent or guardian if the registrant is a minor, to review and correct information contained in the registry;

E. procedures for the registrant, or the registrant's parent or guardian if the registrant is a minor, to withdraw consent for participation at any time and to remove information from the registry;

F. limits on and methods of access to the registry by those authorized to gain access; and

G. procedures for managed care organizations to obtain summary statistics of immunization information on managed care organization members from the registry.

History: Laws 2004, ch. 45, § 6.

ANNOTATIONS

24-5-12. Obligations.

Nothing in the immunization registry is intended to affect the obligations of persons to have their children immunized pursuant to the Immunization Act [24-5-1 NMSA 1978].

History: Laws 2004, ch. 45, § 7.

ANNOTATIONS

24-5-13. Rights.

Nothing in the Immunization Act [24-5-1 NMSA 1978] shall preclude the right of the patient, or the patient's parent or guardian if the patient is a minor, to claim exemption from immunization as defined in Section 24-5-3 NMSA 1978; nor shall anything in the Immunization Act require such patient to be included in the immunization registry if the patient, or the patient's parent or guardian if the patient is a minor, objects on any grounds, including that such registry conflicts with the religious belief of the patient, or the patient's parent or guardian if the patient is a minor.

History: Laws 2004, ch. 45, § 8.

ANNOTATIONS

24-5-14. Participation.

No health care provider shall discriminate in any way against a person solely because that person elects not to participate in the immunization registry.

History: Laws 2004, ch. 45, § 9.

ANNOTATIONS

24-5-15. Liability.

Any person reporting, receiving, using or disclosing information to or from the immunization registry as authorized by the Immunization Act [24-5-1 NMSA 1978] or by any rule adopted pursuant to that act shall not be liable for civil damages of any kind connected with such submission, use or disclosure of immunization information.

History: Laws 2004, ch. 45, § 10.

ANNOTATIONS

ARTICLE 6
Anatomical Gifts

(Repealed by Laws 1995, ch. 116, § 6.)

24-6-1 to 24-6-11. Repealed.

ANNOTATIONS

Repeals. — Laws 1995, ch. 116, § 6 repeals 24-6-1 through 24-6-11 NMSA 1978, amended by Laws 1987, ch. 74, §§ 3 and 4, relating to anatomical gifts, effective July 1, 1995. For provisions of the former sections, *see* New Mexico One Source of Law DVD. For present comparable provisions, see Chapter 24, Article 6A NMSA 1978.

ARTICLE 6A
Uniform Anatomical Gift Act

24-6A-1. Definitions.

As used in the Uniform Anatomical Gift Act [24-6A-1 NMSA 1978]:

A. "anatomical gift" means a donation of all or part of a human body to take effect upon or after death;

B. "decedent" means a deceased individual and includes a stillborn infant;

C. "designated requester" means a person who has completed a course offered or approved by a procurement organization that trains persons to approach potential donor families and request anatomical gifts;

D. "document of gift" means a card, a statement attached to or imprinted on a motor vehicle driver's license, an identification card, a will or other writing used to make an anatomical gift;

E. "donor" means an individual who makes an anatomical gift of all or part of the individual's body;

F. "enucleator" means an individual who has completed a course in eye enucleation conducted and certified by an accredited school of medicine and who possesses a certificate of competence issued upon completion of the course;

G. "hospital" means a facility licensed, accredited or approved as a hospital under the law of any state or a facility operated as a hospital by the United States government, a state or a subdivision of a state;

H. "part" means an organ, tissue, eye, bone, artery, blood, fluid or other portion of a human body;

I. "person" means an individual, corporation, business trust, estate, trust, partnership, joint venture, limited liability company, association, government, governmental subdivision or agency or any other legal or commercial entity;

J. "physician" means an individual licensed or otherwise authorized to practice medicine or osteopathic medicine under the laws of any state;

K. "procurement organization" means a person licensed, accredited or approved under the laws of any state for procurement, distribution or storage of human bodies or parts. The term includes a nonprofit agency that is organized to procure eye tissue for the purpose of transplantation or research and that meets the medical standards set by the eye bank association of America;

L. "state" means a state, territory or possession of the United States, the District of Columbia or the commonwealth of Puerto Rico;

M. "technician" means an individual who, under the supervision of a physician, removes or processes a part; and

N. "vascular organ" means the heart, lungs, kidneys, liver, pancreas or other organ that requires the continuous circulation of blood to remain useful for transplantation purposes and does not include human tissue, bones or corneas.

History: Laws 1995, ch. 116, § 1; 2000, ch. 54, § 1.

ANNOTATIONS

Cross references. — For determination of death, *see* 12-2-4 NMSA 1978.

For application for driver's license, *see* 66-5-10 NMSA 1978.

The 2000 amendment, effective May 17, 2000, deleted "or fetus" from the end of Subsection B, added new Subsection C and redesignated the remaining subsections accordingly, inserted "an identification card" in Subsection D, and added Subsection N.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 22A Am. Jur. 2d Dead Bodies §§ 119 to 122.

Validity and effect of testamentary direction as to disposition of testator's body, 7 A.L.R.3d 747.

Enforcement of preference expressed by decedent as to disposition of his body after death, 54 A.L.R.3d 1037.

Tests of death for organ transplant purposes, 76 A.L.R.3d 913.

Statute authorizing removal of body parts for transplant: validity and construction, 54 A.L.R.4th 1214.

Propriety of surgically invading incompetent or minor for benefit of third party, 4 A.L.R.5th 1000.

24-6A-2. Making, amending, revoking and refusing to make anatomical gifts; by individual.

A. An individual who is at least sixteen years of age may:

(1) make an anatomical gift for any of the purposes stated in Section 24-6A-6 NMSA 1978;

(2) limit an anatomical gift to one or more of those purposes;

(3) refuse to make an anatomical gift; or

(4) revoke an anatomical gift.

B. An anatomical gift may be made only by a document of gift signed by the donor or by complying with the provisions of Section 66-5-10 NMSA 1978. If the donor cannot sign, the document of gift shall be signed by another individual and by two witnesses, all of whom have signed at the direction and in the presence of the donor and of each other, and state that it has been so signed. Revocation, suspension, expiration or cancellation of the license or identification card does not invalidate the anatomical gift.

C. A document of gift may designate a particular physician to carry out the appropriate procedures. In the absence of a designation or if the designee is not available, the donee or other person authorized to accept the anatomical gift may employ or authorize any physician, technician or enucleator to carry out the appropriate procedures.

D. An anatomical gift by will takes effect upon death of the testator, whether or not the will is probated. If, after death, the will is declared invalid for testamentary purposes, the validity of the anatomical gift is unaffected.

E. A donor may amend or revoke an anatomical gift, not made by will, only by:

(1) a signed statement;

(2) an oral statement made in the presence of two individuals;

(3) any form of communication during a terminal illness or injury addressed to a physician; or

(4) the delivery of a signed statement to a specified donee to whom a document of gift had been delivered.

F. The donor of an anatomical gift made by will may amend or revoke the gift in the manner provided for amendment or revocation of wills or as provided in Subsection E of this section.

G. An anatomical gift that is not revoked by the donor before death is irrevocable and does not require the consent or concurrence of any person after the donor's death.

H. An individual may refuse to make an anatomical gift of the individual's body or part by:

(1) a writing signed in the same manner as a document of gift;

(2) complying with the provisions of Section 66-5-10 or 66-5-401 NMSA 1978; or

(3) any other writing used to identify the individual as refusing to make an anatomical gift. During a terminal illness or injury, the refusal may be an oral statement or other form of communication.

I. In the absence of contrary indications by the donor, an anatomical gift of a part is neither a refusal to give other parts nor a limitation on an anatomical gift under Section 24-6A-3 NMSA 1978 or on a removal or release of other parts under Section 24-6A-4 NMSA 1978.

J. In the absence of contrary indications by the donor, a revocation or amendment of an anatomical gift is not a refusal to make another anatomical gift. If the donor intends a revocation to be a refusal to make an anatomical gift, the donor shall make the refusal pursuant to Subsection H of this section.

History: Laws 1995, ch. 116, § 2; 2000, ch. 54, § 2.

ANNOTATIONS

The 2000 amendment, effective May 17, 2000, updated the statutory references throughout the section, added Subsection A(4), and, in Subsection B, inserted "or identification card" in the last sentence.

24-6A-3. Making, revoking and objecting to anatomical gifts; by others.

A. Any member of the following classes of persons, in the order of priority listed, may make an anatomical gift of all or a part of the decedent's body for an authorized purpose, unless the decedent, at the time of death, has made an unrevoked refusal to make that anatomical gift:

(1) a guardian of the person of the decedent at the time of death, if expressly authorized by the court to make health care decisions for the decedent;

(2) an agent under a durable power of attorney that expressly authorizes the agent to make health care decisions on behalf of the decedent;

(3) the spouse of the decedent unless legally separated or unless there is a pending petition for annulment, divorce, dissolution of marriage or separation;

(4) an adult son or daughter of the decedent if only one is present or a majority of adult children present;

(5) either parent of the decedent;

(6) an adult brother or sister of the decedent if only one is present or a majority of adult siblings present;

(7) a grandparent of the decedent; or

(8) an adult who has exhibited special care and concern for the decedent and who is familiar with the decedent's values.

B. An anatomical gift may not be made by a person listed in Subsection A of this section if:

(1) a person in a prior class is available at the time of death to make an anatomical gift;

(2) the person proposing to make an anatomical gift knows of a refusal or contrary indications by the decedent; or

(3) the person proposing to make an anatomical gift knows of an objection to making an anatomical gift by a member of the person's class or a prior class.

C. An anatomical gift by a person authorized under Subsection A of this section shall be made by:

(1) a document of gift signed by the person; or

(2) the person's telegraphic, recorded telephonic or other recorded message or other form of communication from the person that is contemporaneously reduced to writing and signed by the recipient.

D. An anatomical gift by a person authorized under Subsection A of this section may be revoked by any member of the same or a prior class if, before procedures have begun for the removal of a part from the body of the decedent, the physician, technician or enucleator removing the part knows of the revocation.

E. A failure to make an anatomical gift under Subsection A of this section is not an objection to the making of an anatomical gift.

History: Laws 1995, ch. 116, § 3; 2000, ch. 54, § 3.

ANNOTATIONS

The 2000 amendment, effective May 17, 2000, added "if only one is present or a majority of adult children present" to the end of Subsection A(4) and added "if only one is present or a majority of adult siblings present" in Subsection A(6).

24-6A-4. Authorization by office of medical investigator.

A. The office of the state medical investigator may release and permit the removal of a part from a body within that official's custody, for transplantation or therapy, if:

(1) the official has received a request for the part from a hospital, physician, surgeon or procurement organization;

(2) a procurement organization has made a reasonable effort, taking into account the useful life of the part, to locate and examine the decedent's medical records and inform persons listed in Subsection A of Section 3 [24-6A-3 NMSA 1978] of the Uniform Anatomical Gift Act (1987) of their option to make, or object to making, an anatomical gift;

(3) the official does not know of a refusal or contrary indication by the decedent or objection by a person having priority to act as listed in Subsection A of Section 3 of the Uniform Anatomical Gift Act (1987);

(4) the removal will be by a physician, surgeon or technician; but in the case of eyes, by one of them or by an enucleator;

(5) the removal will not interfere with any autopsy or investigation;

(6) the removal will be in accordance with accepted medical standards; and

(7) cosmetic restoration will be done, if appropriate.

B. If the office of the state medical investigator permits the removal of a part, it shall maintain a permanent record of the name of the decedent, the person making the request, the date and purpose of the request, the part requested and the person to whom it was released.

History: Laws 1995, ch. 116, § 4.

ANNOTATIONS

Cross references. — For medical investigations of deaths generally, *see* Chapter 24, Article 11 NMSA 1978.

For disposition of dead bodies, see Chapter 24, Article 12 NMSA 1978.

24-6A-5. Required request; search and notification; civil or criminal immunity.

A. If, at or near the time of death of a patient, there is no medical record that the patient has made or refused to make an anatomical gift, the hospital administrator or a representative designated by the administrator shall discuss the option to make or refuse to make an anatomical gift and request the making of an anatomical gift pursuant to Subsection A of Section 24-6A-3 NMSA 1978. The request shall be made with reasonable discretion and sensitivity to the circumstances of the family. A request is not required if the gift is not suitable, based upon accepted medical standards, for a purpose specified in Section 24-6A-6 NMSA 1978. An entry shall be made in the medical record of the patient, stating the name and affiliation of the person making the request and of the name, response and relationship to the patient of the person to whom the request was made. The secretary of health may adopt rules to implement this subsection.

B. The following persons shall make a reasonable search for a document of gift or other information identifying the bearer as a donor or as a person who has refused to make an anatomical gift:

(1) a law enforcement officer, firefighter, emergency medical technician, emergency medical services first responder or other emergency rescuer finding a person who the searcher believes is dead or near death; and

(2) a hospital, upon the admission of a person at or near the time of death, if there is not immediately available any other source of that information.

C. If a document of gift or evidence of refusal to make an anatomical gift is located by the search required by Paragraph (1) of Subsection B of this section and the person or body to whom the document or evidence relates is taken to a hospital, the hospital shall be notified of the contents and the document or other evidence shall be sent to the hospital.

D. If, at or near the time of death of a patient, a hospital knows that an anatomical gift has been made pursuant to Subsection A of Section 24-6A-3 NMSA 1978, that a release and removal of a part has been permitted pursuant to Section 24-6A-4 NMSA 1978, that a patient or a person identified as in transit to the hospital is a donor or that an anatomical gift has been made in a document of gift, the hospital shall notify the donee if one is named and known to the hospital; if not, it shall notify an appropriate procurement organization. The hospital shall cooperate in the implementation of the anatomical gift or release and removal of a part.

E. A person who in good faith acts or attempts to act in accordance with the provisions of the Uniform Anatomical Gift Act [24-6A-1 NMSA 1978] or the anatomical gift laws of another state is not liable for damages in a civil action or subject to prosecution in a criminal proceeding for his acts.

History: Laws 1995, ch. 116, § 5; 2000, ch. 54, § 4; 2002, ch. 42, § 1.

ANNOTATIONS

The 2000 amendment, effective May 17, 2000, updated the statutory references throughout the section and rewrote Subsection E.

The 2002 amendment, effective May 15, 2002, inserted "or that an anatomical gift has been made in a document of gift" in Subsection D.

24-6A-6. Persons who may become donees; purposes for which anatomical gifts may be made.

A. The following persons may become donees of anatomical gifts for the purposes stated:

(1) a hospital, physician, procurement organization or an accredited medical school, dental school, college or university, for transplantation, therapy, medical or dental education, research or advancement of medical or dental science; or

(2) a designated individual, for transplantation or therapy needed by that individual. A donee may not be designated on the basis of the donee's race, age, religion, color, national origin, ancestry, gender, sexual orientation or physical or mental handicaps.

B. An anatomical gift may be made to a designated donee or without designating a donee. If a donee is not designated in the document of gift or if the donee is not available or rejects the anatomical gift, the anatomical gift may be accepted by any hospital or procurement organization.

C. If the donee knows of the decedent's refusal or contrary indications to make an anatomical gift or that an anatomical gift by a member of a class having priority to act is opposed by a member of the same class or a prior class under Subsection A of Section 24-6A-3 NMSA 1978, the donee shall not accept the anatomical gift.

History: Laws 1995, ch. 116, § 6; 2002, ch. 42, § 2.

ANNOTATIONS

The 2002 amendment, effective May 15, 2002, inserted "in the document of gift" in Subsection B.

24-6A-6.1. Identification of potential donees.

A. If an anatomical gift of a vascular organ is made in New Mexico to a New Mexico procurement organization for transplantation purposes and the donor does not name a

specific donee and the vascular organ is deemed suitable for transplantation, the New Mexico procurement organization shall use its best efforts to determine if there is a suitable recipient in New Mexico.

B. The New Mexico procurement organization may in its sole discretion enter into reciprocal agreements for the sharing of vascular organs with procurement organizations in other states. The terms of these reciprocal vascular organ sharing arrangements may provide that a vascular organ donated to a New Mexico procurement organization may be transferred to a procurement organization in another state for transplantation.

C. A New Mexico procurement organization may transfer a vascular organ to a procurement organization in another state or suitable recipient located in another state for transplantation only if:

(1) a suitable donee awaiting organ transplant in New Mexico cannot be found in a reasonable amount of time; or

(2) the New Mexico procurement organization has a reciprocal agreement for the sharing of vascular organs with a procurement organization in another state.

History: Laws 2000, ch. 54, § 8.

ANNOTATIONS

24-6A-7. Delivery of document of gift.

A. Delivery of a document of gift during the donor's lifetime is not required for the validity of an anatomical gift.

B. If an anatomical gift is made to a designated donee, the document of gift, or a copy, may be delivered to the donee to expedite the appropriate procedures after death. The document of gift, or a copy, may be deposited in any hospital, procurement organization or registry office that accepts it for safekeeping or for facilitation of procedures after death. On request of an interested person, upon or after the donor's death, the person in possession shall allow the interested person to examine or copy the document of gift.

History: Laws 1995, ch. 116, § 7.

24-6A-7.1. Document of gift as a legal document.

A document of gift, which includes a motor vehicle driver's license, constitutes a legal document and has sufficient legal authority to be accepted by a designated or undesignated donee of anatomical gifts pursuant to the Uniform Anatomical Gift Act [24-6A-1 NMSA 1978].

History: Laws 2002, ch. 42, § 3.

ANNOTATIONS

24-6A-8. Rights and duties at death.

A. Rights of a donee created by an anatomical gift are superior to rights of others except with respect to autopsies under Section 11 [24-6A-11 NMSA 1978] of the Uniform Anatomical Gift Act (1987). A donee may accept or reject an anatomical gift. If a donee accepts an anatomical gift of an entire body, the donee, subject to the terms of the gift, may allow embalming and use of the body in funeral services. If the gift is of a part of a body, the donee, upon the death of the donor and before embalming, shall cause the part to be removed without unnecessary mutilation. After removal of the part, custody of the remainder of the body vests in the person under obligation to dispose of the body.

B. The time of death must be determined by a physician who attends the donor at death or, if none, the physician who certifies the death. Neither the physician who attends the donor at death nor the physician who determines the time of death may participate in the procedures for removing or transplanting a part unless the document of gift designates a particular physician pursuant to Section 2 [24-6A-2 NMSA 1978] of the Uniform Anatomical Gift Act (1987).

C. If there has been an anatomical gift, a technician may remove any donated parts and an enucleator may remove any donated eyes or parts of eyes, after determination of death by a physician.

History: Laws 1995, ch. 116, § 8.

ANNOTATIONS

Cross references. — For medical investigations of deaths generally, *see* Chapter 24, Article 11 NMSA 1978.

For disposition of dead bodies, *see* Chapter 24, Article 12 NMSA 1978.

24-6A-9. Coordination of procurement and use.

Each hospital in this state may consult with other hospitals and procurement organizations and may establish agreements or affiliations for coordination of procurement and use of human bodies and parts.

History: Laws 1995, ch. 116, § 9.

24-6A-9.1. Identification of potential donors.

A. Each hospital in New Mexico, with the concurrence of its medical staff, shall develop by July 1, 2000 a protocol for identifying potential donors. The protocol shall be developed in collaboration with a procurement organization. The protocol shall provide that at or near the time of a patient's death and prior to the removal of life support, the hospital shall contact a procurement organization to determine the suitability of the patient as a donor. The person designated by the hospital to contact the procurement organization shall have the following information available prior to making the contact:

(1) the patient's identifier number;

(2) the patient's age;

(3) the cause of death; and

(4) any past medical history available.

B. The procurement organization shall determine the suitability for donation. If the procurement organization determines that donation is not appropriate based on established medical criteria, that determination shall be noted by hospital personnel on the patient's record and no further action is necessary.

C. If the procurement organization determines that the patient is a suitable candidate for donation, the procurement organization shall initiate donor proceedings by making a reasonable search for a document of gift or other information identifying the patient as a donor or as an individual who has refused to make an anatomical gift.

D. The hospital must have and implement written protocols that:

(1) incorporate an agreement with a procurement organization under which the hospital must notify, in a timely manner, the procurement organization or a third party designated by the procurement organization of patients whose deaths are imminent and prior to the removal of life support from a patient who has died in the hospital;

(2) ensure that the retrieval, processing, preservation, storage and distribution of tissues and eyes does not interfere with vascular organ procurement;

(3) ensure that the family of each potential donor is informed of its options to donate organs, tissues or eyes or to decline to donate. The person designated by the hospital to initiate the request to the family must be an organ procurement organization employee or a designated requester;

(4) encourage discretion and sensitivity with respect to the circumstances, views and beliefs of the families of potential donors; and

(5) ensure that the hospital works cooperatively with the procurement organization in educating hospital staff on donation issues, reviewing death records to improve identification of potential donors and maintaining potential donors while necessary testing and placement of anatomical gifts take place.

E. Every hospital in the state shall establish a committee to develop and implement its organ and tissue donation policy and procedure to assist its staff in identifying and evaluating terminal patients who may be suitable organ or tissue donors. The committee shall include members of the administrative, medical and nursing staffs and shall appoint a member to act as a liaison between the hospital and the state procurement organization.

History: Laws 2000, ch. 54, § 7.

ANNOTATIONS

24-6A-9.2. Death record reviews.

Every hospital shall work jointly with the appropriate procurement organization to conduct death record reviews at least annually. The procurement organization shall compile the results of the death record reviews and provide a report to the department of health by September 1 of each year; provided that the report to the department shall not identify hospitals, individual donors or recipients.

History: Laws 2000, ch. 54, § 6.

ANNOTATIONS

24-6A-10. Sale or purchase of parts prohibited; criminal penalty.

A. A person may not knowingly, for valuable consideration, purchase or sell a part for transplantation or therapy.

B. Valuable consideration does not include reasonable payment for the removal, processing, disposal, preservation, quality control, storage, transportation or implantation of a part.

C. All costs which are incurred at the request of a donee or procurement organization and which are related to the evaluation of a potential gift or the removal, processing, disposal, preservation, quality control, storage, transportation and implantation of a part shall be paid by the donee or procurement organization. The donor and next of kin and the estate of the donor shall not be responsible for payment of any of these costs.

D. A person who violates this section is guilty of a fourth degree felony.

History: Laws 1995, ch. 116, § 10.

24-6A-11. Examination; autopsy; liability.

A. An anatomical gift authorizes any reasonable examination necessary to assure medical acceptability of the gift for the purposes intended.

B. The provisions of the Uniform Anatomical Gift Act (1987) [24-6A-1 NMSA 1978] are subject to the laws of New Mexico governing autopsies.

C. A hospital, physician, surgeon, medical investigator, local public health officer, enucleator, technician, nurse, law enforcement officer, firefighter, emergency medical technician, emergency medical services first responder, employee of the motor vehicle division or department of health or other person who acts in accordance with the Uniform Anatomical Gift Act (1987) or with the applicable anatomical gift law of another state, or attempts in good faith to do so, is not liable for that act in a civil action or criminal proceeding.

D. An individual who makes an anatomical gift pursuant to Section 2 [24-6A-2 NMSA 1978] or 3 [24-6A-3 NMSA 1978] of the Uniform Anatomical Gift Act (1987) and the individual's estate are not liable for any injury or damage that may result from the making or the use of the anatomical gift.

History: Laws 1995, ch. 116, § 11.

24-6A-12. Transitional provisions.

The Uniform Anatomical Gift Act (1987) [24-6A-1 NMSA 1978] applies to a document of gift, revocation or refusal to make an anatomical gift signed by the donor or a person authorized to make or object to making an anatomical gift before, on, or after the effective date of that act.

History: Laws 1995, ch. 116, § 12.

ANNOTATIONS

Compiler's notes. — Pursuant to Laws 1995, ch. 116, § 17, the Uniform Anatomical Gift Act (1987) is effective July 1, 1995.

24-6A-13. Uniformity of application and construction.

The Uniform Anatomical Gift Act (1987) [24-6A-1 NMSA 1978] shall be applied and construed to effectuate its general purpose to make uniform the law with respect to the subject of that act among states enacting it.

History: Laws 1995, ch. 116, § 13.

24-6A-14. Severability.

If any provision of the Uniform Anatomical Gift Act (1987) [24-6A-1 NMSA 1978] or its application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of that act which can be given effect without the invalid provision or application, and to this end the provisions of that act are severable.

History: Laws 1995, ch. 116, § 14.

24-6A-15. Short title.

Chapter 24, Article 6A NMSA 1978 may be cited as the "Uniform Anatomical Gift Act".

History: Laws 1995, ch. 116, § 15; 2000, ch. 54, § 5.

ANNOTATIONS

The 2000 amendment, effective May 17, 2000, substituted "Chapter 24, Article 6A NMSA 1978" for "Sections 1 through 15 of this act" and deleted "(1987)" following "Gift Act".

ARTICLE 7
Right to Die

(Repealed by Laws 1984, ch. 99, § 9; 1997, ch. 168, § 15.)

24-7-1 to 24-7-11. Repealed.

ANNOTATIONS

Repeals. — Laws 1997, ch. 168, § 15 repeals 24-7-1 to 24-7-10 NMSA 1978, as enacted by Laws 1977, ch. 287, §§ 1 to 10 and Laws 1984, ch. 99, § 6 and as last amended by Laws 1995, ch. 182, § 19, the Right to Die Act, effective July 1, 1997. Laws 1984, ch. 99, § 9, repeals 24-7-11 NMSA 1978, as enacted by Laws 1977, ch. 287, § 11. For present comparable provisions, see Chapter 24, Article 7A NMSA 1978.

ARTICLE 7A
Uniform Health-Care Decisions

24-7A-1. Definitions.

As used in the Uniform Health-Care Decisions Act [24-7A-1 NMSA 1978]:

A. "advance health-care directive" means an individual instruction or a power of attorney for health care made, in either case, while the individual has capacity;

B. "agent" means an individual designated in a power of attorney for health care to make a health-care decision for the individual granting the power;

C. "capacity" means an individual's ability to understand and appreciate the nature and consequences of proposed health care, including its significant benefits, risks and alternatives to proposed health care and to make and communicate an informed health-care decision. A determination of lack of capacity shall be made only according to the provisions of Section 24-7A-11 NMSA 1978;

D. "emancipated minor" means a person between the ages of sixteen and eighteen who has been married, who is on active duty in the armed forces or who has been declared by court order to be emancipated;

E. "guardian" means a judicially appointed guardian or conservator having authority to make a health-care decision for an individual;

F. "health care" means any care, treatment, service or procedure to maintain, diagnose or otherwise affect an individual's physical or mental condition;

G. "health-care decision" means a decision made by an individual or the individual's agent, guardian or surrogate, regarding the individual's health care, including:

(1) selection and discharge of health-care providers and institutions;

(2) approval or disapproval of diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate;

(3) directions relating to life-sustaining treatment, including withholding or withdrawing life-sustaining treatment and the termination of life support; and

(4) directions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care;

H. "health-care institution" means an institution, facility or agency licensed, certified or otherwise authorized or permitted by law to provide health care in the ordinary course of business;

I. "health-care provider" means an individual licensed, certified or otherwise authorized or permitted by law to provide health care in the ordinary course of business or practice of a profession;

J. "individual instruction" means an individual's direction concerning a health-care decision for the individual, made while the individual has capacity;

K. "life-sustaining treatment" means any medical treatment or procedure without which the individual is likely to die within a relatively short time, as determined to a reasonable degree of medical certainty by the primary physician;

L. "person" means an individual, corporation, business trust, estate, trust, partnership, association, joint venture, government, governmental subdivision, agency or instrumentality or any other legal or commercial entity;

M. "physician" means an individual authorized to practice medicine or osteopathy;

N. "power of attorney for health care" means the designation of an agent to make health-care decisions for the individual granting the power, made while the individual has capacity;

O. "primary physician" means a physician designated by an individual or the individual's agent, guardian or surrogate to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes the responsibility;

P. "principal" means an adult or emancipated minor who, while having capacity, has made a power of attorney for health care by which he delegates his right to make health-care decisions for himself to an agent;

Q. "qualified health-care professional" means a health-care provider who is a physician, physician assistant, nurse practitioner, nurse, psychologist or social worker;

R. "reasonably available" means readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the patient's health-care needs;

S. "state" means a state of the United States, the District of Columbia, the commonwealth of Puerto Rico or a territory or insular possession subject to the jurisdiction of the United States;

T. "supervising health-care provider" means the primary physician or, if there is no primary physician or the primary physician is not reasonably available, the health-care provider who has undertaken primary responsibility for an individual's health care;

U. "surrogate" means an individual, other than a patient's agent or guardian, authorized under the Uniform Health-Care Decisions Act to make a health-care decision for the patient; and

V. "ward" means an adult or emancipated minor for whom a guardian has been appointed.

History: Laws 1995, ch. 182, § 1; 1997, ch. 168, § 1.

ANNOTATIONS

The 1997 amendment, effective July 1, 1997, added Subsections D, K, P and V and Paragraph G(3), and made a stylistic change.

Law reviews. — For lecture, "Euthanasia and the right to die: Nancy Cruzan and New Mexico," 20 N.M.L. Rev. 675 (1990).

Am. Jur. 2d, A.L.R. and C.J.S. references. — Patient's right to refuse treatment allegedly necessary to sustain life, 93 A.L.R.3d 67.

Judicial power to order discontinuance of life-sustaining treatment, 48 A.L.R.4th 67.

Living wills: validity, construction, and effect, 49 A.L.R.4th 812.

Tortious maintenance or removal of life supports, 58 A.L.R.4th 222.

Propriety of, and liability related to, issuance or enforcement of do not resuscitate (DNR) orders, 46 A.L.R.5th 793.

24-7A-2. Advance health-care directives.

A. An adult or emancipated minor, while having capacity, has the right to make his or her own health-care decisions and may give an individual instruction. The instruction may be oral or written; if oral, it must be made by personally informing a health-care provider. The instruction may be limited to take effect only if a specified condition arises.

B. An adult or emancipated minor, while having capacity, may execute a power of attorney for health care, which may authorize the agent to make any health-care decision the principal could have made while having capacity. The power must be in writing and signed by the principal. The power remains in effect notwithstanding the principal's later incapacity under the Uniform Health-Care Decisions Act [24-7A-1 NMSA 1978] or Article 5 of the Uniform Probate Code [Chapter 45, Article 5 NMSA 1978]. The power may include individual instructions. Unless related to the principal by blood, marriage or adoption, an agent may not be an owner, operator or employee of a health-care institution at which the principal is receiving care.

C. Unless otherwise specified in a power of attorney for health care, the authority of an agent becomes effective only upon a determination that the principal lacks capacity, and ceases to be effective upon a determination that the principal has recovered capacity.

D. Unless otherwise specified in a written advance health-care directive, a determination that an individual lacks or has recovered capacity or that another condition exists that affects an individual instruction or the authority of an agent, shall be made according to the provisions of Section 11 [24-7A-11 NMSA 1978] of the Uniform Health-Care Decisions Act.

E. An agent shall make a health-care decision in accordance with the principal's individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the agent's determination of the principal's best interest. In determining the principal's best interest, the agent shall consider the principal's personal values to the extent known to the agent.

F. A health-care decision made by an agent for a principal is effective without judicial approval.

G. A written advance health-care directive may include the individual's nomination of a guardian of the person.

History: Laws 1995, ch. 182, § 2.

24-7A-2.1. Prohibited practice.

A. No insurer or other provider of benefits regulated by the New Mexico Insurance Code [59A-1-1 NMSA 1978] or a state agency shall require a person to execute or revoke an advance health-care directive as a condition for membership in, being insured for or receiving coverage or benefits under an insurance contract or plan.

B. No insurer may condition the sale, procurement or issuance of a policy, plan, contract, certificate or other evidence of coverage, or entry into a pension, profit-sharing, retirement, employment or similar benefit plan, upon the execution or revocation of an advance health-care directive; nor shall the existence of an advance health-care directive modify the terms of an existing policy, plan, contract, certificate or other evidence of coverage of insurance.

C. The provisions of this section shall be enforced by the superintendent of insurance under the New Mexico Insurance Code.

History: Laws 1997, ch. 168, § 14.

24-7A-3. Revocation of advance health-care directive.

A. An individual, while having capacity, may revoke the designation of an agent either by a signed writing or by personally informing the supervising health-care provider. If the individual cannot sign, a written revocation must be signed for the individual and be witnessed by two witnesses, each of whom has signed at the direction and in the presence of the individual and of each other.

B. An individual, while having capacity, may revoke all or part of an advance health-care directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke.

C. A health-care provider, agent, guardian or surrogate who is informed of a revocation shall promptly communicate the fact of the revocation to the supervising health-care provider and to any health-care institution at which the patient is receiving care.

D. The filing of a petition for or a decree of annulment, divorce, dissolution of marriage or legal separation revokes a previous designation of a spouse as agent unless otherwise specified in the decree or in a power of attorney for health care. A designation revoked solely by this subsection is revived by the individual's remarriage to the former spouse, by a nullification of the divorce, annulment or legal separation or by the dismissal or withdrawal, with the individual's consent, of a petition seeking annulment, divorce, dissolution of marriage or legal separation.

E. An advance health-care directive that conflicts with an earlier advance health-care directive revokes the earlier directive to the extent of the conflict.

History: Laws 1995, ch. 182, § 3; 1997, ch. 168, § 2.

ANNOTATIONS

The 1997 amendment, effective July 1, 1997, in Subsection A, substituted "either" for "only" in the first sentence and added the second sentence.

24-7A-4. Optional form.

"OPTIONAL ADVANCE HEALTH-CARE DIRECTIVE

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary physician.

THIS FORM IS OPTIONAL. Each paragraph and word of this form is also optional. If you use this form, you may cross out, complete or modify all or any part of it. You are free to use a different form. If you use this form, be sure to sign it and date it.

PART 1 of this form is a power of attorney for health care. PART 1 lets you name another individual as agent to make health-care decisions for you if you become

incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator or employee of a health-care institution at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition;

(b) select or discharge health-care providers and institutions;

(c) approve or disapprove diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate; and

(d) direct the provision, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

PART 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding life-sustaining treatment, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. In addition, you may express your wishes regarding whether you want to make an anatomical gift of some or all of your organs and tissue. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes.

PART 3 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. It is recommended but not required that you request two other individuals to sign as witnesses. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health-care directive or replace this form at any time.

* *

PART 1

POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health-care decisions for me:

____
____

(name of individual you choose as agent)

____
____

(address) (city) (state) (zip code)

____
____

(home phone) (work phone)

If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

____
____

(name of individual you choose as first alternate agent)

____
____

(address) (city) (state) (zip code)

____
____

(home phone) (work phone)

If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a health-care decision for me, I designate as my second alternate agent:

____
____

(name of individual you choose as second alternate agent)

____
____

(address) (city) (state) (zip code)

____
____

(home phone) (work phone)

(2) AGENT'S AUTHORITY: My agent is authorized to obtain and review medical records, reports and information about me and to make all health-care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition, hydration and all other forms of health care to keep me alive, except as I state here:

____
____

____
____

(Add additional sheets if needed.)

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician and one other qualified health-care professional determine that I am unable to make my own health-care decisions. If I initial this box [ ], my agent's authority to make health-care decisions for me takes effect immediately.

(4) AGENT'S OBLIGATION: My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2

INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may cross out any wording you do not want.

(6) END-OF-LIFE DECISIONS: If I am unable to make or communicate decisions regarding my health care, and IF (i) I have an incurable or irreversible condition that will result in my death within a relatively short time, OR (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, OR (iii) the likely risks and burdens of treatment would outweigh the expected benefits, THEN I direct that my health-care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have initialed below in one of the following three boxes:

[ ] I CHOOSE NOT To Prolong Life

I do not want my life to be prolonged.

[ ] I CHOOSE To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

[ ] I CHOOSE To Let My Agent Decide

My agent under my power of attorney for health care may make life-sustaining treatment decisions for me.

(7) ARTIFICIAL NUTRITION AND HYDRATION: If I have chosen above NOT to prolong life, I also specify by marking my initials below:

[ ] I DO NOT want artificial nutrition OR

[ ] I DO want artificial nutrition.

[ ] I DO NOT want artificial hydration unless required for my comfort OR

[ ] I DO want artificial hydration.

(8) RELIEF FROM PAIN: Regardless of the choices I have made in this form and except as I state in the following space, I direct that the best medical care possible to keep me clean, comfortable and free of pain or discomfort be provided at all times so that my dignity is maintained, even if this care hastens my death:

____

____

(9) ANATOMICAL GIFT DESIGNATION: Upon my death I specify as marked below whether I choose to make an anatomical gift of all or some of my organs or tissue:

[ ] I CHOOSE to make an anatomical gift of all of my organs or tissue to be determined by medical suitability at the time of death, and artificial support may be maintained long enough for organs to be removed.

[ ] I CHOOSE to make a partial anatomical gift of some of my organs and tissue as specified below, and artificial support may be maintained long enough for organs to be removed.

____

____

[ ] I REFUSE to make an anatomical gift of any of my organs or tissue.

[ ] I CHOOSE to let my agent decide.

(10) OTHER WISHES: (If you wish to write your own instructions, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

____

____

(Add additional sheets if needed.)

PART 3

PRIMARY PHYSICIAN

(11) I designate the following physician as my primary physician:

____
____

(name of physician)

____
____

(address) (city) (state) (zip code)

____
____

(phone)

If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

____
____

(name of physician)

____
____

(address) (city) (state) (zip code)

____
____

(phone)

* * * * * * * * * * * * * * * * * * * *

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

(13) REVOCATION: I understand that I may revoke this OPTIONAL ADVANCE HEALTH-CARE DIRECTIVE at any time, and that if I revoke it, I should promptly notify my supervising health-care provider and any health-care institution where I am receiving care and any others to whom I have given copies of this power of attorney. I understand that I may revoke the designation of an agent either by a signed writing or by personally informing the supervising health-care provider.

(14) SIGNATURES: Sign and date the form here:

(date)	(sign your name)
(address)	(print your name)
(city) (state)	(your social security number)

(Optional) SIGNATURES OF WITNESSES:

First witness	Second witness
(print your name)	(print your name)
(address)	(address)
(city) (state)	(city) (state)
(signature of witness)	(signature of witness)
(date)	(date)".

History: Laws 1995, ch. 182, § 4; 1997, ch. 168, § 3; 2000, ch. 54, § 9.

ANNOTATIONS

The 1997 amendment, effective July 1, 1997, in the second paragraph of the form, rewrote the last sentence which read "You do not have to sign any form"; in the paragraph of the form explaining Part 2, substituted "life-sustaining treatment" for "the provision, withholding or withdrawal of treatment to keep you alive" in the second sentence; in paragraph (3) in Part 1 of the form, deleted "unless I mark the following box" at the end of the first sentence and substituted "initial" for "mark" in the second sentence; rewrote paragraphs (6), (7), and (8) in Part 2 of the form; substituted "either" for "only" in the last sentence in paragraph (12) of Part 3 of the form; and made stylistic changes.

The 2000 amendment, effective May 17, 2000, in the fifth paragraph of the Explanation section, added the third sentence; added Item 9 of Part 2 of the form and redesignated the remaining sections accordingly.

24-7A-5. Decisions by surrogate.

A. A surrogate may make a health-care decision for a patient who is an adult or emancipated minor if the patient has been determined according to the provisions of Section 24-7A-11 NMSA 1978 to lack capacity and no agent or guardian has been appointed or the agent or guardian is not reasonably available.

B. An adult or emancipated minor, while having capacity, may designate any individual to act as surrogate by personally informing the supervising health-care provider. In the absence of a designation or if the designee is not reasonably available, any member of the following classes of the patient's family who is reasonably available, in descending order of priority, may act as surrogate:

(1) the spouse, unless legally separated or unless there is a pending petition for annulment, divorce, dissolution of marriage or legal separation;

(2) an individual in a long-term relationship of indefinite duration with the patient in which the individual has demonstrated an actual commitment to the patient similar to the commitment of a spouse and in which the individual and the patient consider themselves to be responsible for each other's well-being;

(3) an adult child;

(4) a parent;

(5) an adult brother or sister; or

(6) a grandparent.

C. If none of the individuals eligible to act as surrogate under Subsection B of this section is reasonably available, an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values and who is reasonably available may act as surrogate.

D. A surrogate shall communicate his assumption of authority as promptly as practicable to the patient, to members of the patient's family specified in Subsection B of this section who can be readily contacted and to the supervising health-care provider.

E. If more than one member of a class assumes authority to act as surrogate and they do not agree on a health-care decision and the supervising health-care provider is so informed, the supervising health-care provider shall comply with the decision of a majority of the members of that class who have communicated their views to the provider. If the class is evenly divided concerning the health-care decision and the supervising health-care provider is so informed, that class and all individuals having lower priority are disqualified from making the decision.

F. A surrogate shall make a health-care decision in accordance with the patient's individual instructions, if any, and other wishes to the extent known to the surrogate.

Otherwise, the surrogate shall make the decision in accordance with the surrogate's determination of the patient's best interest. In determining the patient's best interest, the surrogate shall consider the patient's personal values to the extent known to the surrogate.

G. A health-care decision made by a surrogate for a patient shall not be made solely on the basis of the patient's pre-existing physical or medical condition or pre-existing or projected disability.

H. A health-care decision made by a surrogate for a patient is effective without judicial approval.

I. A patient, at any time, may disqualify any person, including a member of the patient's family, from acting as the patient's surrogate by a signed writing or by personally informing a health-care provider of the disqualification. A health-care provider who is informed by the patient of a disqualification shall promptly communicate the fact of disqualification to the supervising health-care provider and to any health-care institution at which the patient is receiving care.

J. Unless related to the patient by blood, marriage or adoption, a surrogate may not be an owner, operator or employee of a health-care institution at which the patient is receiving care.

K. A supervising health-care provider may require an individual claiming the right to act as surrogate for a patient to provide a written declaration under penalty of perjury stating facts and circumstances reasonably sufficient to establish the claimed authority.

History: Laws 1995, ch. 182, § 5; 1997, ch. 168, § 4.

ANNOTATIONS

The 1997 amendment, effective July 1, 1997, added "and to the supervising health-care provider" at the end of Subsection D; added Subsection G; and made stylistic changes.

24-7A-6. Decisions by guardian.

A. A guardian shall comply with the ward's individual instructions and may not revoke the ward's advance health-care directive unless the appointing court expressly so authorizes after notice to the agent and the ward.

B. A health-care decision of an agent appointed by an individual having capacity takes precedence over that of a guardian, unless the appointing court expressly directs otherwise after notice to the agent and the ward.

C. Subject to the provisions of Subsections A and B of this section, a health-care decision made by a guardian for the ward is effective without judicial approval, if the appointing court has expressly authorized the guardian to make health-care decisions for the ward, in accordance with the provisions of Section 45-5-312 NMSA 1978, after notice to the ward and any agent.

History: Laws 1995, ch. 182, § 6.

24-7A-6.1. Decisions for unemancipated minors.

A. Except as otherwise provided by law, a parent or guardian of an unemancipated minor may make that minor's health-care decisions.

B. A parent or guardian of an unemancipated minor shall have the authority to withhold or withdraw life-sustaining treatment for the unemancipated minor, subject to the provisions of this section and the standards for surrogate decision making for adults provided for in the Uniform Health-Care Decisions Act [24-7A-1 NMSA 1978].

C. Subject to the provisions of Subsection B of this section, if an unemancipated minor has capacity sufficient to understand the nature of that unemancipated minor's medical condition, the risks and benefits of treatment and the contemplated decision to withhold or withdraw life-sustaining treatment, that unemancipated minor shall have the authority to withhold or withdraw life-sustaining treatment.

D. For purposes of Subsection C of this section, a determination of the mental and emotional capacity of an unemancipated minor shall be determined by two qualified health-care professionals, one of whom shall be the unemancipated minor's primary physician and the other of whom shall be a physician that works with unemancipated minors of the minor's age in the ordinary course of that physician's health-care practice. If the unemancipated minor lacks capacity due to mental illness or developmental disability, one of the qualified health-care professionals shall be a person whose training and expertise aid in the assessment of functional impairment.

E. If the unemancipated minor's primary physician has reason to believe that a parent or guardian of an unemancipated minor, including a non-custodial parent, has not been informed of a decision to withhold or withdraw life-sustaining treatment, the primary physician shall make reasonable efforts to determine if the uninformed parent or guardian has maintained substantial and continuous contact with the unemancipated minor and, if so, shall make reasonable efforts to notify that parent or guardian before implementing a decision.

F. If there is disagreement regarding the decision to withhold or withdraw life-sustaining treatment for an unemancipated minor, the provisions of Section 24-7A-11 NMSA 1978 shall apply.

G. For purposes of this section, "unemancipated minor" means a person at or under the age of fifteen.

History: Laws 1997, ch. 168, § 13.

24-7A-7. Obligations of health-care provider.

A. Before implementing a health-care decision made for a patient, a supervising health-care provider shall promptly communicate to the patient the decision made and the identity of the person making the decision.

B. A supervising health-care provider who knows of the existence of an advance health-care directive, a revocation of an advance health-care directive, a challenge to a determination of lack of capacity or a designation or disqualification of a surrogate shall promptly record its existence in the patient's health-care record and, if it is in writing, shall request a copy and, if one is furnished, shall arrange for its maintenance in the health-care record.

C. A supervising health-care provider who makes or is informed of a determination that a patient lacks or has recovered capacity or that another condition exists that affects an individual instruction or the authority of an agent, guardian or surrogate shall promptly record the determination in the patient's health-care record and communicate the determination to the patient and to any person then authorized to make health-care decisions for the patient.

D. Except as provided in Subsections E and F of this section, a health-care provider or health-care institution providing care to a patient shall comply:

(1) before and after the patient is determined to lack capacity, with an individual instruction of the patient made while the patient had capacity;

(2) with a reasonable interpretation of that instruction made by a person then authorized to make health-care decisions for the patient; and

(3) with a health-care decision for the patient that is not contrary to an individual instruction of the patient and is made by a person then authorized to make health-care decisions for the patient, to the same extent as if the decision had been made by the patient while having capacity.

E. A health-care provider may decline to comply with an individual instruction or health-care decision for reasons of conscience. A health-care institution may decline to comply with an individual instruction or health-care decision if the instruction or decision is contrary to a policy of the health-care institution that is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health-care decisions for the patient.

F. A health-care provider or health-care institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective health care or health care contrary to generally accepted health-care standards applicable to the health-care provider or health-care institution. "Medically ineffective health care" means treatment that would not offer the patient any significant benefit, as determined by a physician.

G. A health-care provider or health-care institution that declines to comply with an individual instruction or health-care decision shall:

(1) promptly so inform the patient, if possible, and any person then authorized to make health-care decisions for the patient;

(2) provide continuing care to the patient until a transfer can be effected; and

(3) unless the patient or person then authorized to make health-care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health-care provider or health-care institution that is willing to comply with the instruction or decision.

H. A health-care provider or health-care institution may not require or prohibit the execution or revocation of an advance health-care directive as a condition for providing health care.

I. The Uniform Health-Care Decisions Act [24-7A-1 NMSA 1978] does not require or permit a health-care institution or health-care provider to provide any type of health care for which the health-care institution or health-care provider is not licensed, certified or otherwise authorized or permitted by law to provide.

History: Laws 1995, ch. 182, § 7; 1997, ch. 168, § 5.

ANNOTATIONS

The 1997 amendment, effective July 1, 1997, inserted "health-care" preceding "institution" throughout the section; substituted "supervising health-care provider" for "primary physician" near the beginning of Subsection C; and made stylistic changes.

24-7A-8. Health-care information.

Unless otherwise specified in an advance health-care directive, a person then authorized to make health-care decisions for a patient has the same rights as the patient to request, receive, examine, copy and consent to the disclosure of medical or any other health-care information.

History: Laws 1995, ch. 182, § 8.

24-7A-9. Immunities.

A. A health-care provider or health-care institution acting in good faith and in accordance with generally accepted health-care standards applicable to the health-care provider or health-care institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for:

(1) complying or attempting to comply with a health-care decision of a person apparently having authority to make a health-care decision for a patient, including a decision to withhold or withdraw health care or make an anatomical gift;

(2) declining to comply with a health-care decision of a person based on a belief that the person then lacked authority;

(3) complying or attempting to comply with an advance health-care directive and assuming that the directive was valid when made and has not been revoked or terminated;

(4) declining to comply with a health-care directive as permitted by Subsection E or F of Section 24-7A-7 NMSA 1978; or

(5) complying or attempting to comply with any other provision of the Uniform Health-Care Decisions Act [24-7A-1 NMSA 1978].

B. An individual acting as agent, guardian or surrogate under the Uniform Health-Care Decisions Act is not subject to civil or criminal liability or to discipline for unprofessional conduct for health-care decisions made in good faith.

History: Laws 1995, ch. 182, § 9; 2000, ch. 54, § 10.

ANNOTATIONS

The 2000 amendment, effective May 17, 2000, inserted "health-care" following both instances of "health care provider or" in the preliminary language of Subsection A, inserted "or make an anatomical gift" in Subsection A(1), and updated the statutory reference in Subsection A(4).

24-7A-10. Statutory damages.

A. A health-care provider or health-care institution that intentionally violates the Uniform Health-Care Decisions Act [24-7A-1 NMSA 1978] is subject to liability to the aggrieved individual for damages of five thousand dollars ($5,000) or actual damages resulting from the violation, whichever is greater, plus reasonable attorney fees.

B. A person who intentionally falsifies, forges, conceals, defaces or obliterates an individual's advance health-care directive or a revocation of an advance health-care

directive without the individual's consent or a person who coerces or fraudulently induces an individual to give, revoke or not give or revoke an advance health-care directive is subject to liability to that individual for damages of five thousand dollars ($5,000) or actual damages resulting from the action, whichever is greater, plus reasonable attorney fees.

C. The damages provided in this section are in addition to other types of relief available under other law, including civil and criminal law and law providing for disciplinary procedures.

History: Laws 1995, ch. 182, § 10; 1997, ch. 168, § 6.

ANNOTATIONS

The 1997 amendment, effective July 1, 1997, inserted "health-care" preceding "institution" in Subsection A; substituted "five thousand dollars ($5,000)" for "two thousand five hundred dollars ($2,500) in Subsections A and B; and made stylistic changes.

24-7A-11. Capacity.

A. The Uniform Health-Care Decisions Act [24-7A-1 NMSA 1978] does not affect the right of an individual to make health-care decisions while having capacity to do so.

B. An individual is presumed to have capacity to make a health-care decision, to give or revoke an advance health-care directive and to designate a surrogate.

C. Unless otherwise specified in a written advance health- care directive, a determination that an individual lacks or has recovered capacity or that another condition exists that affects an individual instruction or the authority of an agent shall be made by two qualified health-care professionals, one of whom shall be the primary physician. If the lack of capacity is determined to exist because of mental illness or developmental disability, one of the qualified health-care professionals shall be a person whose training and expertise aid in the assessment of functional impairment.

D. An individual shall not be determined to lack capacity solely on the basis that the individual chooses not to accept the treatment recommended by a health-care provider.

E. An individual, at any time, may challenge a determination that the individual lacks capacity by a signed writing or by personally informing a health-care provider of the challenge. A health-care provider who is informed by the individual of a challenge shall promptly communicate the fact of the challenge to the supervising health-care provider and to any health-care institution at which the individual is receiving care. Such a challenge shall prevail unless otherwise ordered by the court in a proceeding brought pursuant to the provisions of Section 24-7A-14 NMSA 1978.

F. A determination of lack of capacity under the Uniform Health-Care Decisions Act shall not be evidence of incapacity under the provisions of Article 5 [Chapter 45, Article 5 NMSA 1978] of the Uniform Probate Code.

History: Laws 1995, ch. 182, § 11; 1997, ch. 168, § 7.

ANNOTATIONS

The 1997 amendment, effective July 1, 1997, deleted "or disqualify" following "designate" in Subsection B; and made a stylistic change.

24-7A-12. Effect of copy.

A copy of a written advance health-care directive, revocation of an advance health-care directive or designation or disqualification of a surrogate has the same effect as the original.

History: Laws 1995, ch. 182, § 12.

24-7A-13. Effect of the Uniform Health-Care Decisions Act.

A. The Uniform Health-Care Decisions Act [24-7A-1 NMSA 1978] does not create a presumption concerning the intention of an individual who has not made or who has revoked an advance health-care directive.

B. Death resulting from the withholding or withdrawal of health care in accordance with the Uniform Health-Care Decisions Act does not for any purpose:

(1) constitute a suicide, a homicide or other crime; or

(2) legally impair or invalidate a governing instrument, notwithstanding any term of the governing instrument to the contrary. "Governing instrument" means a deed, will, trust, insurance or annuity policy, account with POD (payment on death designation), security registered in beneficiary form (TOD), pension, profit-sharing, retirement, employment or similar benefit plan, instrument creating or exercising a power of appointment or a dispositive, appointive or nominative instrument of any similar type.

C. The Uniform Health-Care Decisions Act does not authorize mercy killing, assisted suicide, euthanasia or the provision, withholding or withdrawal of health care, to the extent prohibited by other statutes of this state.

D. The Uniform Health-Care Decisions Act does not authorize or require a health-care provider or health-care institution to provide health care contrary to generally accepted health-care standards applicable to the health-care provider or health-care institution.

E. The Uniform Health-Care Decisions Act does not authorize an agent or surrogate to consent to the admission of an individual to a mental health-care facility. If the individual's written advance health-care directive expressly permits treatment in a mental health-care facility, the agent or surrogate may present the individual to a facility for evaluation for admission.

F. The Uniform Health-Care Decisions Act does not affect other statutes of this state governing treatment for mental illness of an individual admitted to a mental health-care institution.

History: Laws 1995, ch. 182, § 13; 1997, ch. 168, § 8.

ANNOTATIONS

The 1997 amendment, effective July 1, 1997, inserted "health-care" preceding "institution" in two places in Subsection D and substituted "admitted" for "involuntarily committed" in Subsection F.

24-7A-14. Judicial relief.

On petition of a patient, the patient's agent, guardian or surrogate, a health-care provider or health-care institution involved with the patient's care, an individual described in Subsection B or C of Section 24-7A-5 NMSA 1978, the district court may enjoin or direct a health-care decision or order other equitable relief. A proceeding under this section is governed by the Rules of Civil Procedure for the District Courts.

History: Laws 1995, ch. 182, § 14; 1997, ch. 168, § 9.

ANNOTATIONS

Cross references. — For Rules of Civil Procedure for the District Courts, *see* Rule 1-001 NMRA.

The 1997 amendment, effective July 1, 1997, in the first sentence, inserted "health-care" preceding "institution"; deleted "or another person having an interest in the patient's welfare" following "NMSA 1978"; and made a stylistic change.

Standing. — A not-for-profit corporation authorized by federal law to pursue legal remedies on behalf of persons with developmental disabilities lacked standing to bring an action to stay the district court's order permitting termination of artificial nutrition and hydration of a patient. Protection & Advocacy Sys. v. Presbyterian Healthcare Servs., 1999-NMCA-122, 122 N.M. 73, 989 P.2d 890.

24-7A-15. Uniformity of application and construction.

The Uniform Health-Care Decisions Act [24-7A-1 NMSA 1978] shall be applied and construed to effectuate its general purpose to make uniform the law with respect to the subject matter of that act among states enacting it.

History: Laws 1995, ch. 182, § 15.

24-7A-16. Transitional provisions.

A. An advance health-care directive is valid for purposes of the Uniform Health-Care Decisions Act [24-7A-1 NMSA 1978] if it complies with the provisions of that act, regardless of when or where executed or communicated.

B. The Uniform Health-Care Decisions Act does not impair a guardianship, living will, durable power of attorney, right-to-die statement or declaration or other advance directive for health-care decisions that is in effect before July 1, 1995.

C. Any advance directive, durable power of attorney for heath care decisions, living will, right-to-die statement or declaration or similar document that is executed in another state or jurisdiction in compliance with the laws of that state or jurisdiction shall be deemed valid and enforceable in this state to the same extent as if it were properly made in this state.

History: Laws 1995, ch. 182, § 16; 1997, ch. 168, § 10.

ANNOTATIONS

The 1997 amendment, effective July 1, 1997, added Subsection C and made a stylistic change.

24-7A-17. Short title.

Sections 1 through 17 [24-7A-1 to 24-7A-17 NMSA 1978] of this act may be cited as the "Uniform Health-Care Decisions Act".

History: Laws 1995, ch. 182, § 17.

24-7A-18. Severability.

If any provision of the Uniform Health-Care Decisions Act [24-7A-1 NMSA 1978] or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of that act which can be given effect without the invalid provision or application, and to this end the provisions of that act are severable.

History: Laws 1995, ch. 182, § 18.

ARTICLE 7B
Mental Health Care Treatment Decisions

24-7B-1. Short title.

This act may be cited as the "Mental Health Care Treatment Decisions Act".

History: Laws 2006, ch. 7, § 1.

ANNOTATIONS

Effective dates. — Laws 2006, ch. 7 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

24-7B-2. Purpose.

The purpose of the Mental Health Care Treatment Decisions Act [24-7B-1 NMSA 1978] is to ensure appropriate care and treatment of persons with behavioral health needs in the community.

History: Laws 2006, ch. 7, § 2.

ANNOTATIONS

Effective dates. — Laws 2006, ch. 7 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

24-7B-3. Definitions.

As used in the Mental Health Care Treatment Decisions Act [24-7B-1 NMSA 1978]:

A. "advance directive for mental health treatment" means an individual instruction or power of attorney for mental health treatment made pursuant to the Mental Health Care Treatment Decisions Act;

B. "agent" means an individual designated in a power of attorney for mental health treatment to make a mental health treatment decision for the individual granting the power;

C. "capacity" means an individual's ability to understand and appreciate the nature and consequences of proposed mental health treatment, including significant benefits and risks and alternatives to the proposed mental health treatment, and to make and communicate an informed mental health treatment decision. A written

determination or certification of lack of capacity shall be made only according to the provisions of the Mental Health Care Treatment Decisions Act;

D. "emancipated minor" means a person between the ages of sixteen and eighteen who has been married, who is on active duty in the armed forces or who has been declared by court order to be emancipated;

E. "guardian" means a judicially appointed guardian having authority to make a mental health decision for an individual;

F. "individual instruction" means an individual's direction concerning a mental health treatment decision for the individual, made while the individual has capacity, which is to be implemented when the individual has been determined to lack capacity;

G. "mental health treatment" means services provided for the prevention of, amelioration of symptoms of or recovery from mental illness or emotional disturbance, including electroconvulsive treatment, treatment with medication, counseling, rehabilitation services or evaluation for admission to a facility for care or treatment of persons with mental illness, if required;

H. "mental health treatment decision" means a decision made by an individual or the individual's agent or guardian regarding the individual's mental health treatment, including:

(1) selection and discharge of health care or mental health treatment providers and institutions;

(2) approval or disapproval of diagnostic tests, programs of medication and mental health treatment; and

(3) directions relating to mental health treatment;

I. "mental health treatment facility" means an institution, facility or agency licensed, certified or otherwise authorized or permitted by law to provide mental health treatment in the ordinary course of business;

J. "mental health treatment provider" or "health care provider" means an individual licensed, certified or otherwise authorized or permitted by law to provide diagnosis or mental health treatment in the ordinary course of business or practice of a profession;

K. "mental illness" means a substantial disorder of a person's emotional process, thoughts or cognition that grossly impairs judgment, behavior or capacity to recognize reality, but "mental illness" does not mean a developmental disability;

L. "power of attorney for mental health treatment" means the designation of an agent to make mental health treatment decisions for the individual granting the power, made while the individual has capacity;

M. "primary health care professional" means a qualified health care professional designated by an individual or the individual's agent or guardian to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated qualified health care professional is not reasonably available, a qualified health care professional who undertakes that responsibility;

N. "principal" means an adult or emancipated minor who, while having capacity, has made a power of attorney for mental health treatment by which the adult or emancipated minor delegates the right to make mental health treatment decisions for that adult or emancipated minor to an agent;

O. "qualified health care professional" means a licensed health care provider who is a physician, physician assistant, nurse practitioner, nurse or psychologist;

P. "reasonably available" means able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the patient's mental health treatment needs;

Q. "supervising health care provider" means the primary qualified health care professional or, if the primary qualified health care professional is not reasonably available, the health care provider who has undertaken primary responsibility for an individual's health care; and

R. "ward" means an adult or emancipated minor for whom a guardian has been appointed.

History: Laws 2006, ch. 7, § 3.

ANNOTATIONS

Effective dates. — Laws 2006, ch. 7 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

24-7B-4. Advance directive for mental health treatment.

A. An adult or emancipated minor, while having capacity, has the right to make the adult or emancipated minor's own mental health treatment decisions and may give an individual instruction. The individual instruction may be oral or written; if oral, it shall be made by personally informing a health care provider. The individual instruction may be limited to take effect only if a specified condition arises.

B. An adult or emancipated minor, while having capacity, may execute a power of attorney for mental health treatment that may authorize the agent to make any mental health treatment decision the principal could have made while having capacity. The power of attorney for mental health treatment shall be in writing signed by the principal and witnessed pursuant to Subsections I and J of this section. The power of attorney for mental health treatment shall remain in effect notwithstanding the principal's later incapacity under the Mental Health Care Treatment Decisions Act [24-7B-1 NMSA 1978] or Article 5 [45-5-101 NMSA 1978] of the Uniform Probate Code. The power of attorney for mental health treatment may include individual instructions. Unless related to the principal by blood, marriage or adoption, an agent may not be an attending qualified health care professional or an employee of the qualified health care professional or an owner, operator or employee of a mental health treatment facility at which the principal is receiving care.

C. Unless otherwise specified in a power of attorney for mental health treatment, the authority of an agent becomes effective only upon certification that the principal lacks capacity and ceases to be effective upon a determination that the principal has recovered capacity.

D. Unless otherwise specified in a written advance directive for mental health treatment, written certification that an individual lacks or has recovered capacity or that another condition exists that affects an individual instruction or the authority of an agent shall be made according to the provisions of the Mental Health Care Treatment Decisions Act.

E. An agent shall make a mental health treatment decision in accordance with the principal's individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the agent's determination of the principal's best interest. In determining the principal's best interest, the agent shall consider the principal's personal values to the extent known to the agent.

F. A mental health treatment decision made by an agent for a principal is effective without judicial approval.

G. A written advance directive for mental health treatment may include the individual's nomination of a choice of guardian of the individual.

H. The fact that an individual has executed an advance directive for mental health treatment shall not constitute an indication of mental illness.

I. A written advance directive for mental health treatment is valid only if it is signed by the principal and a witness who is at least eighteen years of age and who attests that the principal:

(1) is known to the witness;

(2) signed the advance directive for mental health treatment in the witness' presence;

(3) appears to have capacity; and

(4) is not acting under duress, fraud or undue influence.

J. For purposes of the advance directive for mental health treatment, the witness shall not be:

(1) an agent of the principal;

(2) related to the principal by blood or marriage;

(3) entitled to any part of the principal's estate or have a claim against the principal's estate;

(4) the attending qualified health care professional; or

(5) an owner, operator or employee of a mental health treatment facility at which the principal is receiving care or of any parent organization of the mental health treatment facility.

History: Laws 2006, ch. 7, § 4.

ANNOTATIONS

Effective dates. — Laws 2006, ch. 7 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

24-7B-5. Capacity.

A. The Mental Health Care Treatment Decisions Act [24-7B-1 NMSA 1978] does not affect the right of an individual to make mental health treatment decisions while having the capacity to do so.

B. An individual is presumed to have capacity to make a mental health treatment decision, to give an advance directive for mental health treatment or to revoke an advance directive for mental health treatment.

C. An individual shall not be determined to lack capacity solely on the basis that the individual chooses not to accept the treatment recommended by a health care provider.

D. An individual, at any time, may challenge a determination that the individual lacks capacity by a signed writing or by personally informing a health care provider of the

challenge. A health care provider who is informed by the individual of a challenge shall promptly communicate the fact of the challenge to the supervising health care provider and to any mental health treatment facility at which the individual is receiving care. Such a challenge shall prevail unless the agent or the treating mental health care provider obtains an order in district court finding the principal does not have the capacity to make mental health treatment decisions.

E. A determination of lack of capacity under the Mental Health Care Treatment Decisions Act shall not be evidence of incapacity under the provisions of Article 5 [45-5-101 NMSA 1978] of the Uniform Probate Code.

F. A determination of incapacity shall only be made by two persons, a qualified health care professional and a mental health treatment provider. If after the examination the principal is determined to lack capacity and is in need of mental health treatment, a written certification, substantially in the form provided in Subsection G of this section, of the principal's condition shall be made a part of the principal's medical record.

G. The following certification of the examination of a principal determining whether the principal is in need of mental health treatment and whether the principal does or does not lack capacity may be used by examiners:

"OPTIONAL EXAMINER'S CERTIFICATION

We, the undersigned, have made an examination of ___________, and do hereby certify that we have made a careful personal examination of the actual condition of the person and on such examination we find that __________________:

1. (Is) (Is not) in need of mental health treatment; and

2. (Does) (Does not) lack capacity to participate in decisions about (her) (his) mental health treatment.

The facts and circumstances on which we base our opinions are stated in the following report of symptoms and history of case, which is hereby made a part hereof.

According to the advance directive for mental health treatment, (name of patient) _____________________, wishes to receive mental health treatment in accordance with the preferences and instructions stated in the advance directive for mental health treatment.

We are duly licensed to practice in this state of New Mexico, are not related to _____________________ by blood or marriage and have no interest in her/his estate.

Witness our hands this _______ day of ____________, 20___

_________________________________ M.D., D.O., Ph.D., Other

_________________________________ M.D., D.O., Ph.D., Other

Subscribed and sworn to

before me this ________ day of _____________________, 20____

____

Notary Public

REPORT OF SYMPTOMS AND HISTORY OF CASE BY EXAMINERS

I. GENERAL

Complete name __________________________________

Place of residence ________________________________

Sex ________ Ethnicity ___________________________

Age ________

Date of Birth ____________________________________

II. STATEMENT OF FACTS AND CIRCUMSTANCES

Our determination that the principal (is) (is not) in need for mental health treatment is based on the following:

____
____

____
____

Our determination that the principal does not have the capacity to participate in the principal's mental health treatment decisions is based on:

1. the principal's ability to understand and communicate the nature of the proposed health care or mental health treatment described as:

____
____

____
____

2. the principal's ability to understand and communicate the consequences of the proposed health care or mental health treatment described as:

____
____

____
____

3. the principal's ability to understand and communicate the significant benefits, risks and alternatives to the proposed health care or mental health treatment described as:

____
____

____
____

4. the principal's ability to understand and communicate a choice about the proposed health care or mental health treatment described as:

____
____

____
____

III. NAME AND RELATIONSHIPS OF FAMILY MEMBERS/OTHERS TO BE NOTIFIED

Other data ____

Dated at ________________, New Mexico, this _______ day

of _______________, 20____

____ M.D., D.O., Ph.D.,

____ Other Address

____ M.D., D.O., Ph.D.,

____ Other Address."

History: Laws 2006, ch. 7, § 5.

ANNOTATIONS

Effective dates. — Laws 2006, ch. 7 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

24-7B-6. Revocation of advance directive for mental health treatment.

A. An individual, while having capacity, may revoke the designation of an agent either by a signed writing or by personally informing the supervising health care provider. If the individual cannot sign, a written revocation shall be signed for the individual and be witnessed by two witnesses pursuant to Subsections I and J of Section 4 [24-7B-4 NMSA 1978] of the Mental Health Care Treatment Decisions Act, each of whom has signed at the direction of the individual and in the presence of the individual and each other.

B. An individual, while having capacity, may revoke all or part of an advance directive for mental health treatment, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke.

C. A mental health treatment provider, agent or guardian who is informed of a revocation shall promptly communicate the fact of the revocation to the supervising health care provider and to any mental health treatment facility at which the patient is receiving care.

D. The filing of a petition for or a decree of annulment, divorce, dissolution of marriage or legal separation revokes a previous designation of a spouse as agent, unless otherwise specified in the decree or in a power of attorney for mental health treatment. A designation revoked solely by this subsection is revived by the individual's remarriage to the former spouse, by a nullification of the divorce, annulment or legal separation or by the dismissal or withdrawal, with the individual's consent, of a petition seeking annulment, divorce, dissolution of marriage or legal separation.

E. An advance directive for mental health treatment that conflicts with an earlier advance directive for mental health treatment revokes the earlier directive to the extent of the conflict.

F. Unless otherwise specified in the power of attorney for mental health treatment, an advance health-care directive pursuant to the Uniform Health-Care Decisions Act [24-7A-1 NMSA 1978] and an advance directive for mental health treatment shall be treated separately. A revocation of a power of attorney for mental health treatment shall not affect the validity of a power of attorney.

History: Laws 2006, ch. 7, § 6.

ANNOTATIONS

Effective dates. — Laws 2006, ch. 7 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

24-7B-7. Optional form for advance directive for mental health treatment.

A. The form provided in Subsection E of this section may be used to create an individual instruction regarding mental health treatment. An individual may complete or modify all or any part of the form. The Mental Health Care Treatment Decisions Act [24-7B-1 NMSA 1978] governs the effect of this or any other writing used to create an advance directive for mental health treatment.

B. A principal may designate a capable person eighteen years of age or older to act as an agent to make mental health treatment decisions. An alternative agent may also be designated to act as an agent if the original agent is unable or unwilling to act at any time. An appointment of an agent may be accomplished by using the form provided by Subsection E of this section.

C. An agent who has accepted the appointment in writing shall have authority to make decisions, in consultation with the primary health care professional, about mental health treatment on behalf of the principal only when the principal is certified to lack capacity and to require mental health treatment as provided by the Mental Health Care Treatment Decisions Act. These decisions shall be consistent with any wishes or instructions the principal has expressed in the instruction. If the wishes or instructions of the principal are not expressed, the agent shall act in what the agent believes to be the best interest of the principal. The agent may consent to evaluation for admission to inpatient mental health treatment on behalf of the principal if so authorized in the advance directive for mental health treatment.

D. An agent may renounce the agent's authority by giving notice to the principal. If a principal lacks capacity, the agent may renounce the agent's authority by giving notice to the named alternative agent, if any, or, if none, to the attending qualified health care professional or health care provider. The primary health care professional or health care provider shall note the withdrawal of the last named agent as part of the principal's medical record.

E. An advance directive for mental health treatment may be executed by using the following optional form, completed or modified to the extent desired by the individual, and the form may be notarized:

"ADVANCE DIRECTIVE FOR MENTAL HEALTH TREATMENT

I, ______________________, being a person with capacity, willfully and voluntarily make known my wishes about mental health treatment, by my instructions to others through my advance directive for mental health treatment, or by my appointment of an agent, or both. If a guardian or an agent is appointed to make mental health decisions for me, I intend this document to take precedence over other means of ascertaining my wishes and interests.

The fact that I may have left blanks in this directive does not affect its validity in any way. I intend that all completed sections be followed. I intend this directive to take precedence over any other mental health directives I have previously executed, to the extent that they are inconsistent with this document, or unless I expressly state otherwise in either document.

I understand that I may revoke this directive in whole or in part if I am a person with capacity. I understand that I cannot revoke this directive if one qualified health care professional and one mental health treatment provider find that I am an incapacitated person, unless I successfully challenge the determination of incapacity.

I understand there are some circumstances where my provider may not have to follow my directive, specifically, if the treatment requested in this directive is infeasible or unavailable, the facility or provider is not licensed or authorized to provide the treatment requested or the directive conflicts with other applicable law.

I thus do hereby declare:

I. DECLARATION FOR MENTAL HEALTH TREATMENT

If a mental health treatment provider and a qualified health care professional, one of whom is my primary health care professional, if reasonably available, determine that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment and that mental health treatment is necessary, I direct my primary health care professional and a mental health treatment provider, pursuant to the Mental Health Care Treatment Decisions Act, to provide the mental health treatment I have indicated below by my signature.

I understand that "mental health treatment" means services provided for the prevention of, amelioration of symptoms of or recovery from mental illness or emotional disturbance, including but not limited to electroconvulsive treatment, treatment with medication, counseling, rehabilitation services or evaluation for admission to a facility for care or treatment of persons with mental illness, if required.

Preferences and Instructions About Treatment, Facilities and Physicians

I would like the physician(s) named below to be involved in my treatment decisions:

Dr. ______________________ Contact information ____________________

Dr. ______________________ Contact information ____________________

I do not wish to be treated by Dr. _______________________________

Other Preferences: ____

Preferences and Instructions About Other Providers

I am receiving other treatment or care from providers who I feel have an impact on my mental health care. I would like the following treatment provider(s) to be contacted when this directive is effective:

Name: ____________________ Profession: _______________________

Contact Information ________________________

Name: ____________________ Profession: _______________________

Contact Information ________________________

Preferences and Instructions About Medications for Mental Health Treatment

(*initial and complete all that apply*)

____ I consent, and authorize my agent to consent, to the following medications:

____ ___________

____ I do not consent, and I do not authorize my agent to consent, to the administration of the following medications:

____ ___________

____ I am willing to take the medications excluded above if my only reason for excluding them is the side effects, which include ____________________________________, and these side effects can be eliminated by dosage adjustment or other means.

____ I am willing to try any other medications the hospital doctor recommends.

____ I am willing to try any other medications my outpatient doctor recommends.

____ I do not want to try any other medications.

Medication Allergies

I have allergies to, or severe side effects from, the following:

____
____

I have the following other preferences or instructions about medications:

____
____

Preferences and Instructions About Hospitalization and Alternatives

(*initial all that apply and, if desired, rank "1" for first choice, "2" for second choice, and so on*)

____ In the event my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I prefer to receive this care in programs/facilities designed as alternatives to psychiatric hospitalization.

____ I would also like the interventions below to be tried before hospitalization is considered:

____ Calling someone or having someone call me when needed

Name: _________________ Telephone: _____________________

____ Having a mental health service provider come to see me

____ Going to a crisis triage center or emergency room

____ Staying overnight at a crisis respite (temporary) bed

____ Seeing a provider for help with psychiatric medications

____ Other, specify: ____

Authority to Consent to Inpatient Treatment

I consent, and authorize my agent to consent, to evaluation for admission to inpatient mental health treatment.

(*Sign one*)

____ If deemed appropriate by my agent and treating physician

____

Signature

or

____ Under the following circumstances (*specify symptoms, behaviors or circumstances that indicate the need for hospitalization*)

____
____

____

Signature

____ I do not consent, or authorize my agent to consent, to evaluation for admission to inpatient treatment

____

Signature

Preferences and Instructions About Use of Seclusion or Restraint

I would like the interventions below to be tried before use of seclusion or restraint is considered (*initial all that apply*)

____ "Talk me down": one-on-one

____ More medication

____ Time out/privacy

____ Show of authority/force

____ Shift my attention to something else

____ Set firm limits on my behavior

____ Help me to discuss/vent feelings

____ Decrease stimulation

____ Offer to have neutral person settle dispute

____ Other, specify ____________________________________

If it is determined that I am engaging in behavior that requires seclusion, physical restraint and/or emergency use of medication, I prefer these interventions in the order I have chosen (*choose "1" for first choice, "2" for second choice, and so on*):

____ Seclusion

____ Seclusion and physical restraint (combined)

____ Medication by injection

____ Medication in pill or liquid form

In the event my physician decides to use medication in response to an emergency situation after due consideration of my preferences and instructions for emergency treatments stated above, I expect the choice of medication to reflect any preferences and instructions I have expressed in this directive. The preferences and instructions I have expressed in this section regarding medication in emergency situations do not constitute consent to use of the medication for nonemergency treatment.

Preferences and Instructions About Electroconvulsive Therapy

My wishes regarding electroconvulsive therapy are (*sign one*):

____ I do not consent, nor authorize my agent to consent, to the administration of electroconvulsive therapy.

____

Signature

____ I consent, and authorize my agent to consent, to the administration of electroconvulsive therapy.

____

Signature

____ I consent, and authorize my agent to consent, to the administration of electroconvulsive therapy, but only under the following conditions:

____

____

Signature

Preferences and Instructions About Who Is Permitted to Visit

If I have been admitted to a mental health treatment facility, the following people are not permitted to visit me there:

Name: ____

Name: ____

Name: ____

I understand that persons not listed above may be permitted to visit me.

Additional Instructions About My Mental Health Care

Other instructions about my mental health care: _______________

In case of emergency, please contact: _________________________

Name: __________________________ Address: ______________________

Work Telephone: ________________ Home telephone: _______________

Physician: _____________________ Address: ______________________

Telephone: _____________________

The following may help me to avoid a hospitalization:

____

I generally react to being hospitalized as follows:

____

Staff of the hospital or crisis unit can help me by doing the following:

____
____

Refusal of Treatment

I do not consent to any mental health treatment.

____

Signature

I further state that this document and the information contained in it may be released to any requesting licensed mental health professional.

_____________________________ _____________________________

Signature of principal Date

_____________________________ _____________________________

Signature of witness Date

II. APPOINTMENT OF AGENT

If my primary health care professional and a mental health provider determine that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment and that mental health treatment is necessary, I direct my primary health care professional and other health care providers, pursuant to the Mental Health Care Treatment Decisions Act, to follow the instructions of my agent.

I hereby appoint:

Name ____

Address _____________________________________

Telephone _________________________________ to act as my agent to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

If the person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my agent, I authorize the following person to act as my agent:

Name ____

Address ____

Telephone ____________________________________

My agent is authorized to make decisions that are consistent with the wishes I have expressed in my declaration. If my wishes are not expressed, my agent is to act in what he or she believes to be my best interest.

________________________________ ________________________________

Signature of principal Date

III. CONFLICTING PROVISION

I understand that if I have completed both a declaration and have appointed an agent and if there is a conflict between my agent's decision and my declaration, my declaration shall take precedence unless I indicate otherwise.

____

Signature

I understand that if I have completed both an advance health care directive and an advance directive for mental health treatment, that those directives should be executed as separate instructions.

____

Signature

IV. OTHER PROVISIONS

1. In the absence of my ability to give directions regarding my mental health treatment, it is my intention that this advance directive for mental health treatment shall be honored as the expression of my legal right to consent or to refuse to consent to mental health treatment.

2. I direct the following concerning the care of my minor children:

____
____

3. This advance directive for mental health treatment shall be in effect until it is revoked.

4. I understand that I may revoke this advance directive for mental health treatment at any time.

5. I understand and agree that if I have any prior advance directives for mental health treatment, and if I sign this advance directive for mental health treatment, my prior advance directives for mental health treatment are revoked.

6. I understand the full importance of this advance directive for mental health treatment and I am emotionally and mentally competent to make this advance directive for mental health treatment.

Signed this _______ day of ___________, 20__

____

Signature

____

City, county and state of residence

This advance directive was signed in my presence.

____

Signature of witness

____

Address

____."

History: Laws 2006, ch. 7, § 7.

ANNOTATIONS

Effective dates. — Laws 2006, ch. contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

24-7B-8. Decisions by guardian.

A. A guardian shall comply with the ward's individual instructions and may not revoke the ward's advance directive for mental health treatment unless the appointing court expressly so authorizes after notice to the agent and the ward.

B. A mental health treatment decision of an agent appointed by an individual having capacity takes precedence over that of a guardian, unless the appointing court expressly directs otherwise after notice to the agent and the ward.

C. Subject to the provisions of Subsections A and B of this section, a mental health treatment decision made by a guardian for the ward is effective without judicial approval, if the appointing court has expressly authorized the guardian to make mental health treatment decisions for the ward, in accordance with the provisions of Sections 43-1-15 or 45-5-312 NMSA 1978, after notice to the ward and any agent.

History: Laws 2006, ch. 7, § 8.

ANNOTATIONS

Effective dates. — Laws 2006, ch. 7 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

24-7B-9. Obligations of mental health treatment provider.

A. Before implementing a mental health treatment decision made for a patient, a supervising health care provider shall promptly communicate to the patient the decision made and the identity of the person making the decision.

B. A supervising health care provider who knows of the existence of an advance directive for mental health treatment, a revocation of an advance directive for mental health treatment or a challenge to a determination or certification of lack of capacity shall promptly record its existence in the patient's health care record and, if it is in writing, shall request a copy and, if one is furnished, shall arrange for its maintenance in the health care record.

C. A qualified health care professional shall disclose an advance directive for mental health treatment to other qualified health care professionals only when it is determined that disclosure is necessary to give effect to or provide treatment in accordance with an individual instruction.

D. A supervising health care provider who makes or is informed of a written determination or certification pursuant to Section 5 [24-7B-5 NMSA 1978] of the Mental Health Care Treatment Decisions Act that a patient lacks or has recovered capacity or that another condition exists that affects an individual instruction or the authority of an agent or guardian shall promptly record the determination in the patient's health care record and communicate the determination or certification to the patient and to any person then authorized to make mental health treatment decisions for the patient.

E. Except as provided in Subsections F and G of this section, a health care provider or mental health treatment facility providing care to a patient shall comply:

(1) before and after the patient is determined to lack capacity, with an individual instruction of the patient made while the patient had capacity;

(2) with a reasonable interpretation of the individual instruction made by a person then authorized to make mental health treatment decisions for the patient; and

(3) with a mental health treatment decision for the patient that is not contrary to an individual instruction of the patient and is made by a person then authorized to make mental health treatment decisions for the patient, to the same extent as if the decision had been made by the patient while having capacity.

F. A mental health treatment provider may only decline to comply with an individual instruction or mental health treatment decision for any of the following reasons:

(1) the treatment requested is infeasible or unavailable;

(2) the facility or provider is not licensed or authorized to provide the treatment requested; or

(3) the treatment requested conflicts with other applicable law.

G. A mental health treatment provider or mental health treatment facility may decline to comply with an individual instruction or mental health treatment decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the mental health treatment provider or mental health treatment facility. "Medically ineffective health care" means treatment that would not offer the patient any significant benefit, as determined by a physician chosen by the principal or agent.

H. A health care provider or mental health treatment facility that declines to comply with an individual instruction or mental health care decision shall:

(1) promptly so inform the patient, if possible, and any person then authorized to make mental health care decisions for the patient;

(2) provide continuing care to the patient until a transfer can be effected; and

(3) unless the patient or person then authorized to make mental health treatment decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or mental health treatment facility that is willing to comply with the individual instruction or decision.

I. A health care provider or mental health treatment facility shall not require or prohibit the execution or revocation of an advance directive for mental health treatment as a condition for providing health care.

J. The Mental Health Care Treatment Decisions Act [24-7B-1 NMSA 1978] does not require or permit a mental health treatment facility or health care provider to provide any type of mental health treatment for which the mental health treatment facility or health care provider is not licensed, certified or otherwise authorized or permitted by law to provide.

History: Laws 2006, ch. 7, § 9.

ANNOTATIONS

Effective dates. — Laws 2006, ch. contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

24-7B-10. Health care information.

Unless otherwise specified in an advance directive for mental health treatment, a person then authorized to make mental health treatment decisions for a patient has the same rights as the patient to request, receive, examine, copy and consent to the disclosure of medical or any other health care information.

History: Laws 2006, ch. 7, § 10.

ANNOTATIONS

Effective dates. — Laws 2006, ch. 7 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

24-7B-11. Immunities.

A. A health care provider or mental health treatment facility acting reasonably and on reasonable grounds and in accordance with generally accepted health care standards applicable to the health care provider or mental health treatment facility is not subject to civil or criminal liability or to discipline for unprofessional conduct for:

(1) complying or attempting to comply with a mental health treatment decision of a person apparently having authority to make a mental health treatment decision for a patient;

(2) declining to comply with a mental health treatment decision of a person based on a belief that the person then lacked authority;

(3) complying or attempting to comply with an advance directive for mental health treatment and assuming that the directive was valid when made and has not been revoked or terminated;

(4) declining to comply with a mental health treatment directive as permitted; or

(5) complying or attempting to comply with any other provision of the Mental Health Care Treatment Decisions Act [24-7B-1 NMSA 1978].

B. An individual acting as agent or guardian under the Mental Health Care Treatment Decisions Act is not subject to civil or criminal liability or to discipline for unprofessional conduct for mental health treatment decisions made in good faith.

History: Laws 2006, ch. 7, § 11.

ANNOTATIONS

Effective dates. — Laws 2006, ch. 7 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

24-7B-12. Prohibited practice.

A. No insurer or other provider of benefits regulated by the New Mexico Insurance Code [59A-1-1 NMSA 1978] or a state agency shall require a person to execute or revoke an advance directive for mental health treatment as a condition for membership in, being insured for or receiving coverage or benefits under an insurance contract or plan.

B. No insurer may condition the sale, procurement or issuance of a policy, plan, contract, certificate or other evidence of coverage, or entry into a pension, profit-sharing, retirement, employment or similar benefit plan, upon the execution or revocation of an advance directive for mental health treatment; nor shall the existence of an advance directive for mental health treatment modify the terms of an existing policy, plan, contract, certificate or other evidence of coverage of insurance.

C. The provisions of this section shall be enforced by the superintendent of insurance under the New Mexico Insurance Code [59A-1-1 NMSA 1978].

History: Laws 2006, ch. 7, § 12.

ANNOTATIONS

Effective dates. — Laws 2006, ch. 7 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

24-7B-13. Statutory damages.

A. A health care provider or mental health treatment facility that intentionally violates the Mental Health Care Treatment Decisions Act [24-7B-1 NMSA 1978] is subject to liability to the aggrieved individual for damages of five thousand dollars ($5,000) or actual damages resulting from the violation, whichever is greater, plus reasonable attorney fees.

B. A person who intentionally falsifies, forges, conceals, defaces or obliterates an individual's advance directive for mental health treatment or a revocation of an advance directive for mental health treatment without the individual's consent or a person who coerces or fraudulently induces an individual to give, revoke or not give or revoke an advance directive for mental health treatment is subject to liability to that individual for damages of five thousand dollars ($5,000) or actual damages resulting from the action, whichever is greater, plus reasonable attorney fees.

C. The damages provided in this section are in addition to other types of relief available under other law, including civil and criminal law and law providing for disciplinary procedures.

History: Laws 2006, ch. 7, § 13.

ANNOTATIONS

Effective dates. — Laws 2006, ch. 7 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

24-7B-14. Effect of copy.

A copy of a written advance directive for mental health treatment or revocation of an advance directive for mental health treatment has the same effect as the original.

History: Laws 2006, ch. 7, § 14.

ANNOTATIONS

Effective dates. — Laws 2006, ch. 7 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

24-7B-15. Effect of the Mental Health Care Treatment Decisions Act.

A. The Mental Health Care Treatment Decisions Act [24-7B-1 NMSA 1978] does not create a presumption concerning the intention of an individual who has not made or who has revoked an advance directive for mental health treatment.

B. Death resulting from the withholding or withdrawal of health care in accordance with the Mental Health Care Treatment Decisions Act does not for any purpose:

(1) constitute a suicide, a homicide or other crime; or

(2) legally impair or invalidate a governing instrument, notwithstanding any term of the governing instrument to the contrary. "Governing instrument" means a deed, will, trust, insurance or annuity policy, account with POD (payment on death designation), security registered in beneficiary form (TOD), pension, profit-sharing, retirement, employment or similar benefit plan, instrument creating or exercising a power of appointment or a dispositive, appointive or nominative instrument of any similar type.

C. The Mental Health Care Treatment Decisions Act does not authorize mercy killing, assisted suicide, euthanasia or the provision, withholding or withdrawal of health care, to the extent prohibited by other statutes of this state.

D. The Mental Health Care Treatment Decisions Act does not authorize or require a health care provider or mental health treatment facility to provide health care contrary to generally accepted health care standards applicable to the health care provider or mental health treatment facility.

E. The Mental Health Care Treatment Decisions Act does not authorize an agent to consent to the admission of an individual to a mental health treatment facility. If the individual's written advance directive for mental health treatment expressly permits treatment in a mental health treatment facility, the agent may present the individual to a facility for evaluation for admission.

F. The Mental Health Care Treatment Decisions Act does not affect other statutes of this state governing treatment for mental illness of an individual admitted to a mental health treatment facility, including involuntary commitment to a mental health treatment facility for mental illness.

History: Laws 2006, ch. 7, § 15.

ANNOTATIONS

Effective dates. — Laws 2006, ch. 7 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

24-7B-16. Transitional provisions.

A. An advance directive for mental health treatment is valid for purposes of the Mental Health Care Treatment Decisions Act [24-7B-1 NMSA 1978] if it complies with the provisions of that act, regardless of when or where executed or communicated.

B. The Mental Health Care Treatment Decisions Act does not impair a guardianship, living will, durable power of attorney, right-to-die statement or declaration or other advance directive for health care decisions that is in effect before July 1, 2006.

C. Any mental health treatment or psychiatric advance directive, durable power of attorney for health care decisions, living will, right-to-die statement or declaration or similar document that is executed in another state or jurisdiction in compliance with the laws of that state or jurisdiction shall be deemed valid and enforceable in this state to the same extent as if it were properly made in this state.

History: Laws 2006, ch. 7, § 16.

ANNOTATIONS

Effective dates. — Laws 2006, ch. 7 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

ARTICLE 8
Family Planning

24-8-1. Short title.

This act [24-8-1 NMSA 1978] may be cited as the "Family Planning Act".

History: 1953 Comp., § 12-30-1, enacted by Laws 1973, ch. 107, § 1.

ANNOTATIONS

Am. Jur. 2d, A.L.R. and C.J.S. references. — 12 Am. Jur. 2d Birth Control §§ 1 et seq.

Validity of regulations as to contraceptives or the dissemination of birth control information, 96 A.L.R.2d 955.

Liability of manufacturer or seller for injury or death allegedly caused by use of contraceptive, 70 A.L.R.3d 315.

Sexual partner's tort liability to other partner for fraudulent misrepresentation regarding sterility or use of birth control resulting in pregnancy, 2 A.L.R.5th 301.

Parent's child support liability as affected by other parent's fraudulent misrepresentation regarding sterility or use of birth control, or refusal to abort pregnancy, 2 A.L.R.5th 337.

Liability of manufacturer or seller for injury or death allegedly caused by use of contraceptive, 54 A.L.R.5th 1.

1 C.J.S. Abortion and Birth Control; Family Planning §§ 1 to 12; 39A C.J.S. Health and Environment § 43.

24-8-2. Definitions.

As used in the Family Planning Act [24-8-1 NMSA 1978]:

A. "contraceptive procedures" means any medically accepted procedure to prevent pregnancy;

B. "family planning services" includes contraceptive procedures and services (diagnosis, treatment, supplies and follow-up), social services, educational and informational services;

C. "health facility" means a hospital, clinic, nursing home, intermediate care facility or pharmacy;

D. "medically indigent" means a person who has insufficient funds to pay for family planning services;

E. "local governmental units" means counties, municipalities and public school districts and any of their agencies, departments, commissions, committees, institutions and educational institutions;

F. "physician" means a person licensed or authorized to practice medicine or osteopathy under the provisions of Sections 61-6-1 through 61-6-28 and 61-10-1 through 61-10-21 NMSA 1978; and

G. "state" means the state and its agencies, departments, commissions, committees, institutions and educational institutions.

History: 1953 Comp., § 12-30-2, enacted by Laws 1973, ch. 107, § 2.

ANNOTATIONS

Law reviews. — For comment, "Voluntary Sterilization in New Mexico: Who Must Consent?" see 7 N.M. L. Rev. 121 (1976-77).

24-8-3. Legislative findings; purpose of act.

A. The legislature finds that:

(1) family planning has been recognized as an essential component of standard health care and has been recognized nationally and internationally as a universal human right;

(2) continuing population growth causes or aggravates many social, economic and environmental problems, both in this state and in the nation;

(3) family planning services are not available as a practical matter to many persons in this state;

(4) it is desirable that family planning services be readily accessible to all who want and need them; and

(5) dissemination of information about family planning by the state and its local governmental units is consistent with public policy.

B. It is the purpose of the Family Planning Act [24-8-1 NMSA 1978] to assure that comprehensive family planning services are accessible on a voluntary basis to all who want and need them.

History: 1953 Comp., § 12-30-3, enacted by Laws 1973, ch. 107, § 3.

24-8-4. Prohibition against interference with medical judgment of physicians.

The Family Planning Act [24-8-1 NMSA 1978] does not prohibit or inhibit any person from refusing to provide any family planning service on the grounds that there are valid medical reasons for the refusal and those reasons are based upon the judgment of a physician given in the specific case of the person for whom services are refused.

History: 1953 Comp., § 12-30-4, enacted by Laws 1973, ch. 107, § 4.

24-8-5. Prohibition against imposition of standards and requirements as prerequisites for receipt of requested family planning services.

Neither the state, its local governmental units nor any health facility furnishing family planning services shall subject any person to any standard or requirement as a prerequisite to the receipt of any requested family planning service except for:

A. a requirement of referral to a physician when the requested family planning service is something other than information about family planning or nonprescription items;

B. any requirement imposed by law or regulation as a prerequisite to the receipt of a family planning service; or

C. payment for the service when payment is required in the ordinary course of providing the particular service to the person involved.

History: 1953 Comp., § 12-30-5, enacted by Laws 1973, ch. 107, § 5.

ANNOTATIONS

Law reviews. — For comment, "Voluntary Sterilization in New Mexico: Who Must Consent?" see 7 N.M. L. Rev. 121 (1976-77).

For article, "Treating Children Under the New Mexico Mental Health and Developmental Disabilities Code," see 10 N.M. L. Rev. 279 (1980).

24-8-6. Health facility licensure; affirmative statement of compliance required as condition of licensure; prohibition against certain policies of health facilities, state and local governmental units.

A. No health facility shall include in its bylaws or other governing policy statement a statement that:

(1) interferes with the physician-patient relationship in connection with the provision of any family planning service; or

(2) establishes or authorizes any standard or requirement in violation of Section 5 [24-8-5 NMSA 1978] of the Family Planning Act, provided that nothing in the Family Planning Act [24-8-1 NMSA 1978] shall be construed to require any hospital or clinic that objects on moral or religious grounds to admit any person for the purpose of being sterilized.

B. Neither the state nor its local governmental units shall have any written or unwritten policy that interferes with the physician-patient relationship in connection with the provision of family planning services except for provisions required by law or regulations relating to payment from public funds to a provider of family planning services.

C. No license or a renewal of a license shall be issued by the state to a health facility if it is in violation of the provisions of Subsection A of this section.

History: 1953 Comp., § 12-30-6, enacted by Laws 1973, ch. 107, § 6.

ANNOTATIONS

Cross references. — For licensing of health facilities generally, *see* 24-1-5 NMSA 1978.

24-8-7. Publicly funded family planning services; provision of certain services to medically indigent persons free of charge and to other persons at a cost consistent with their ability to pay.

To the extent that public funds are available, in any family planning services program operated by the state and its governmental units and in any family planning services program in which public funds are expended:

A. family planning services consisting only of information about family planning shall be furnished to persons free of charge; and

B. other family planning services shall be furnished to medically indigent persons free of charge and to all other persons at a cost consistent with their ability to pay.

History: 1953 Comp., § 12-30-7, enacted by Laws 1973, ch. 107, § 7.

24-8-8. Coordination of family planning services.

Any family planning services program developed or operated by the state or its local governmental units shall be developed and operated in coordination with other public and private family planning services programs existing in the state.

History: 1953 Comp., § 12-30-8, enacted by Laws 1973, ch. 107, § 8.

ARTICLE 9
Sterilization

24-9-1. Sterilization; consent of abandoning spouse unnecessary.

Any person, otherwise capable of consenting to medical treatment, need not obtain the consent of his spouse for his voluntary medical sterilization if such person has been abandoned by his spouse.

History: 1953 Comp., § 12-3-43, enacted by Laws 1971, ch. 14, § 3; 1973, ch. 266, § 1.

ANNOTATIONS

Cross references. — For prohibition against requiring special qualifications of individuals upon whom sterilization operation is to be performed, *see* 24-1-14 NMSA 1978.

Law reviews. — For comment, "Voluntary Sterilization in New Mexico: Who Must Consent?" see 7 N.M. L. Rev. 121 (1976-77).

Am. Jur. 2d, A.L.R. and C.J.S. references. — 39 Am. Jur. 2d Health §§ 74, 107.

Medical malpractice, and measure and element of damages, in connection with sterilization or birth control procedures, 27 A.L.R.3d 906.

Legality of voluntary nontherapeutic sterilization, 35 A.L.R.3d 1444.

Promise: recovery against physician on basis of breach of contract to achieve particular result or cure, 43 A.L.R.3d 1221.

Asexualization or sterilization of criminals or defectives, 53 A.L.R.3d 960.

When a statute of limitations begins to run against malpractice action in connection with sterilization or birth control procedures, 93 A.L.R.3d 218.

39A C.J.S. Health and Environment § 43.

ARTICLE 9A
Maternal, Fetal and Infant Experimentation

24-9A-1. Definitions.

As used in the Maternal, Fetal and Infant Experimentation Act [24-9A-1 NMSA 1978]:

A. "viability" means that stage of fetal development when the unborn child is potentially able to live outside the mother's womb, albeit with artificial aid;

B. "conception" means the fertilization of the ovum of a human female by the sperm of a human male;

C. "health" means physical or mental health;

D. "clinical research" means any biomedical or behavioral research involving human subjects, including the unborn, conducted according to a formal procedure. The term is to be construed liberally to embrace research concerning all physiological processes in man and includes research involving human in vitro fertilization, but shall not include diagnostic testing, treatment, therapy or related procedures conducted by formal protocols deemed necessary for the care of the particular patient upon whom such activity is performed and shall not include human in vitro fertilization performed to treat infertility; provided that this procedure shall include provisions to insure that each living fertilized ovum, zygote or embryo is implanted in a human female recipient, and

no physician may stipulate that a woman must abort in the event the pregnancy should produce a deformed or handicapped child. Provided that emergency medical procedures necessary to preserve the life or health of the mother or the fetus shall not be considered to be clinical research;

E. "subject at risk", "subject" or "at risk" means any individual who may be exposed to the likelihood of injury, including physical or psychological injury, as a consequence of participation as a subject in:

(1) any research, development or related activity which departs from the application of those established and accepted methods deemed necessary to meet his needs;

(2) controlled research studies necessary to establish accepted methods designed to meet his needs; or

(3) research activity which poses a significant risk to the subject;

F. "significant risk" means any activity which is likely to cause disfigurement or loss or impairment of the function of any member or organ;

G. "fetus" means the product of conception from the time of conception until the expulsion or extraction of the fetus or the opening of the uterine cavity, but shall not include the placenta, extraembryonic membranes, umbilical cord, extraembryonic fluids and their resident cell types and cultured cells;

H. "live-born infant" means an offspring of a human being which exhibits either heartbeat, spontaneous respiratory activity, spontaneous movement of voluntary muscles or pulsation of the umbilical cord if still attached to the infant ex utero; provided the Maternal, Fetal and Infant Experimentation Act does not apply to a fetus or infant absent the characteristics set forth in this subsection;

I. "infant" means an offspring of a human being from the time it is born until the end of its first chronological year;

J. "born" means the time the head or any other part of the body of the fetus emerges from the vagina or the time the uterine cavity is opened during a caesarean section or hysterotomy; and

K. "in vitro fertilization" means any fertilization of human ova which occurs outside the body of a female, either through admixture of donor human sperm and ova or by any other means.

History: Laws 1979, ch. 132, § 1; 1985, ch. 98, § 1.

ANNOTATIONS

Law reviews. — For article, "Constitutional Limits on New Mexico's In Vitro Fertilization Law," see 24 N.M.L. Rev. 125 (1994).

Am. Jur. 2d, A.L.R. and C.J.S. references. — Physician's use of patient's tissues, cells or bodily substances for medical research or economic purposes, 16 A.L.R.5th 143.

24-9A-2. Pregnant woman.

A. No woman, known to be pregnant according to generally accepted medical standards, shall be involved as a subject in any clinical research activity unless:

(1) the purpose of the activity is to meet the health needs of the mother or the fetus and the fetus will be placed at risk only to the minimum extent necessary to meet such needs; or

(2) there is no significant risk to the fetus.

B. An activity permitted under Subsection A of this section may be conducted only if the mother is legally competent and has given her informed consent after having been fully informed regarding possible impact on the fetus.

History: Laws 1979, ch. 132, § 2.

24-9A-3. Fetus.

A. No fetus shall be involved as a subject in any clinical research activity unless the purpose of the activity is to meet the health needs of the particular fetus and the fetus will be placed at risk only to the minimum extent necessary to meet such needs or no significant risk to the fetus is imposed by the research activity.

B. An activity permitted under Subsection A of this section shall be conducted only if the mother is legally competent and has given her informed consent.

History: Laws 1979, ch. 132, § 3.

24-9A-4. Live-born infant.

A. No live-born infant shall be involved as a subject in any clinical research activity unless the purpose of the activity is to meet the health needs of that particular infant, and the infant will be placed at risk only to the minimum extent necessary to meet such needs or no significant risk to such infant is imposed by the research activity.

B. An activity permitted under Subsection A of this section shall be conducted only if:

(1) the nature of the investigation is such that adults or mentally competent persons would not be suitable subjects; and

(2) the mother or father or the infant's legal guardian is mentally competent and has given his or her informed consent.

History: Laws 1979, ch. 132, § 4.

24-9A-5. Research activity.

A. No clinical research activity involving fetuses, live-born infants or pregnant women shall be conducted unless:

(1) appropriate studies on animals and nonpregnant human beings have been completed;

(2) anyone engaged in conducting the research activity will have no part in:

(a) any decisions as to the timing, method and procedures used to terminate the pregnancy; and

(b) determining the viability of the fetus at the termination of the pregnancy; and

(3) no procedural changes which may cause significant risk to the fetus or the pregnant woman will be introduced into the procedure for terminating the pregnancy solely in the interest of the research activity.

B. No inducements, monetary or otherwise, shall be offered to any woman to terminate her pregnancy for the purpose of subjecting her fetus or live-born infant to clinical research activity.

C. No consent to involve a pregnant woman, fetus or infant as a subject in clinical research activity shall be valid unless the pregnant woman or the parent or guardian of the infant has been fully informed of the following:

(1) a fair explanation of the procedures to be followed and their purposes, including identification of any procedures which are experimental;

(2) a description of any attendant discomforts and risks reasonably to be expected;

(3) a description of any benefits reasonably to be expected;

(4) a disclosure of any appropriate alternative procedures that might be advantageous for the subject;

(5) an offer to answer any inquiries concerning the procedure; and

(6) an instruction that the person who gave the consent is free to withdraw his consent and to discontinue participation in the project or activity at any time without prejudice to the subject.

History: Laws 1979, ch. 132, § 5.

24-9A-6. Penalty.

Whoever knowingly and willfully violates the provisions of Section 2, 3 or 4 [24-9A-2, 24-9A-3 or 24-9A-4 NMSA 1978] of this act shall be deemed guilty of a misdemeanor, and upon conviction shall be punished by imprisonment in the county jail for a definite term of less than one year, or to the payment of a fine of not more than one thousand dollars ($1,000), or to both imprisonment and fine in the discretion of the judge.

History: Laws 1979, ch. 132, § 6.

24-9A-7. Short title.

Sections 1 through 7 [24-9A-1 to 24-9A-7 NMSA 1978] of this act may be cited as the "Maternal, Fetal and Infant Experimentation Act".

History: Laws 1979, ch. 132, § 7.

ARTICLE 10
Consent to Medical Care; Emergency Care; Transfusions

24-10-1. Emancipated minors; hospital, medical and surgical care.

Notwithstanding any other provision of the law, and without limiting cases in which consent may otherwise be obtained or is not required, any emancipated minor or any minor who has contracted a lawful marriage may give consent to the furnishing of hospital, medical and surgical care to such minor, and the consent is not subject to disaffirmance because of minority. The consent of a parent of an emancipated minor or of a minor who has contracted a lawful marriage is not necessary in order to authorize hospital, medical and surgical care. For the purposes of this section only, subsequent judgment of annulment of the marriage or judgment of divorce shall not deprive the minor of his adult status once attained.

History: 1953 Comp., § 12-12-1, enacted by Laws 1963, ch. 32, § 1; recompiled as 1953 Comp., § 12-25-1, by Laws 1972, ch. 51, § 9.

ANNOTATIONS

Cross references. — For health care decisions, *see* Chapter 24, Article 7A NMSA 1978.

For age of majority, *see* 28-6-1 NMSA 1978.

For effect of minority upon limitations period for malpractice actions, *see* 41-5-13 NMSA 1978.

Am. Jur. 2d, A.L.R. and C.J.S. references. — Power of courts or other public agencies, in the absence of statutory authority, to order compulsory medical care for adult, 9 A.L.R.3d 1391.

Voluntary acts: what voluntary acts of child, other than marriage or entry in military service, terminate parent's obligation to support, 32 A.L.R.3d 1055.

Medical practitioner's liability for treatment given child without parent's consent, 67 A.L.R.4th 511.

Power of court or other public agency to order medical treatment over parental religious objections for child whose life is not immediately endangered. 21 A.L.R.5th 248.

What voluntary acts of child, other than marriage or entry into military service, terminate parent's obligation to support, 55 A.L.R.5th 557.

42 C.J.S. Infants § 116.

24-10-2. Consent for emergency attention by person in loco parentis.

Notwithstanding any other provision of the law, in cases of emergency in which a minor is in need of immediate hospitalization, medical attention or surgery and the parents of the minor cannot be located for the purpose of consenting thereto, after reasonable efforts have been made under the circumstances, consent for the emergency attention may be given by any person standing in loco parentis to the minor.

History: 1953 Comp., § 12-12-2, enacted by Laws 1963, ch. 32, § 2; recompiled as 1953 Comp., § 12-25-2, by Laws 1972, ch. 51, § 9.

ANNOTATIONS

Cross references. — For age of majority, *see* 28-6-1 NMSA 1978.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 42 Am. Jur. 2d Infants §§ 16, 17, 55, 72; 59 Am. Jur. 2d Parent and Child §§ 11, 48, 74, 88.

Propriety of surgically invading incompetent or minor for benefit of third party, 4 A.L.R.5th 1000.

42 C.J.S. Infants §§ 93, 181.

24-10-3. Persons coming to aid or rescue of another rendering emergency care; release from liability.

No person who comes to the aid or rescue of another person by providing care or assistance in good faith at or near the scene of an emergency, as defined in Section 24-10-4 NMSA 1978, shall be held liable for any civil damages as a result of any action or omission by that person in providing that care or assistance, except when liable for an act of gross negligence; but nothing in this section applies to the provision of emergency care or assistance when it is rendered for remuneration or with the expectation of remuneration or is rendered by a person or agent of a principal who was at the scene of the accident or emergency because he or his principal was soliciting business or performing or seeking to perform some services for remuneration.

History: 1953 Comp., § 12-12-3, enacted by Laws 1963, ch. 59, § 1; recompiled as 1953 Comp., § 12-25-3, by Laws 1972, ch. 51, § 9; 1997, ch. 86, § 1.

ANNOTATIONS

Cross references. — For medical malpractice generally, *see* Chapter 41, Article 5 NMSA 1978.

The 1997 amendment rewrote this section. Laws 1997, ch. 86 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective on June 20, 1997, 90 days after adjournment of the legislature.

Border patrol agents. — In a suit alleging that border patrol agents negligently caused plaintiff's injuries in the course of extricating him from his vehicle after an accident, the agents were liable for their actions only to the extent a private person, in the same circumstances, would be liable and, under this section, would be liable only for gross negligence, rather than ordinary negligence. Ortiz v. United States Border Patrol, 39 F. Supp. 2d 1321 (D.N.M. 1999).

Law reviews. — For note, "The New Mexico Medico - Legal Malpractice Panel - An Analysis," see 3 N.M. L. Rev. 311 (1973).

Am. Jur. 2d, A.L.R. and C.J.S. references. — 61 Am. Jur. 2d Physicians, Surgeons and Other Healers, § 160.

Liability of operator of ambulance service for personal injuries to person being transported, 68 A.L.R.4th 14.

Construction and application of "Good Samaritan" statutes, 68 A.L.R.4th 294.

Rescue doctrine: liability of one who negligently causes motor vehicle accident for injuries to person subsequently attempting to rescue persons or property, 73 A.L.R.4th 737.

65 C.J.S. Negligence § 63(107).

24-10-4. Emergency defined.

As used in Sections 24-10-3 and 24-10-4 NMSA 1978, "emergency" means an unexpected occurrence of injury or illness occurring in public or private places to a person that results from:

A. motor vehicle accidents and collisions;

B. acts of God; and

C. other accidents and events of similar nature.

History: 1953 Comp., § 12-12-4, enacted by Laws 1963, ch. 59, § 2; recompiled as 1953 Comp., § 12-25-4, by Laws 1972, ch. 51, § 9; 1999, ch. 141, § 1.

ANNOTATIONS

The 1999 amendment, effective June 18, 1999, added the section heading and rewrote the section which read: "As used in this act 'emergency' means an unexpected occurrence involving injury or illness to persons, including motor vehicle accidents and collisions, disasters, and other accidents and events of similar nature occurring in public or private places".

24-10-5. Transfusions; limited liability.

The procuring, furnishing, donating, processing, distributing or using of human whole blood, plasma, blood products, blood derivatives, human tissue or organs or any component thereof shall not give rise to any implied warranties of any type, and the doctrine of strict tort liability shall not be applicable to the transmission of hepatitis or human immunodeficiency virus in the blood, plasma, blood products, blood derivatives, human tissue or organs or any component thereof. Nothing in this section shall be construed as affecting the liability of any person, firm, corporation or other organization for negligence or willful misconduct.

History: 1953 Comp., § 12-12-5, enacted by Laws 1971, ch. 119, § 1; 1953 Comp., § 12-25-5 by Laws 1972, ch. 51, § 9; 1978 Comp., § 24-10-5; Laws 1987, ch. 104, § 1.

ANNOTATIONS

Law reviews. — For note, "The New Mexico Medico - Legal Malpractice Panel - An Analysis," see 3 N.M. L. Rev. 311 (1973).

Am. Jur. 2d, A.L.R. and C.J.S. references. — 40 Am. Jur. 2d Hospitals and Asylums § 27 et seq; 61 Am. Jur. 2d Physicians, Surgeons and Other Healers, §§ 132, 159, 161, 173, 178.

Application of rule of strict liability in tort to person or entity rendering medical services, 100 A.L.R.3d 1205.

Liability of hospital, physician, or other individual medical practitioner for injury or death resulting from blood transfusion, 20 A.L.R.4th 136.

Liability of blood supplier or donor for injury or death resulting from blood transfusion, 24 A.L.R.4th 508.

Discovery of identity of blood donor, 56 A.L.R.4th 755.

Liability for donee's contraction of Acquired Immune Deficiency Syndrome (AIDS) from blood transfusion, 64 A.L.R.5th 333.

Validity, construction, and application of blood shield statutes, 75 A.L.R.5th 229.

24-10-6. Blood donation; minors.

A. A minor who is at least seventeen years of age may donate blood to a licensed, accredited or approved blood bank, storage facility or hospital without parental consent.

B. A minor shall not receive monetary payment from a licensed, accredited or approved blood bank, storage facility or hospital for a donation of blood or blood components.

History: Laws 2003, ch. 79, § 1.

ANNOTATIONS

ARTICLE 10A
Emergency Medical Services Fund

24-10A-1. Short title.

Chapter 24, Article 10A NMSA 1978 may be cited as the "Emergency Medical Services Fund Act".

History: 1978 Comp., § 24-10A-1, enacted by Laws 1978, ch. 178, § 1; 1987, ch. 246, § 1.

24-10A-2. Purpose of act.

The purpose of the Emergency Medical Services Fund Act [24-10A-1 NMSA 1978] is to make money available to municipalities and counties for use in the establishment and enhancement of local emergency medical services, statewide emergency medical services and trauma services in order to reduce injury and loss of life.

History: 1978 Comp., § 24-10A-2, enacted by Laws 1978, ch. 178, § 2; 1987, ch. 246, § 2; 1994, ch. 61, § 1; 2001, ch. 258, § 1; 2001, ch. 273, § 1.

ANNOTATIONS

The 1994 amendment, effective July 1, 1994, deleted "It is" at the beginning, inserted "is" following "Act", substituted "money" for "funds", deleted "incorporated" before "municipalities", inserted "and" following "municipalities", deleted "and fire districts of the state" following "counties", deleted "of emergency medical services; the purchase, repair and maintenance of emergency medical service vehicles, equipment and supplies; and the training and licensing" following "establishment", inserted "and enhancement" before "of local", and deleted "personnel" following "services" near the end.

2001 amendments. — Identical amendments to this section were enacted by Laws 2001, ch. 258, § 1 and Laws 2001, ch. 273, § 1, effective July 1, 2001, deleting "in proportion to their needs" following "municipalities and counties" and inserting "statewide emergency medical services and trauma services". This section is set out as amended by Laws 2001, ch. 273, § 1. *See* 12-1-8 NMSA 1978.

24-10A-2.1. Definitions.

As used in the Emergency Medical Services Fund Act [24-10A-1 NMSA 1978]:

A. "bureau" means the injury prevention and emergency medical services bureau of the public health division of the department;

B. "committee" means the statewide emergency medical services advisory committee appointed pursuant to the provisions of Section 24-10B-7 NMSA 1978;

C. "department" means the department of health;

D. "fund" means the emergency medical services fund;

E. "local recipient" means an ambulance service, medical rescue service, fire department rescue service, air ambulance service or other prehospital care provider:

(1) that routinely responds to an individual's need for immediate medical care in order to prevent loss of life or aggravation of physical or psychological illness or injury;

(2) whose application for funding through the Emergency Medical Services Fund Act is sponsored by a municipality or county; and

(3) that meets department guidelines concerning personnel training, use of bureau-approved run forms, participation in mutual aid agreements and medical control;

F. "municipality" means an incorporated city, town or village; and

G. "secretary" means the secretary of health.

History: Laws 1994, ch. 61, § 2; 2001, ch. 258, § 2; 2001, ch. 273, § 2.

ANNOTATIONS

2001 amendments. — Identical amendments to this section were enacted by Laws 2001, ch. 258, § 2 and Laws 2001, ch. 273, § 2, effective July 1, 2001, substituting "injury prevention" for "primary care" in Subsection A; inserting "statewide" in Subsection B; in the introductory language of Subsection E, inserting "medical" preceding "rescue services" and inserting "air ambulance service"; deleting Subsection G, which defined "run" and redesignating former Subsection H as G. This section is set out as amended by Laws 2001, ch. 273, § 2. *See* 12-1-8 NMSA 1978.

24-10A-3. Emergency medical services fund created; funding.

A. The "emergency medical services fund" is created in the state treasury. Money in the fund shall not revert at the end of any fiscal year. Money appropriated to the fund or accruing to it through gifts, grants, fees or bequests shall be deposited in the fund. Interest earned on investment of the fund shall be credited to the general fund. Disbursements from the fund shall be made upon warrants drawn by the secretary of finance and administration pursuant to vouchers signed by the secretary or his authorized representative.

B. The bureau shall administer the fund and provide for the distribution of the fund pursuant to the Emergency Medical Services Fund Act [24-10A-1 NMSA 1978] and rules adopted pursuant to the provisions of that act.

C. In any fiscal year, no less than seventy-five percent of the money in the fund shall be used for the local emergency medical services funding program to support the cost of supplies and equipment and operational costs other than salaries and benefits for emergency medical services personnel. This money shall be distributed to municipalities and counties on behalf of eligible local recipients, using a formula established pursuant to rules adopted by the department. The formula shall determine

each municipality's and county's share of the fund based on the relative geographic size and population of each county. The formula shall also base the distribution of money for each municipality and county on the relative number of runs of each local recipient eligible to participate in the distribution.

D. In any fiscal year, no more than:

(1) twenty-two percent of the fund may be used for emergency medical services system improvement projects, including the purchase of emergency medical services vehicles, local and statewide emergency medical services system support projects, the statewide trauma care system program and the emergency medical dispatch agency support program; and

(2) three percent of the fund may be used by the bureau and emergency medical services regional offices for administrative costs, including monitoring and providing technical assistance.

E. In any fiscal year, money in the fund that is not distributed pursuant to the provisions of Subsection D of this section may be distributed pursuant to the provisions of Subsection C of this section.

History: 1978 Comp., § 24-10A-3, enacted by Laws 1978, ch. 178, § 3; 1987, ch. 246, § 3; 1989, ch. 324, § 18; 1994, ch. 61, § 3; 2001, ch. 258, § 3; 2001, ch. 273, § 3.

ANNOTATIONS

The 1994 amendment, effective July 1, 1994, rewrote Subsection A, deleted former Subsections B and D, rewrote and redesignated former Subsection C as Subsection B, and added Subsections C to E.

2001 amendments. — Identical amendments to this section were enacted by Laws 2001, ch. 258, § 3 and Laws 2001, ch. 273, § 3, effective July 1, 2001, inserting "and the emergency medical dispatch agency support program" at the end of Paragraph D(1) and inserting "and emergency medical services regional offices" in Paragraph D(2). This section is set out as amended by Laws 2001, ch. 273, § 3. *See* 12-1-8 NMSA 1978.

24-10A-3.1. Regulations.

The department shall adopt regulations pursuant to Subsection E of Section 9-7-6 NMSA 1978 to carry out the provisions of the Emergency Medical Services Fund Act [24-10A-1 NMSA 1978].

History: Laws 1994, ch. 61, § 13.

24-10A-4. Funding program; purpose; determination of needs.

A. The "local emergency medical services funding program" is created. The program shall provide for the:

(1) establishment or enhancement of local emergency medical services, including the use of advanced technology equipment;

(2) operational costs other than salaries and benefits of local emergency medical services personnel;

(3) purchase, repair and maintenance of emergency medical services vehicles, equipment and supplies, including the use of advanced technology equipment; and

(4) training and licensing of local emergency medical services personnel.

B. Annually on or before June 1, the bureau shall consider and determine, in accordance with the formula adopted by rule of the department, the amount of distribution to municipalities and counties that have applied for money from the fund. In making its determination, the bureau shall ensure that no municipality or county receives money from the fund for the purpose of accumulation as defined by rule of the department, except as waived by the bureau in writing for good cause shown. The bureau shall also ensure that each local recipient is in compliance with the rules of the department.

History: 1978 Comp., § 24-10A-4, enacted by Laws 1978, ch. 178, § 4; 1979, ch. 141, § 1; 1987, ch. 246, § 4; 1994, ch. 61, § 4; 2000, ch. 16, § 1; 2001, ch. 258, § 4; 2001, ch. 273, § 4.

ANNOTATIONS

The 1994 amendment, effective July 1, 1994, inserted "Funding program; purpose" in the section heading, added Subsection A, and rewrote and designated the formerly undesignated provisions as Subsection B.

The 2000 amendment, effective May 17, 2000, in Subsection B, substituted "rule" for "regulation" in both the first and second sentence; added the proviso in the second sentence; and substituted "rules" for "regulations" in the last sentence.

2001 amendments. — Identical amendments to this section were enacted by Laws 2001, ch. 258, § 4 and Laws 2001, ch. 273, § 4, effective July 1, 2001, in Subsection B, substituting "except as waived by the bureau in writing for good cause shown" for the provision that a municipality or county may accumulate balances only for the purpose of purchasing vehicles or equipment with bureau approval. This section is set out as amended by Laws 2001, ch. 273, § 4. *See* 12-1-8 NMSA 1978.

Applicability. — Laws 2000, ch. 16, § 2 makes the provisions of that act applicable to the 2001 and subsequent funding cycles.

24-10A-4.1. Emergency medical services system improvement projects.

A. Applications for emergency medical services system improvement projects shall be submitted separately from applications for the local emergency medical services funding program. The bureau shall award emergency medical services system improvement projects after a review of the applications. The awards shall be made based on a priority ranking, demonstrated need for funding and recommendations from the committee. Money awarded shall be used in compliance with applicable rules.

B. Applications for funding to purchase emergency medical services vehicles shall be submitted by municipalities or counties on behalf of local recipients. The municipality or county shall commit to providing matching funds of at least twenty-five percent of the cost of purchasing the vehicle.

C. Applications for funding of local and statewide projects shall demonstrate the need for funding and a plan to use the funding to enhance or better integrate local emergency medical services systems or to improve the health, safety and training of emergency medical services technicians statewide.

D. A statewide trauma care system program shall be developed and determined by the bureau in consultation with the committee. The statewide trauma care system program shall provide for the support, development and expansion of the statewide trauma care system in accordance with rules adopted by the department.

E. The emergency medical dispatch agency support program shall fund allowable costs of dispatch agencies that meet criteria established pursuant to rules by the department.

History: Laws 1994, ch. 61, § 10; 2001, ch. 258, § 5; 2001, ch. 273, § 5.

ANNOTATIONS

2001 amendments. — Identical amendments to this section were enacted by Laws 2001, ch. 258, § 5 and Laws 2001, ch. 273, § 5, effective July 1, 2001, adding Subsection E. This section is set out as amended by Laws 2001, ch. 273, § 5. See 12-1-8 NMSA 1978.

24-10A-4.2. Mutual aid agreements.

Incorporated municipalities, counties and local recipients are encouraged to develop mutual aid agreements with other municipalities, counties and local recipients for the purpose of ensuring that adequate emergency medical services coverage exists

throughout the state. For the benefit of the public, equipment and other emergency medical services resources obtained through money from the fund shall be shared among the parties to a mutual aid agreement.

History: Laws 1994, ch. 61, § 11.

24-10A-5. Funding program; awards; appeals.

The bureau shall promptly notify each municipality and county that has applied for money and the local recipient of the bureau's determination to grant or deny an application for funding through the local emergency medical services funding program. A municipality or county may appeal a determination of the bureau within ten working days after notification of the determination. The bureau shall refer the appeal to the committee for its review and recommendation. The committee shall make its recommendation to the secretary, who shall make a final determination about whether to grant or deny an application for funding. The secretary shall notify the appellant of his decision on or before June 30.

History: 1978 Comp., § 24-10A-5, enacted by Laws 1978, ch. 178, § 5; 1987, ch. 246, § 5; 1994, ch. 61, § 5.

ANNOTATIONS

The 1994 amendment, effective July 1, 1994, rewrote this section to the extent that a detailed comparison is impracticable.

24-10A-6. Distribution of fund.

On or before August 31, the local emergency medical services funding program distribution shall be made to each municipality and county as determined by the department. No more than one percent of the amount appropriated to the local emergency medical services funding program shall be distributed from the fund to the benefit of a single local recipient in any fiscal year pursuant to the local emergency medical services funding program, to ensure that appropriate emergency medical service is available statewide.

History: 1978 Comp., § 24-10A-6, enacted by Laws 1978, ch. 178, § 6; 1979, ch. 141, § 2; 1987, ch. 246, § 6; 1994, ch. 61, § 6; 2001, ch. 258, § 6; 2001, ch. 273, § 6.

ANNOTATIONS

The 1994 amendment, effective July 1, 1994, deleted "emergency medical services" preceding "fund" in the section heading and rewrote the section.

2001 amendments. — Identical amendments to this section were enacted by Laws 2001, ch. 258, § 6 and Laws 2001, ch. 273, § 6, effective July 1, 2001, deleting

"incorporated" preceding "municipality" in the first sentence; substituting "No more than one percent of the amount appropriated to the local emergency medical services funding program shall" for "No more than twenty thousand dollars ($20,000) shall"; and inserting "to ensure that appropriate emergency medical service is available statewide" at the end of the subsection. This section is set out as amended by Laws 2001, ch. 273, § 6. *See* 12-1-8 NMSA 1978.

24-10A-7. Funding program; expenditures from fund.

Any money distributed from the fund for the purposes of the local emergency medical services funding program shall be expended only for those purposes.

History: 1978 Comp., § 24-10A-7, enacted by Laws 1978, ch. 178, § 7; 1979, ch. 141, § 3; 1987, ch. 246, § 7; 1994, ch. 53, § 1; 1994, ch. 61, § 7.

ANNOTATIONS

1994 amendments. — Laws 1994, ch. 53, § 1, effective May 18, 1994, inserting "and the financing and refinancing thereof" following the former language "equipment and supplies", was approved March 3, 1994. However, Laws 1994, ch. 61, § 7, effective July 1, 1994, rewriting the section heading, which read: "Expenditures from fund", and rewriting the body of section to the extent that a detailed comparison is impracticable, was approved March 4, 1994. The section is set out as amended by Laws 1994, ch. 61, § 7. *See* 12-1-8 NMSA 1978.

24-10A-8. Funding program; control of expenditures.

Money distributed from the fund shall be expended only for the purposes stated in the application to the bureau and shall be expended on the authorization of the chief executive of the incorporated municipality or county upon vouchers issued by its treasurer.

History: 1978 Comp., § 24-10A-8, enacted by Laws 1978, ch. 178, § 8; 1987, ch. 246, § 8; 1994, ch. 61, § 8.

ANNOTATIONS

The 1994 amendment, effective July 1, 1994, added "Funding program" at the beginning of the section heading, deleted "emergency medical services" in two places, deleted "of the health services division of the health and environment department" following "bureau", inserted "or" following "municipality", deleted "or fire district" following "county", and corrected a misspelling.

24-10A-9. Funding program; inspection by the bureau.

The bureau and its designated agents have the authority at all normal hours of operation to enter in and upon all buildings and premises where emergency medical services vehicles, equipment and supplies acquired with expenditures from the fund are located for the purposes of examination and inspection.

History: 1978 Comp., § 24-10A-9, enacted by Laws 1978, ch. 178, § 9; 1987, ch. 246, § 9; 1994, ch. 61, § 9.

ANNOTATIONS

The 1994 amendment, effective July 1, 1994, in the section heading, added "Funding program" at the beginning and deleted "emergency medical services" after "the"; and rewrote the section.

24-10A-10. Loss of funding eligibility.

A municipality, county or local recipient that the bureau finds has expended money in violation of the Emergency Medical Services Fund Act [24-10A-1 NMSA 1978] may be ineligible to receive funding from the bureau for a period of not less than one year or more than three years, as determined by the bureau in accordance with rules and regulations adopted by the department.

History: Laws 1994, ch. 61, § 12.

ARTICLE 10B
Emergency Medical Services System

24-10B-1. Short title.

This act [24-10B-1 to 24-10B-12 NMSA 1978] may be cited as the "Emergency Medical Services Act".

History: Laws 1983, ch. 190, § 1.

ANNOTATIONS

Am. Jur. 2d, A.L.R. and C.J.S. references. — Liability of operator of ambulance service for personal injuries to person being transported, 68 A.L.R.4th 14.

Liability for negligence of ambulance attendants, emergency medical technicians and the like, rendering emergency medical care outside hospital, 16 A.L.R.5th 605.

24-10B-2. Purpose.

The purpose of the Emergency Medical Services Act [24-10B-1 NMSA 1978] is to enhance and regulate a comprehensive emergency medical services system in the state as set forth in that act. Nothing in the Emergency Medical Services Act shall be construed to preclude a local emergency medical services system from adopting standards that are more stringent than those authorized by the Emergency Medical Services Act.

History: Laws 1983, ch. 190, § 2; 1993, ch. 161, § 1; 2003, ch. 243, § 1.

ANNOTATIONS

The 1993 amendment, effective June 18, 1993, rewrote this section to the extent that a detailed comparison would be impracticable.

The 2003 amendment, effective July 1, 2003, rewrote the first sentence of the section.

24-10B-3. Definitions.

As used in the Emergency Medical Services Act [24-10B-1 NMSA 1978]:

A. "academy" means an emergency medical services training program administered through the department of emergency medicine of the university of New Mexico school of medicine;

B. "advance directive" means a written instruction, such as a living will, durable power of attorney for health care or emergency medical services do not resuscitate form recognizable under state law and relating to the provision of health care when an individual is incapacitated;

C. "air ambulance service" means any governmental or private service that provides air transportation specifically designed to accommodate the medical needs of a person who is ill, injured or otherwise mentally or physically incapacitated and who requires in-flight medical supervision;

D. "approved emergency medical services training program" means an emergency medical services training program that is sponsored by a post-secondary educational institution, accredited by a national educational accrediting organization for emergency medical services or active in the accreditation process, and is approved by the joint organization on education committee and participates in the joint organization on education committee;

E. "bureau" means the injury prevention and emergency medical services bureau of the public health division of the department;

F. "certified emergency medical service" means an organization that meets minimum standards to provide emergency services and is approved by the bureau,

including emergency medical dispatch agencies, pre-hospital or interfacility care services and special event services organized to provide emergency medical services;

G. "critical incident stress management program" means a program of preventive education and crisis intervention intended to reduce the negative effects of critical stress on emergency responders;

H. "department" means the department of health;

I. "emergency medical dispatch" means an advanced form of dispatch communications used to improve emergency medical services response to medical and traumatic emergencies that utilizes specially trained emergency medical dispatchers, in accordance with an emergency medical dispatch priority reference system and the department-approved scopes of practice;

J. "emergency medical dispatcher" means a person who is trained and licensed pursuant to Subsection F of Section 24-10B-4 NMSA 1978 to receive calls for emergency medical assistance, provide pre-arrival medical instructions, dispatch emergency medical assistance and coordinate its response;

K. "emergency medical services" means the services rendered by providers in response to an individual's need for immediate medical care to prevent loss of life or aggravation of physical or psychological illness or injury;

L. "emergency medical services first responder" means a person who is licensed by the department and who functions within the emergency medical services system to provide initial emergency aid;

M. "emergency medical services system" means a coordinated system of health care delivery that responds to the needs of the sick and injured and includes emergency medical services;

N. "emergency medical technician" means a provider who has been licensed by the department to provide patient care;

O. "health care facility" means a hospital, clinic or other entity licensed or approved by the department;

P. "injury prevention" means to promote and implement efforts to reduce the risk and severity of intentional and unintentional injuries;

Q. "medical direction" means guidance or supervision provided by a physician to a provider or emergency medical services system and that may include authority over and responsibility for emergency medical dispatch, direct patient care and transport of patients, arrangements for medical control and all other aspects of patient care delivered by a provider;

R. "paramedic" means a provider licensed at that level by the department to provide patient care;

S. "physician" means a doctor of medicine or doctor of osteopathy who is licensed or otherwise authorized to practice medicine or osteopathic medicine in New Mexico;

T. "protocol" means a predetermined, written medical care plan and includes standing orders;

U. "provider" means a person who has been licensed by the department to provide patient care pursuant to the Emergency Medical Services Act;

V. "regional office" means an emergency medical services planning and development agency formally recognized and supported by the bureau;

W. "secretary" means the secretary of health;

X. "special skills" means a set of procedures or therapies that are beyond the scope of practice of a given level of licensure and that have been approved by the medical direction committee for use by a specified provider; and

Y. "state emergency medical services medical director" means a physician designated by the department to provide overall medical direction to the statewide emergency medical services system, whose duties include serving as a liaison to the medical community and chairing the medical direction committee.

History: 1978 Comp., § 24-10B-3, enacted by Laws 1993, ch. 161, § 2; 2003, ch. 243, § 2.

ANNOTATIONS

Cross references. — For references to state corporation commission being construed as references to the public regulation commission, *see* 8-8-21 NMSA 1978.

Repeals and reenactments. — Laws 1993, ch. 161, § 2 repeals 24-10B-3 NMSA 1978, as enacted by Laws 1983, ch. 190, § 3, and enacts the above section, effective June 18, 1993. For provisions of former section, *see* New Mexico One Source of Law DVD.

The 2003 amendment, effective July 1, 2003, rewrote the section.

24-10B-4. Bureau; duties.

The bureau is designated as the lead agency for the emergency medical services system, including injury prevention, and shall establish and maintain a program for

regional planning and development, improvement, expansion and direction of emergency medical services throughout the state, including:

A. design, development, implementation and coordination of emergency medical services communications systems to join the personnel, facilities and equipment of a given region or system that will allow for medical direction;

B. provision of technical assistance to the public regulation commission for further development and implementation of standards for certification of ambulance services, vehicles and equipment;

C. development of requirements for the collection of data and statistics to evaluate the availability, operation and quality of providers in the state;

D. adoption of rules for emergency medical services medical direction upon the recommendation of the medical direction committee;

E. approval of continuing education programs for emergency medical services personnel;

F. adoption of rules pertaining to the training and licensure of emergency medical dispatchers and their instructors;

G. adoption of rules based upon the recommendations of a trauma advisory committee, for implementation and monitoring of a statewide, comprehensive trauma care system, including:

(1) minimum standards for designation or retention of designation as a trauma center or a participating trauma facility;

(2) pre-hospital care management guidelines for the triage and transportation of traumatized persons;

(3) establishment for interfacility transfer criteria and transfer agreements;

(4) standards for collection of data relating to trauma system operation, patient outcome and trauma prevention; and

(5) creation of a state trauma care plan;

H. adoption of rules, based upon the recommendations of the air transport advisory committee, for the certification of air ambulance services;

I. adoption of rules pertaining to authorization of providers to honor advance directives, such as emergency medical services do not resuscitate forms, to withhold or

terminate care in certain pre-hospital or interfacility circumstances, as guided by local medical protocols;

J. operation of a critical incident stress management program for emergency providers utilizing specifically trained volunteers who shall be considered public employees for the purposes of the Tort Claims Act [41-4-1 NMSA 1978] when called upon to perform their duties;

K. adoption of rules to establish a cardiac arrest targeted response program pursuant to the Cardiac Arrest Response Act [24-10C-1 NMSA 1978], including registration of automated external defibrillator programs, maintenance of equipment, data collection, approval of automated external defibrillator training programs and a schedule of automated external defibrillator program registration fees;

L. adoption of rules for the administration of an emergency medical services certification program for certified emergency medical services; and

M. promoting, developing, implementing, coordinating and evaluating risk reduction and injury prevention systems.

History: Laws 1983, ch. 190, § 4; 1993, ch. 161, § 3; 1999, ch. 94, § 8; 2003, ch. 243, § 3.

ANNOTATIONS

The 1993 amendment, effective June 18, 1993, substituted "the emergency medical services system" for "emergency medical services" and deleted "but not limited to" from the end in the introductory language; substituted "or interfacility care" for "or hospital to hospital care" in Subsection A; inserted "state corporation" in Subsection B; inserted "development of requirements for the" and substituted "providers" for "emergency medical services" in Subsection C; rewrote Subsection D; rewrote former Subsection E as present Subsection F; deleted former Subsection F, relating to the adoption of guidelines for the survey and elective designation of medical facilities according to critical care categories; and added present Subsections E and G through L.

The 1999 amendment, effective July 1, 1999, substituted "public regulation commission" for "state corporation commission" in Subsection B; added Subsection M; and made related stylistic changes.

The 2003 amendment, effective July 1, 2003, rewrote the section.

24-10B-4.1. Records confidentiality.

A. Any files or records in the possession of the bureau, a regional office or a provider containing identifying information about individuals requesting or receiving

treatment or other health services and any unsubstantiated complaints received by the bureau regarding any provider shall be confidential and not subject to public inspection.

B. Such files, records and complaints may be subject to subpoena for use in any pending cause in any administrative proceeding or in any of the courts of this state, unless otherwise provided by law.

History: Laws 2003, ch. 243, § 11.

ANNOTATIONS

Effective dates. — Laws 2003, ch. 243, § 14, makes the section effective on July 1, 2003.

24-10B-4.2. Approved training programs.

Approved emergency medical services training programs for providers are an integral part of the emergency medical services system and the programs shall include:

A. improving and expanding emergency medical services within regions through focused emergency medical services educational activities;

B. furthering the knowledge base of emergency medical services education; and

C. securing physicians as medical directors to advise approved training programs in medical matters and to serve as liaison to the state emergency medical services medical director and the medical community as a whole.

History: Laws 2003, ch. 243, § 12.

ANNOTATIONS

Effective dates. — Laws 2003, ch. 243, § 14, makes the section effective on July 1, 2003.

24-10B-4.3. Regional offices; duties.

A. Regional offices may be established by the department to assist the bureau to provide regional planning and development, improvement, expansion and direction of emergency medical services and injury prevention in their respective geographic regions.

B. Regional offices may provide technical support and assistance, training coordination, outreach, advocacy, prevention and public education and leadership to communities and providers in their respective geographic regions. They may also

provide specific support to the bureau for functions such as licensing examination, planning, evaluation and Emergency Medical Services Fund Act [24-10A-1 NMSA 1978] administration.

History: Laws 2003, ch. 243, § 13.

ANNOTATIONS

Effective dates. — Laws 2003, ch. 243, § 14, makes the section effective on July 1, 2003.

24-10B-5. Licensure required; penalty.

A. The department shall by rule adopt and enforce licensure requirements, including minimum standards for training, continuing education and disciplinary actions consistent with the Uniform Licensing Act [61-1-1 NMSA 1978], for all persons who provide emergency medical services within the state, irrespective of whether the services are remunerated. The rules shall include authorization for the bureau to issue at least annually an updated list of skills, techniques and medications approved for use at each level of licensure. The secretary may waive licensure requirements as needed during a declared emergency.

B. Licensed emergency medical technicians may function within health care facilities under their licensure and approved New Mexico emergency medical services scope of practice. Nothing in this subsection shall prohibit a health care facility from assigning additional duties and responsibilities in accordance with law. This subsection shall not expand the New Mexico emergency medical services scope of practice under the emergency medical technician's license.

C. In addition to the requirements specified in Subsection A of this section, the department may:

(1) prohibit the use of "emergency medical dispatcher", "emergency medical technician", "emergency medical services first responder", "paramedic" or similar terms connoting expertise in providing emergency medical services by any person not licensed or certified under the Emergency Medical Services Act [24-10B-1 NMSA 1978];

(2) deny, suspend or revoke licensure in accordance with the provisions of the Uniform Licensing Act; and

(3) establish a schedule of reasonable fees for application, examination or licensure and regular renewal thereof.

D. Any person who represents himself to be an "emergency medical dispatcher", "emergency medical technician-basic", "emergency medical technician-intermediate", "emergency medical technician-paramedic", "emergency medical services first

responder" or "paramedic", or who uses similar terms connoting expertise in providing emergency medical services while not currently licensed under the Emergency Medical Services Act is guilty of a misdemeanor.

History: Laws 1983, ch. 190, § 5; 1993, ch. 161, § 4; 2003, ch. 243, § 4.

ANNOTATIONS

Cross references. — For references to state corporation commission being construed as references to the public regulation commission, see 8-8-21 NMSA 1978.

The 1993 amendment, effective June 18, 1993, rewrote Subsection A and Paragraph (1) of Subsection B, and substituted "department" for "bureau" in the introductory language of Subsection B.

The 2003 amendment, effective July 1, 2003, rewrote the section heading; in Subsection A, substituted "licensure" and the present final sentence for "life support. When setting requirements for licensure of persons also subject to the Ambulance Standards Act, the bureau shall consult with the state corporation commission"; inserted present Subsection B and redesignated former Subsection B as Subsection C; deleted "certified" preceding "emergency medical services" and "or certification" following "licensure" twice in present Subsection C; and added Subsection D.

24-10B-5.1. Licensing commission established.

A. The secretary shall appoint an "emergency medical services licensing commission", which shall be staffed by the bureau and composed of one lay person, three emergency medical technicians, one from each level of licensure, and three physicians, at least two of whom shall have expertise in emergency medicine and who are appointed from a list proposed by the New Mexico chapter of the American college of emergency physicians.

B. The composition of the emergency medical services licensing commission shall reflect geographic diversity and both public and private interests. The members shall serve for three-year staggered terms. The duties of and procedures for the emergency medical services licensing commission shall be delineated in rules promulgated pursuant to Subsection A of Section 24-10B-5 NMSA 1978. Such duties include:

(1) providing a forum for the receipt of public comment regarding emergency medical services licensing matters;

(2) oversight of the bureau's licensure functions;

(3) receiving complaints, directing investigations and authorizing the initiation of actions by the bureau regarding contemplated refusal to grant initial licensure and for disciplinary actions against licensees; and

(4) the granting of waivers, for good cause shown, of rules pertaining to licensure renewal.

C. The emergency medical services licensing commission may compel the production of books, records and papers pertinent to any investigation authorized by the Emergency Medical Services Act [24-10B-1 NMSA 1978] and may seek enforcement of any subpoena so issued through the district court in the county in which the custodian of the document is located in camera.

D. The emergency medical services licensing commission shall meet as needed, but not less frequently than semiannually. The emergency medical services licensing commission shall be subject to the provisions of the Per Diem and Mileage Act [10-8-1 NMSA 1978].

History: Laws 1993, ch. 161, § 5; 2003, ch. 243, § 5.

ANNOTATIONS

The 2003 amendment, effective July 1, 2003, inserted present Subsection C and redesignated former Subsection C as Subsection D.

24-10B-6. Treatment authorized.

A. Notwithstanding the provisions of the Medical Practice Act [61-6-1 NMSA 1978], Sections 61-10-1 through 61-10-22 NMSA 1978 or the Nursing Practice Act [61-3-1 NMSA 1978], any person licensed by the bureau may render emergency medical services commensurate with his level of licensure, as medically indicated.

B. Individuals licensed pursuant to the provisions of the Medical Practice Act, Sections 61-10-1 through 61-10-22 NMSA 1978 or the Nursing Practice Act are not required to be licensed under the Emergency Medical Services Act [24-10B-1 NMSA 1978].

History: Laws 1983, ch. 190, § 6; 1993, ch. 161, § 6; 2003, ch. 243, § 6.

ANNOTATIONS

The 1993 amendment, effective June 18, 1993, rewrote Subsection A; deleted former Subsection B, which read: "In addition to the activities allowed under the provisions of Subsection A of this section, any licensed advanced life support personnel, under medical control, may render advanced life support"; and renumbered former Subsection C as Subsection B.

The 2003 amendment, effective July 1, 2003, substituted "the Medical Practice Act" for the references to Sections 61-6-1 through 61-6-31 NMSA 1978 in Subsections A and B and deleted the terms "certification" or "certified" throughout the section.

24-10B-7. Committees established.

A. The secretary shall appoint a statewide emergency medical services advisory committee to advise the bureau in carrying out the provisions of the Emergency Medical Services Act [24-10B-1 NMSA 1978]. The advisory committee shall include, at a minimum, representatives from the state medical society, the state emergency medical technicians' association, the state firefighters' association, the New Mexico ambulance association, the state nurses' association, the association of public safety communications organization/national emergency numbers association, the lead state agency for public safety and emergency preparedness, the state emergency services council, the New Mexico health and hospital systems association, the university of New Mexico health sciences center, the state fire chiefs' association, a consumer, emergency medical service regional offices and other interested provider and consumer groups as determined by the secretary. The advisory committee shall establish appropriate subcommittees, including a trauma advisory committee and an air transport advisory committee.

B. The joint organization on education committee shall be composed, at a minimum, of the director and medical director of the academy and each approved emergency medical services training program or their designee, the state emergency medical services medical director, the bureau chief or his designee, who shall serve without vote, each emergency medical services regional office training coordinator and one provider from the three highest levels of licensure, who are appointed by the secretary from a list proposed by the statewide emergency medical services advisory committee. The duties of the joint organization on education committee include:

(1) developing minimum curricula content for approved emergency medical services training programs;

(2) establishing minimum standards for approved emergency medical services training programs;

(3) reviewing and approving the applications of organizations seeking to become approved emergency medical services training programs; and

(4) developing minimum qualifications for and maintaining a list of instructors for each of the approved emergency medical services training programs.

C. The secretary shall appoint a medical direction committee to advise the bureau on matters relating to medical direction. The state emergency medical services medical director shall be a member of the committee and shall act as its chairman. The medical direction committee shall include, at a minimum, a physician representative experienced in pre-hospital medical care selected from a list proposed by the New Mexico chapter of the American college of emergency physicians, a physician representative from the academy, one physician from each of the emergency medical services geographic regions, one physician with pediatric emergency medicine expertise, one physician

representing emergency medical dispatchers and one provider from the three highest levels of licensure. Members shall be selected to represent both public and private interests. The duties of the medical direction committee include:

(1) reviewing the medical appropriateness of all rules proposed by the bureau;

(2) reviewing and approving the applications of providers for special skills authorizations;

(3) assisting in the development of rules pertaining to medical direction; and

(4) reviewing at least annually a list of skills, techniques and medications approved for use at each level of licensure that shall be approved by the secretary and issued by the bureau.

D. The committees created in this section are subject to the provisions of the Per Diem and Mileage Act [10-8-1 NMSA 1978], to the extent that funds are available for that purpose.

E. Any decision that the bureau proposes to make contrary to the recommendation of any committee created in this section shall be communicated in writing to that committee. Upon the request of that committee, the decision shall be submitted for reconsideration to the director of the public health division of the department and subsequently to the secretary. Any decision made pursuant to a request for reconsideration shall be communicated in writing by the department to the appropriate committee.

History: Laws 1983, ch. 190, § 7; 1993, ch. 161, § 8; 2003, ch. 243, § 7.

ANNOTATIONS

The 1993 amendment, effective June 18, 1993, rewrote the section heading; designated the existing provisions as Subsection A; in Subsection A, substituted "The secretary shall appoint a statewide emergency medical services" for "Pursuant to Section 9-7-11 NMSA 1978, the secretary of health and environment shall appoint an" in the first sentence, substituted "firefighters'" for "firemen's" and "offices" for "planning bodies" in the second sentence, and added the last sentence; and added Subsections B through E.

The 2003 amendment, effective July 1, 2003, in Subsection A, inserted "at a minimum" following "advisory committee shall include"; in the second sentence, added the language following "state firefighters' association" and preceding "emergency medical service"; and added "as determined by the secretary" at the end of the sentence; and rewrote Subsections B and C.

24-10B-8. Liability.

In any claim for civil damages arising out of the provision of emergency medical services by personnel described in Section 24-10B-5 NMSA 1978, those personnel shall be considered health care providers for purposes of the Tort Claims Act [41-4-1 NMSA 1978] if the claim is against a governmental entity or a public employee as defined by that act.

History: Laws 1983, ch. 190, § 8; 1993, ch. 161, § 9.

ANNOTATIONS

The 1993 amendment, effective June 18, 1993, substituted "24-10B-5 NMSA 1978" for "5 of the Emergency Medical Services Act".

Am. Jur. 2d, A.L.R. and C.J.S. references. — Liability for injury or death allegedly caused by activities of hospital "rescue team," 64 A.L.R.4th 1200.

Application of "firemen's rule" to bar recovery by emergency medical personnel injured in responding to, or at scene of, emergency, 89 A.L.R.4th 1079.

24-10B-9. Emergency first aid.

Nothing in the Emergency Medical Services Act [24-10B-1 NMSA 1978] shall prevent fire and rescue services, public safety organizations and other trained units or individuals from rendering emergency first aid to the public commensurate with their training. Nothing in the Emergency Medical Services Act shall be construed to supersede other statutory authority permitting the rendering of first aid.

History: Laws 1983, ch. 190, § 9; 1993, ch. 161, § 10; 2003, ch. 243, § 8.

ANNOTATIONS

The 1993 amendment, effective June 18, 1993, deleted "service" after "first aid" in the first sentence, and substituted "other statutory authority permitting the rendering of first aid" for "the provisions of the Search and Rescue Act" in the second sentence.

The 2003 amendment, effective July 1, 2003, did not change the text of the section.

24-10B-9.1. Emergency transportation.

Any person may be transported to an appropriate health care facility by an emergency medical technician, under medical direction, when the emergency medical technician makes a good faith judgment that the person is incapable of making an informed decision about his own safety or need for medical attention and is reasonably

likely to suffer disability or death without the medical intervention available at such a facility.

History: Laws 1993, ch. 161, § 11; 2003, ch. 243, § 9.

ANNOTATIONS

The 2003 amendment, effective July 1, 2003, substituted ""medical direction" for "medical control".

24-10B-10. Enforcement.

The department may bring civil action in any district court to enforce any of the provisions of the Emergency Medical Services Act [24-10B-1 NMSA 1978].

History: Laws 1983, ch. 190, § 10.

24-10B-11. Summoning emergency vehicle without cause; penalty.

Any person who willfully summons an ambulance or emergency response vehicle or reports that one is needed when that person knows that the ambulance or emergency response vehicle is not needed is guilty of a petty misdemeanor.

History: Laws 1983, ch. 190, § 11.

ANNOTATIONS

Cross references. — For sentencing for misdemeanors, see Chapter 31, Article 19 NMSA 1978.

24-10B-12. Academy; duties.

The academy is designated as the lead emergency medical services training agency. Its duties include:

A. administering formal emergency medical services training conducted in New Mexico, other than training provided by other approved emergency medical services training programs;

B. furthering the knowledge of emergency medical services education;

C. securing a physician as its medical director to advise it in medical matters and to serve as liaison to the state emergency medical services medical director and the medical community as a whole;

D. supporting, promoting and conducting scholarly research regarding emergency medical services; and

E. reporting and publishing emergency medical services information.

History: Laws 1993, ch. 161, § 7; 2003, ch. 243, § 10.

ANNOTATIONS

The 2003 amendment, effective July 1, 2003, inserted "emergency medical services" preceding "training" in the introductory sentence; substituted "formal emergency medical services" for "all basic life support" in Subsection A; and added Subsections D and E.

ARTICLE 10C
Cardiac Arrest Response

24-10C-1. Short title.

Sections 1 through 7 [24-10C-1 to 24-10C-7 NMSA 1978] of this act may be cited as the "Cardiac Arrest Response Act".

History: Laws 1999, ch. 94, § 1.

ANNOTATIONS

Effective dates. — Laws 1999, ch. 94, § 9, makes the act effective on July 1, 1999.

24-10C-2. Findings and purpose.

A. The legislature finds that:

(1) each year more than three hundred fifty thousand Americans die from out-of-hospital sudden cardiac arrest;

(2) the American heart association estimates that more than twenty thousand deaths could be prevented each year if early defibrillation were more widely available. In cardiac arrest the first several minutes are the most crucial time in which performing defibrillation can significantly improve chances for survival;

(3) the reality is that even in the best emergency medical services systems, emergency medical technicians or first responders may not always be able to arrive during that critical window of time; and

(4) virtually all communities in New Mexico have invested in 911 emergency response systems, emergency medical personnel and ambulance vehicles. However, many of them do not have enough defibrillators in their community [communities].

B. It is the purpose of the Cardiac Arrest Response Act [24-10C-1 NMSA 1978] to encourage greater acquisition, deployment and use of automated external defibrillators in communities across the state.

History: Laws 1999, ch. 94, § 2.

ANNOTATIONS

Bracketed material. — The bracketed material was inserted by the compiler. It was not enacted by the legislature and is not part of the law.

Effective dates. — Laws 1999, ch. 94, § 9, makes the act effective on July 1, 1999.

24-10C-3. Definitions.

As used in the Cardiac Arrest Response Act [24-10C-1 NMSA 1978]:

A. "automated external defibrillator and semi-automatic external defibrillation (AED)" means a medical device heart monitor and defibrillator that:

(1) has received approval of its pre-market modification filed pursuant to 21 U.S.C. 360(k), from the United States food and drug administration;

(2) is capable of recognizing cardiac arrest that will respond to defibrillation, ventricular fibrillation or rapid ventricular tachycardia, and is capable of determining whether defibrillation should be performed; and

(3) upon determining that defibrillation should be performed, automatically charges and is capable of delivering an electrical impulse to an individual's heart;

B. "AED program" means a program of trained targeted responders operating under the supervision of a physician medical director and is registered with the department;

C. "defibrillation" means the administration of a controlled electrical charge to the heart to restore a viable cardiac rhythm;

D. "department" means the department of health;

E. "physician" means a doctor of medicine or doctor of osteopathy who is licensed or otherwise authorized to practice medicine or osteopathic medicine in New Mexico; and

F. "trained targeted responder" means a person who has completed an authorized AED training program and who uses an AED.

History: Laws 1999, ch. 94, § 3.

ANNOTATIONS

Effective dates. — Laws 1999, ch. 94, § 9, makes the act effective on July 1, 1999.

24-10C-4. Protection of public safety.

A person who acquires an AED shall ensure that:

A. a physician medical director oversees all aspects of the defibrillation program, including training, emergency medical services coordination, protocol approval, AED deployment strategies and other program requirements, and that the physician medical director provides overall quality assurance and reviews each case in which the AED is used by the program;

B. the trained targeted responder receives appropriate training in cardiopulmonary resuscitation and in the use of an AED by a nationally recognized course in cardiopulmonary response and AED use approved by the department or other training programs authorized by the department;

C. the defibrillator is maintained and tested according to the manufacturer's guidelines;

D. any person who renders emergency care or treatment on a person in cardiac arrest by using an AED activates the emergency medical system as soon as possible, and reports any clinical use of the AED to the physician medical director;

E. the AED program is registered with the department; and

F. the local emergency medical services and local 911 agencies have been notified of the AED program.

History: Laws 1999, ch. 94, § 4.

ANNOTATIONS

Effective dates. — Laws 1999, ch. 94, § 9, makes the act effective on July 1, 1999.

24-10C-5. Authority.

Any person may use an AED if the person has met all the requirements of Section 4 [24-10C-4 NMSA 1978] of the Cardiac Arrest Response Act. Nothing in this section

limits the right of an individual to practice a health profession that the individual is otherwise authorized to practice under the laws of New Mexico.

History: Laws 1999, ch. 94, § 5.

ANNOTATIONS

Effective dates. — Laws 1999, ch. 94, § 9, makes the act effective on July 1, 1999.

24-10C-6. Exemption.

Nothing in the Cardiac Arrest Response Act [24-10C-1 NMSA 1978] precludes a physician from prescribing an AED to a patient for use by the patient's caregiver on an individual patient and the use does not require the individual to function in an approved program.

History: Laws 1999, ch. 94, § 6.

ANNOTATIONS

Effective dates. — Laws 1999, ch. 94, § 9, makes the act effective on July 1, 1999.

24-10C-7. Limited immunity protections.

The following persons or entities who render emergency care or treatment by the use of an AED under the provisions of the Cardiac Arrest Response Act [24-10C-1 NMSA 1978] shall not be subject to civil liability provided they have acted with reasonable care and in compliance with the requirements of that act:

A. a physician who provides supervisory services pursuant to the Cardiac Arrest Response Act;

B. a person or entity that provides training in cardiopulmonary resuscitation and use of automated external defibrillation;

C. a person or entity that acquires an AED pursuant to the Cardiac Arrest Response Act;

D. the owner of the property or facility where the AED is located; and

E. the trained targeted responder.

History: Laws 1999, ch. 94, § 7.

ANNOTATIONS

Effective dates. — Laws 1999, ch. 94, § 9, makes the act effective on July 1, 1999.

ARTICLE 10D
Sexual Assault Survivors Emergency Care

24-10D-1. Short title.

This act [24-10D-1 to 24-10D-5 NMSA 1978] may be cited as the "Sexual Assault Survivors Emergency Care Act".

History: Laws 2003, ch. 91, § 1.

ANNOTATIONS

Cross references. — For sexual offenses, *see* Chapter 30, Article 9 NMSA 1978.

24-10D-2. Definitions.

As used in the Sexual Assault Survivors Emergency Care Act [24-10D-1 NMSA 1978]:

A. "department" means the department of health;

B. "emergency care for sexual assault survivors" means medical examinations, procedures and services provided by a hospital to a sexual assault survivor following an alleged sexual assault;

C. "emergency contraception" means a drug approved by the federal food and drug administration that prevents pregnancy after sexual intercourse;

D. "hospital" means a facility providing emergency or urgent health care;

E. "medically and factually accurate and objective" means verified or supported by the weight of research conducted in compliance with accepted scientific methods and standards; published in peer-reviewed journals; and recognized as accurate and objective by leading professional organizations and agencies with relevant expertise in the field of obstetrics and gynecology, such as the American college of obstetricians and gynecologists;

F. "sexual assault" means the crime of criminal sexual penetration; and

G. "sexual assault survivor" means a female who alleges or is alleged to have been sexually assaulted and who presents as a patient to a hospital.

History: Laws 2003, ch. 91, § 2.

ANNOTATIONS

24-10D-3. Emergency care for sexual assault survivors; standard of care.

A. A hospital that provides emergency care for sexual assault survivors shall:

(1) provide each sexual assault survivor with medically and factually accurate and objective written and oral information about emergency contraception;

(2) orally and in writing inform each sexual assault survivor of her option to be provided emergency contraception at the hospital; and

(3) provide emergency contraception at the hospital to each sexual assault survivor who requests it.

B. The provision of emergency contraception pills shall include the initial dose that the sexual assault survivor can take at the hospital as well as the subsequent dose that the sexual assault survivor may self-administer twelve hours following the initial dose.

History: Laws 2003, ch. 91, § 3.

ANNOTATIONS

24-10D-4. Training.

No later than September 30, 2003:

A. a hospital shall ensure that all personnel who provide care to sexual assault survivors are trained to provide medically and factually accurate and objective information about emergency contraception; and

B. the department shall adopt rules regulating the training to be provided by hospitals pursuant to the Sexual Assault Survivors Emergency Care Act [24-10D-1 NMSA 1978] to personnel who provide emergency care for sexual assault survivors.

History: Laws 2003, ch. 91, § 4.

ANNOTATIONS

24-10D-5. Enforcement; administrative fines.

A. Complaints of failure to provide services required by the Sexual Assault Survivors Emergency Care Act [24-10D-1 NMSA 1978] may be filed with the department.

B. The department shall immediately investigate every complaint it receives regarding failure of a hospital to provide services required by the Sexual Assault Survivors Emergency Care Act to determine the action to be taken to satisfy the complaint.

C. The department shall compile all complaints it receives regarding failure to provide services required by the Sexual Assault Survivors Emergency Care Act and shall retain the complaints for at least ten years so that they can be analyzed for patterns of failure to provide services pursuant to that act.

D. If the department determines that a hospital has failed to provide the services required in the Sexual Assault Survivors Emergency Care Act, the department shall:

(1) issue a written warning to the hospital upon receipt of a complaint that the hospital is not providing the services required by the Sexual Assault Survivors Emergency Care Act; and

(2) based on the department's investigation of the first complaint, require the hospital to correct the deficiency leading to the complaint.

E. If after the issuance of a written warning to the hospital pursuant to Subsection D of this section, the department finds that the hospital has failed to provide services required by the Sexual Assault Survivors Emergency Care Act, the department shall, for a second through fifth complaint, impose on the hospital a fine of one thousand dollars ($1,000):

(1) per sexual assault survivor who is found by the department to have been denied medically and factually accurate and objective information about emergency contraception or who is not offered or provided emergency contraception; or

(2) per month from the date of the complaint alleging noncompliance until the hospital provides training pursuant to the rules of the department.

F. For the sixth and subsequent complaint against the same hospital if the department finds the hospital has failed to provide services required by the Sexual Assault Survivors Emergency Care Act, the department shall impose an intermediate sanction pursuant to Section 24-1-5.2 NMSA 1978 or suspend or revoke the license of the hospital issued pursuant to the Public Health Act [24-1-1 NMSA 1978].

History: Laws 2003, ch. 91, § 5.

ANNOTATIONS

Severability clauses. — Laws 2003, ch. 91, § 6 provides for the severability of the act if any part or application thereof is held invalid.

ARTICLE 10E
Trauma System Fund Authority

24-10E-1. Short title.

This act may be cited as the "Trauma System Fund Authority Act".

History: Laws 2006, ch. 13, § 1.

ANNOTATIONS

Effective dates. — Laws 2006, ch. contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

24-10E-2. Purpose of act.

The purpose of the Trauma System Fund Authority Act [24-10E-1 NMSA 1978] is to provide funding to sustain existing trauma centers, support the development of new trauma centers and develop a statewide trauma system.

History: Laws 2006, ch. 13, § 2.

ANNOTATIONS

Effective dates. — Laws 2006, ch. contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

24-10E-3. Definitions.

As used in the Trauma System Fund Authority Act [24-10E-1 NMSA 1978]:

A. "authority" means the trauma system fund authority;

B. "department" means the department of health;

C. "fund" means the trauma system fund;

D. "secretary" means the secretary of health; and

E. "statewide trauma system" means a coordinated continuum of care that includes injury prevention, emergency medical, acute care hospital and rehabilitative services and that is subject to accountability and system improvement.

History: Laws 2006, ch. 13, § 3.

ANNOTATIONS

Effective dates. — Laws 2006, ch. contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

24-10E-4. Trauma system fund authority created; membership.

A. The "trauma system fund authority" is created. The authority is administratively attached to the department.

B. The authority shall consist of at least nine members, all of whom shall be appointed by and serve at the pleasure of the governor. The membership of the authority shall include the following:

(1) the secretary or the secretary's designee;

(2) representation from the medical specialty of trauma physicians;

(3) at least one member of a statewide organization representing physicians in New Mexico;

(4) at least one member representing emergency and trauma nursing practice;

(5) at least one member of a statewide organization representing hospitals and health systems in New Mexico;

(6) at least one member of a statewide organization representing injury prevention;

(7) the chair of the statewide emergency medical services advisory committee;

(8) the chair of the trauma advisory committee; and

(9) at least one member of a statewide organization representing rehabilitation services.

C. Authority members shall elect a chair and other officers as the authority deems appropriate.

D. The authority shall meet regularly at the call of the chair.

History: Laws 2006, ch. 13, § 4.

ANNOTATIONS

Effective dates. — Laws 2006, ch. contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

24-10E-5. Duties.

The authority shall:

A. develop criteria by which distribution of funds to existing trauma centers and potential new centers will occur;

B. receive applications and determine and monitor the actual distribution of money from the fund that will support the development of a statewide system of trauma care;

C. oversee the department's administration of the fund and the development of a trauma system; and

D. report annually to the interim legislative health and human services committee and the legislative finance committee.

History: Laws 2006, ch. 13, § 5.

ANNOTATIONS

Effective dates. — Laws 2006, ch. contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

24-10E-6. Trauma system fund created; funding.

A. The "trauma system fund" is created in the state treasury. The fund shall consist of money appropriated and transferred to the fund, money received by the authority from any public or private source and tax revenues distributed to the fund by law. Interest earned on investment of the fund shall be credited to the fund. Disbursements from the fund shall be made upon warrants drawn by the secretary of finance and administration pursuant to vouchers signed by the secretary of health or the secretary's authorized representative. Money in the fund shall not revert at the end of any fiscal year.

B. Money in the fund is appropriated to the department for the purpose of making distributions approved by the authority and for administering the Trauma System Fund

Authority Act [24-10E-1 NMSA 1978]; provided that no more than five percent of the fund may be used by the department for administrative costs, including monitoring, trauma system development and providing technical assistance.

History: Laws 2006, ch. 13, § 6.

ANNOTATIONS

Effective dates. — Laws 2006, ch. contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

24-10E-7. Rules.

The department shall promulgate rules to carry out the provisions of the Trauma System Fund Authority Act [24-10E-1 NMSA 1978].

History: Laws 2006, ch. 13, § 7.

ANNOTATIONS

Effective dates. — Laws 2006, ch. contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective May 17, 2006, 90 days after adjournment of the legislature.

ARTICLE 11
Medical Investigations

24-11-1. Board of medical investigators; creation; membership; compensation.

There is created the "board of medical investigators", consisting of the dean of the university of New Mexico school of medicine, the secretary of health, the chief of the New Mexico state police, the chairman of the state board of thanatopractice and the director of the New Mexico office of Indian affairs. The members of the board of medical investigators shall receive no compensation for their services as board members other than as provided in the Per Diem and Mileage Act [10-8-1 NMSA 1978].

History: 1953 Comp., § 12-17-1, enacted by Laws 1971, ch. 112, § 1; and recompiled as 1953 Comp., § 12-29-1, by Laws 1972, ch. 51, § 9; 1973, ch. 286, § 1; 1977, ch. 253, § 38; 1981, ch. 96, § 1; 2003, ch. 191, § 1.

ANNOTATIONS

Cross references. — For chairman of state board of thanatopractice, *see* 61-32-5 NMSA 1978.

The 2003 amendment, effective July 1, 2003, deleted "medical school at the" following "dean of the", inserted "school of medicine" following "of New Mexico", substituted "health, the chief of the New Mexico" for "health and environment, the chief of the" following " the secretary of", and substituted "and the director of the New Mexico office of Indian affairs" for "of the state of New Mexico" following "state board of thanatopractice".

Am. Jur. 2d, A.L.R. and C.J.S. references. — 18 Am. Jur. 2d Coroners or Medical Examiners § 1 et seq.

18 C.J.S. Coroners § 1 et seq.

24-11-2. Meetings; duties.

A. The board of medical investigations [investigators] shall meet at least annually and as often as necessary to conduct the business of the board. Additional meetings may be called by the chairman or by a majority of the members of the board.

B. At the first annual meeting of the board, the members shall elect one of their number as chairman.

C. The board of medical investigations [investigators] shall formulate broad policy for the operation of the office of the state medical investigator and the offices of the district medical investigators.

D. The board of medical investigations [investigators] shall employ and fix the compensation of a qualified state medical investigator who shall be assigned as an employee of the university of New Mexico school of medicine.

History: 1953 Comp., § 12-17-2, enacted by Laws 1971, ch. 112, § 2; recompiled as 1953 Comp., § 12-29-2, by Laws 1972, ch. 51, § 9; 1973, ch. 286, § 2.

ANNOTATIONS

Bracketed material. — The bracketed material in this section was inserted by the compiler; it was not enacted by the legislature and is not a part of the law.

24-11-3. State medical investigator; qualifications; duties; office.

A. The state medical investigator shall be a physician licensed to practice in New Mexico. Insofar as practicable, the medical investigator shall be trained in the fields of pathology and forensic medicine.

B. The state medical investigator shall maintain his office at the school of medicine at the university of New Mexico.

C. The state medical investigator shall appoint district medical investigators and where necessary deputy medical investigators who shall serve at his pleasure. The state medical investigator may assign deputy medical investigators to districts to work under the supervision of a district medical investigator. The district medical investigator shall be a licensed physician. When deemed necessary by the state medical investigator, he may direct a deputy or district medical examiner to enter another district for the purpose of carrying out medical investigations.

D. Any district created by the state medical investigator to be staffed by a district medical investigator shall be co-extensive with one or more counties.

E. The state medical investigator may enter into agreements for services to be performed by persons in the course of medical investigations.

F. The state medical investigator shall, subject to the approval of the board of medical investigations, promulgate rules and regulations for the proper investigation of deaths occurring within this state.

G. The state medical investigator shall maintain records of the deaths occurring within this state which are investigated by either state or district medical investigators.

H. In addition to other duties prescribed in this section, the state medical investigator shall also serve as the district medical investigator for Bernalillo county.

I. Funds for the operation of the state and district medical investigators' offices shall be appropriated to and administered by the university of New Mexico school of medicine.

History: 1953 Comp., § 12-17-3, enacted by Laws 1971, ch. 112, § 3; recompiled as 1953 Comp., § 12-29-3, by Laws 1972, ch. 51, § 9; 1973, ch. 286, § 3.

ANNOTATIONS

Am. Jur. 2d, A.L.R. and C.J.S. references. — 18 C.J.S. Coroners §§ 3 to 9.

24-11-4. [References to coroner.]

As used in the New Mexico Statutes Annotated, 1978 Compilation, "coroner" means the district medical investigator.

History: 1953 Comp., § 15-43-43.1, enacted by Laws 1971, ch. 112, § 10.

24-11-5. Reports of violent death.

When any person comes to a sudden, violent or untimely death or is found dead and the cause of death is unknown, anyone who becomes aware of the death shall report it immediately to law enforcement authorities or the office of the state or district medical investigator. The public official so notified, shall in turn notify either, or both, the appropriate law enforcement authorities or the office of the state or district medical investigator. The state or district medical investigator, or a deputy medical investigator under his direction, shall, without delay, view and take legal custody of the body.

History: 1953 Comp., § 15-43-44, enacted by Laws 1961, ch. 91, § 2; 1971, ch. 112, § 4; 1973, ch. 286, § 4; 1975, ch. 7, § 1.

ANNOTATIONS

Cross references. — For failure to report death, *see* 24-11-10 NMSA 1978.

24-11-6. Death certificate; release of body; reports.

A. If, after viewing the body, notifying the law enforcement agency with jurisdiction and making an investigation, the state or district medical investigator is satisfied that the death was not caused by criminal act or omission and that there are no suspicious circumstances about the death, he shall execute a death certificate in the form required by law. He shall also execute a certificate on a form prescribed by the health and social services department [department of health], authorizing release of the body to the funeral director for burial. In those cases in which the investigation is performed by a deputy medical investigator, if, after viewing the body, notifying the law enforcement agency with jurisdiction and making an investigation, he is satisfied that the death was not caused by criminal act or omission and that there are no suspicious circumstances about the death, he shall report this finding to the state or district medical investigator under whose direction he is working. Upon receipt of a report from a deputy medical investigator under this subsection, the state or district medical investigator may execute a death certificate and a certificate authorizing release of the body for burial.

B. In those cases where the death resulted from a motor vehicle accident on a public highway, and the state, district or deputy medical investigator performs or causes to be performed a test or tests to determine the alcoholic content of the deceased's blood, a copy of the report of this test shall be sent to the planning division of the state highway department for the department's use only for statistical purposes. The copy of the report sent to the planning division of the state highway department of the results shall not contain any identification of the deceased and shall not be subject to judicial process.

History: 1953 Comp., § 15-43-45, enacted by Laws 1961, ch. 91, § 3; 1969, ch. 36, § 1; 1971, ch. 112, § 5; 1973, ch. 286, § 5; 1975, ch. 7, § 2.

ANNOTATIONS

Cross references. — For disposition of dead bodies generally, *see* 24-12-1 NMSA 1978 et seq.

Bracketed material. — The health and social services department, referred to in the second sentence in Subsection A, was abolished and its property, personnel, etc., transferred to the health and environment department by Laws 1977, ch. 253, §§ 5 and 14. Laws 1991, ch. 25, § 16 repeals former 9-7-4 NMSA 1978, relating to the health and environment department and enacts a new 9-7-4 NMSA 1978 creating the department of health. The bracketed material was not enacted by the legislature and is not part of the law.

Use of original report. — Under Subsection B, no evidentiary limitation is placed on an original report which identifies the deceased person; to disallow its use in civil and criminal cases would render the report valueless. South v. Lucero, 92 N.M. 798, 595 P.2d 768 (Ct. App.)

Am. Jur. 2d, A.L.R. and C.J.S. references. — 18 Am. Jur. 2d Coroners or Medical Examiners § 1 et seq.

Admissibility of finding of coroner to show cause of death in workmen's compensation cases, 6 A.L.R. 548.

Insurance: coroner's verdict or report as evidence on issue of suicide, 28 A.L.R.2d 352.

Homicide: cremation of victim's body as violation of accused's right, 70 A.L.R.4th 1091.

18 C.J.S. Coroners § 23.

24-11-6.1. Deceased members of Indian nations, tribes or pueblos; consultation and certification required.

A. The state medical investigator shall make reasonable efforts to determine if a deceased person is a member of a federally recognized Indian nation, tribe or pueblo. If a deceased person has been determined to be a member of a federally recognized Indian nation, tribe or pueblo, the state medical investigator shall use all due diligence to avoid an autopsy except when legally required due to possible criminal acts or omissions, an obscure cause of death or other reasons or pursuant to consent given according to the provisions of Section 24-12-4 NMSA 1978. The state medical investigator shall use the least invasive means possible to satisfy the investigator's legal duties in conducting an autopsy.

B. If the state medical investigator determines that an autopsy cannot be avoided, the investigator shall attempt to provide advance notice of the autopsy to the surviving spouse or next of kin, or to the Indian nation, tribe or pueblo of the deceased. The state medical investigator shall provide documentation concerning the autopsy upon request

of the surviving spouse or next of kin, or if none is identified, to the Indian nation, tribe or pueblo of which the deceased was a member.

C. If requested by the surviving spouse or the next of kin, or if none is identified, by the Indian nation, tribe or pueblo through an official representative designated pursuant to Subsection E of this section, the state medical investigator shall permit a law enforcement officer of the Indian nation, tribe or pueblo of the deceased to be present during the autopsy. The law enforcement officer attending the autopsy may not interfere with the autopsy procedure and shall follow the health regulations governing autopsy procedures.

D. After any legally required autopsy or postmortem examination has been conducted, the state medical investigator shall use all due diligence to consult with the surviving spouse or next of kin of the deceased regarding the disposition of all of the deceased's remains. Unless other treatment of the remains is required by law, the state medical investigator shall replace all body parts and, if requested, shall provide written certification to the surviving spouse or next of kin of the deceased that the investigator has replaced all body parts.

E. The state medical investigator shall request that each Indian nation, tribe and pueblo located in New Mexico designate, and keep current the designation of, an official representative that the state medical investigator shall contact when it is necessary to contact a tribal representative regarding an autopsy or the disposition of the remains of a deceased member of the Indian nation, tribe or pueblo.

History: Laws 2003, ch. 191, § 2; 2005, ch. 263, § 1.

ANNOTATIONS

The 2005 amendment, effective June 17, 2005, deletes the former provision that if a deceased person is a member of a federally recognized Indian nation, tribe or pueblo, the state medical investigator shall use all due diligence after a legally required autopsy or post-mortem examination, to consult with the legal next of kin of the deceased regarding the disposition of all of her deceased's remains, unless other treatment of the remains is provided for by law and adds Subsections A through E to provide for the autopsy of deceased members of an Indian nation, tribe or pueblo and for the disposition of the remains of the deceased.

24-11-7. Examination; autopsy; inquest.

If the deceased is unidentified, the state, district or deputy medical investigator may order the body fingerprinted and photographed. When the state, district or deputy medical investigator suspects a death was caused by a criminal act or omission or the cause of death is obscure, he shall order an autopsy performed by a qualified pathologist certified by the state board of medical examiners who shall record every fact found in the examination tending to show the identity and condition of the body and the

time, manner and cause of death. The pathologist shall sign the report under oath and deliver it to the state, district or deputy medical investigator within a reasonable time. The state, district or deputy medical investigator may take the testimony of the pathologist and any other persons and this testimony, combined with the written report of the pathologist, constitutes an inquest.

History: 1953 Comp., § 15-43-46, enacted by Laws 1961, ch. 91, § 4; 1971, ch. 112, § 6; 1973, ch. 286, § 6.

ANNOTATIONS

Am. Jur. 2d, A.L.R. and C.J.S. references. — 18 Am. Jur. 2d Coroners or Medical Examiners §§ 7 to 15.

Reviewing, setting aside or quashing verdict at coroner's inquest, 78 A.L.R.2d 1218.

Civil liability in conjunction with autopsy, 97 A.L.R.5th 419.

18 C.J.S. Coroners §§ 10 to 26.

24-11-8. Reports to district attorney.

The state or district medical investigator shall promptly report his findings, or the findings of a deputy medical investigator that has performed an investigation under his direction, to the district attorney in each death investigated. Upon request of the district attorney, the state or district medical investigator shall send a complete record of the medical investigation in any case, including a transcript of the testimony of witnesses examined at any inquest.

History: 1953 Comp., § 15-43-47, enacted by Laws 1961, ch. 91, § 5; 1971, ch. 112, § 7; 1973, ch. 286, § 7.

24-11-9. Subpoena; oath.

The state, district or deputy medical investigator may administer oaths and may issue a subpoena to compel the attendance and production of evidence by any necessary witness and the subpoena may be enforced in the district court. Any subpoena shall be served without cost by the sheriff or any deputy or by any member of the New Mexico state police.

History: 1953 Comp., § 15-43-48, enacted by Laws 1961, ch. 91, § 6; 1971, ch. 112, § 8; 1973, ch. 286, § 8.

24-11-10. Penalties.

A. It is unlawful to:

(1) willfully and without good cause neglect or refuse to report a death to law enforcement authorities or the office of the state or district medical investigator as required by law; or

(2) willfully and unnecessarily touch, remove or disturb any dead body required by law to be reported to the state or district medical investigator, or any article on or near the body or disturb its surroundings until authority is granted by the state, district or deputy medical investigator.

B. Any person violating this section is guilty of a petty misdemeanor.

History: 1953 Comp., § 15-43-50, enacted by Laws 1961, ch. 91, § 8; 1971, ch. 112, § 9; 1973, ch. 286, § 9; 1975, ch. 7, § 3.

ANNOTATIONS

Cross references. — For duty to report deaths, *see* 24-11-5 NMSA 1978.

For sentencing for misdemeanors, *see* 31-19-1 NMSA 1978.

ARTICLE 12
Disposition of Dead Bodies

24-12-1. Notification of relatives of deceased.

A. State, county or municipal officials having charge or control of a body of a dead person shall use due diligence to notify the relatives of the deceased.

B. If no claimant is found who will assume the cost of burial, the official having charge or control of the body shall notify the medical investigator stating, when possible, the name, age, sex and cause of death of the deceased.

C. The body shall be embalmed according to regulations of the state agency having jurisdiction. After the exercise of due diligence required in Subsection A of this section and the report to the medical investigator required in Subsection B of this section, the medical investigator shall be furnished detailed data demonstrating such due diligence and the fact that no claimant has been found. When the medical investigator has determined that due diligence has been exercised, that reasonable opportunity has been afforded relatives to claim the body and that the body has not been claimed, he shall issue his certificate determining that the remains are unclaimed. In no case shall an unclaimed body be disposed of in less than two weeks from the date of the discovery of the body.

History: Laws 1941, ch. 148, § 1; 1941 Comp., § 71-501; 1953 Comp., § 12-7-1; reenacted by Laws 1973, ch. 354, § 1; 1977, ch. 204, § 1; 1999, ch. 241, § 1.

ANNOTATIONS

Cross references. — For medical investigations generally, *see* Chapter 24, Article 11 NMSA.

For burial of indigents generally, *see* Chapter 24, Article 13 NMSA 1978.

The 1999 amendment, effective June 18, 1999, in Subsection A, substituted "having charge or control of a body of a dead person" for "having charge or control of bodies to be buried at public expense"; and in Subsection B, substituted "sex and cause of death of the deceased" for "sex and cause of death of any person required to be buried at public expense".

Am. Jur. 2d, A.L.R. and C.J.S. references. — 22A Am. Jur. 2d Dead Bodies § 1 et seq.

Dead bodies: liability for improper manner of reinterment, 53 A.L.R.4th 394.

25A C.J.S. Dead Bodies § 1 et seq.

24-12-2. Disposition of unclaimed body; transmission of records of institution.

A. Upon the issuance of his certificate that the remains are unclaimed, the medical investigator shall retain the body for use only for medical education or shall certify that the body is unnecessary or unsuited for medical education and release it to the state, county or municipal officials having charge or control of the body for burial. The state, county or municipal officials shall have the body removed for disposition within three weeks from the date on which the medical investigator released the body.

B. If the body is retained for use in medical education, the facility or person receiving the body for that use shall pay the costs of preservation and transportation of the body and shall keep a permanent record of bodies received.

C. If a deceased person was an inmate of a public institution, the institution shall transmit, upon request of the medical investigator, a brief medical history of the unclaimed dead person for purposes of identification and permanent record. The records shall be open to inspection by any state or county official or district attorney.

History: Laws 1941, ch. 148, §§ 3 to 5; 1941 Comp., §§ 71-503 to 71-505; 1953 Comp., § 12-7-2, reenacted by Laws 1973, ch. 354, § 2; 1977, ch. 204, § 2; 1999, ch. 241, § 2.

ANNOTATIONS

Cross references. — For burial of indigents, *see* 24-13-1 NMSA 1978.

Repeals and reenactments. — Laws 1973, ch. 354, § 2, repealed 12-7-2, 1953 Comp., relating to conduct of postmortem examinations, and enacted a new section. Provisions relating to postmortem examinations presently appear in 24-12-4 NMSA 1978.

The 1999 amendment, effective June 18, 1999, in Subsection A, added the last sentence.

Am. Jur. 2d, A.L.R. and C.J.S. references. — Homicide: cremation of victim's body as violation of accused's right, 70 A.L.R.4th 1091.

24-12-3. Penalties.

A. Any person who conducts a postmortem examination on an unclaimed body without express permission of the medical investigator is guilty of a misdemeanor and shall be punished by imprisonment in the county jail for not more than one year or by the imposition of a fine of not more than one thousand dollars ($1,000), or both such imprisonment and fine.

B. Any person who unlawfully disposes of, uses or sells an unclaimed body is guilty of a fourth degree felony and shall be punished by imprisonment in the state penitentiary for a term of not less than one year nor more than five years or by the imposition of a fine of not more than five thousand dollars ($5,000), or both such imprisonment and fine.

History: Laws 1941, ch. 148, §§ 2, 4; 1941 Comp., §§ 71-502, 71-504; 1953 Comp., § 12-7-4, reenacted by Laws 1973, ch. 354, § 3.

ANNOTATIONS

Cross references. — For medical investigations generally, *see* Chapter 24, Article 11 NMSA 1978.

Repeals and reenactments. — Laws 1973, ch. 354, § 3, repeals 12-7-4, 1953 Comp., relating to disposition of unclaimed bodies, and enacts the above section. Provisions relating to the disposition of unclaimed bodies presently appear in 24-12-2 NMSA 1978.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 22A Am. Jur. 2d Dead Bodies §§ 4, 44 to 47, 58, 112.

Validity, construction and application of statutes making it a criminal offense to mistreat or wrongfully dispose of dead body, 81 A.L.R.3d 1071.

25A C.J.S. Dead Bodies § 10.

24-12-4. Post-mortem examinations and autopsies; consent required.

A. An autopsy or post-mortem examination may be performed on the body of a deceased person by a physician or surgeon whenever consent to the procedure has been given by:

(1) written authorization signed by the deceased during his lifetime;

(2) authorization of any person or on behalf of any entity whom the deceased designated in writing during his lifetime to take charge of his body for burial or other purposes;

(3) authorization of the deceased's surviving spouse;

(4) authorization of an adult child, parent or adult brother or sister of the deceased if there is no surviving spouse or if the surviving spouse is unavailable, incompetent or has not claimed the body for burial after notification of the death of the decedent;

(5) authorization of any other relative of the deceased if none of the persons enumerated in Paragraphs (2) through (4) of this subsection is available or competent to give authorization; or

(6) authorization of the public official, agency or person having custody of the body for burial if none of the persons enumerated in Paragraphs (2) through (5) of this subsection is available or competent to give authorization.

B. An autopsy or post-mortem examination shall not be performed under authorization given under the provisions of Paragraph (4) of Subsection A of this section by any one of the persons enumerated if, before the procedure is performed, any one of the other persons enumerated objects in writing to the physician or surgeon by whom the procedure is to be performed.

C. An autopsy or post-mortem examination may be performed by a pathologist at the written direction of the district attorney or his authorized representative in any case in which the district attorney is conducting a criminal investigation.

D. An autopsy or post-mortem examination may be performed by a pathologist at the direction of the state, district or deputy medical investigator when he suspects the death was caused by a criminal act or omission or if the cause of death is obscure.

E. For purposes of this section, "autopsy" means a post-mortem dissection of a dead human body in order to determine the cause, seat or nature of disease or injury and includes the retention of tissues customarily removed during the course of autopsy for evidentiary, identification, diagnosis, scientific or therapeutic purposes.

History: 1953 Comp., § 12-7-9, enacted by Laws 1965, ch. 86, § 1; reenacted by 1973, ch. 354, § 4; 1993, ch. 129, § 1.

ANNOTATIONS

Cross references. — For medical investigations generally, *see* Chapter 24, Article 11 NMSA 1978.

The 1993 amendment, effective June 18, 1993, made minor stylistic changes throughout Subsection A and added Subsection E.

Purpose of Subsection D is to authorize a medical investigator to order an autopsy when he suspects that criminal conduct caused a death or that the cause of a death is obscure, even when no consent is obtained. In re Johnson, 94 N.M. 491, 612 P.2d 1302 (1980).

State registrar shall issue permit to disinter when medical investigator so requires pursuant to the duties and responsibilities of his office. In re Johnson, 94 N.M. 491, 612 P.2d 1302 (1980).

Requirement of notice of intended autopsy or disinterment. — Under some circumstances due process may require than an interested relative be given notice of an intended autopsy or disinterment of a deceased. In re Johnson, 94 N.M. 491, 612 P.2d 1302 (1980).

Immunity for wrongful decision to perform autopsy. — In an action for damages on the basis of an alleged wrongful decision to perform an autopsy, even if this section, which provides for consent for postmortem examinations created a private cause of action, it did not override the state medical investigator's grant of immunity under the Tort Claims Act [41-4-1 to 41-4-27 NMSA 1978]. Begay v. State, 104 N.M. 483, 723 P.2d 252 (Ct. App. 1985).

Religious freedom suit where consent not given. — The right given by this statute to a number of alternative persons to authorize an autopsy is not co-extensive with the right of any of those same statutorily-named persons to assert a violation of a personal religious freedom if his consent was not obtained. Smialek v. Begay, 104 N.M. 375, 721 P.2d 1306, cert. denied, 479 U.S. 1020, 107 S. Ct. 677, 93 L. Ed. 2d 727 (1986).

Am. Jur. 2d, A.L.R. and C.J.S. references. — 22A Am. Jur. 2d Dead Bodies §§ 59, 60, 64 to 69.

Removal and reinterment of remains, 21 A.L.R.2d 472.

Power of court to order disinterment and autopsy or examination for evidential purposes in a civil case, 21 A.L.R.2d 538.

Immunity from liability for damages in tort of state or governmental unit in operating hospital, 25 A.L.R.2d 203, 18 A.L.R.4th 858.

Insurance policy, time for making autopsy or making demand therefor, 30 A.L.R.2d 837.

Disinterment in criminal cases, 63 A.L.R.3d 1294.

Liability for wrongful autopsy, 18 A.L.R.4th 858.

Civil liability in conjunction with autopsy, 97 A.L.R.5th 419.

25A C.J.S. Dead Bodies § 8(3).

ARTICLE 12A
Cremations

24-12A-1. Right to authorize cremation; definitions.

A. Any adult may authorize his own cremation and the lawful disposition of his cremated remains by:

(1) stating his desire to be cremated in a written statement that is signed by the individual and notarized or witnessed by two persons; or

(2) including an express statement in his will indicating that the testator desired that his remains be cremated upon his death.

B. A personal representative acting pursuant to a will or Article 3 of Chapter 45 NMSA 1978 or a funeral establishment, a commercial establishment, a direct disposition establishment or a crematory shall comply with a statement made in conformance with the provisions of Subsection A of this section. A statement that conforms to the provisions of Subsection A of this section is authorization to a personal representative, funeral establishment, commercial establishment, direct disposition establishment or crematory that the remains of the decedent are to be cremated. Statements dated prior to the effective date of this act are to be given effect if they meet the requirements of Subsection A of this section.

C. A personal representative, funeral establishment or crematory acting in reliance upon a document executed pursuant to the provisions of this section, who has no actual notice of revocation or contrary indication, is presumed to be acting in good faith.

D. No funeral establishment, commercial establishment, direct disposition establishment, crematory or employee of a funeral establishment, commercial establishment, direct disposition establishment or crematory or other person that relies in good faith on a statement written pursuant to this section shall be subject to liability

for cremating the remains in accordance with the express instructions of a decedent. The written document is a complete defense to a cause of action by any person against any other person acting in accordance with the instructions of the decedent.

E. As used in this section:

(1) "commercial establishment" means an office, premises or place of business that provides for the practice of funeral service or direct disposition services exclusively to licensed funeral or direct disposition establishments;

(2) "cremate" means to reduce a dead human body by direct flame to a residue that may include bone fragments; and

(3) "direct disposition establishment" means an office, premises or place of business that provides for the disposition of a dead human body as quickly as possible, without a funeral, graveside service, committal service or memorial service, whether public or private, and without embalming of the body unless embalming is required by the place of disposition.

History: Laws 1993, ch. 200, § 1.

ANNOTATIONS

Cross references. — For cremations, *see* 61-32-19 NMSA 1978.

24-12A-2. No written instructions; priority of others to decide disposition.

If a decedent has left no written instructions regarding the disposition of his remains, the following persons in the order listed shall determine the means of disposition, not to be limited to cremation, of the remains of the decedent:

A. the surviving spouse;

B. a majority of the surviving adult children of the decedent;

C. the surviving parents of the decedent;

D. a majority of the surviving siblings of the decedent;

E. an adult who has exhibited special care and concern for the decedent, who is aware of the decedent's views and desires regarding the disposition of his body and who is willing and able to make a decision about the disposition of the decedent's body; or

F. the adult person of the next degree of kinship in the order named by New Mexico law to inherit the estate of the decedent.

History: Laws 1993, ch. 200, § 2; 1995, ch. 17, § 1.

ANNOTATIONS

Cross references. — For cremations, *see* 61-32-19 NMSA 1978.

The 1995 amendment, effective June 16, 1995, inserted "adult" in Subsection B.

24-12A-3. Unclaimed bodies and bodies of indigent persons; cremation permitted.

The body of an unclaimed decedent or an indigent person, the disposition of which is the responsibility of the county pursuant to the provisions of Chapter 24, Article 13 NMSA 1978, may be cremated upon the order of the county official responsible for ensuring the disposition of the body or upon the order of any other government official authorized to order the cremation. Absent a showing of bad faith or malicious intent, the official ordering the cremation and the person or establishment carrying out the cremation shall be immune from liability related to the cremation.

History: 1978 Comp., § 24-12A-3, enacted by Laws 1999, ch. 241, § 3.

ANNOTATIONS

ARTICLE 13
Burial of Indigents

24-13-1. Burial or cremation of unclaimed decedents and of indigents.

For the purposes of Chapter 24, Article 13 NMSA 1978, a dead person whose body has not been claimed by a friend, relative or other interested person assuming the responsibility for and expense of disposition shall be considered an unclaimed decedent. It is the duty of the board of county commissioners of each county in this state to cause to be decently interred or cremated the body of any unclaimed decedent or indigent person. The county shall ensure that the body is buried or cremated no later than thirty days after a determination has been made that the body has not been claimed, but no less than two weeks after death. If the body is cremated, the county shall ensure that the cremated remains are retained and stored for no less than two years in a manner that allows for identification of the remains. After the expiration of two years the cremated remains may be disposed of, provided the county retains a record of the place and manner of disposition for not less than five years after such disposition.

History: Laws 1939, ch. 224, § 1; 1941 Comp., § 73-204; 1953 Comp., § 13-2-4; Laws 1999, ch. 241, § 4.

ANNOTATIONS

Cross references. — For disposition of dead bodies generally, *see* Chapter 24, Article 12 NMSA 1978.

For definitions applicable to provisions of this article, *see* 27-1-1 NMSA 1978.

The 1999 amendment, effective June 18, 1999, added the section heading; added the first sentence; in the second sentence, substituted "It is the duty" for "It shall be the duty" and "or cremated the body of any unclaimed decedent or indigent person" for "the body of any dead having no visible estate out of which to defray the cost of his burial, and when no relative or friend of such decedent will undertake to bury him"; and added the third and fourth sentences.

County's responsibility for burial of indigents does not rest upon residence of the indigents. 1941-42 Op. Att'y Gen. No. 4081.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 22A Am. Jur. 2d Dead Bodies § 19.

24-13-2. Persons deemed indigent.

A deceased person shall be considered to be an indigent for purposes of Chapter 24, Article 13 NMSA 1978 if his estate is insufficient to cover the cost of burial or cremation.

History: Laws 1939, ch. 224, § 2; 1941 Comp., § 73-205; 1953 Comp., § 13-2-5; Laws 1999, ch. 241, § 5.

ANNOTATIONS

The 1999 amendment, effective June 18, 1999, added the section heading; and rewrote the section, which formerly read "No deceased person shall be considered to be an indigent if there are any sums, no matter how small, with which to defray the cost of such burial".

24-13-3. Expenses for burial or cremation.

If the unclaimed decedent had known assets or property of sufficient value to defray the expenses of cremation or burial, invoices for the expenses shall be forwarded to such person or official authorized by law to be appointed administrator of the estate of the decedent, and such person or official shall pay the expenses out of the decedent's estate. To the extent that the deceased person is indigent, the burial or cremation expenses shall be borne by the county of residence of the deceased person. If the

county of residence of the deceased person is not known, the burial or cremation expenses shall be borne by the county in which the body was found. The burial or cremation expenses may be paid by the county out of the general fund or the county indigent hospital claims fund in an amount up to six hundred dollars ($600) for the burial or cremation of any adult or minor.

History: Laws 1939, ch. 224, § 3; 1941 Comp., § 73-206; 1953 Comp., § 13-2-6; Laws 1957, ch. 123, § 1; 1959, ch. 59, § 1; 1987, ch. 274, § 1; 1991, ch. 6, § 1; 1999, ch. 241, § 6; 2001, ch. 307, § 1.

ANNOTATIONS

The 1991 amendment, effective March 9, 1991, rewrote the section following "general fund in", which read "the amount of three hundred dollars ($300) for the burial of any adult or minor over the age of six years and three hundred dollars ($300) for the burial of any minor up to the age of six years".

The 1999 amendment, effective June 18, 1999, rewrote the section, which formerly read "The expenses for the burial or cremation of an indigent person may be paid by the county out of the general fund in an amount up to six hundred dollars ($600) for the burial of any adult or minor".

The 2001 amendment, effective June 15, 2001, inserted the county indigent hospital claims fund in the last sentence.

Commissioners are under duty to pay $100 (now $600) for burial of indigent regardless of the particular circumstances prior to the indigent's burial. 1970 Op. Att'y Gen. No. 70-44.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 25A C.J.S. Dead Bodies § 7.

24-13-4. Burial after investigation; cost of opening and closing grave.

The board of county commissioners after proper investigation shall cause any deceased indigent or unclaimed decedent to be decently interred or cremated. The cost to be paid by the county of opening and closing a grave shall not exceed six hundred dollars ($600), which sum shall be in addition to the sums enumerated in Section 24-13-3 NMSA 1978.

History: Laws 1939, ch. 224, § 4; 1941 Comp., § 73-207; 1953 Comp., § 13-2-7; Laws 1957, ch. 123, § 2; 1997, ch. 116, § 1; 1999, ch. 241, § 7.

ANNOTATIONS

The 1997 amendment, effective June 20, 1997, substituted $600 for $35 and made a stylistic change.

The 1999 amendment, effective June 18, 1999, inserted "or unclaimed decedent" in the first sentence and "to be paid by the county" in the second sentence.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 22A Am. Jur. 2d Dead Bodies §§ 75, 78 to 81.

25A C.J.S. Dead Bodies §§ 4(3), 8(4).

24-13-5. Payment of burial or cremation expenses; commissioners liability.

The board of county commissioners of any county within this state may authorize payment for the burial or cremation of an indigent person, as defined in Section 24-13-2 NMSA 1978 or of an unclaimed decedent, as defined in Section 24-13-1 NMSA 1978. All available assets of the deceased shall be used to reimburse the county for the cost of burial or cremation. Should the county be required to pay expenses for burial or cremation of an unclaimed decedent who has left an estate, the estate shall reimburse the county for those expenses. The county commissioners shall be liable either personally or officially to the county they represent in double the amount they have paid toward the burial or cremation of a person other than as authorized by this section.

History: Laws 1939, ch. 224, § 5; 1941 Comp., § 73-208; 1953 Comp., § 13-2-8; Laws 1999, ch. 241, § 8.

ANNOTATIONS

The 1999 amendment, effective June 18, 1999, rewrote the section which formerly read "If the board of county commissioners of any county within this state shall pay to any person any sum purporting to be for the burial of an indigent person when in fact such deceased person was known by the board of county commissioners to be not an indigent, as above defined, said county commissioners shall be liable either personally or officially to the county which they represent in double the amount which they have paid".

24-13-6. Money from relatives; duty of funeral director.

Should any funeral director or other person allowed by law to conduct the business of a funeral director accept money from the relatives or friend of a deceased person whom the board of county commissioners has determined to be an indigent or an unclaimed decedent, the funeral director shall immediately notify the board of county commissioners of the payment or offer for payment, and the board of county commissioners shall not thereafter pay for the burial or cremation involved, or, if the board of county commissioners has already paid for the burial or cremation, the funeral

director shall immediately refund the money paid to him by the board of county commissioners for the burial or cremation.

History: Laws 1939, ch. 224, § 6; 1941 Comp., § 73-209; 1953 Comp., § 13-2-9; Laws 1999, ch. 241, § 9.

ANNOTATIONS

The 1999 amendment, effective June 18, 1999, added the section heading and made stylistic changes throughout.

24-13-7. Failure to notify; funeral director's liability.

If any funeral director or other person authorized by law to conduct the business of a funeral director receives or contracts to receive any money or thing of value from relatives or friends of a deceased alleged indigent or unclaimed decedent whose burial or cremation expenses are paid or to be paid by the board of county commissioners and fails to notify the board of county commissioners of that fact, the funeral director or other person authorized by law to conduct the business of a funeral director shall be liable to the county in an amount double the amount paid or to be paid by the board of county commissioners of that county.

History: Laws 1939, ch. 224, § 7; 1941 Comp., § 73-211; 1953 Comp., § 13-2-11; Laws 1999, ch. 241, § 10.

ANNOTATIONS

The 1999 amendment, effective June 18, 1999, added the section heading and made stylistic changes throughout.

24-13-8. [District attorneys to enforce burial act.]

The various district attorneys of this state are hereby expressly empowered and directed to enforce the provisions of this act [24-13-1 to 24-13-8 NMSA 1978] on behalf of the various counties which they represent.

History: Laws 1939, ch. 224, § 8; 1941 Comp., § 73-211; 1953 Comp., § 13-2-11.

ARTICLE 14
Vital Statistics

24-14-1. Short title.

This act [24-14-1 to 24-14-17, 24-14-20 to 24-14-31 NMSA 1978] may be cited as the "Vital Statistics Act".

History: 1953 Comp., § 12-4-23, enacted by Laws 1961, ch. 44, § 1.

ANNOTATIONS

Am. Jur. 2d, A.L.R. and C.J.S. references. — 39 Am. Jur. 2d Health § 51.

Official death certificate as evidence of cause of death in civil or criminal action, 21 A.L.R.3d 418.

39A C.J.S. Health and Environment § 41.

24-14-2. Definitions.

As used in the Vital Statistics Act [24-14-1 to 24-14-17, 24-14-20 to 24-14-31 NMSA 1978]:

A. "vital statistics" means the data derived from certificates and reports of birth, death, spontaneous fetal death, induced abortion and related reports;

B. "system of vital statistics" includes the registration, collection, preservation, amendment and certification of vital records and related activities, including the tabulation, analysis and publication of statistical data derived from these records;

C. "filing" means the presentation of a certificate, report or other record of a birth, death, spontaneous fetal death or adoption for registration by the vital statistics bureau;

D. "registration" means the acceptance by the vital statistics bureau and the incorporation in its official records of certificates, reports or other records provided for in the Vital Statistics Act of births, deaths, spontaneous fetal deaths, adoptions and legitimations;

E. "live birth" means the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which after the expulsion or extraction breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached;

F. "spontaneous fetal death" means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, resulting in other than a live birth and which is not an induced abortion; and death is indicated by the fact that after the expulsion or extraction the fetus does not breathe or show any other evidence of life as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles;

G. "dead body" means a human body, or parts of such body or bones thereof other than skeletal remains which can be classified as artifacts, dead within the meaning of Section 12-2-4 NMSA 1978;

H. "final disposition" means the burial, interment, cremation, entombment, pulverization or other authorized disposition of a dead body or fetus;

I. "department" means the health and environment department [department of health];

J. "court" means a court of competent jurisdiction;

K. "state registrar" means the designated employee of the health services division of the health and environment department [department of health];

L. "vital records" means certificates of birth and death;

M. "induced abortion" means the purposeful interruption of pregnancy with the intention other than to produce a live-born infant;

N. "physician" means a person authorized or licensed to practice medicine or osteopathy pursuant to the laws of this state; and

O. "institution" means any establishment, public or private:

(1) which provides in-patient medical, surgical, or diagnostic care or treatment;

(2) which provides nursing, custodial or domiciliary care; or

(3) to which persons are committed by law.

History: 1953 Comp., § 12-4-24, enacted by Laws 1961, ch. 44, § 2; 1973, ch. 264, § 1; 1977, ch. 206, § 1; 1977, ch. 253, § 26; 1981, ch. 309, § 1.

ANNOTATIONS

Cross references. — For department of health, *see* 9-7-4 NMSA 1978.

Bracketed material. — The bracketed reference relating to the department of health was inserted by the compiler, as Laws 1991, ch. 25, § 16 repeals former 9-7-4 NMSA 1978, relating to the health and environment department and enacts a new 9-7-4 NMSA 1978 creating the department of health. Section 9-7-5 NMSA 1978, as amended by Laws 1991, ch. 25, § 17 makes the secretary of health the administrative head of the department. The bracketed material was not enacted by the legislature and is not part of the law.

24-14-3. Vital statistics unit [bureau]; state system.

There is established in the health services division of the department a "vital statistics bureau" for the purpose of installing, maintaining and operating a system of vital statistics throughout this state, and carrying out all regulations relating to vital statistics established by the department.

History: 1953 Comp., § 12-4-25, enacted by Laws 1961, ch. 44, § 3; 1973, ch. 264, § 2; 1977, ch. 253, § 27; 1981, ch. 309, § 2.

24-14-4. State registrar; appointment.

The director [secretary] of the department shall appoint the state registrar in accordance with provisions of the state Personnel Act [10-9-1 NMSA 1978].

History: 1953 Comp., § 12-4-26, enacted by Laws 1961, ch. 44, § 4; 1973, ch. 264, § 3.

ANNOTATIONS

Bracketed material. — The administrative head of the department of health is the secretary. See 24-14-2I and 9-7-5 NMSA 1978. The bracketed material was not enacted by the legislature and is not part of the law.

24-14-5. Duties of state registrar.

A. The state registrar shall:

(1) administer and enforce the Vital Statistics Act [24-14-1 to 24-14-17, 24-14-20 to 24-14-31 NMSA 1978] and regulations issued pursuant to it, and issue instructions for the efficient administration of the state system of vital statistics;

(2) direct and supervise the state system of vital statistics and be custodian of its records;

(3) direct, supervise and control the activities of all public employees, other than hospital employees, when they are engaged in activities pertaining to the operation of the vital statistics system;

(4) prescribe, with the approval of the department, and after consultation with medical records professionals in the state, furnish and distribute such forms as are required by the Vital Statistics Act;

(5) prepare and publish reports of vital statistics of this state and such other reports as may be required by the department;

(6) conduct training programs to promote uniformity of policy and procedures throughout the state; and

(7) provide to local health agencies copies of or data derived from certificates and reports required under the Vital Statistics Act as determined necessary for local health planning and program activities. The copies or data shall remain the property of the vital statistics bureau, and the uses which may be made of them shall be prescribed by the state registrar.

B. The state registrar may establish or designate offices in the state to aid in the efficient administration of the system of vital statistics and may delegate such functions and duties vested in him to employees of the vital statistics bureau and to employees of any office of the state or political subdivision designated to aid in administering the Vital Statistics Act.

History: 1953 Comp., § 12-4-27, enacted by Laws 1961, ch. 44, § 5; 1973, ch. 264, § 4; 1977, ch. 253, § 28; 1981, ch. 309, § 3.

24-14-6. Repealed.

ANNOTATIONS

Repeals. — Laws 1981, ch. 309, § 26, repeals 24-14-6 NMSA 1978, as enacted by Laws 1961, ch. 44, § 6, relating to registration districts, effective March 21, 1981.

24-14-7. Appointment and removal of local registrars.

The state registrar:

A. may appoint local registrars in order to carry out the provisions of the Vital Statistics Act [24-14-1 to 24-14-17, 24-14-20 to 24-14-31 NMSA 1978]; and

B. may remove local registrars for reasonable cause.

History: 1953 Comp., § 12-4-29, enacted by Laws 1961, ch. 44, § 7; 1981, ch. 309, § 4.

24-14-8. Duties of local registrar.

The local registrar shall:

A. administer and enforce the provisions of the Vital Statistics Act [24-14-1 to 24-14-17, 24-14-20 to 24-14-31 NMSA 1978] and instructions, rules and regulations issued pursuant thereto;

B. require that certificates be completed and filed in accordance with the Vital Statistics Act and the rules and regulations issued pursuant thereto; and

C. transmit to the state registrar bimonthly, or more frequently when directed by that official, the certificates, reports or other returns filed with him.

History: 1953 Comp., § 12-4-30, enacted by Laws 1961, ch. 44, § 8; 1981, ch. 309, § 5.

24-14-9 to 24-14-11. Repealed.

ANNOTATIONS

Repeals. — Laws 1981, ch. 309, § 26, repeals 24-14-9 to 24-14-11 NMSA 1978, as enacted by Laws 1961, ch. 44, § 11, and amended by Laws 1977, ch. 253, §§ 29 and 30, relating to the compensation of, and payment of fees to, the subregistrar and insufficiency of county funds, effective March 21, 1981.

24-14-12. Form contents of certificates and reports.

A. In order to promote and maintain uniformity in the system of vital statistics, the forms of certificates, reports and other returns required by the Vital Statistics Act [24-14-1 to 24-14-17, 24-14-20 to 24-14-31 NMSA 1978] or by regulations adopted pursuant to that act shall include as a minimum the items recommended by the federal agency responsible for national vital statistics subject to the approval of modifications by the department.

B. Each certificate, report and other document required to be registered under the Vital Statistics Act shall be on a form or in a format prescribed by the state registrar.

C. All vital records shall contain the date received for registration.

D. Information required in certificates or reports required or authorized by the Vital Statistics Act may be filed and registered by photographic, electronic or other means as prescribed by the state registrar; provided that certificates shall be filed and registered by either physical or photographic means.

History: 1953 Comp., § 12-4-34, enacted by Laws 1961, ch. 44, § 12; 1973, ch. 264, § 7; 1977, ch. 253, § 31; 1981, ch. 309, § 6.

24-14-13. Birth registration.

A. A certificate of birth for each live birth which occurs in this state shall be filed with the vital statistics bureau of the public health division of the department or as otherwise directed by the state registrar within ten days after the birth and shall be registered if it has been completed and filed in accordance with this section. When a birth, however, occurs on a moving conveyance, a birth certificate shall be registered in this state and the place where the child is first removed shall be considered the place of birth.

B. When a birth occurs in an institution, the person in charge of the institution or his designated representative shall obtain the personal data, prepare the certificate, secure the signatures required and file it as directed in this section. The physician or other person in attendance shall certify the medical information required by the certificate within ten working days after the birth in accordance with policies established by the institution where the birth occurred. The person in charge of the institution or his designee shall complete and sign the certificate.

C. When a birth occurs outside an institution, the certificate shall be prepared and filed by one of the following in the indicated order of priority:

(1) the physician in attendance at or immediately after the birth;

(2) any other person in attendance at or immediately after the birth or in the absence of this person; or

(3) the father, the mother or, in the absence of the father and the inability of the mother, the person in charge of the premises where the birth occurred.

D. If the mother was married at the time of either conception or birth, the name of the husband shall be entered on the certificate as the father of the child, unless paternity has been determined pursuant to Subsection F or G of this section or by a court, in which case the name of the father as determined by the court shall be entered.

E. If the mother was not married at the time of either conception or birth, but the father has signed an acknowledgment of paternity, as provided by this section, the father's name, date of birth and social security number shall be entered on the acknowledgement of paternity. The name of the father shall not be entered on the certificate of birth without the written consent of the mother and the person to be named as the father, unless a determination of paternity has been made by a court, in which case the name of the father as determined by the court shall be entered.

F. At or before the birth of a child to an unmarried woman, the person in charge of the institution, a designated representative, the attending physician or midwife shall:

(1) provide an opportunity for the child's mother and natural father to complete an acknowledgement of paternity. The completed affidavit shall be filed with the vital statistics bureau of the public health division of the department. The acknowledgement shall contain or have attached to it:

(a) a sworn statement by the mother consenting to the assertion of paternity;

(b) a sworn statement by the father that he is the natural father of the child;

(c) written information, furnished by the human services department, explaining the implications of signing, including legal parental rights and responsibilities; and

(d) the social security numbers of both parents;

(2) provide written information, furnished by the human services department, to the mother and father or putative father, regarding the benefits of having the child's paternity established and of the availability of paternity establishment services and child support enforcement services.

G. If a married mother claims that her husband is not the father of the child, the husband agrees that he is not the father and the putative father agrees that he is the father, an acknowledgement of paternity may be signed by the respective parties and duly notarized. Upon filing this affidavit with the state registrar, the name of the nonhusband shall be entered on the certificate of birth as the father.

H. Pursuant to an interagency agreement for proper reimbursement, the vital statistics bureau of the public health division of the department shall make available to the human services department the birth certificate, the mother's and father's social security numbers and paternity acknowledgements. The human services department shall use these records only in conjunction with its duties as the state IV-D agency responsible for the child support program under Title IV-D of the federal Social Security Act.

History: 1953 Comp., § 12-4-35, enacted by Laws 1961, ch. 44, § 13; 1981, ch. 309, § 7; 1993, ch. 287, § 1.

ANNOTATIONS

Cross references. — For issuance of new birth certificates following adoptions, legitimations and paternity determinations, *see* 24-14-17 NMSA 1978.

For requirement for reporting on birth certificate whether blood test for syphilis taken from mother, *see* 24-1-11 NMSA 1978.

For Title IV-D of the federal Social Security Act, *see* 42 U.S.C. § 651 et seq.

The 1993 amendment, effective June 18, 1993, inserted "of the public health division of the department" in the first sentence of Subsection A; inserted "or G" in Subsection D; added the language beginning "but the father has signed" to the end of the first sentence of Subsection E; added Subsections F and H, redesignating former Subsection F as Subsection G; substituted "acknowledgment" for "affidavit" in the first sentence and inserted "of birth" in the second sentence, in Subsection G; and made stylistic changes in Subsections D, E, and G.

ANNOTATIONS

Am. Jur. 2d, A.L.R. and C.J.S. references. — 39 Am. Jur. 2d Health § 106.

39A C.J.S. Health and Environment § 41.

24-14-14. Unknown parentage; foundling registration.

A. Whoever assumes the custody of a living infant of unknown parentage shall report on a form and in the manner prescribed by the state registrar within ten days the following information:

(1) the date and place of finding;

(2) sex, color or race and approximate age of child;

(3) name and address of the person or institution with whom the child has been placed for care;

(4) name given to the child by the custodian; and

(5) other data required by the state registrar.

B. A report registered under this section constitutes the certificate of birth for the infant.

C. If the child is subsequently identified and a standard certificate of birth can be established, any report registered under this section shall be sealed and may be opened only by order of the district court or as provided by regulation.

History: 1953 Comp., § 12-4-36, enacted by Laws 1961, ch. 44, § 14; 1981, ch. 309, § 8.

24-14-15. Delayed registration of births.

A. When the birth of a person born in this state has not been registered, a certificate may be filed in accordance with regulations of the department. The certificate shall be registered subject to evidentiary requirements prescribed by regulation to substantiate the alleged facts of birth.

B. Certificates of birth registered one year or more after the date of birth shall show on their face the date of the delayed registration.

C. A summary statement of the evidence submitted in support of the delayed registration shall be endorsed on the certificate.

D. When an applicant does not submit the minimum documentation required in the regulations for delayed registration or when the state registrar finds reason to question the validity or adequacy of the certificate or the documentary evidence, the state registrar shall not register the delayed certificate and shall advise the applicant of the reason for this action.

E. The department may by regulation provide for the denial of an application for delayed registration which is not actively prosecuted.

History: 1953 Comp., § 12-4-37, enacted by Laws 1961, ch. 44, § 15; 1981, ch. 309, § 9.

24-14-16. Judicial procedure to establish facts of birth.

A. If a delayed certificate of birth is rejected under the provisions of Section 24-14-15 NMSA 1978, a petition may be filed with a court for an order establishing a record of the date and place of the birth and the parentage of the person whose birth is to be registered.

B. The petition shall allege that:

(1) the person for whom a delayed certificate of birth is sought was born in this state;

(2) no record of birth of the person can be found in the vital statistics bureau;

(3) diligent efforts by the petitioner have failed to obtain the evidence required in accordance with Section 24-14-15 NMSA 1978;

(4) the state registrar has refused to register a delayed certificate of birth; and

(5) any other allegations as may be required.

C. The petition shall be accompanied by a statement of the registration official made in accordance with Section 24-14-15 NMSA 1978 and all documentary evidence which was submitted to the registration official in support of the registration. The petition shall be sworn to by the petitioner.

D. The court shall fix a time and place for hearing the petition and shall give the registration official who refused to register the petitioner's delayed certificate of birth ten days' notice of the hearing. The official or his authorized representative may appear and testify in the proceeding.

E. If the court from the evidence presented finds that the person for whom a delayed certificate of birth is sought was born in this state, it shall make findings as to the place and date of birth, parentage and other findings as the case may require and

shall issue an order to establish a record of birth. This order shall include the birth data to be registered, a description of the evidence presented in the manner prescribed by Section 24-14-15 NMSA 1978 and the date of the court's action.

F. The clerk of the court shall forward each order to the state registrar not later than the tenth day of the calendar month following the month in which it was entered. The order shall be registered by the state registrar and shall constitute the record of birth from which copies may be issued in accordance with Sections 24-14-28 and 24-14-29 NMSA 1978.

History: 1953 Comp., § 12-4-38, enacted by Laws 1961, ch. 44, § 16; 1981, ch. 309, § 10.

24-14-17. New birth certificates following adoption, legitimation and paternity determination.

A. The state registrar shall establish a new certificate of birth for a person born in this state when he receives the following:

(1) a report of adoption as provided in this section, a report of adoption prepared and filed in accordance with the laws of another state or country or a certified copy of the decree of adoption together with the information necessary to identify the original certificate of birth and to establish a new certificate of birth; except that a new certificate of birth shall not be established if so requested by the court decreeing the adoption, the adoptive parents or the adopted person; or

(2) a request that a new certificate of birth be established and evidence as required by regulation proving that the person has been legitimated or that a court has determined the paternity of the person.

B. When a new certificate of birth is established, the actual place and date of birth shall be shown. It shall be substituted for the original certificate of birth. Thereafter, the original certificate and the evidence of adoption, paternity determination or legitimation shall not be subject to inspection except upon order of a court or in accordance with the provisions of Section 24-14-13 NMSA 1978 or in the case of a single adoptive parent.

C. Upon receipt of notice of annulment of adoption, the original certificate of birth shall be restored to its place in the files, and the new certificate and evidence shall not be subject to inspection except upon order of a court.

D. If no certificate of birth is on file for the person for whom a new certificate is to be established under this section, a delayed certificate of birth shall be filed with the state registrar as provided in Section 24-14-15 NMSA 1978 before a new certificate of birth is established.

E. For each adoption decreed by a court in this state, the court shall require the preparation of a report of adoption on a form prescribed and furnished by the state registrar. The report shall include such facts as are necessary to locate and identify the certificate of birth of the person adopted, shall provide information necessary to establish a new certificate of birth of the person adopted and shall identify the order of adoption and be certified by the clerk of the court.

History: 1953 Comp., § 12-4-39, enacted by Laws 1961, ch. 44, § 17; 1973, ch. 264, § 8; 1981, ch. 309, § 11; 1993, ch. 287, § 2.

ANNOTATIONS

Cross references. — For registration of births generally, *see* 24-14-13 to 24-14-15 NMSA 1978.

The 1993 amendment, effective June 18, 1993, in Subsection A, deleted "foreign" after "another state or" in Paragraph (1) and inserted "of birth" in Paragraph (2), and in Subsection B, inserted "or in accordance with the provisions of Section 24-14-13 NMSA 1978" in the second sentence.

Am. Jur. 2d, A.L.R. and C.J.S. references. — Validity and application of statute authorizing change in record of birthplace of adopted child, 14 A.L.R.4th 739.

24-14-18. Report of induced abortions.

A. Each induced abortion which occurs in this state shall be reported to the state registrar within five days by the person in charge of the institution in which the induced abortion was performed. If the induced abortion was performed outside an institution, the attending physician shall prepare and file the report.

B. The reports required under this section are statistical reports to be used only for medical and health purposes and shall not be incorporated into the permanent official records of the system of vital statistics. The report shall not include the name or address of the patient involved in the abortion. The department shall not release the name or address of the physician involved in the abortion. A schedule for the disposition of these reports shall be provided for by regulation.

History: 1953 Comp., § 12-4-39.1, enacted by Laws 1977, ch. 206, § 2; 1981, ch. 309, § 12.

ANNOTATIONS

Compiler's notes. — Inasmuch as both Laws 1977, ch. 206, § 2, and Laws 1977, ch. 223, § 1, enacted a new 12-4-39.1, 1953 Comp., though dealing with different matters, the provision in Chapter 223 was compiled as 12-4-39.2, 1953 Comp. instead. Chapter 223 is now compiled as 24-14-19 NMSA 1978.

Law reviews. — For comment, "Perspectives on the Abortion Decision," see 9 N.M. L. Rev. 175 (1978-79).

24-14-19. Adoption of foreign-born; certificate of birth.

A. The state registrar shall establish a certificate of birth for a person of foreign birth adopted under New Mexico law when the registrar receives:

(1) a certified copy of a judgment of adoption granted by the court;

(2) an order issued by the court to establish a certificate of birth for that adopted person; and

(3) any other evidence as provided in Section 24-14-17 NMSA 1978 necessary to establish a new certificate of birth.

B. The certificate of birth established under this section shall be on a form prescribed by the state registrar and shall show the probable country of birth, pursuant to the findings of the court, and shall state that the certificate is not evidence of United States citizenship.

History: 1953 Comp., § 12-4-39.1, enacted by Laws 1977, ch. 223, § 1; 1981, ch. 309, § 13.

ANNOTATIONS

Compilation of section. — Although this section was enacted as 12-4-39.1, 1953 Comp., it was originally compiled as 12-4-39.2, 1953 Comp., since there already existed a 12-4-39.1, 1953 Comp. See compilers notes under 24-14-18 NMSA 1978.

24-14-20. Death registration.

A. A death certificate for each death that occurs in this state shall be filed within five days after the death and prior to final disposition. The death certificate shall be registered by the state registrar if it has been completed and filed in accordance with this section, subject to the exception provided in Section 24-14-24 NMSA 1978; provided that:

(1) if the place of death is unknown but the dead body is found in this state, a death certificate shall be filed with a local registrar within ten days after the occurrence. The place where the body is found shall be shown as the place of death. If the date of death is unknown, it shall be approximated by the state medical investigator; and

(2) if death occurs in a moving conveyance in the United States and the body is first removed from the conveyance in this state, the death shall be registered in this state and the place where the body is first removed shall be considered the place of

death. When a death occurs on a moving conveyance while in international waters or air space or in a foreign country or its air space and the body is first removed from the conveyance in this state, the death shall be registered in this state, but the certificate shall show the actual place of death insofar as can be determined by the state medical investigator.

B. The funeral service practitioner or person acting as a funeral service practitioner who first assumes custody of a dead body shall file the death certificate. He shall obtain the personal data from the next of kin or the best qualified person or source available. He shall obtain the medical certification of cause of death.

C. The medical certification shall be completed and signed within forty-eight hours after death by the physician in charge of the patient's care for the illness or condition that resulted in death, except when inquiry is required by law. Except as provided in Subsection D of this section, in the absence of the physician, or with his approval, the medical certification may be completed and signed by his associate physician, the chief medical officer of the institution in which death occurred or the physician who performed an autopsy on the decedent, provided that individual has access to the medical history of the case, views the deceased at or after death, and death is due to natural causes.

D. Unless there is reasonable cause to believe that the death is not due to natural causes, a registered nurse employed by a nursing home may pronounce the death of a resident of the nursing home and a registered nurse employed by a hospital may pronounce the death of a patient of the hospital. The nurse shall have access to the medical history of the case and view the deceased at or after death, and the individual who completes the medical certification shall not be required to view the deceased at or after death. The death shall be pronounced pursuant to procedures or facility protocols prescribed by the hospital for patients or by the physician who is the medical director of the nursing home for residents. The procedures or facility protocols shall ensure that the medical certification of death is completed in accordance with the provisions of Subsection C of this section.

E. For purposes of this section:

(1) "nursing home" means any nursing institution or facility required to be licensed under state law as a nursing facility by the public health division of the department of health, whether proprietary or nonprofit, including skilled nursing home facilities; and

(2) "hospital" means a public hospital, profit or nonprofit private hospital or a general or special hospital that is licensed as a hospital by the department of health.

F. When death occurs without medical attendance as set forth in Subsection C or D of this section or when death occurs more than ten days after the decedent was last treated by a physician, the case shall be referred to the state medical investigator for investigation to determine and certify the cause of death.

G. An amended death certificate based on an anatomical observation shall be filed within thirty days of the completion of an autopsy.

History: 1953 Comp., § 12-4-40, enacted by Laws 1961, ch. 44, § 18; 1973, ch. 264, § 9; 1981, ch. 309, § 14; 1995, ch. 104, § 1; 2001, ch. 83, § 1.

ANNOTATIONS

Cross references. — For extension of time for registration, *see* 24-14-24 NMSA 1978.

For medical investigations of deaths, *see* Chapter 24, Article 11 NMSA 1978.

For disposition of dead bodies, *see* Chapter 24, Article 12 NMSA 1978.

The 1995 amendment, effective June 16, 1995, inserted the proviso at the beginning of the second sentence of Subsection C, added Subsections D and E, redesignated former Subsections D and E as Subsections F and G, substituted "Subsection C or D" for "Paragraph C" in Subsection F, and made minor stylistic changes throughout the section.

The 2001 amendment, effective June 15, 2001, inserted the provision that a registered nurse employed by a hospital may pronounce the death of a patient in certain circumstances in Subsection D; and in Subsection E, inserted the Paragraph (1) designation and added Paragraph (2).

Issuance of copies by county clerk. — County clerks may not issue copies of death certificates on file in their office unless the vital statistics bureau promulgates regulations authorizing it or unless the legislature amends this article to grant county clerks such authority. 1988 Op. Att'y Gen. No. 88-01.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 39 Am. Jur. 2d Health § 106.

Official death certificate as evidence of cause of death in civil or criminal action, 21 A.L.R.3d 418.

39A C.J.S. Health and Environment § 41.

24-14-21. Delayed registration of death.

A. When a death occurring in this state has not been registered, a certificate may be filed in accordance with regulations of the board of medical investigators. The certificate shall be registered subject to evidentiary requirements as prescribed by regulation to substantiate the alleged facts of death.

B. Certificates of death registered one year or more after the date of death shall be marked "delayed" and shall show on their face the date of the delayed registration.

History: 1953 Comp., § 12-4-41, enacted by Laws 1961, ch. 44, § 19; 1973, ch. 264, § 10; 1981, ch. 309, § 15.

ANNOTATIONS

Cross references. — For medical investigations of deaths generally, *see* Chapter 24, Article 11 NMSA 1978.

24-14-22. Reports of spontaneous fetal death.

A. Each spontaneous fetal death, where the fetus has a weight of five hundred grams or more, which occurs in this state shall be reported to the state registrar.

B. When a dead fetus is delivered in an institution, the person in charge of the institution or his designated representative shall prepare and file the report.

C. When the spontaneous fetal death occurs on a moving conveyance and the fetus is first removed from the conveyance in this state, or when a dead fetus is found in this state and the place of fetal death is unknown, the fetal death shall be reported in this state. The place where the fetus was first removed from the conveyance or the dead fetus was found shall be considered the place of fetal death.

D. When a spontaneous fetal death required to be reported by this section occurs without medical attendance at or immediately after the delivery or when inquiry is required by law, the state medical investigator shall investigate the cause of fetal death and shall prepare and file the report.

E. The names of the parents shall be entered on the spontaneous fetal death report in accordance with the provisions of Section 24-14-13 NMSA 1978.

F. Except as otherwise provided in this section, all spontaneous fetal death reports shall be completed and filed with the state registrar within ten days following the spontaneous fetal death.

History: 1953 Comp., § 12-4-42, enacted by Laws 1961, ch. 44, § 20; 1981, ch. 309, § 16.

ANNOTATIONS

Cross references. — For extension of time for filing certificate, *see* 24-14-24 NMSA 1978.

24-14-23. Permits; authorization for final disposition.

A. For deaths or spontaneous fetal deaths which have occurred in this state, no burial-transit permit shall be required for final disposition of the remains if the disposition occurs in this state and is performed by a funeral service practitioner or direct disposer.

B. A burial-transit permit shall be issued by the state registrar or a local registrar for those bodies which are to be transported out of the state for final disposition or when final disposition is being made by a person other than a funeral service practitioner or direct disposer.

C. A burial-transit permit issued under the law of another state or country which accompanies a dead body or fetus brought into this state shall be authority for final disposition of the body or fetus in this state.

D. A permit for disinterment and reinterment shall be required prior to disinterment of a dead body or fetus except as authorized by regulation or otherwise provided by law. The permit shall be issued by the state registrar or state medical investigator to a licensed funeral service practitioner or direct disposer.

E. A permit for cremation of a body shall be required prior to the cremation. The permit shall be issued by the state medical investigator to a licensed funeral service practitioner, direct disposer or any other person who makes the arrangements for final disposition.

History: 1953 Comp., § 12-4-43, enacted by Laws 1961, ch. 44, § 21; 1981, ch. 309, § 17; 1985, ch. 230, § 1.

ANNOTATIONS

Cross references. — For disposition of dead bodies, *see* Chapter 24, Article 12 NMSA 1978.

For burial of indigents, *see* Chapter 24, Article 13 NMSA 1978.

State registrar shall issue permit to disinter when medical investigator so requires pursuant to the duties and responsibilities of his office. In re Johnson, 94 N.M. 491, 612 P.2d 1302 (1980).

Requirement of notice of intended autopsy or disinterment. — Under some circumstances due process may require that an interested relative be given notice of an intended autopsy or disinterment of a deceased. In re Johnson, 94 N.M. 491, 612 P.2d 1302 (1980).

Am. Jur. 2d, A.L.R. and C.J.S. references. — 22A Am. Jur. 2d Dead Bodies §§ 5, 6, 48, 49.

Dead bodies: liability for improper manner of reinterment, 53 A.L.R.4th 394.

39A C.J.S. Health and Environment § 42.

24-14-24. Extension of time.

A. The department may, by regulation and upon conditions as it may prescribe to assure compliance with the purposes of the Vital Statistics Act [24-14-1 to 24-14-17, 24-14-20 to 24-14-31 NMSA 1978], provide for the extension of the periods prescribed in Sections 24-14-20, 24-14-22 and 24-14-23 NMSA 1978 for the filing of death certificates, spontaneous fetal death reports, medical certifications of cause of death and for the obtaining of burial-transit permits in cases where compliance with the applicable prescribed period would result in undue hardship.

B. Regulations of the department may provide for the issuance of a burial-transit permit prior to the filing of a certificate upon conditions designed to assure compliance with the purposes of the Vital Statistics Act in cases where compliance with the requirement that the certificate be filed prior to the issuance of the permit would result in undue hardship.

History: 1953 Comp., § 12-4-44, enacted by Laws 1961, ch. 44, § 22; 1973, ch. 264, § 11; 1977, ch. 253, § 32; 1981, ch. 309, § 18.

ANNOTATIONS

Cross references. — For death certificates, *see* 24-14-20 NMSA 1978.

For spontaneous fetal death reports, *see* 24-14-22 NMSA 1978.

For burial-transit permits, *see* 24-14-23 NMSA 1978.

For issuance of death certificates subsequent to medical investigations, *see* 24-11-6 NMSA 1978.

24-14-25. Correction and amendment of vital records.

A. A certificate or report registered under the Vital Statistics Act [24-14-1 to 24-14-17, 24-14-20 to 24-14-31 NMSA 1978] may be amended only in accordance with that act and regulations thereunder adopted by the department to protect the integrity and accuracy of vital statistics records.

B. Upon receipt of a certified copy of a court order changing the name of a person born in this state and upon request of the person or his parent, guardian or legal representative, the state registrar shall amend the original certificate of birth to reflect the new name.

C. Upon request and receipt of a sworn acknowledgement of paternity of a child born out of wedlock signed by both parents, or in the case of a married mother as

provided for in Subsection F of Section 24-14-13 NMSA 1978, the state registrar shall amend a certificate of birth to show the paternity if paternity is not shown on the birth certificate. The certificate shall not be marked "amended".

D. Upon receipt of a duly notarized statement from the person in charge of an institution or from the attending physician indicating that the sex of an individual born in this state has been changed by surgical procedure, together with a certified copy of an order changing the name of the person, the certificate of birth of the individual shall be amended as prescribed by regulation.

E. When an applicant does not submit the minimum documentation required in the regulations for amending a vital record or when the state registrar has reasonable cause to question the validity or adequacy of the applicant's sworn statements or the documentary evidence and if the deficiencies are not corrected, the state registrar shall not amend the vital records and shall advise the applicant of the reason for this action.

F. A certificate or report that is amended under this section shall be marked "amended", except as otherwise provided in this section. The date of the amendment and a summary description of the evidence submitted in support of the amendment shall be endorsed on or made a part of the record. The department shall prescribe by regulation the conditions under which additions or minor corrections may be made to certificates or records within one year after the date of the event without the certificate or record being marked "amended".

History: 1953 Comp., § 12-4-45, enacted by Laws 1961, ch. 44, § 23; 1981, ch. 309, § 19.

ANNOTATIONS

Cross references. — For issuance of new birth certificates following adoptions, legitimations and paternity determinations, *see* 24-14-17 NMSA 1978.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 76 C.J.S. Records § 21 et seq.

24-14-26. Reproduction of records.

To preserve vital records, the state registrar is authorized to prepare typewritten, photographic, electronic or other reproductions of original records and files in his office. The reproductions when certified by him shall be accepted as the original record. The documents from which permanent reproductions have been made and verified may be disposed of as provided by regulation.

History: 1953 Comp., § 12-4-46, enacted by Laws 1961, ch. 44, § 24; 1981, ch. 309, § 20.

ANNOTATIONS

Am. Jur. 2d, A.L.R. and C.J.S. references. — Photostatic or other method of recording instrument, 57 A.L.R. 159.

24-14-27. Disclosure of records.

A. It is unlawful for any person to permit inspection of or to disclose information contained in vital records or to copy or issue a copy of all or part of any record except as authorized by law.

B. The department shall provide access to record level data required by the New Mexico health policy commission and the health information system created in the Health Information System Act [24-14A-1 NMSA 1978]. The New Mexico health policy commission and the health information system may only release record level data obtained from vital records in the aggregate. For the purposes of this subsection, "record level data" means one or more unique and non-aggregated data elements relating to a single identifiable individual. The department may authorize the disclosure of data contained in vital records for other research purposes.

C. When one hundred years have elapsed after the date of birth or fifty years have elapsed after the date of death, the vital records of these events in the custody of the state registrar shall become open public records, and information shall be made available in accordance with regulations that provide for the continued safekeeping of the records; provided that vital records of birth shall not become open public records prior to the individual's death.

History: 1953 Comp., § 12-4-47, enacted by Laws 1961, ch. 44, § 25; 1981, ch. 309, § 21; 1994, ch. 59, § 1.

ANNOTATIONS

The 1994 amendment, effective March 4, 1994, in Subsection B, added the first three sentences and inserted "other" in the last sentence; and substituted "that provide" for "which shall provide" in Subsection C.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 66 Am. Jur. 2d Records and Recording Laws §§ 12 to 30.

False news reports as to births, betrothals, marriages, divorces or similar marital matters as libel and slander, 9 A.L.R.3d 559.

76 C.J.S. Records § 60 et seq.

24-14-28. Copies or data from the system of vital statistics.

In accordance with the Vital Statistics Act [24-14-1 to 24-14-17, 24-14-20 to 24-14-31 NMSA 1978] and the regulations adopted pursuant to that act:

A. the state registrar shall upon receipt of a written application issue a certified copy of any certificate or record in his custody to anyone demonstrating a tangible and direct interest, except that:

(1) certified copies of birth records shall exclude all medical information unless a complete certificate is specifically requested and the request for a complete certificate is approved by the state registrar; and

(2) issuance of copies of birth records shall be subject to the provisions of the Missing Child Reporting Act [32A-14-1 NMSA 1978];

B. a certified copy of a certificate or any part thereof, including records reproduced from paper documents or photographic, magnetic or electronic files, shall be considered for all purposes the same as the original and is prima facie evidence of the facts therein stated; provided that the evidentiary value of a certificate or record filed more than one year after the event or a record which has been amended shall be determined by the judicial or administrative body or official before whom the certificate is offered as evidence;

C. the agency of the United States government responsible for national vital statistics may be furnished copies or data as it may require for national statistics, upon the condition that the data shall not be used for other than statistical purposes unless so authorized by the state registrar;

D. at the discretion of the state registrar, federal, state, local and other public or private agencies may upon request be furnished copies or data for statistical or administrative purposes upon the conditions as may be prescribed by the department;

E. no person shall prepare or issue any report of an induced abortion or any certificate which purports to be an original, certified copy or copy of a certificate of birth, death or spontaneous fetal death or reproduction of a certified copy except as authorized in the Vital Statistics Act or regulations adopted pursuant to that act; and

F. the state registrar may by written agreement transmit copies of records and other reports required by the Vital Statistics Act to offices of vital statistics outside this state when the records or other reports relate to residents of those jurisdictions or persons born outside those jurisdictions. The agreement shall require that the copies be used for statistical purposes only and shall provide for the retention and disposition of copies. Copies received by the state registrar from offices of vital statistics in other states shall be handled in the manner prescribed in this section.

History: 1953 Comp., § 12-4-48, enacted by Laws 1961, ch. 44, § 26; 1972, ch. 34, § 1; 1977, ch. 206, § 3; 1981, ch. 309, § 22; 1987, ch. 25, § 5.

ANNOTATIONS

Am. Jur. 2d, A.L.R. and C.J.S. references. — 29A Am. Jur. 2d Evidence § 1372 et seq.; 39 Am. Jur. 2d Health § 51; 66 Am. Jur. 2d Records and Recording Laws §§ 13, 14, 28.

Admissibility, under public records exception to hearsay rule, of record kept by public official without express statutory direction or authorization, 80 A.L.R.3d 414.

76 C.J.S. Records § 60 et seq.

24-14-29. Fees for copies and searches.

A. The fee for each search of a vital record to produce a certified copy of a birth certificate shall be ten dollars ($10.00) and shall include one certified copy of the record, if available.

B. The fee for the establishment of a delayed record or for the revision or amendment of a vital record, as a result of an adoption, a legitimation, a correction or other court-ordered change to a vital record, shall be ten dollars ($10.00). The fee shall include one certified copy of the delayed record.

C. The fee for each search of a vital record to produce a certified copy of a death certificate shall be five dollars ($5.00) and shall include one certified copy of the record, if available.

D. Revenue from the fees imposed in this section shall be distributed as follows:

(1) an amount equal to three-fifths of the revenue from the fee imposed by Subsection A of this section, an amount equal to one-half of the revenue from the fee imposed by Subsection B of this section and an amount equal to one-fifth of the revenue from the fee imposed by Subsection C of this section shall be distributed to the day-care fund; and

(2) the remainder of the revenue from the fees imposed by Subsections A, B and C of this section shall be deposited in the state general fund.

History: 1953 Comp., § 12-4-49, enacted by Laws 1961, ch. 44, § 27; 1973, ch. 264, § 12; 1981, ch. 309, § 23; 1987, ch. 62, § 1; 1988, ch. 114, § 1.

ANNOTATIONS

Cross references. — For day-care fund, *see* 24-14-29.1 NMSA 1978.

For state general fund, *see* 6-4-2 NMSA 1978.

County clerks may not issue certified copies of death certificates simply to allow someone the chance to avoid the higher fees charged for the issuance of such certificates by the vital statistics bureau. 1988 Op. Att'y Gen. No. 88-01.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 66 Am. Jur. 2d Records and Recording Laws §§ 13, 14.

76 C.J.S. Records § 60 et seq.

24-14-29.1. Day-care fund created; use; appropriation.

There is created in the state treasury a fund to be known as the "day-care fund". The fund shall be invested by the state treasurer as other state funds are invested. The fund shall consist of distributions of revenue collected since July 1, 1987 and future revenues collected pursuant to Section 24-14-29 NMSA 1978. All balances in the day-care fund are appropriated to the children, youth and families department for use in implementing the income-eligible day-care program under the Social Services Block Grant Act Title XX.

History: Laws 1988, ch. 114, § 2; 1989, ch. 324, § 19; 1993, ch. 151, § 1.

ANNOTATIONS

Cross references. — For the Social Services Block Grant Act (Title XX), *see* 42 U.S.C. §§ 1397 et seq.

The 1993 amendment, effective July 1, 1993, substituted "children, youth and families department" for "human services department" in the last sentence.

24-14-30. Duty to furnish information.

A. Any person having knowledge of the facts regarding any birth, death, spontaneous fetal death or induced abortion shall furnish this information upon demand to the state registrar.

B. Not later than the tenth day of the month following the month of occurrence, each funeral service practitioner shall send to the state registrar a list showing all dead bodies embalmed or otherwise prepared for final disposition during the preceding month. Such list shall be made on forms prescribed by the state registrar.

History: 1953 Comp., § 12-4-50, enacted by Laws 1961, ch. 44, § 28; 1981, ch. 309, § 24.

24-14-31. Penalties.

A. Except for violations of Section 24-14-18 NMSA 1978, any person is guilty of a fourth degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978, who willfully and knowingly:

(1) makes any false statement or supplies any false information in a report, record or certificate required to be filed;

(2) with the intent to deceive, alters, amends or mutilates any report, record or certificate;

(3) uses or attempts to use or furnishes to another for use for any purpose of deception any certificate, record, report or certified copy that has been altered, amended or mutilated or that contains false information; or

(4) neglects or violates any of the provisions of the Vital Statistics Act [24-14-1 to 24-14-17, 24-14-20 to 24-14-31 NMSA 1978] or refuses to perform any of the duties imposed upon him by that act.

B. Any person who willfully and knowingly permits inspection of or discloses information contained in vital statistics records of adoptions or induced abortions or copies or issues a copy of all or part of any record of an adoption or induced abortion, except as authorized by law, is guilty of a fourth degree felony and shall be sentenced in accordance with the provisions of the Criminal Sentencing Act [31-18-1 NMSA 1978].

History: 1953 Comp., § 12-4-51, enacted by Laws 1961, ch. 44, § 29; 1977, ch. 206, § 4; 1981, ch. 309, § 25; 1993, ch. 247, § 1.

ANNOTATIONS

Cross references. — For disclosure of information or records, *see* 24-14-27 NMSA 1978.

The 1993 amendment, effective July 1, 1993, in Subsection A, rewrote the introductory language, made stylistic changes in Paragraph (3), and substituted "fails to perform" for "neglects" in Paragraph (4).

Am. Jur. 2d, A.L.R. and C.J.S. references. — 66 Am. Jur. 2d Records and Recording Laws §§ 10, 11.

76 C.J.S. Records § 57 et seq.

ARTICLE 14A
Health Information Systems

24-14A-1. Short title.

Chapter 24, Article 14A NMSA 1978 may be cited as the "Health Information System Act".

History: Laws 1989, ch. 29, § 1; 1994, ch. 59, § 2.

ANNOTATIONS

Cross references. — For confidential health records, *see* 24-1-20 NMSA 1978.

The 1994 amendment, effective March 4, 1994, substituted "Chapter 24, Article 14A NMSA 1978" for "This act".

24-14A-2. Definitions.

As used in the Health Information System Act [24-14A-1 NMSA 1978]:

A. "aggregate data" means data which is obtained by combining like data in a manner which precludes specific identification of a single client or provider;

B. "commission" means the New Mexico health policy commission;

C. "department" means the department of health;

D. "health information" or "health data" means any data relating to health care; health status, including environmental, social and economic factors; the health system; or health costs and financing;

E. "hospital" means any general or special hospital licensed by the department, whether publicly or privately owned;

F. "long-term care facility" means any skilled nursing facility or nursing facility licensed by the department, whether publicly or privately owned;

G. "data source" includes those categories of persons or entities that possess health information, including any public or private sector licensed health care practitioner, primary care clinic, ambulatory surgery center, ambulatory urgent care center, ambulatory dialysis unit, home health agency, long-term care facility, hospital, pharmacy, third-party payer and any public entity that has health information; and

H. "third-party payer" means any public or private payer of health care services and includes health maintenance organizations and health insurers.

History: Laws 1989, ch. 29, § 2; 1994, ch. 59, § 3.

ANNOTATIONS

The 1994 amendment, effective March 4, 1994, deleted former Subsection B, which defined "committee"; inserted present Subsection B; rewrote Subsection C, which read " 'department' means the health and environment department"; substituted "environmental, social and economic factors; the health system; or health costs and financing" for "environmental factors; the health system; and health costs" in Subsection D; deleted "health and environment" preceding "department" in Subsection E; substituted "nursing facility licensed by the department" for "intermediate care facility licensed by the health and environment department" in Subsection F; rewrote Subsection G, which formerly defined "private sector data source"; deleted former Subsection H, which defined "public sector data source"; and redesignated former Subsection I as present Subsection H.

24-14A-3. Health information system; creation; duties of commission.

A. The "health information system" is created for the purpose of assisting the commission, legislature and other agencies and organizations in the state's efforts in collecting, analyzing and disseminating health information to assist:

(1) in the performance of health planning and policymaking functions, including identifying personnel, facility, education and other resource needs and allocating financial, personnel and other resources where appropriate;

(2) consumers in making informed decisions regarding health care; and

(3) in administering, monitoring and evaluating a statewide health plan.

B. In carrying out its powers and duties pursuant to the Health Information System Act, the commission shall not duplicate databases that exist in the public sector or databases in the private sector to which it has electronic access. Every governmental entity shall provide the commission with access to its health-related data as needed by the commission. The commission shall collect data from data sources in the most cost-effective and efficient manner.

C. The commission shall establish, operate and maintain the health information system.

D. In establishing, operating and maintaining the health information system, the commission shall:

(1) obtain information on the following health factors:

(a) mortality and natality, including accidental causes of death;

(b) morbidity;

(c) health behavior;

(d) disability;

(e) health system costs, availability, utilization and revenues;

(f) environmental factors;

(g) health personnel;

(h) demographic factors;

(i) social, cultural and economic conditions affecting health, including language preference;

(j) family status;

(k) medical and practice outcomes as measured by nationally accepted standards and quality of care; and

(l) participation in clinical research trials;

(2) give the highest priority in data gathering to information needed to implement and monitor progress toward achievement of the state health policy, including determining where additional health resources such as personnel, programs and facilities are most needed, what those additional resources should be and how existing resources should be reallocated;

(3) standardize collection and specific methods of measurement across databases and use scientific sampling or complete enumeration for collecting and reporting health information;

(4) take adequate measures to provide health information system security for all health data acquired under the Health Information System Act and protect individual patient and provider confidentiality. The right to privacy for the individual shall be a major consideration in the collection and analysis of health data and shall be protected in the reporting of results;

(5) adopt and promulgate rules necessary to establish and administer the provisions of the Health Information System Act, including an appeals process for data sources and procedures to protect data source proprietary information from public disclosure;

(6) establish definitions, formats and other common information standards for core health data elements of the health information system in order to provide an integrated financial, statistical and clinical health information system, including a

geographic information system, that allows data sharing and linking across databases maintained by data sources and federal, state and local public agencies;

(7) develop and maintain health and health-related data inventories and technical documentation on data holdings in the public and private sectors;

(8) collect, analyze and make available health data to support preventive health care practices and to facilitate the establishment of appropriate benchmark data to measure performance improvements over time;

(9) establish and maintain a systematic approach to the collection and storage of health data for longitudinal, demographic and policy impact studies;

(10) use expert system-based protocols to identify individual and population health risk profiles and to assist in the delivery of primary and preventive health care services;

(11) collect health data sufficient for consumers to be able to evaluate health care services, plans, providers and payers and to make informed decisions regarding quality, cost and outcome of care across the spectrum of health care services, providers and payers;

(12) collect comprehensive information on major capital expenditures for facilities, equipment by type and by data source and significant facility capacity reductions; provided that for the purposes of this paragraph and Section 24-14A-5 NMSA 1978, "major capital expenditure" means purchases of at least one million dollars ($1,000,000) for construction or renovation of facilities and at least five hundred thousand dollars ($500,000) for purchase or lease of equipment, and "significant facility capacity reductions" means those reductions in facility capacities as defined by the advisory committee established by the commission;

(13) serve as a health information clearinghouse, including facilitating private and public collaborative, coordinated data collection and sharing and access to appropriate data and information, maintaining patient and client confidentiality in accordance with state and federal requirements;

(14) collect data in the most cost-efficient and effective method feasible and adopt regulations, after receiving recommendations from the advisory committee, that place a limit on the maximum amount of unreimbursed costs that a data source can incur in any year for the purposes of complying with the data requirements of the Health Information System Act; and

(15) identify disparities in health care access and quality by aggregating the information collected pursuant to Paragraph (1) of Subsection D of this section by population subgroups to include race, ethnicity, gender and age.

History: Laws 1989, ch. 29, § 3; 1994, ch. 59, § 4; 2005, ch. 321, § 12; 2005, ch. 322, § 1.

ANNOTATIONS

The 1994 amendment, effective March 4, 1994, substituted "commission" for "department" in the section heading and throughout the section; rewrote and designated the former undesignated provisions as Subsections A and C to E; added a new Subsection B; redesignated former Subsections A to E as Paragraphs D(1) to D(5); redesignated former Paragraphs A(1) to A(10) as present Subparagraphs D(1)(a) to D(1)(j); inserted "cultural" in Subparagraph D(1)(i); added Subparagraph D(1)(k) and made a related stylistic change; added the language beginning "including" in Paragraph D(2); and added Paragraphs D(6) to D(14).

2005 amendments. — Section 24-14A-3 NMSA 1978 was amended by Laws 2005, ch. 321, § 12 and Laws 2005, ch. 322, § 1. Pursuant to Section 12-1-8 NMSA 1978, this section is set out as amended by Laws 2005, ch. 322, § 1.

Laws 2005, ch. 322, § 1, effective June 17, 2005, changes "system" to "health information system" in Subsections D and D(4); provides in Subsection D(1)(i) that condition affecting health include language preference; adds Subsection D(1)(l) to provide that the commission shall obtain information on participation in clinical research trials; and adds Subsection D(15) to provide that the commission identify disparities in health care access and quality by aggregating information collected pursuant to Paragraph (1) of Subsection D by population subgroups to include race, ethnicity, gender and age.

Laws 2005, ch. 321, § 12, deletes the former reference to the "advisory committee established" by the commission in Subsection D(12); deletes the former provision in Subsection D(14) which provided that the commission adopt regulations after receiving recommendation from the advisory committee.

24-14A-3.1. Repealed.

History: Laws 1994, ch. 59, § 13; repealed Laws 2005, ch. 321, § 14.

ANNOTATIONS

Repeals. — Laws 2005, ch. 321, § 14 repeals 24-14A-3.1 NMSA 1978, relating to creation of advisory committee, effective June 17, 2005. For provisions of former section, *see* New Mexico One Source of Law DVD.

24-14A-3.2. Repealed.

History: Laws 1994, ch. 59, § 14; repealed Laws 2005, ch. 321, § 14.

ANNOTATIONS

Repeals. — Laws 2005, ch. 321, § 14 repeals 24-14A-3.2 NMSA 1978, relating to health information alliance, effective June 17, 2005. For provisions of former section, *see* New Mexico One Source of Law DVD.

24-14A-4. Health information system; applicability.

A. All data sources shall participate in the health information system. Requests for health data under the Health Information System Act [24-14A-1 NMSA 1978] from a member of a data source category shall, where reasonable and equitable, be made to all members of that data source category.

B. Upon making any request for health data pursuant to the Health Information System Act, the commission shall provide reasonable deadlines for compliance and shall give notice that noncompliance may subject the person to a civil penalty pursuant to Section 24-14A-10 NMSA 1978.

C. To the extent possible, the health information system shall be established in a manner to facilitate the exchange of information with other databases, including those maintained by the Indian health service and various agencies of the federal government.

History: Laws 1989, ch. 29, § 4; 1994, ch. 59, § 5.

ANNOTATIONS

The 1994 amendment, effective March 4, 1994, rewrote Subsection A; substituted "commission" for "department" and "Section 24-14A-10 NMSA 1978" for "Section 10 of the Health Information System Act" in Subsection B; deleted former Subsections C to E, relating to submitting reports for periods ending December 31, 1990, June 30, 1991, and March 31, 1991; and redesignated former Subsection F as present Subsection C, and inserted "health information" before "system" therein.

24-14A-4.1. Annual review of data needs.

At least once each year, the commission shall review its data collection requirements to determine the relevancy of the data elements on which it collects data and review its regulations and procedures for collecting, analyzing and reporting data for efficiency, effectiveness and appropriateness. The review shall consider the cost incurred by data sources to collect and submit data.

History: Laws 1994, ch. 59, § 11; 2005, ch. 321, § 13.

ANNOTATIONS

The 2005 amendment, effective June 17, 2005, deletes the former provision that the commission review its data collection requirements with the recommendations of the advisory committee and health information alliance.

24-14A-4.2. Investigatory powers.

The commission has the right to verify the accuracy of data provided by any data source. The verification may include requiring the data source to submit documentation sufficient to verify the accuracy of the data in question or to provide direct inspection during normal business hours of only the records and documents that pertain directly to the data in question; provided that no data source shall be required to expend more than twenty-five thousand dollars ($25,000) each year to comply with the provisions of this section.

History: Laws 1994, ch. 59, § 12.

24-14A-4.3. Agency cooperation.

All state agencies and political subdivisions shall cooperate with and assist the commission in carrying out the provisions of the Health Information System Act [24-14A-1 NMSA 1978], including sharing information and joining in any appropriate health information system.

History: Laws 1994, ch. 59, § 15.

24-14A-5. Health information system; implementation; regulations.

In order to minimize the imposition of new reporting requirements on persons subject to the provisions of the Health Information System Act [24-14A-1 NMSA 1978], the regulations to the extent reasonably possible shall provide that:

A. data shall be collected in a uniform manner;

B. when practicable, data collection shall be through the use of a standardized billing form as required by law;

C. other health data required to be submitted may include:

(1) data that would customarily be collected in the ordinary course of business for the data source;

(2) annual audited financial statements customarily prepared by a data source;

(3) information on major capital expenditures;

(4) data established by regulation to be collected to carry out the requirements of the Health Information System Act; and

(5) data required to be collected by other state or federal laws; and

D. annual surveys or collection of data may be used as an alternative to collection of health data from some health service providers to the extent it can be shown that the information collected will meet validity and quality standards.

History: Laws 1989, ch. 29, § 5; 1994, ch. 59, § 6.

ANNOTATIONS

The 1994 amendment, effective March 4, 1994, redesignated the subsections; deleted "health data collection" preceding "provisions" in the introductory language; deleted former Paragraph A(2) relating to obtaining data from third party payers; rewrote Subsections B and C; and deleted former Subsections B and E, relating to schedule of implementation and regulations, respectively.

24-14A-6. Health information system; access.

A. Access to data in the health information system shall be provided in accordance with regulations adopted by the commission pursuant to the Health Information System Act [24-14A-1 NMSA 1978].

B. A data provider may obtain data it has submitted to the system, as well as aggregate data, but it may not access data submitted by another provider which is limited only to that provider. In no event may a data provider obtain data regarding an individual patient except in instances where that data was originally submitted by the requesting provider. Prior to the release of any data, in any form, data sources shall be permitted the opportunity to verify the accuracy of the data pertaining to that data source. Any data identified in writing as inaccurate shall be corrected prior to the data's release. Time limits shall be set for the submission and review of data by data sources and penalties shall be established for failure to submit and review the data within the established time.

C. Any person may obtain any aggregate data.

History: Laws 1989, ch. 29, § 6; 1994, ch. 59, § 7.

ANNOTATIONS

The 1994 amendment, effective March 4, 1994, substituted "commission" for "department" in Subsection A, and rewrote Subsection B.

24-14A-7. Health information system; reports.

A. A report in printed format that provides information of use to the general public shall be produced annually. The report shall be made available upon request. The commission may make the report available on tape or other electronic format.

B. The commission shall provide an annual report of its activities, including health care system statistics, to the legislature. The report shall be submitted by November 15 each year.

History: Laws 1989, ch. 29, § 7; 1994, ch. 59, § 8.

ANNOTATIONS

The 1994 amendment, effective March 4, 1994, designated the formerly undesignated provisions as Subsection A, and in that subsection, substituted "that" for "which" in the first sentence, deleted "to health care providers, purchasers, employers, consumers and other interested parties" following "available" in the second sentence, and substituted "commission" for "department" in the third sentence; and added Subsection B.

24-14A-8. Health information system; confidentiality.

A. Health information collected and disseminated pursuant to the Health Information System Act [24-14A-1 NMSA 1978] is strictly confidential and shall not be a matter of public record or accessible to the public except as provided in Sections 24-14A-6 and 24-14A-7 NMSA 1978. No data source shall be liable for damages to any person for having furnished the information.

B. The individual forms, computer tapes or other forms of data collected by and furnished for the health information system shall not be public records subject to inspection pursuant to Section 14-2-1 NMSA 1978. Compilations of aggregate data prepared for release or dissemination from the data collected, except for a report prepared for an individual data provider containing information concerning only its transactions, shall be public records.

History: Laws 1989, ch. 29, § 8; 1994, ch. 59, § 9.

ANNOTATIONS

The 1994 amendment, effective March 4, 1994, substituted the language beginning "strictly confidential" for "subject to the confidentiality provisions of Section 14-6-1 NMSA 1978" in Subsection A, and inserted "health information" in the first sentence of Subsection B.

24-14A-9. Health information system; fees.

Except for the annual reports required pursuant to the Health Information System Act [24-14A-1 NMSA 1978], the commission may collect a fee of up to one hundred

dollars ($100) per hour to offset partially the costs of producing public-use data aggregations or data for single use special studies. Entities contributing data to the system shall be charged reduced rates. Rates shall be established by regulation and shall be reviewed annually. Fees collected pursuant to this section are appropriated to the commission to carry out the provisions of the Health Information System Act.

History: Laws 1989, ch. 29, § 9; 1994, ch. 59, § 10.

ANNOTATIONS

The 1994 amendment, effective March 4, 1994, added at the beginning of the first sentence "Except for the annual reports required pursuant to the Health Information System Act," and made a related stylistic change; substituted "commission may" for "department has authority to establish and", and "a fee of up to one hundred dollars ($100) per hour" for "fees" in the first sentence; and substituted "commission" for "department" in the last sentence.

24-14A-10. Health information system; violation; civil penalty.

A. It is unlawful for any person subject to the data reporting requirements of the Health Information System Act [24-14A-1 NMSA 1978] and the regulations adopted pursuant to that act not to comply with any of those requirements.

B. A civil action may be brought in the name of the state alleging a violation of Subsection A of this section and a petition may be made to the district court for temporary or permanent injunctive relief. In any such action, if the court finds that a person has wilfully violated Subsection A of this section, upon petition to the court there may be recovered on behalf of the state a civil penalty not to exceed one thousand dollars ($1,000).

History: Laws 1989, ch. 29, § 10.

ARTICLE 15
Ski Safety

24-15-1. Short title.

Chapter 24, Article 15 NMSA 1978 may be cited as the "Ski Safety Act".

History: 1953 Comp., § 12-16-1, enacted by Laws 1969, ch. 218, § 1; recompiled as 1953 Comp., § 12-28-1, by Laws 1972, ch. 51, § 9; 1979, ch. 279, § 1.

ANNOTATIONS

Doctrine of comparative negligence is applicable to claims brought under the Ski Safety Act where both the skier and the ski area operator are alleged to have breached statutory duties. Lopez v. Ski Apache Resort, 114 N.M. 202, 836 P.2d 648 (Ct. App. 1992).

Law reviews. — For note, "Tort Law - The Application of the Rescue Doctrine Under Comparative Negligence Principles: Govich v. North American Systems, Inc.," see 23 N.M.L. Rev. 349 (1993).

Am. Jur. 2d, A.L.R. and C.J.S. references. — 27A Am. Jur. 2d Entertainment and Sports Law § 54 et seq.

Private owner's liability to trespassing children for injury sustained by sledding, tobogganing, skiing, skating or otherwise sliding on his land, 19 A.L.R.3d 184.

24-15-2. Purpose of act.

A. In order to safeguard life, health, property and the welfare of this state, it is the policy of New Mexico to protect its citizens and visitors from unnecessary hazards in the operation of ski lifts and passenger aerial tramways and to require liability insurance to be carried by operators of ski lifts and tramways. The primary responsibility for the safety of operation, maintenance, repair and inspection of ski lifts and tramways rests with the operators of such devices. The primary responsibility for the safety of the individual skier while engaging in the sport of skiing rests with the skier himself. The state, through the Ski Safety Act [24-15-1 NMSA 1978], recognizes these responsibilities and duties on the part of the ski area operator and the skier.

B. It is recognized that there are inherent risks in the sport of skiing, which should be understood by each skier and which are essentially impossible to eliminate by the ski area operator. It is the purpose of the Ski Safety Act to define those areas of responsibility and affirmative acts for which ski area operators shall be liable for loss, damage or injury and those risks which the skier or passenger expressly assumes and for which there can be no recovery.

History: 1953 Comp., § 12-16-2, enacted by Laws 1969, ch. 218, § 2; recompiled as 1953 Comp., § 12-28-2, by Laws 1972, ch. 51, § 9; 1979, ch. 279, § 2; 1997, ch. 211, § 1.

ANNOTATIONS

The 1997 amendment, effective June 20, 1997, designated the existing paragraphs as Subsections A and B, respectively, and inserted "or passenger" following "skier" near the end of Subsection B.

Duties for ski operators. — Section 24-15-7 NMSA 1978, not this section, sets out the specific duties for ski operators in a skiing area. Barba v. Taos Ski Valley, Inc., 1998

Colo. J. C.A.R. 2324, (10th Cir. 1998), decision without published opinion, 145 F.3d 1345 (10th Cir. 1998).

24-15-3. Definitions.

As used in the Ski Safety Act [24-15-1 NMSA 1978]:

A. "ski lift" means any device operated by a ski area operator used to transport passengers by single or double reversible tramway, chair lift or gondola lift, T-bar lift, J-bar lift, platter lift or similar device or a fiber rope tow;

B. "passenger" means any person, at any time in the year, who is lawfully using a ski lift or is waiting to embark or has recently disembarked from a ski lift and is in its immediate vicinity;

C. "ski area" means the property owned, permitted, leased or under the control of the ski area operator and administered as a single enterprise within the state;

D. "ski area operator" means any person, partnership, corporation or other commercial entity and its agents, officers, employees or representatives who has operational responsibility for any ski area or ski lift;

E. "skiing" means participating in the sport in which a person slides on snow, ice or a combination of snow and ice while using skis;

F. "skiing area" means all slopes, trails, terrain parks and competition areas, not including any ski lift;

G. "skier" means any person, including a person enrolled in ski school or other class for instruction, who is on skis and present at a skiing area under the control of a ski area operator for the purpose of engaging in the sport of skiing by utilizing the ski slopes and trails and does not include a passenger;

H. "ski slopes and trails" means those areas designated by the ski area operator to be used by skiers for the purpose of participating in the sport of skiing;

I. "ski retention device" means a device designed to help prevent runaway skis; and

J. "skis" means any device used for skiing, including alpine skis, telemark skis, cross-country skis, mono-skis, snowboards, bladerunners, adaptive devices used by disabled skiers, or tubes, sleds or any other device used to accomplish the same or a similar purpose to participate in the sport of skiing.

History: Laws 1969, ch. 218, § 3; 1953 Comp., § 12-16-3; recompiled as 1953 Comp., § 12-28-3 by Laws 1972, ch. 51, § 9; 1979, ch. 279, § 3; 1997, ch. 211, § 2.

ANNOTATIONS

The 1997 amendment, effective June 20, 1997, inserted "at any time in the year" near the beginning of Subsection A, added Subsections E and J, redesignated former Subsections E to H as Subsections F to I, inserted "terrain parks and competition areas" in Subsection F, inserted "including a person enrolled in ski school or other class for instruction, who is on skis and" near the beginning of Subsection G, substituted "a passenger" for "the use of a ski lift" at the end of Subsection G, and made minor stylistic changes throughout the section.

24-15-4. Insurance.

A. Every operator shall file with the state corporation commission [public regulation commission] and keep on file therewith proof of financial responsibility in the form of a current insurance policy in a form approved by the commission, issued by an insurance company authorized to do business in the state, conditioned to pay, within the limits of liability herein prescribed, all final judgments for personal injury or property damage proximately caused or resulting from negligence of the operator covered thereby, as such negligence is defined and limited by the Ski Safety Act [24-15-1 NMSA 1978]. The minimum limits of liability insurance to be provided by operators shall be as follows:

SKI SAFETY ACT
LIABILITY INSURANCE
LIMITS OF LIABILITY
REQUIRED MINIMUM COVERAGES
FOR INJURIES, DEATH OR DAMAGES

KIND AND NUMBERS OF LIFTS OPERATED	LIMITS FOR BODILY INJURY TO OR DEATH OF ONE PERSON	LIMITS FOR BODILY INJURY TO OR DEATH OF ALL PERSONS INJURED OR KILLED IN ANY ONE ACCIDENT	PROPERTY DAMAGE
Not more than three surface lifts	$100,000	$300,000	$5,000
Not more than three ski lifts, including one or more chair lifts	250,000	500,00	25,000
More than three ski lifts or one			

or more tramways	500,000	1,000,000	50,000.

B. No ski lift or tramway shall be operated in this state after the effective date of the Ski Safety Act unless a current insurance policy as required herein is in effect and properly filed with the state corporation commission [public regulation commission]. Each policy shall contain a provision that it cannot be canceled prior to its expiration date without thirty days' written notice of intent to cancel served by registered mail on the insured and on the commission.

History: 1953 Comp., § 12-16-4, enacted by Laws 1969, ch. 218, § 4; recompiled as 1953 Comp., § 12-28-4, by Laws 1972, ch. 51, § 9; 1997, ch. 211, § 3.

ANNOTATIONS

Cross references. — For duties of operators, *see* 24-15-7 NMSA 1978.

Bracketed material. — The bracketed material in this section was inserted by the compiler. It was not enacted by the legislature and is not part of the law. For references to state corporation commission being construed as references to the public regulation commission, see 8-8-21 NMSA 1978.

Effective dates. — The effective date of the Ski Safety Act was March 22, 1969.

The 1997 amendment, effective June 20, 1997, designated the existing paragraphs as Subsections A and B respectively, in Subsection A, added the table heading which reads "SKI SAFETY ACT LIABILITY INSURANCE LIMITS OF LIABILITY REQUIRED MINIMUM COVERAGES FOR INJURIES, DEATH OR DAMAGES", increased the minimum limits of liability insurance throughout the table, and made a minor stylistic change in Subsection B.

Am. Jur. 2d, A.L.R. and C.J.S. references. — 27A Am. Jur. 2d Entertainment and Sports Law § 4.

24-15-5. Penalty.

Any operator convicted of operating a ski lift or aerial passenger tramway without having obtained and kept in force an insurance policy as required by the Ski Safety Act [24-15-1 NMSA 1978] is guilty of a misdemeanor punishable by a fine of not more than five hundred dollars ($500) for each day of illegal operation. The attorney general or the district attorney of the county where the ski area is located has the power to bring proceedings in the district court of the county in which the ski area is located to enjoin the operation of any ski lift or tramway being operated without a current insurance policy, in the amounts prescribed herein, being obtained and kept in force and covering the operator concerned.

History: 1953 Comp., § 12-16-5, enacted by Laws 1969, ch. 218, § 5; recompiled as 1953 Comp., § 12-28-5, by Laws 1972, ch. 51, § 9; 1997, ch. 211, § 4.

ANNOTATIONS

The 1997 amendment, effective June 20, 1997, substituted "having obtained and kept in force" for "having filed" near the beginning of the section, substituted "five hundred dollars ($500)" for "one hundred dollars ($100)" in the first sentence, and substituted "being obtained and kept in force" for "being on file" near the end of the section.

24-15-6. Provisions in lieu of others.

Provisions of the Ski Safety Act [24-15-1 NMSA 1978] are in lieu of all other regulations, registration or licensing requirements for ski areas, ski lifts and tramways. Ski lifts and tramways shall not be construed to be common carriers within the meaning of the laws of New Mexico.

History: 1953 Comp., § 12-16-6, enacted by Laws 1969, ch. 218, § 6; recompiled as 1953 Comp., § 12-28-6, by Laws 1972, ch. 51, § 9.

ANNOTATIONS

Skier as third party beneficiary of permit between United States and ski resort. — The dismissal of an injured skier's claim that she was a third party beneficiary under the terms of the permit between the United States and the ski resort was proper since the Ski Safety Act provided the exclusive remedy available to the skier. Kidd v. Taos Ski Valley, Inc., 88 F.3d 848 (10th Cir. 1996).

24-15-7. Duties of ski area operators with respect to skiing areas.

Every ski area operator shall have the following duties with respect to the operation of a skiing area:

A. to mark all snow-maintenance vehicles and to furnish such vehicles with flashing or rotating lights, which shall be in operation whenever the vehicles are working or are in movement in the skiing area;

B. to mark with a visible sign or other warning implement the location of any hydrant or similar equipment used in snow-making operations and located on ski slopes and trails;

C. to mark in a plainly visible manner the top or entrance to each slope, trail or area with the appropriate symbol for its relative degree of difficulty, using the symbols established or approved by the national ski areas association; and those slopes, trails or areas which are closed, or portions of which present an unusual obstacle or hazard, shall be marked at the top or entrance or at the point of the obstacle or hazard with the

appropriate symbols as are established or approved by the national ski areas association or by the New Mexico ski area operators association;

D. to maintain one or more trail boards at prominent locations at each ski area displaying that area's network of ski trails and slopes with each trail and slope rated in accordance with the symbols and containing a key to the symbols;

E. to designate by trail board or otherwise at the top of or entrance to the subject trail or slope which trails or slopes are open or closed;

F. to place or cause to be placed, whenever snow-maintenance vehicles or snow-making operations are being undertaken upon any trail or slope while such trail or slope is open to the public, a conspicuous notice to that effect at or near the top or entrance of such trail or slope;

G. to provide ski patrol personnel trained in first aid, which training meets at least the requirements of the national ski patrol outdoor emergency care course, and also trained in winter rescue and toboggan handling to serve the anticipated number of injured skiers and to provide personnel trained for the evacuation of passengers from stalled aerial ski lifts. A first aid room or building shall be provided with adequate first aid supplies, and properly equipped rescue toboggans shall be made available at all reasonable times at the top of ski slopes and trails to transport injured skiers from the ski slopes and trails to the first aid room;

H. to post notice of the requirements of the Ski Safety Act [24-15-1 NMSA 1978] concerning the use of ski retention devices;

I. to warn of or correct particular hazards or dangers known to the operator where feasible to do so; and

J. to warn of snowmobiles or all-terrain vehicles (ATV's) operated on the ski slopes or trails with at least one lighted headlamp, one lighted red tail lamp, a brake system and a fluorescent flag that is at least forty square inches and is mounted at least six feet above the bottom of the tracks or tires.

History: Laws 1969, ch. 218, § 7; 1953 Comp., § 12-16-7; recompiled as 1953 Comp., § 12-28-7 by Laws 1972, ch. 51, § 9; 1979, ch. 279, § 4; 1997, ch. 211, § 5.

ANNOTATIONS

The 1997 amendment, effective June 20, 1997, rewrote Subsection C, inserted "at the top of or entrance to the subject trail or slope" in Subsection E, inserted "or entrance" near the end of Subsection F, substituted "meets at least the requirements of the national ski patrol outdoor emergency care course" for "meets the requirements of the American Red Cross advanced first aid course" near the beginning of Subsection G, added Subsection J, and made minor stylistic changes in Subsections H and I.

Duty to provide warning to skiers of the degree of difficulty of ski slopes or the existence of unusual obstacles or hazards located in skiing areas, imposed under Subsections C and I, may assume additional significance as the difficulty of the skiing area becomes more pronounced, or the degree of danger posed by the risk of collision with an unprotected ski tower located in the designated skiing area increases. Lopez v. Ski Apache Resort, 114 N.M. 202, 836 P.2d 648 (Ct. App. 1992).

A ski resort did not breach its duty to warn under this section when it installed a singled strand diversionary rope and blocked off an otherwise skiable area since the evidence was that the rope had been in place for at least 12 years and over one million skiers had managed to ski past it without injury. Kidd v. Taos Ski Valley, Inc., 88 F.3d 848 (10th Cir. 1996).

Conspicuous warnings not required. — The Ski Safety Act does not require the trail warnings of unusual obstacles or hazards to be conspicuous. Barba v. Taos Ski Valley, Inc., 145 F.3d 1345 (10th Cir. 1998).

Duties for ski operators. — This section, not Section 24-15-2 NMSA 1978, sets out the specific duties for ski operators in a skiing area. Barba v. Taos Ski Valley, Inc., 145 F.3d 1345 (10th Cir. 1998).

Warning adequate. — Where the uncontroverted evidence was that Taos did not "know" that the picnic table near ski trail was a hazard because it had been at that same location for more than twenty years and no one had collided with it, the trail map board marking the location of the picnic table on the ski run and the sign warning of unmarked obstacles were adequate under the standards of the National Ski Areas Association, and, therefore, under the Ski Safety Act. Barba v. Taos Ski Valley, Inc., 1998 Colo. J. C.A.R. 2324, (10th Cir. 1998), decision without published opinion, 145 F.3d 1345 (10th Cir. 1998).

"Warn or correct" hazards. — Where skier was injured by colliding with picnic table while skiing and argued that rather than warn of the picnic table, the operator should have corrected the hazard, the plain language of the Ski Safety Act specifically states that the operator must "warn or correct" hazards. Barba v. Taos Ski Valley, Inc., 1998 Colo. J. C.A.R. 2324, (10th Cir. 1998), decision without published opinion, 145 F.3d 1345 (10th Cir. 1998).

Doctrine of comparative negligence is applicable to claims brought under the Act where both the skier and the ski area operator are alleged to have breached statutory duties. Lopez v. Ski Apache Resort, 114 N.M. 202, 836 P.2d 648 (Ct. App. 1992).

General duty to novice skier. — The scope of the duty imposed on ski operations in Subsection I of this section was not broad enough to encompass the duty to provide a general warning to a novice skier that, because of the skier's limited abilities, portions of a beginner slope may have been dangerous. Philippi v. Sipapu, Inc., 961 F.2d 1492 (10th Cir. 1992).

Am. Jur. 2d, A.L.R. and C.J.S. references. — 27A Am. Jur. 2d Entertainment and Sports Law §§ 54 et seq., 81, 82.

Ski resort's liability for skier's injuries resulting from condition of ski run or slope, 55 A.L.R.4th 632.

24-15-8. Duties of ski area operators with respect to ski lifts.

Every ski area operator shall have the duty to operate, repair and maintain all ski lifts in safe condition. The ski area operator, prior to December 1 of each year, shall certify to the state corporation commission [public regulation commission] the policy number and name of the company providing liability insurance for the ski area and the date of the ski lift inspections and the name of the person making such inspections.

History: Laws 1969, ch. 218, § 8; 1953 Comp., § 12-16-8; recompiled as 1953 Comp., § 12-28-8 by Laws 1972, ch. 51, § 9; 1979, ch. 279, § 5.

ANNOTATIONS

Cross references. — For public regulation commission, *see* N.M. Const., art. XI, § 1.

For references to state corporation commission being construed as references to the public regulation commission, *see* 8-8-21 NMSA 1978.

Bracketed material. — The bracketed material in this section was inserted by the compiler. It was not enacted by the legislature and is not part of the law.

The doctrine of comparative negligence is applicable to claims brought under the Act where both the skier and the ski area operator are alleged to have breached statutory duties. Lopez v. Ski Apache Resort, 114 N.M. 202, 836 P.2d 648 (Ct. App. 1992).

24-15-9. Duties of passengers.

Every passenger shall have the duty to conduct himself carefully and not to:

A. board or embark upon or disembark from a ski lift except at an area designated for such purpose;

B. drop, throw or expel any object from a ski lift;

C. do any act which shall interfere with the running or operation of a ski lift;

D. use any ski lift unless the passenger has the ability to use it safely without any instruction on its use by the ski area operator or requests and receives instruction before boarding the ski lift;

E. willfully or negligently engage in any type of conduct which contributes to or causes injury to any person;

F. embark on a ski lift without the authority of the ski area operator;

G. use any ski lift without engaging such safety or restraining devices as may be provided; or

H. wear skis without properly securing ski retention devices; or

I. use a ski lift while intoxicated or under the influence of any controlled substance.

History: 1978 Comp., § 24-15-9, enacted by Laws 1979, ch. 279, § 6.

ANNOTATIONS

Am. Jur. 2d, A.L.R. and C.J.S. references. — 27A Am. Jur. 2d Entertainment and Sports Law § 88 et seq.

24-15-10. Duties of the skiers.

A. It is recognized that skiing as a recreational sport is inherently hazardous to skiers, and it is the duty of each skier to conduct himself carefully.

B. A person who takes part in the sport of skiing accepts as a matter of law the dangers inherent in that sport insofar as they are obvious and necessary. Each skier expressly assumes the risk of and legal responsibility for any injury to person or property which results from participation in the sport of skiing, in the skiing area, including any injury caused by the following: variations in terrain; surface or subsurface snow or ice conditions; bare spots; rocks, trees or other forms of forest growth or debris; lift towers and components thereof, pole lines and snow-making equipment which are plainly visible or are plainly marked in accordance with the provisions of Section 24-15-7 NMSA 1978; except for any injuries to persons or property resulting from any breach of duty imposed upon ski area operators under the provisions of Sections 24-15-7 and 24-15-8 NMSA 1978. Therefore, each skier shall have the sole individual responsibility for knowing the range of his own ability to negotiate any slope or trail, and it shall be the duty of each skier to ski within the limits of the skier's own ability, to maintain reasonable control of speed and course at all times while skiing, to heed all posted warnings, to ski only on a skiing area designated by the ski area operator and to refrain from acting in a manner which may cause or contribute to the injury of anyone.

C. Responsibility for collisions by any skier while actually skiing, with any person or object, shall be solely that of each individual involved in the collision, except where an employee, agent or officer of the ski area operator is personally involved in a collision while in the course and scope of his employment or where a collision resulted from any

breach of duty imposed upon a ski area operator under the provisions of Sections 24-15-7 or 24-15-8 NMSA 1978. Each skier has the duty to stay clear of and avoid collisions with snow-maintenance equipment, all-terrain vehicles and snowmobiles marked in compliance with the provisions of Subsections A and J of Section 24-15-7 NMSA 1978, all other vehicles, lift towers, signs and any other structures, amenities or equipment on the ski slopes and trails or in the skiing area.

D. No person shall:

(1) place any object in the skiing area or on the uphill track of any ski lift which may cause a passenger or skier to fall;

(2) cross the track of any T-bar lift, J-bar lift, platter lift or similar device or a fiber rope tow, except at a designated location;

(3) when injured while skiing or using a ski lift or, while skiing, when involved in a collision with any skier or object in which an injury results, leave the ski area before giving his name and current address to the ski area operator, or representative or employee of the ski area operator, and the location where the injury or collision occurred and the circumstances thereof; provided, however, in the event a skier fails to give the notice required by this paragraph, a court, in determining whether or not such failure constitutes a violation of the Ski Safety Act [24-15-1 NMSA 1978], may consider the reasonableness or feasibility of giving such notice; or

(4) use a ski lift, skiing area, slopes or trails while intoxicated or under the influence of any controlled substance.

E. No skier shall fail to wear retention straps or other ski retention devices to help prevent runaway skis.

F. Any skier upon being injured shall indicate, to the ski patrol personnel offering first aid treatment or emergency removal to a first aid room, his acceptance or rejection of such services as provided by the ski area operator. If such service is not refused or if the skier is unable to indicate his acceptance or rejection of such service, the acceptance of the service is presumed to have been accepted by the skier. Such acceptance shall not constitute a waiver of any action for negligent provision of the service by the ski patrol personnel.

History: 1978 Comp., § 24-15-10, enacted by Laws 1979, ch. 279, § 7; 1997, ch. 211, § 6.

ANNOTATIONS

The 1997 amendment, effective June 20, 1997, deleted the former fourth sentence of Subsection B relating to responsibilities for collisions by skiers, added Subsection C and

redesignated the remaining subsections accordingly, and inserted "skiing area, slopes or trails" in Paragraph D(4).

Failure of a skier to give notice of her alleged injury to the ski lift operator was not a proper ground for summary judgment for the operator, where there was no evidence that any alleged failure of the skier to comply with the provisions of this section was causally related to the loss or damage claimed by the skier. Wood v. Angel Fire Ski Corp., 108 N.M. 453, 774 P.2d 447 (Ct. App. 1989).

Doctrine of comparative negligence. — The doctrine of comparative negligence is applicable to claims brought under the Act where both the skier and the ski area operator are alleged to have breached statutory duties. Lopez v. Ski Apache Resort, 114 N.M. 202, 836 P.2d 648 (Ct. App. 1992).

Am. Jur. 2d, A.L.R. and C.J.S. references. — 27A Am. Jur. 2d Entertainment and Sports Law § 88 et seq.

Skier's liability for injuries to or death of another person, 75 A.L.R.5th 583.

24-15-11. Liability of ski area operators.

Any ski area operator shall be liable for loss or damages caused by the failure to follow the duties set forth in Sections 24-15-7 and 24-15-8 NMSA 1978 where the violation of duty is causally related to the loss or damage suffered, and shall continue to be subject to liability in accordance with common-law principles of vicarious liability for the willful or negligent actions of its principals, agents or employees which cause injury to a passenger, skier or other person. The ski area operator shall not be liable to any passenger or skier acting in violation of his duties as set forth in Sections 24-15-9 and 24-15-10 NMSA 1978 where the violation of duty is causally related to the loss or damage suffered.

History: 1978 Comp., § 24-15-11, enacted by Laws 1979, ch. 279, § 8.

ANNOTATIONS

Failure to stop ski lift. — Genuine issue of material fact, precluding summary judgment, existed concerning whether, despite any alleged negligence attributable to a skier, the ski lift operator negligently failed to stop the ski lift once he became aware that the skier had just disembarked from the ski lift, was unable to move, and was in a position of peril. Wood v. Angel Fire Ski Corp., 108 N.M. 453, 774 P.2d 447 (Ct. App. 1989).

Am. Jur. 2d, A.L.R. and C.J.S. references. — Liability of operator of skiing, tobogganing or bobsledding facilities for injury to patron or participant, 94 A.L.R.2d 1431, 95 A.L.R.3d 203.

Ski resort's liability for skier's injuries resulting from condition of ski run or slope, 55 A.L.R.4th 632.

24-15-12. Liability of passengers.

Any passenger shall be liable for loss or damages resulting from violations of the duties set forth in Section 24-15-9 NMSA 1978, and shall not be able to recover from the ski area operator for any losses or damages where the violation of duty is causally related to the loss or damage suffered.

History: 1978 Comp., § 24-15-12, enacted by Laws 1979, ch. 279, § 9.

24-15-13. Liability of skiers.

Any skier shall be liable for loss or damages resulting from violations of the duties set forth in Section 24-15-10 NMSA 1978, and shall not be able to recover from the ski area operator for any losses or damages where the violation of duty is causally related to the loss or damage suffered.

History: 1978 Comp., § 24-15-13, enacted by Laws 1979, ch. 279, § 10.

ANNOTATIONS

Am. Jur. 2d, A.L.R. and C.J.S. references. — Skier's liability for injuries to or death of another person, 75 A.L.R.5th 583.

24-15-14. Limitation of actions; notice of claim.

A. Unless a ski area operator is in violation of the Ski Safety Act [24-15-1 NMSA 1978], with respect to the skiing area and ski lifts, and the violation is a proximate cause of the injury complained of, no action shall lie against such ski area operator by any skier or passenger or any representative of a skier or passenger. This prohibition shall not prevent the bringing of an action against a ski area operator for damages arising from injuries caused by negligent operation, maintenance or repair of the ski lift.

B. No suit or action shall be maintained against any ski area operator for injuries incurred as a result of the use of a ski lift or ski area unless the same is commenced within three years of the time of the occurrence of the injuries complained of.

History: 1978 Comp., § 24-15-14, enacted by Laws 1979, ch. 279, § 11.

ANNOTATIONS

Am. Jur. 2d, A.L.R. and C.J.S. references. — Liability of operator of skiing, tobogganing or bobsledding facilities for injury to patron or participant, 94 A.L.R.2d 1431, 95 A.L.R.3d 203.

ARTICLE 15A
Search and Rescue

24-15A-1. Short title.

This act [24-15A-1 to 24-15A-6 NMSA 1978] may be cited as the "Search and Rescue Act".

History: 1978 Comp., § 24-15A-1, enacted by Laws 1978, ch. 107, § 1.

24-15A-2. Purpose of act.

It is the purpose of the Search and Rescue Act [24-15A-1 NMSA 1978]:

A. to prepare, organize and coordinate efforts of federal, state and local governmental agencies and volunteer organizations for prompt and efficient search, location, rescue, recovery, care and treatment of persons lost, entrapped or in physical danger;

B. to further coordinate national and state search and rescue agreements; and

C. to develop and administer a statewide plan for search and rescue.

History: 1978 Comp., § 24-15A-2, enacted by Laws 1978, ch. 107, § 2.

24-15A-3. Definitions.

As used in the Search and Rescue Act [24-15A-1 NMSA 1978]:

A. "search and rescue" or "SAR" means the employment, coordination and utilization of available resources and personnel in locating, relieving the distress and preserving the lives of and removing survivors from the site of a disaster, emergency or hazard to a place of safety in the case of lost, stranded, entrapped or injured persons;

B. "board" means the state search and rescue review board;

C. "AFRCC" means the air force rescue coordination center, which is the federal agency responsible for coordinating federal SAR activities within the inland region pursuant to the national search and rescue plan;

D. "state SAR control agency" means the department of public safety;

E. "state SAR mission initiator" means the New Mexico state police officer so appointed and SAR trained;

F. "state SAR resource officer" means the official located within the department of public safety responsible for coordinating SAR resources and administering the state SAR plan;

G. "field coordinator" means a person certified by the board with special training and expertise responsible for the efficient organization and conduction of a SAR mission;

H. "civil air patrol" means the civil air patrol division of the department of military affairs and an air force auxiliary responsible for coordinating air searches which are authorized by the AFRCC;

I. "mission" means each separate group effort in the employment, direction and guidance of personnel and facilities in searching for and rendering aid to persons lost or in distress;

J. "chief" means the chief of the New Mexico state police division of the department of public safety; and

K. "director" means the director of the technical and emergency support division of the department of public safety.

History: 1978 Comp., § 24-15A-3, enacted by Laws 1978, ch. 107, § 3; 1979, ch. 202, § 8; 1989, ch. 204, § 16.

ANNOTATIONS

Cross references. — For the public safety department, *see* 9-19-1 NMSA 1978 et seq.

For the civil air patrol division, *see* 20-7-1 NMSA 1978 et seq.

24-15A-4. State search and rescue resource officer; position created.

A. The position of "state search and rescue resource officer" is created within the department of public safety.

B. The state search and rescue resource officer shall be a noncommissioned employee.

C. The state search and rescue resource officer shall be the chief administrator of the state search and rescue plan.

History: 1978 Comp., § 24-15A-3, enacted by Laws 1978, ch. 107, § 4; 1979, ch. 202, § 8; 1989, ch. 204, § 17.

24-15A-5. State search and rescue resource officer; powers and duties.

The state search and rescue resource officer shall, with the approval of the director:

A. compile, maintain and disseminate an inventory of resources available in the state;

B. compile, maintain and disseminate rosters of persons, agencies and organizations available for search and rescue purposes;

C. develop a training program for the certification of search and rescue instructors and, by regulation, adopt a system of certification of search and rescue persons;

D. act as contact agent for the state in search and rescue matters;

E. develop and periodically review requirements for insurance coverage for search and rescue volunteers;

F. coordinate the training of mission initiators and field coordinators; and

G. maintain records of missions at the state SAR control agency.

History: 1978 Comp., § 24-15A-5, enacted by Laws 1978, ch. 107, § 5; 1979, ch. 202, § 10; 1989, ch. 204, § 18.

24-15A-6. State search and rescue review board created; membership; duties and responsibilities; terms.

A. There is created a policy advisory committee, to be known as the "state search and rescue review board", whose duty it is to evaluate the operation of the New Mexico search and rescue plan; evaluate problems of specific missions; and make findings of fact and recommendations to the chief, director and other appropriate authorities. The board shall consist of the state search and rescue resource officer, who shall be a nonvoting member, and seven members appointed by the governor as follows:

(1) the secretary of public safety or his designee;

(2) the secretary of health or his designee;

(3) a representative of the civil air patrol division of the department of military affairs;

(4) a representative of the New Mexico emergency services council;

(5) a member certified as a search and rescue person;

(6) a member of the New Mexico sheriff's association;

(7) the chief of the New Mexico state police division of the department of public safety or his designee; and

(8) a member of the general public who shall act as chairman of the board and who shall vote only in case of a tie.

B. The board shall have the duty and responsibility to:

(1) meet at least quarterly or more frequently at the call of the chairman;

(2) evaluate the operation and effectiveness of the state SAR plan and make recommendations to the director;

(3) evaluate the operational effectiveness of specific missions, make findings of fact and recommendations to the chief and other appropriate authorities for the elimination of problems and the improvement of overall conduct of the mission;

(4) hold hearings and invite individuals to appear and testify before the board and reimburse such witnesses for travel expenses incurred;

(5) prepare a report for the attorney general's office in cases of victim hospitalization or death; and

(6) with the approval of the chief, certify field coordinators and confirm certification of SAR persons.

C. The governor shall appoint the seven appointed members for staggered terms of three years each made in such a manner that the terms of not more than three members expire on January 1 of 1979, 1980 and 1981. Thereafter, appointments shall be made so that the terms of not more than three members expire on January 1 of each year. Vacancies shall be filled by appointment by the governor for the unexpired term. Any member of the board who misses more than two consecutive meetings shall automatically be removed as a member of the board.

History: 1978 Comp., § 24-15A-6, enacted by Laws 1978, ch. 107, § 6; 1979, ch. 202, § 11; 1983, ch. 296, § 28; 1989, ch. 204, § 19; 1993, ch. 15, § 1.

ANNOTATIONS

Cross references. — For the public safety department, *see* Chapter 9, Article 19 NMSA 1978.

For the civil air patrol division, *see* Chapter 20, Article 7 NMSA 1978.

The 1993 amendment, effective June 18, 1993, in Subsection A, deleted "and environment" following "health" in Paragraph (2) and inserted "or his designee" in Paragraph (7).

ARTICLE 16
Clean Indoor Air

24-16-1. Short title.

This act [24-16-1 to 24-16-11 NMSA 1978] may be cited as the "Clean Indoor Air Act".

History: Laws 1985, ch. 85, § 1.

ANNOTATIONS

Banning smoking entirely in schools. — Although the Clean Indoor Air Act allows the use of tobacco products by adults in smoking-permitted areas of public buildings, including school buildings, owned or leased by the state or any of its political subdivisions, the state board of education or local school boards can choose to ban smoking by both adults and minors on public school campuses. 1994 Op. Att'y Gen. No. 94-03.

Am. Jur. 2d, A.L.R. and C.J.S. references. — Validity, construction, and application of nonsmoking regulations, 65 A.L.R.4th 1205.

Secondary smoke as battery, 46 A.L.R.5th 813.

24-16-2. Declaration of policy and intent; public health.

The legislature finds and declares that the smoking of tobacco, or any other weed or plant, is a positive danger to health and a health hazard to those who are present in enclosed places and that smoking in such areas should be confined to designated smoking areas. The legislature further declares its intention to protect the public health from such hazards in public places and places of employment without imposing exorbitant costs on persons in management and control of the places subject to the Clean Indoor Air Act [24-16-1 NMSA 1978]. It is not the intent of the legislature to preempt the field of regulation of smoking in public from the enactment of ordinances by local governing bodies which are not inconsistent with the Clean Indoor Air Act.

History: Laws 1985, ch. 85, § 2.

ANNOTATIONS

Am. Jur. 2d, A.L.R. and C.J.S. references. — Constitutional law, validity, construction and application of municipal ordinances restricting smoking in restaurants, 105 A.L.R. 5th 333.

24-16-3. Definitions.

As used in the Clean Indoor Air Act [24-16-1 NMSA 1978]:

A. "employer" means the state or any political subdivision of the state who employs the services of more than fifteen persons;

B. "place of employment" means any enclosed indoor area under the control of a public employer which employees normally frequent during the course of employment, including but not limited to work areas, employee lounges, conference rooms and employee cafeterias;

C. "public meeting" means any meeting required by law to be an open meeting;

D. "public place" means any enclosed indoor area in a building owned or leased by the state or any of its political subdivisions;

E. "smoke" or "smoking" means the carrying or holding of a lighted pipe, cigar or cigarette of any kind, or any other lighted smoking equipment or the lighting or emitting or exhaling the smoke of a pipe, cigar or cigarette of any kind; and

F. "smoking-permitted area" means that portion of a public place in which smoking may be permitted.

History: Laws 1985, ch. 85, § 3.

ANNOTATIONS

Public place. — State law regulating smoking does not impose controls on Indians who sell jewelry on the portal of the Palace of the Governors, because the portals are not a "public place" for the purposes of this article. 1987 Op. Att'y Gen. No. 87-21.

A jail is a "public place" within the meaning of Subsection D. 1989 Op. Att'y Gen. No. 89-03.

Municipal ordinance which was broader than the Clean Air Act, in that the ordinance applied to private businesses and work areas, was permissible because it contemplated rather than conflicted with the purpose of the act. 1989 Op. Att'y Gen. No. 89-03.

24-16-4. Smoking prohibited except in permitted areas.

It is unlawful for a person to smoke in a public place or at a public meeting except in smoking-permitted areas. No part of the state capitol or capitol north shall be designated as a smoking-permitted area.

History: Laws 1985, ch. 85, § 4; 1999, ch. 250, § 1; 2002, ch. 2, § 1.

ANNOTATIONS

The 1999 amendment, effective June 18, 1999, added the last sentence.

The 2002 amendment, effective May 15, 2002, made a minor stylistic change in the first sentence, and in the second sentence deleted "Except for private offices and the house and senate lounges" and added "or capitol north".

24-16-5. Smoking-permitted areas.

Smoking-permitted areas in public places are:

A. fully enclosed offices or rooms occupied exclusively by smokers, although the offices or rooms may be visited by nonsmokers;

B. rooms or halls being used by a person or group for a nongovernmental function where the seating arrangements are under the control of the sponsor of the function;

C. smoking-permitted areas designated by the proprietor or person in charge of a public place or public meeting pursuant to Section 6 [24-16-6 NMSA 1978] of the Clean Indoor Air Act; and

D. smoking-permitted areas designated in a place of employment by an employer pursuant to Section 7 [24-16-7 NMSA 1978] of the Clean Indoor Air Act.

History: Laws 1985, ch. 85, § 5.

24-16-6. Designation of smoking-permitted area.

The person in charge of a public place or public meeting shall designate as a smoking-permitted area, by appropriate signs, a contiguous area or areas which shall not exceed fifty percent of the public place.

History: Laws 1985, ch. 85, § 6.

24-16-7. Smoking in places of employment.

A. For places of employment, within one year after the effective date of the Clean Indoor Air Act [24-16-1 NMSA 1978], each employer shall adopt, implement and

maintain a written smoking policy which shall contain, at a minimum, provisions relating to the following:

(1) the prohibition of smoking in elevators and nurses aid stations or similar facilities for treatment of employees;

(2) the provision and maintenance of a contiguous nonsmoking area of not less than one-half of the seating capacity and floor space in cafeterias, lunchrooms and employee lounges; and

(3) in places of work in which smokers and nonsmokers work in the same office or room, providing smoke-free work areas to accommodate employees who request such areas.

B. It is the responsibility of employers to provide smoke-free work areas for nonsmokers where possible but employers are not required to make structural or other physical modifications in providing these areas. An employer who makes reasonable efforts to develop and promulgate a policy regarding smoking and nonsmoking in the work place shall be deemed to be in compliance with this subsection, provided that a policy which designates an entire work place as a smoking area shall not be deemed in compliance with this subsection.

C. An employer shall post "No Smoking" signs in any area designated as a nonsmoking area.

D. Notwithstanding the provisions of Subsection B of this section, every employer shall have the authority to designate any work area as a nonsmoking area.

E. An employer who fails to adopt a smoking policy, or who fails to post signs in any area designated as a nonsmoking area as required by Section 8 [24-16-8 NMSA 1978] of the Clean Indoor Air Act is in violation of this section.

History: Laws 1985, ch. 85, § 7.

ANNOTATIONS

Effective dates. — The effective date of the Clean Indoor Air Act was January 1, 1986.

Am. Jur. 2d, A.L.R. and C.J.S. references. — Employer's liability to employee for failure to provide work environment free from tobacco smoke, 63 A.L.R.4th 1021.

24-16-8. Required signs.

To advise persons of the existence of nonsmoking areas or smoking-permitted areas, signs shall be posted as follows:

A. in public places where the person in charge prohibits smoking in the entire establishment, a sign using the words "No Smoking" or the international no-smoking symbol or both shall be conspicuously posted either on all public entrances or in a position where the sign is clearly visible on entry into the establishment;

B. in public places where certain areas are designated as smoking-permitted areas pursuant to the provisions of the Clean Indoor Air Act [24-16-1 NMSA 1978], the statement "No Smoking Except in Designated Areas" shall be conspicuously posted on all public entrances or in a position where it is clearly visible on entry into the establishment; and

C. in public places where smoking is permitted in the entire establishment, a sign using the words "Smoking Permitted" or the international smoking symbol or both shall be conspicuously posted either on all public entrances or in a position where it is clearly visible on entry into the establishment.

History: Laws 1985, ch. 85, § 8.

24-16-9. Person in charge; compliance.

The person in charge of a public place or public meeting shall make reasonable efforts to secure compliance with the provisions of the Clean Indoor Air Act [24-16-1 NMSA 1978] by:

A. posting appropriate signs;

B. arranging seating and work areas to provide smoke-free areas;

C. asking smokers to refrain from smoking upon request of a client or an employee suffering discomfort from the smoke;

D. affirmatively directing smokers to smoking-permitted areas; and

E. using existing physical barriers and ventilation systems to minimize the toxic effect of transient smoke in adjacent no-smoking areas.

History: Laws 1985, ch. 85, § 9.

24-16-10. Evidence.

Violation of any of the provisions of the Clean Indoor Air Act [24-16-1 tNMSA 1978] shall not constitute evidence of negligence nor sustain an action for nuisance.

History: Laws 1985, ch. 85, § 10.

ANNOTATIONS

Am. Jur. 2d, A.L.R. and C.J.S. references. — Employer's liability to employee for failure to provide work environment free from tobacco smoke, 63 A.L.R.4th 1021.

24-16-11. Penalties.

Any person who commits an unlawful act under any of the provisions of the Clean Indoor Air Act [24-16-1 NMSA 1978] shall be fined in an amount not less than ten dollars ($10.00) or more than twenty-five dollars ($25.00) for each violation.

History: Laws 1985, ch. 85, § 11.

ANNOTATIONS

Severability clauses. — Laws 1985, ch. 85, § 12 provides for the severability of the act if any part or application thereof is held invalid.

ARTICLE 17
Continuing Care

24-17-1. Short title.

Sections 1 through 13 of this act may be cited as the "Continuing Care Act".

History: Laws 1985, ch. 102, § 1.

ANNOTATIONS

Cross references. — For the Long-Term Care Ombudsman Act, *see* 28-17-1 NMSA 1978.

Compiler's notes. — "Sections 1 through 13 of this act", referred to in this section, means §§ 1 through 13 of Laws 1985, ch. 102, §§ 1 through 11 of which appear as 24-17-1 through 24-17-11 NMSA 1978. Sections 12 and 13 of Laws 1985, ch. 102 have not been compiled. Also, 24-17-12 to 24-17-18 NMSA 1978, enacted by Laws 1991, ch. 263, § 1, were enacted as part of the Continuing Care Act.

Am. Jur. 2d, A.L.R. and C.J.S. references. — Liability of nursing home for violating statutory duty to notify third party concerning patient's medical condition, 46 A.L.R.5th 821.

24-17-2. Findings and purpose.

A. The legislature finds that continuing care communities are an important and growing alternative for the provision of long-term residential, social and health maintenance needs for the elderly; however, the legislature also finds that severe

consequences to residents may result when a provider becomes insolvent or unable to provide responsible care.

B. The purpose of the Continuing Care Act [24-17-1 NMSA 1978] is to provide for disclosure and the inclusion of certain information in continuing care contracts in order that residents may make informed decisions concerning continuing care and to provide protection for residents and communities.

History: Laws 1985, ch. 102, § 2.

24-17-3. Definitions.

As used in the Continuing Care Act [24-17-1 NMSA 1978]:

A. "affiliate" means a person having a five percent or greater interest in a provider;

B. "community" means a retirement home, retirement community, home for the aged or other place that undertakes to provide continuing care;

C. "continuing care" means furnishing, pursuant to a contract that requires entrance or advance fees and service or periodic fees, independent living and health or health-related services. Entrance or advanced fees do not include security or damage deposit fees that amount to less than three months' service or periodic fees. These services may be provided in the community, in the resident's independent living unit or in another setting, designated by the continuing care contract, to an individual not related by consanguinity or affinity to the provider furnishing the care. The services include, at a minimum, priority access to a nursing facility or hospital either on site or at a site designated by the continuing care contract;

D. "continuing care contract" means an agreement by a provider to furnish continuing care to a resident;

E. "person" means an individual, corporation, partnership, trust, association or other legal entity;

F. "priority access to a nursing facility or hospital" means that a nursing facility or hospital services the residents of independent living units or that there is a promise of such health care or health-related services being available in the future;

G. "provider" means the owner or manager of a community;

H. "resident" means, unless otherwise specified, an actual or prospective purchaser of, nominee of or subscriber to a continuing care contract; and

I. "unit" means the living quarters that a resident buys, leases or has assigned as part of the continuing care contract.

History: Laws 1985, ch. 102, § 3; 1991, ch. 263, § 8; 2005, ch. 215, § 1.

ANNOTATIONS

The 1991 amendment, effective June 14, 1991, rewrote Subsection C; deleted "for life or a specified time of more than one year" at the end of the first sentence and a second sentence reading " 'Continuing care contract' includes a life interest or similar agreement, long-term leases and agreements that are terminable by either party" in Subsection D; deleted former Subsections E to G, which defined "entrance fee", "life interest" and "long-term lease"; redesignated former Subsection H as present Subsection E; added present Subsection F; and redesignated former Subsections I to K as present Subsections G to I.

The 2005 amendment, effective June 17, 2005, defines "continuing care" in Subsection C to mean furnishing services, pursuant to a contract that requires entrance or advance fees and service or periodic fees and provides in Subsection C that entrance or advanced fees do not include security or damage deposit fees that amount to less than three months' service or periodic fees.

24-17-4. Disclosure.

A. A person who provides or offers to provide continuing care in this state shall furnish a current annual disclosure statement and a consumer's guide to continuing care communities as furnished by the aging and long-term services department or the attorney general's office to actual residents and to a prospective resident at least seven days prior to entering into a continuing care contract with the prospective resident. For the purposes of this subsection, the obligation to furnish information to actual residents shall be deemed satisfied if a copy is given to the residents' association, if there is one, and a written message has been delivered to all residents that personal copies are available upon request.

B. The disclosure statement shall include:

(1) a brief narrative summary of the contents of the disclosure statement written in plain language;

(2) the name and business address of the provider;

(3) if the provider is a partnership, corporation or association, the names, addresses and duties of its officers, directors, trustees, partners or managers;

(4) the name and business address of any affiliate;

(5) a statement as to whether the provider or any of its officers, directors, trustees, partners, managers or affiliates, within ten years prior to the date of application:

(a) was convicted of a felony, a crime that if committed in New Mexico would be a felony or any crime having to do with the provision of continuing care;

(b) has been held liable or enjoined in a civil action by final judgment, if the civil action involved fraud, embezzlement, fraudulent conversion or misappropriation of property;

(c) had a prior discharge in bankruptcy or was found insolvent in any court action; or

(d) had any state or federal licenses or permits suspended or revoked or had any state, federal or industry self-regulatory agency commence an action against him and the result of such action;

(6) the name and address of any person whose name is required to be provided in the disclosure statement who owns any interest in or receives any remuneration from, either directly or indirectly, any other person providing or expected to provide to the community goods, leases or services with a real or anticipated value of five hundred dollars ($500) or more and the name and address of the person in which such interest is held. The disclosure shall describe such goods, leases or services and the actual or probable cost to the community or provider and shall describe why such goods, leases or services should not be purchased from an independent entity;

(7) the name and address of any person owning land or property leased to the community and a statement of what land or property is leased;

(8) a statement as to whether the provider is, or is associated with, a religious, charitable or other organization and the extent to which the associate organization is responsible for the financial and contractual obligations of the provider or community;

(9) the location and description of real property being used or proposed to be used in connection with the community's contracts to furnish care;

(10) a statement as to whether the community maintains reserves to assure payment of debt obligations and the ability to provide services to residents and a description of such reserves;

(11) for those communities that charge an entrance fee that were not in operation on June 14, 1985, an actuarial analysis of the community performed by an actuary experienced in analyzing continuing care communities;

(12) an audited financial statement as of the end of the provider's last fiscal year or a copy of the previous year's tax filings with the internal revenue service;

(13) a sample copy of the contract used by the provider; and

(14) a list of documents and other information available upon request, including:

(a) a copy of the Continuing Care Act [24-17-1 NMSA 1978];

(b) if the provider is a corporation, a copy of the articles of incorporation; if the provider is a partnership or other unincorporated association, a copy of the partnership agreement, articles of association or other membership agreement; and if the provider is a trust, a copy of the trust agreement or instruments;

(c) resumes of the provider and officers, directors, trustees, partners or managers;

(d) a copy of lease agreements between the community and any person owning land or property leased to the community;

(e) information concerning the location and description of other properties, both existing and proposed, of the provider in which the provider owns any interest and on which communities are or are intended to be located and the identity of previously owned or operated communities;

(f) a copy of the community's policies and procedures; and

(g) such other data, financial statements and pertinent information requested by the resident with respect to the provider or community, or its directors, trustees, members, managers, branches, subsidiaries or affiliates, that is reasonably necessary for the resident to determine the financial status of the provider and community and the management capabilities of the managers and owners, including the most recent audited financial statements of comparable communities owned, managed or developed by the provider or its principal.

C. Each year, within one hundred eighty days after the end of the community's fiscal year, the provider shall furnish to actual residents the disclosure statement as outlined in this section. For purposes of this subsection, the obligation to furnish the required information to residents shall be deemed satisfied if the information is given to the residents' association, if there is one, and a written message has been delivered to all residents stating that personal copies of the information are available upon request.

History: Laws 1985, ch. 102, § 4; 1991, ch. 263, § 9; 2005, ch. 215, § 2.

ANNOTATIONS

Effective dates. — The effective date of the Continuing Care Act was June 14, 1985.

The 1991 amendment, effective June 14, 1991, in Subsection A, inserted the second sentence and deleted the former final sentence, which read "A community that is in operation on the effective date of the Continuing Care Act may have a grace period of not more than one hundred eighty days to prepare its disclosure statement"; and substituted "eighty days" for "twenty days" near the beginning of the first sentence in Subsection C.

The 2005 amendment, effective June 17, 2005, deletes the former provision in Subsection A which provided that advertising, representations or contractual provisions indicating that a nursing facility or hospital services the residents of independent living units or advertising that there is a close proximity of residential units to nursing or acute care units shall imply an agreement to provide or offer to provide continuing care; deletes the former provision of Subsection B(12) which required the audit report to be prepared in accordance with generally accepted accounting principles applied on a consistent basis and certified by a certified public accountant, including a cash flow statement or sources and application of funds statement and a balance sheet and a description of long-term obligations and the holders of mortgages and notes; provides in Subsection B(12) that the disclosure statement include an audited financial statement or a copy of the previous year's tax filing with the internal revenue service; deletes the former provision of Subsection C which required the provider to furnish a current financial statement and audit report prepared in accordance with generally accepted accounting principles applied on a consistent basis and certified by a certified public accountant, including a cash flow statement or sources and application of funds statement and a balance sheet and a description of the long-term obligations and any other changes in the disclosure statement required to be furnished by Subsection A; and provides in Subsection C that the provider shall provide the disclosure statement outlined in this section.

24-17-5. Contract information.

A. A continuing care contract shall be written in clear and understandable language.

B. A continuing care contract shall, at a minimum:

(1) describe the community's admission policies, including age, health status and minimum financial requirements, if any;

(2) describe the health and financial conditions required for a person to continue to be a resident;

(3) describe the circumstances under which the resident will be permitted to remain in the community in the event of possible financial difficulties of the resident;

(4) list the total consideration paid, including donations, entrance fees, subscription fees, periodic fees and other fees paid or payable; provided, however, that a provider cannot require a resident to transfer all the resident's assets to the provider or community as a condition for providing continuing care and the provider shall reserve the right to charge periodic fees;

(5) describe in detail all items of service to be received by the resident such as food, shelter, medical care, nursing care and other health services and whether services will be provided for a designated time period or for life;

(6) provide as an addendum to the contract a description of items of service, if any, that are available to the resident but are not covered in the entrance or monthly fee;

(7) specify taxes and utilities, if any, that the resident must pay;

(8) specify that deposits or entrance fees paid by or for a resident shall be held in trust for the benefit of the resident in a federally insured New Mexico bank until the resident has occupied his unit or the resident's contract cancellation period has ended;

(9) state the terms under which a continuing care contract may be canceled by the resident or the community and the basis for establishing the amount of refund of the entrance fee;

(10) state the terms under which a continuing care contract is canceled by the death of the resident and the basis for establishing the amount of refund, if any, of the entrance fee;

(11) state when fees will be subject to periodic increases and what the policy for increases will be; provided, however, that the provider shall give advance notice of not less than thirty days to the residents before the change becomes effective and increases shall be based upon economic necessity, the reasonable cost of operating the community, the cost of care and a reasonable return on investment as defined by rules promulgated by the aging and long-term services department no later than January 31, 2006;

(12) state the entrance fee and periodic fees that will be charged if the resident marries while living in the community, the terms concerning the entry of a spouse to the community and the consequences if the spouse does not meet the requirements for entry;

(13) indicate funeral and burial services that are not furnished by the provider;

(14) state the rules and regulations of the provider then in effect and state the circumstances under which the provider claims to be entitled to have access to the resident's unit;

(15) list the resident's and provider's respective rights and obligations as to any real or personal property of the resident transferred to or placed in the custody of the provider;

(16) describe the rights of the residents to form a residents' association and the participation, if any, of the association in the community's decision-making process;

(17) describe the living quarters purchased by or assigned to the resident;

(18) provide under what conditions, if any, the resident may assign the use of a unit to another;

(19) include the policy and procedure with regard to changes in accommodations due to an increase or decrease in the number of persons occupying an individual unit;

(20) state the conditions upon which the community may sublet or relet a resident's unit;

(21) state, in the event of voluntary absence from the community for an extended period of time by the resident, what fee adjustments, if any, will be made;

(22) include the procedures to be followed when the provider temporarily or permanently changes the resident's accommodations, either within the community or by transfer to a health facility; provided that the contract shall state that such changes in accommodations shall only be made to protect the health or safety of the resident or the general and economic welfare of all other residents of the community;

(23) if the community includes a nursing facility, describe the admissions policies and what will occur if a nursing facility bed is not available at the time it is needed;

(24) describe, if the resident is offered a priority for nursing facility admission at a facility that is not owned by the community, with which nursing facility the formal arrangement is made and what will occur if a nursing facility bed is not available at the time it is needed;

(25) include the policy and procedures for determining under what circumstances a resident will be considered incapable of independent living and will require a permanent move to a nursing facility. The contract shall also state who will participate in the decision for permanent residency in the nursing facility and shall provide that the resident shall have an advocate involved in that decision; provided that

if the resident has no family member, attorney, guardian or other responsible person to act as the resident's advocate, the provider shall request the local office of the human services department to serve as advocate;

(26) specify the types of insurance, if any, the resident must maintain, including medicare, other health insurance and property insurance;

(27) specify the circumstances, if any, under which the resident will be required to apply for medicaid, public assistance or any other public benefit programs;

(28) state, in bold type of not less than twelve-point type on the front of the contract, that a contract for continuing care may present a significant financial risk and that a person considering a continuing care contract should consult with an attorney and with a financial advisor concerning the advisability of pursuing continuing care. Provided, however, failure to consult with an attorney or financial advisor shall not be raised as a defense to bar recovery for a resident in any claims arising under the provisions of the Continuing Care Act [24-17-1 NMSA 1978];

(29) state, in bold type of not less than twelve-point type on the front of the contract, that nothing in the contract or the Continuing Care Act should be construed to constitute approval, recommendation or endorsement of any continuing care community by the state of New Mexico;

(30) state in immediate proximity to the space reserved in the contract for the signature of the resident in bold type of not less than twelve-point type the following:

"You, the buyer, may cancel this transaction at any time prior to midnight of the seventh day after the date of this transaction. See the attached notice of cancellation form for an explanation of this right."; and

(31) contain a completed form in duplicate, captioned "Notice of Cancellation", which shall be attached to the contract and easily detachable, and which shall contain in twelve-point boldface type the following information and statements in the same language as that used in the contract.

"NOTICE OF CANCELLATION

Date: ______________________________

(enter date of transaction)

You may cancel this transaction without any penalty or obligation within seven days from the above date. If you cancel, any payments made by you under the contract or sale and any negotiable instrument executed by you will be returned within ten business days following receipt by the provider of your cancellation notice, and any security interest or lien arising out of the transaction will be canceled.

To cancel this transaction, deliver a signed and dated copy of this cancellation notice or any other written notice, or send a telegram, to:

_____________________________________ (Name of Provider)

at

____

(Address of Provider's Place of Business)

not later than midnight of ______________________

(Date)

I hereby cancel this transaction.

____

(Buyer's Signature)

____

(Date)".

History: Laws 1985, ch. 102, § 5; 2005, ch. 215, § 3.

ANNOTATIONS

The 2005 amendment, effective June 17, 2005, deletes the former requirements in Subsection B(8) that payments be held in trust in a cash escrow account in a New Mexico trust company on a trust department of a federally insured New Mexico bank and that after the resident has notified the trustee that he has occupied his unit, the money, including interest, be released to the provider; adds the provisions in Subsection B(8) that the trust be held for the benefit of the resident until the resident's contract cancellation period has ended, and provides in Subsection B(11) that economic necessity, the reasonable cost of operating the community and the cost of care and reasonable return on investment as defined by rule promulgated by the aging and long-term services department not later than January 31, 2006.

Effective dates. — The effective date of the Continuing Care Act was June 14, 1985.

Am. Jur. 2d, A.L.R. and C.J.S. references. — Plaintiff's rights to punitive or multiple damages when cause of action renders both available, 2 A.L.R.5th 449.

24-17-6. Escrow requirements.

Any deposits or entrance fees paid by or for a resident shall be held in trust for the benefit of the resident in a federally insured New Mexico bank until the resident has occupied his unit or the resident's contract cancellation period has ended.

History: Laws 1985, ch. 102, § 6; 2005, ch. 215, § 4.

ANNOTATIONS

The 2005 amendment, effective June 17, 2005, deletes the former requirements that payments be held in trust in a cash escrow account in a New Mexico trust company on a trust department of a federally insured New Mexico bank and that after the resident has notified the trustee that he has occupied his unit, the money, including interest, be released to the provider; adds the provision that the trust be held for the benefit of the resident until the resident's contract cancellation period has ended.

24-17-7. Disclosure statements filed with the state agency on aging for public inspection.

A provider shall file a copy of the disclosure statement and any amendments to that statement with the state agency on aging for public inspection during regular working hours.

History: Laws 1985, ch. 102, § 7.

ANNOTATIONS

Cross references. — For state agency on aging, *see* 28-4-4 NMSA 1978.

24-17-8. Consumer's guide to continuing care communities.

The office of the attorney general and the aging and long-term services department may publish and distribute a consumer's guide to continuing care communities and may publish an annual directory of communities in New Mexico.

History: Laws 1985, ch. 102, § 8; 2005, ch. 215, § 5.

ANNOTATIONS

Cross references. — For state agency on aging, *see* 28-4-4 NMSA 1978.

The 2005 amendment, effective June 17, 2005, changes the publication requirements from "shall" to "may".

24-17-9. Repealed.

ANNOTATIONS

Repeals. — Laws 1991, ch. 263, § 11 repeals 24-17-9 NMSA 1978, as enacted by Laws 1985, ch. 102, § 9, relating to civil liability, effective June 14, 1991. For provisions of former section, *see* New Mexico One Source of Law DVD.

24-17-10. Restraint of prohibited acts; remedies.

A. Whenever the attorney general has reasonable belief that any person is violating or is about to violate any provision of the Continuing Care Act [24-17-1 NMSA 1978] and that proceedings would be in the public interest, he may bring an action in the name of the state to restrain or prevent violations of that act. The action may be brought in the district court of the county in which the person resides or has his principal place of business or in the district court for Santa Fe county. The attorney general acting on behalf of the state shall not be required to post bond when seeking a temporary or permanent injunction in such action.

B. In any action filed pursuant to this section of the Continuing Care Act, including an action with respect to unimproved real property, the attorney general may petition the district court for temporary or permanent injunctive relief and restitution.

C. Any person who is the subject of an action brought under this section shall have the right to demand a jury trial.

History: Laws 1985, ch. 102, § 10; 1991, ch. 263, § 10.

ANNOTATIONS

The 1991 amendment, effective June 14, 1991, deleted "has violated" following "violating" and substituted "to restrain or prevent" for "alleging" in the first sentence in Subsection A; inserted "this section of" in Subsection B; deleted former Subsection C, which read "In any action brought under this section, if the court finds that a person is willfully violating or has willfully violated the Continuing Care Act, the attorney general, upon petition to the court, may recover on behalf of the state, a civil penalty of not exceeding five thousand dollars ($5,000) per violation"; and redesignated former Subsection D as present Subsection C.

24-17-11. Applicability.

A. The provisions of the Continuing Care Act [24-17-1 NMSA 1978] apply equally to for-profit and nonprofit provider organizations and shall be construed as the minimum requirements to be imposed upon any person offering or providing continuing care.

B. The provisions of the Continuing Care Act do not apply to closed-membership organizations that operate communities solely for the benefit of their members.

History: Laws 1985, ch. 102, § 11.

ANNOTATIONS

Saving clauses. — Laws 1985, ch. 102, § 12 provides that nothing in the Continuing Care Act shall be construed in any way to impair contracts in effect prior to the effective date of that act, June 14, 1985.

24-17-12. Right to a written transfer policy.

A provider shall adopt and follow a written policy establishing the procedure and criteria applicable when deciding to transfer residents from one level of care to another.

History: Laws 1991, ch. 263, § 1.

24-17-13. Right to organize and participate.

A. Residents have the right to organize a resident association and to engage in concerted activities for the purpose of keeping themselves informed of the operation of the facility or for the purpose of other mutual aid or protection. A provider shall take appropriate steps to encourage and facilitate the establishment of a resident association in each facility. At a minimum, these steps shall include the posting in conspicuous places of written notices of the right of residents to organize into a resident association and to use the facility for association meetings.

B. The administration of an operating facility shall meet at least quarterly with the resident association, if one exists, or with interested residents if there is no resident association. The following procedures shall apply:

(1) the provider shall notify all residents at least seven days in advance of each meeting;

(2) the provider shall post the meeting agenda in a conspicuous place and make copies of it available; and

(3) if the resident association requests, the provider shall ensure that a member or an authorized representative of the board of directors, a general partner or a principal owner attends the meeting.

History: Laws 1991, ch. 263, § 2.

24-17-14. Right to protection against retaliatory conduct.

Retaliatory conduct by a provider or any person acting on the provider's behalf against a resident for lawful efforts to secure or enforce his legal rights as a resident is a violation of the Continuing Care Act [24-17-1 NMSA 1978].

History: Laws 1991, ch. 263, § 3.

24-17-15. Right to civil action for damages.

A. Residents, as a class or otherwise, may bring an action in a court of competent jurisdiction to recover actual and punitive damages for injury resulting from a violation of the Continuing Care Act [24-17-1 NMSA 1978].

B. The court may award reasonable attorneys' fees and costs to the prevailing party in an action brought under this section.

C. The right of a resident to bring an action pursuant to this section is in addition to any other rights or remedies the resident may have by statute or common law.

History: Laws 1991, ch. 263, § 4.

24-17-16. Identification and procedures for correction of violations.

A. If the state agency on aging determines that a person or an organization has engaged in or is about to engage in an act or practice constituting a violation of the Continuing Care Act [24-17-1 NMSA 1978] or any rule adopted pursuant to that act, the state agency on aging shall issue a notice of violation in writing to that person or organization and send copies to the resident association of any facility affected by the notice.

B. The notice of violation shall state the following:

(1) a description of a violation at issue;

(2) the action that, in the judgment of the state agency on aging, the provider should take to conform to the law or the assurances that the state agency on aging requires to establish that no violation is about to occur;

(3) the compliance date by which the provider shall correct any violation or submit assurances;

(4) the requirements for filing a report of compliance; and

(5) the applicable sanctions for failure to correct the violation or failure to file the report of compliance according to the terms of the notice of violation.

C. At any time after receipt of a notice of violation, the person or organization to which the notice is addressed or the state agency on aging may request a conference. The state agency on aging shall schedule a conference within seven days of a request.

D. The purpose of the conference is to discuss the contents of the notice of violation and to assist the addressee to comply with the requirements of the Continuing Care Act. Subject to rules that the state agency on aging may promulgate, a representative of the resident association at any facility affected by the notice shall have a right to attend the conference.

E. A person receiving a notice of violation shall submit a signed report of compliance as provided by the notice. The state agency on aging shall send a copy to the resident association of any facility affected by the notice.

F. Upon receipt of the report of compliance the state agency on aging shall take steps to determine that compliance has been achieved.

History: Laws 1991, ch. 263, § 5.

24-17-17. Rules and regulations authorized.

The state agency on aging shall promulgate all rules and regulations necessary or appropriate to administer the provisions of the Continuing Care Act [24-17-1 NMSA 1978].

History: Laws 1991, ch. 263, § 6.

24-17-18. Report to attorney general; civil action; civil penalties.

Any time after the state agency on aging issues a notice of violation, the state agency on aging may send the attorney general a written report alleging a possible violation of the Continuing Care Act [24-17-1 NMSA 1978] or any rule adopted pursuant to that act. Upon receipt of that report, the attorney general shall promptly conduct an investigation to determine whether grounds exist for formally finding a violation. If the attorney general makes that finding, he shall file an appropriate action against the alleged violator in a court of competent jurisdiction. Upon finding violations of any provisions of the Continuing Care Act or any rule adopted pursuant to that act, the court may impose a civil penalty in the amount of five dollars ($5.00) per resident or up to five hundred dollars ($500), in the discretion of the court, for each day that the violation remains uncorrected after the compliance date stipulated in a notice of violation issued pursuant to the Continuing Care Act.

History: Laws 1991, ch. 263, § 7.

ARTICLE 17A
Long-Term Care Services

24-17A-1. Short title.

This act [24-17A-1 NMSA 1978] may be cited as the "Long-term Care Services Act".

History: Laws 1998, ch. 82, § 1.

24-17A-2. Definitions.

As used in the Long-term Care Services Act [24-17A-1 NMSA 1978]:

A. "consumer" means a long-term care service recipient who has a physical or mental illness, injury or disability or who suffers from any cognitive impairment that restricts or limits the person's activities of daily living or instrumental activities of daily living and who is under the care of a provider;

B. "long-term care" means home- or community-based care provided to a consumer that is designed to maintain the consumer's independence and autonomy in the consumer's residence and includes support services such as personal, respite, attendant, residential or institutional care; case management; services such as meals, homemaker, home repair, transportation, companion, adult day health care, emergency response or day habilitation; physical, occupational or speech therapy; nursing; or help with chores;

C. "residence" means a consumer's home, an independent living center, an adult day health care facility, a community center, an assisted living facility, an adult residential care facility, a nursing home or a senior citizen center; and

D. "service delivery system" means a unified statewide, comprehensive home- and community-based service delivery system that integrates and coordinates all health, medical and social services that meet the individual needs of consumers and support them in remaining in their own homes and communities.

History: Laws 1998, ch. 82, § 2.

24-17A-3. Interagency committee created; coordinated service delivery system; lead agency; service delivery system.

A. The "interagency committee on long-term care" is created.

B. Members of the interagency committee on long-term care shall be the heads of the following agencies or their designated representatives:

(1) the state agency on aging;

(2) the human services department;

(3) the department of health;

(4) the children, youth and families department;

(5) the labor department;

(6) the governor's committee on concerns of the handicapped;

(7) the developmental disabilities planning council; and

(8) the department of insurance.

C. The interagency committee on long-term care shall design and implement a coordinated service delivery system that fulfills the legislative mandate to develop a coordinated long-term care system.

D. The governor shall appoint a chairperson from the membership of the interagency committee on long-term care.

History: Laws 1998, ch. 82, § 3.

24-17A-4. Service delivery system; components; principles.

The interagency committee on long-term care shall take into consideration, within available resources, the following principles in the design, development and implementation of the integrated long-term care delivery system to:

A. ensure the dignity and respect of consumers in the treatment and support provided;

B. tailor home- and community-based long-term care services and programs to provide full access and coordination to meet the individual needs of consumers;

C. develop and provide home- and community-based long-term care services and programs of the highest quality;

D. provide for consumer self-determination by providing options for individual choice and consumer input in home- and community-based long-term care;

E. implement a state policy that defines the state's obligation regarding long-term care by integrating applicable state and federal mandates related to long-term care services;

F. diversify institutional care options that explore and enhance appropriate alternatives to institutional care; and

G. integrate various funding sources to provide quality, affordable services to the consumer.

History: Laws 1998, ch. 82, § 4.

24-17A-5. Report.

The chairperson shall present a report to the legislature on the progress of the interagency committee on long-term care and the status of the coordinated service delivery system. The report shall include conclusions and recommendations to further the work of the interagency committee on long-term care and to complete the process of integrating the service delivery system in the state.

History: Laws 1998, ch. 82, § 5.

ARTICLE 18
Children's and Juvenile Facility Criminal Records Screening

(Recompiled)

24-18-1 to 24-18-4. Recompiled.

ANNOTATIONS

Recompilations. — Former 24-18-1 to 24-18-4 NMSA 1978, as enacted by Laws 1985, Chapter 140, were recompiled as 32-9-1 to 32-9-4 NMSA 1978. See the table of corresponding sections immediately preceding Chapter 32A NMSA 1978.

ARTICLE 19
Children's Trust Fund

24-19-1. Short title.

Chapter 24, Article 19 NMSA 1978 may be cited as the "Children's Trust Fund Act".

History: Laws 1986, ch. 15, § 1; 2005, ch. 65, § 1.

ANNOTATIONS

The 2005 amendment, effective June 17, 2005, changes the statutory reference for the act.

24-19-2. Purpose.

It is the purpose of the Children's Trust Fund Act [24-19-1 NMSA 1978] to:

A. provide the means to develop innovative children's projects that address one or more of the following:

(1) preventing abuse and neglect of children;

(2) providing medical, psychological and other appropriate treatment for children who are victims of abuse or neglect; and

(3) developing community-based services aimed at the prevention and treatment of child abuse and neglect; and

B. manage next generation fund projects.

History: Laws 1986, ch. 15, § 2; 2005, ch. 65, § 2.

ANNOTATIONS

The 2005 amendment, effective June 17, 2005, adds the purpose of managing next generation fund projects.

24-19-3. Definitions.

As used in the Children's Trust Fund Act [24-19-1 NMSA 1978]:

A. "board" means the children's trust fund board of trustees;

B. "children's projects" means projects that provide services to children on a one-time, short-term demonstration basis, including services to their families, consistent with the purposes of the Children's Trust Fund Act;

C. "council" means the next generation council;

D. "department" means the children, youth and families department;

E. "next generation fund projects" means projects funded from the next generation fund that meet the requirements for funding provided in Section 5 of this 2005 act; and

F. "secretary" means the secretary of children, youth and families.

History: Laws 1986, ch. 15, § 3; 1992, ch. 57, § 19; 2005, ch. 65, § 3.

ANNOTATIONS

Cross references. — For children, youth and families department, *see* 9-2A-1 NMSA 1978 et seq.

The 1992 amendment, effective July 1, 1992, substituted "that" for "which" in Subsection B; and substituted "children, youth and families" for "human services" in Subsections C and D.

The 2005 amendment, effective June 17, 2005, adds definitions for "council" and "next generation fund projects".

24-19-4. Children's trust fund created; expenditure limitations.

A. The "children's trust fund" is created in the state treasury. The children's trust fund may be used for any purpose enumerated in Section 24-19-2 NMSA 1978. All income received from investment of the fund shall be credited to the fund. No money appropriated to the fund or otherwise accruing to it shall be disbursed in any manner except as provided in the Children's Trust Fund Act [24-19-1 NMSA 1978].

B. The children's trust fund shall be administered by the department for the purpose of funding children's projects from the income received from investment of the fund; provided that none of the income shall be used for capital expenditures. All income from investment of the fund is appropriated to the department for that purpose or for administrative costs as provided in Subsection C of this section. Grants, distributions and transfers of money from the fund shall be made only from the income received from investment of the fund.

C. Up to ten percent of the income received from investment of the children's trust fund may be expended for costs of administration of the fund and administration of the children's projects undertaken with fund money. Administrative costs include per diem and mileage, staff salaries and expenses related to administration of the fund.

D. Disbursements from income credited to the children's trust fund and appropriated to the department shall be made only upon warrants drawn by the secretary of finance and administration pursuant to vouchers signed by the secretary of children, youth and families or the secretary's designated representative to fund children's projects approved by the board.

E. One-half of the money transferred to the children's trust fund pursuant to Section 40-1-11 NMSA 1978 and all of the money transferred to the children's trust fund pursuant to Section 66-3-420 NMSA 1978 shall be deemed income received from investment of the fund.

History: Laws 1986, ch. 15, § 4; 1990, ch. 26, § 1; 1992, ch. 57, § 20; 1993, ch. 175, § 1; 1993, ch. 199, § 1; 2004, ch. 74, § 1; 2005, ch. 65, § 4.

ANNOTATIONS

Cross references. — For secretary of children, youth and families, *see* 9-2A-6 NMSA 1978.

The 1990 amendment, effective May 16, 1990, substituted "Section 24-19-2 NMSA 1978" for "Section 2 of the Children's Trust Fund Act" in the first sentence in Subsection A, substituted "children's trust fund" for "fund" and "children's projects" for "projects" in the first sentence in Subsection C, and substituted "June 30, 1994" for "June 30, 1992" in Subsection E.

The 1992 amendment, effective July 1, 1992, substituted "children, youth and families" for "human services" in Subsection D.

1993 amendments. — Identical amendments to this section were enacted by Laws 1993, ch. 175, § 1 and Laws 1993, ch. 199, § 1, both approved April 3, 1993 and both effective June 18, 1993, which substituted "1997" for "1994" in Subsection E. This section is set out as amended by Laws 1993, ch. 199, § 1. See 12-1-8 NMSA 1978.

The 2004 amendment, effective March 4, 2004, amended Subsection E to add "and all of the money transferred to the children's trust fund pursuant to Section 66-3-420 NMSA 1978".

The 2005 amendment, effective June 17, 2005, deletes "appropriations" in Subsection B and substitutes "distributions" and makes non-substantive changes in wording in Subsections A and D.

Severability clauses. — Laws 1992, ch. 57, § 57 provides for the severability of the act if any part or application thereof is held invalid.

24-19-5. Children's trust fund board of trustees created; members.

A. There is created the "children's trust fund board of trustees" consisting of nine members, not employees of the state, knowledgeable in the area of children's programs, who shall be appointed by the governor with the advice and consent of the senate. Of these members, at least two shall be individuals of recognized standing in the field of children's services. On the initial board, two members shall be appointed for terms ending on July 1, 1988; two members shall be appointed for terms ending on July 1, 1989; and three members shall be appointed for terms ending on July 1, 1990. Thereafter, appointments shall be made for terms of four years. Vacancies of appointed members shall be filled by the governor for the unexpired term.

B. The board shall select a person from its membership to serve as chairman.

History: Laws 1986, ch. 15, § 5; 1987, ch. 135, § 1.

24-19-6. Per diem and mileage; board.

Members of the board shall be reimbursed as provided in the Per Diem and Mileage Act [10-8-1 NMSA 1978] and shall receive no other compensation, perquisite or allowance.

History: Laws 1986, ch. 15, § 6.

24-19-7. Duties of the board.

At least four times a year, the board shall meet upon the call of its chairman to review proposals submitted to the department by public or private entities and take all action necessary or proper for the administration of the Children's Trust Fund Act [24-19-1 NMSA 1978]. The board shall approve or disapprove each proposal submitted and shall base its decision on the proposal's merit and feasibility, the best interest of the beneficiaries of the children's project proposal and the capacity of the children's project's success or failure for evaluation.

History: Laws 1986, ch. 15, § 7; 2005, ch. 65, § 6.

ANNOTATIONS

The 2005 amendment, effective June 17, 2005, changes the reference to "projects" to "children's projects".

24-19-8. Children, youth and families department; additional powers and duties.

The department shall:

A. promulgate rules approved by the board;

B. transmit proposals for children's projects to the board and next generation fund projects to the council for evaluation and report on the proposals;

C. enter into contracts approved by the board to carry out the proposed children's project or next generation fund project, provided that:

(1) not more than fifty percent of the total funds distributed for any one fiscal year from the children's trust fund shall be allocated for any single children's project;

(2) not more than fifty percent of the total funds distributed for any one fiscal year from the next generation fund shall be allocated for any single next generation fund project;

(3) each children's project shall be funded for a specified period, not to exceed four years, and funds shall not be used for maintenance of ongoing or permanent efforts extending beyond the period specified, except that a children's project may be extended once for a period not to exceed the original, and the board shall approve rules providing procedures and guidelines for the preparation and approval of proposals for children's projects and providing for any other matter the board deems

necessary for the administration of the Children's Trust Fund Act [24-19-1 NMSA 1978]; and

(4) no contract shall be entered into if the department finds it contrary to law;

D. furnish the board and the council with the necessary technical and clerical assistance;

E. adopt standard contract provisions; and

F. report at least annually to the governor and the legislature on the progress of its work and the results of children's projects and next generation fund projects.

History: Laws 1986, ch. 15, § 8; 2005, ch. 65, § 8.

ANNOTATIONS

The 2005 amendment, effective June 17, 2005, requires the children, youth and families department to adopt rules; transmit next generation fund projects to the next generation council; enter into contracts to carry out next generation fund projects and providing that not more than fifty percent of the children's trust fund may be allocated to a single project and that not more than fifty percent of the total funds distributed in a fiscal year from the next generation fund shall be allocated to a single next generation fund project.

24-19-9. Acceptance of federal funds and private donations.

To carry out the provisions of the Children's Trust Fund Act [24-19-1 NMSA 1978], the department may accept any federal matching funds or grants for children's projects or next generation fund projects. The department may accept donations and bequests from private sources for deposit in the children's trust fund or the next generation fund, as applicable.

History: Laws 1986, ch. 15, § 9; 2005, ch. 65, § 9.

ANNOTATIONS

The 2005 amendment, effective June 17, 2005, permits the children, youth and families department to accept federal matching funds or grants for next generation fund projects and to accept donations and bequests for deposit into the next generation fund.

24-19-10. Next generation fund; created; expenditure limitations.

A. The "next generation fund" is created in the state treasury. The next generation fund may be used for any purpose enumerated in Section 24-19-2 NMSA 1978. All income received from investment of the fund shall be credited to the fund. No money

appropriated to the fund or otherwise accruing to it shall be disbursed in any manner except as provided in the Children's Trust Fund Act [24-19-1 NMSA 1978].

B. The fund shall be used to fund next generation fund projects that are approved by the board. Next generation fund projects shall:

(1) provide positive child and youth development activities that support physical, mental and social well-being;

(2) promote strong, healthy families and help to prevent child abuse and neglect;

(3) promote community service, leadership and citizenship; and

(4) provide community coordination of child and youth development programming across the age zero to twenty-four developmental continuum.

C. The next generation fund shall be administered by the department, and the income from investment of the fund is appropriated to the department to carry out the purposes of the fund. None of the income shall be used for capital expenditures. Grants, distributions and transfers of money from the fund shall be made only from the income received from investment of the fund.

D. Up to ten percent of the income received from investment of the fund may be expended for costs of administering the fund and next generation projects. Administrative costs include per diem and mileage, staff salaries and expenses related to administration of the fund.

E. Disbursements from the fund shall be made by warrants drawn by the secretary of finance and administration pursuant to vouchers signed by the secretary of children, youth and families or the secretary's designated representative.

History: Laws 2005, ch. 65, § 5.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 65 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective June 17, 2005, 90 days after adjournment of the legislature.

24-19-11. Next generation council; created; membership; purpose.

A. The "next generation council" is created. The board shall appoint ten members, at least two from each congressional district, who are not employees of the state who are knowledgeable in the area of positive child and youth development programs. Members serve at the pleasure of the board. Members shall select a member to serve

as chairperson of the council. Members are entitled to per diem and mileage as provided in the Per Diem and Mileage Act [10-8-1 NMSA 1978] and shall receive no other compensation, perquisite or allowance.

B. The council shall evaluate proposed next generation fund projects and make funding recommendations to the board. The board shall approve or disapprove next generation fund projects for funding and transmit those proposals to the department.

History: Laws 2005, ch. 65, § 7.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 65 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective June 17, 2005, 90 days after adjournment of the legislature.

ARTICLE 20
Health Research

24-20-1. Medical trust fund for cancer and other medical research; appropriation.

A. There is created at the university of New Mexico school of medicine a medical trust fund to be administered by the school of medicine. The fund shall consist of balances transferred to the fund from the dedicated health research fund and any other distributions, transfers and deposits that may be made to the fund. Earnings from investment of the medical trust fund are appropriated to the university of New Mexico school of medicine for cancer and other medical research.

B. The university of New Mexico school of medicine shall report annually to the commission on higher education, the department of health and the legislative finance committee regarding the use of the earnings on the medical trust fund.

History: 1978 Comp., § 24-20-1, enacted by Laws 1993, ch. 358, § 3.

ANNOTATIONS

Repeals and reenactments. — Laws 1993, ch. 358, § 3 repeals 24-20-1 NMSA 1978, as enacted by Laws 1986, ch. 13, § 5, creating a dedicated health research fund, and enacts the above section, effective July 1, 1993. For provisions of former section, *see* New Mexico One Source of Law DVD.

24-20-2. Repealed.

ANNOTATIONS

Repeals. — Laws 1995, ch. 189, § 2 repeals 24-20-2 NMSA 1978, amended by Laws 1993, ch. 215 §§ 1 and 2, relating to a head injury task force, effective July 1, 1995. For provisions of former section, *see* New Mexico One Source of Law DVD.

24-20-3. Brain injury advisory council; created; powers and duties.

A. The "brain injury advisory council" is created to advise the developmental disabilities planning council, the governor, the legislature and other state agencies.

B. The brain injury advisory council shall consist of no fewer than eighteen and no more than twenty-four members appointed by the governor, and shall include survivors of brain injuries; family members of persons with brain injuries; and health care professionals and other representatives of private sector organizations and state agencies that provide services and support to persons with brain injuries.

C. Members shall be appointed for staggered terms of three years, so that the terms of one-third of the members shall expire in a given year.

D. Members shall elect annually a chairman and vice chairman. Staff and other administrative support shall be provided by the developmental disabilities planning council or other state agency as assigned by the governor. Members shall meet at the call of the chairman.

E. Members who are not state employees may receive per diem and travel expenses as provided in the Per Diem and Mileage Act [10-8-1 NMSA 1978] for state employees. Reasonable accommodations shall be made available to permit full participation in council activities by its members, including personal assistance to members who are survivors of brain injuries and respite care for members who are family members of persons with brain injuries.

F. The brain injury advisory council shall:

(1) study and make recommendations to the developmental disabilities planning council, the governor, the legislature and other state agencies concerning case management, community support systems, long-term care, employment, emergency medical services, rehabilitation and prevention and the improvement and coordination of state activities relative to the concerns of persons with brain injuries and their families or other care givers; and

(2) advise appropriate state agencies and private organizations on the development of services and supports that meet the needs of persons with brain injuries.

History: Laws 1995, ch. 189, § 1.

24-20-4. Amyotrophic lateral sclerosis research fund.

The "amyotrophic lateral sclerosis research fund" is created in the state treasury. The fund shall consist of distributions made to the fund pursuant to the Tax Administration Act [7-1-1 NMSA 1978]. Money in the fund is appropriated to the board of regents of the university of New Mexico for amyotrophic lateral sclerosis research. Disbursements from the fund shall be by warrant of the secretary of finance and administration upon vouchers signed by the president of the university of New Mexico. Money in the fund shall revert to the general fund at the end of a fiscal year.

History: Laws 2005, ch. 56, § 3.

ANNOTATIONS

Applicability. — Section 24-20-4 NMSA 1978 applies to taxable years beginning on or after January 1, 2005.

ARTICLE 21
Genetic Information Privacy

24-21-1. Short title.

This act [24-21-1 to 24-21-7 NMSA 1978] may be cited as the "Genetic Information Privacy Act".

History: Laws 1998, ch. 77, § 1.

24-21-2. Definitions.

As used in the Genetic Information Privacy Act:

A. "DNA" means deoxyribonucleic acid, including mitochondrial DNA, complementary DNA and DNA derived from ribonucleic acid;

B. "gene products" means gene fragments, ribonucleic acids or proteins derived from DNA that would be a reflection of or indicate DNA sequence information;

C. "genetic analysis" means a test of a person's DNA, gene products or chromosomes that indicates a propensity for or susceptibility to illness, disease, impairment or other disorders, whether physical or mental; that demonstrates genetic or chromosomal damage due to environmental factors; or that indicates carrier status for disease or disorder; excluded, however, are routine physical measurements, chemical, blood and urine analysis, tests for drugs, tests for the presence of HIV virus and any other tests or analyses commonly accepted in clinical practice at the time ordered;

D. "genetic information" means information about the genetic makeup of a person or members of a person's family, including information resulting from genetic

testing, genetic analysis, DNA composition, participation in genetic research or use of genetic services;

E. "genetic propensity" means the presence in a person or members of a person's family of real or perceived variations in DNA or other genetic material from that of the normal genome that do not represent the outward physical or medical signs of a genetic disease at the time of consideration;

F. "genetic testing" means a test of an individual's DNA, ribonucleic acid, chromosomes or proteins, including carrier status, that are linked with physical or mental disorders, impairments or genetic characteristics or that indicate that an individual may be predisposed to an illness, disease, impairment or other disorder; and

G. "insurer" means an insurance company, insurance service or insurance organization that is licensed to engage in the business of insurance in the state and that is subject to state law that regulates insurance within the meaning of Paragraph (2) of Subsection (b) of Section 514 of the federal Employee Retirement Income Security Act of 1974, as amended. "Insurer" does not include an insurance company that is licensed under the Prepaid Dental Plan Law or a company that is solely engaged in the sale of dental insurance and is not licensed under the Prepaid Dental Plan Law, but under another provision of the New Mexico Insurance Code.

History: Laws 1998, ch. 77, § 2; 2005, ch. 204, § 1.

ANNOTATIONS

Cross references. — For Section 514(b)(2) of ERISA, *see* 29 U.S.C. § 1144(b)(2).

The 2005 amendment, effective July 1, 2005, adds the definition of "genetic testing" in Subsection F to mean a test of DNA, ribonucleic acid, chromosomes or proteins.

24-21-3. Genetic analysis prohibited without informed consent; exceptions.

A. Except as provided in Subsection C of this section, no person shall obtain genetic information or samples for genetic analysis from a person without first obtaining informed and written consent from the person or the person's authorized representative.

B. Except as provided in Subsection C of this section, genetic analysis of a person or collection, retention, transmission or use of genetic information without the informed and written consent of the person or the person's authorized representative is prohibited.

C. A person's DNA, genetic information or the results of genetic analysis may be obtained, retained, transmitted or used without the person's written and informed consent pursuant to federal or state law or regulations only:

(1) to identify a person in the course of a criminal investigation by a law enforcement agency;

(2) if the person has been convicted of a felony, for purposes of maintaining a DNA database for law enforcement purposes;

(3) to identify deceased persons;

(4) to establish parental identity;

(5) to screen newborns;

(6) if the DNA, genetic information or results of genetic analysis are not identified with the person or person's family members;

(7) by a court for determination of damage awards pursuant to the Genetic Information Privacy Act [24-21-1 NMSA 1978];

(8) by medical repositories or registries;

(9) for the purpose of medical or scientific research and education, including retention of gene products, genetic information or genetic analysis if the identity of the person or person's family members is not disclosed; or

(10) for the purpose of emergency medical treatment consistent with applicable law.

D. Actions of an insurer and third parties dealing with an insurer in the ordinary course of conducting and administering the business of life, disability income or long-term care insurance are exempt from the provisions of this section if the use of genetic analysis or genetic information for underwriting purposes is based on sound actuarial principles or related to actual or reasonably anticipated experience. However, before or at the time of collecting genetic information for use in conducting and administering the business of life, disability income or long-term care insurance, the insurer shall notify in writing an applicant for insurance or the insured that the information may be used, transmitted or retained solely for the purpose of conducting and administering the business of life, disability income or long-term care insurance.

E. Nothing in Paragraph (5), (6), (8), (9) or (10) of Subsection C of Section 3 [24-21-3 NMSA 1978] of the Genetic Information Privacy Act authorizes obtaining, retaining, transmitting or using a person's DNA, genetic information or the results of genetic analysis if the person, his authorized representative or guardian, or the parent or guardian of a minor child, objects on the basis of religious tenets or practices.

History: Laws 1998, ch. 77, § 3.

24-21-4. Genetic discrimination prohibited.

A. Discrimination by an insurer against a person or member of the person's family on the basis of genetic analysis, genetic information or genetic propensity is prohibited.

B. The provisions of this section do not require a health insurer to provide particular benefits other than those provided under the terms of the plan or coverage. A health insurer shall not consider a genetic propensity, susceptibility or carrier status as a pre-existing condition for the purpose of limiting or excluding benefits, establishing rates or providing coverage.

C. The provisions of this section do not prohibit use of genetic analysis, genetic propensity or genetic information by an insurer in the ordinary conduct of business in connection with life, disability income or long-term care insurance if use of genetic analysis, genetic propensity or genetic information in underwriting is based on sound actuarial principles or related to actual or reasonably anticipated experience.

D. It is unlawful for a person to use genetic information in employment, recruiting, housing or lending decisions or in extending public accommodations and services.

History: Laws 1998, ch. 77, § 4; 2005, ch. 204, § 2.

ANNOTATIONS

The 2005 amendment, effective July 1, 2005, adds Subsection D to provide that it is unlawful to use genetic information in employment, recruiting, housing or lending decisions or in extending public accommodations and services.

24-21-5. Rights of retention.

A. Unless otherwise authorized by Subsection C of Section 3 [24-21-3 NMSA 1978] of the Genetic Information Privacy Act, no person shall retain a person's genetic information, gene products or samples for genetic analysis without first obtaining informed and written consent from the person or the person's authorized representative. This subsection does not affect the status of original medical records of patients, and the rules of confidentiality and accessibility applicable to the records continue in force.

B. A person's genetic information or samples for genetic analysis shall be destroyed promptly upon the specific request by that person or that person's authorized representative unless:

(1) retention is necessary for the purposes of a criminal or death investigation or a criminal or juvenile proceeding;

(2) retention is authorized by order of a court of competent jurisdiction;

(3) retention is authorized under a research protocol approved by an institution review board pursuant to federal law or a medical registry or repository authorized by state or federal law; or

(4) the genetic information or samples for genetic analysis have been obtained pursuant to Subsection C of Section 3 of the Genetic Information Privacy Act.

C. Actions of an insurer and third parties dealing with an insurer in the ordinary course of conducting and administering the business of life, disability income or long-term care insurance are exempt from the provisions of this section. However, before or at the time of collecting genetic information for use in conducting and administering the business of life, disability income or long-term care insurance, the insurer shall notify in writing an applicant for insurance or the insured that the information may be used, transmitted or retained solely for the purpose of conducting and administering the business of life, disability income or long-term care insurance.

D. Nothing in Paragraph (3) or (4) of Subsection B of Section 5 [24-21-5 NMSA 1978] of the Genetic Information Privacy Act authorizes retention of a person's genetic information or samples for genetic analysis if the person, his authorized representative or guardian, or the parent or guardian of a minor child, objects on the basis of religious tenets or practices.

History: Laws 1998, ch. 77, § 5.

24-21-6. Penalties.

A. The attorney general or district attorney may bring a civil action against a person for violating the provisions of the Genetic Information Privacy Act [24-21-1 NMSA 1978] or to otherwise enforce those provisions.

B. A person whose rights under the provisions of the Genetic Information Privacy Act have been violated may bring a civil action for damages or other relief.

C. The court may order a person who violates the provisions of the Genetic Information Privacy Act to comply with those provisions and may order other appropriate relief, including:

(1) directing an insurer who has violated Section 3 [24-21-3 NMSA 1978] or 4 [24-21-4 NMSA 1978] of the Genetic Information Privacy Act to provide a policy for hospital and medical expenses, including health insurance, group disability insurance or long-term care coverage, to the injured person under the same terms and conditions as would have applied had the violation not occurred;

(2) actual damages;

(3) damages of up to five thousand dollars ($5,000) in addition to any economic loss if the violation results from willful or grossly negligent conduct; and

(4) reasonable attorney fees and appropriate court costs.

D. Pursuant to Subsection C of Section 3 of the Genetic Information Privacy Act, the court may use genetic information to determine the cause of damage or injury and penalty awards.

E. Each instance of wrongful collection, analysis, retention, disclosure or use of genetic information constitutes a separate and actionable violation of the Genetic Information Privacy Act.

History: Laws 1998, ch. 77, § 6.

24-21-7. Application of act.

The provisions of the Genetic Information Privacy Act [24-21-1 NMSA 1978] shall apply to genetic analysis performed and genetic information and gene products obtained after May 20, 1998, except that Section 24-21-4 NMSA 1978 and proceedings brought alleging violations of that section shall apply to genetic analysis whenever performed and genetic information and gene products whenever obtained.

History: Laws 1998, ch. 77, § 7; 1999, ch. 82, § 1.

ANNOTATIONS

The 1999 amendment, effective June 18, 1999, substituted "the Genetic Information Privacy Act" for "this act" and "May 20, 1998" for "the effective date of this act" and added the exception at the end.

ARTICLE 22
Safe Haven for Infants

24-22-1. Short title.

Chapter 24, Article 22 NMSA 1978 may be cited as the "Safe Haven for Infants Act".

History: Laws 2001, ch. 31, § 1 and Laws 2001, ch. 132, § 1; 2005, ch. 26, § 1.

ANNOTATIONS

Duplicate laws. — Laws 2001, ch. 31, § 1, effective March 14, 2001, and Laws 2001, ch. 132, § 1, effective April 2, 2001, enact identical new sections of the law. Both have been compiled as 24-22-1 NMSA 1978.

The 2005 amendment, effective June 17, 2005, changes the section references of the original enactment to a compiled chapter and article reference.

24-22-1.1. Purpose.

The purpose of the Safe Haven for Infants Act [24-22-1 NMSA 1978] is to promote the safety of infants and to immunize a parent from criminal prosecution for leaving an infant, ninety days of age or less, at a hospital. This act is not intended to abridge the rights or obligations created by the federal Indian Child Welfare Act of 1978 or the rights of parents.

History: Laws 2005, ch. 26, § 2.

ANNOTATIONS

Effective dates. — Laws 2005, ch 26 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective June 17, 2005, 90 days after adjournment of the legislature.

24-22-2. Definitions.

As used in the Safe Haven for Infants Act [24-22-1 NMSA 1978]:

A. "hospital" means an acute care general hospital or health care clinic licensed by the state;

B. "Indian child" means an Indian child as defined by the federal Indian Child Welfare Act of 1978;

C. "infant" means a child no more than ninety days old, as determined within a reasonable degree of medical certainty; and

D. "staff" means an employee, contractor, agent or volunteer performing services as required and on behalf of the hospital.

History: Laws 2001, ch. 31, § 2 and Laws 2001, ch. 132, § 2; 2005, ch. 26, § 3.

ANNOTATIONS

Cross references. — For the Indian Child Welfare Act of 1978, *see* 25 U.S.C.A. Sections 1901 *et seq*.

Duplicate laws. — Laws 2001, ch. 31, § 2, effective March 14, 2001, and Laws 2001, ch. 132, § 2, effective April 2, 2001, enact identical new sections of the law. Both have been compiled as 24-22-2 NMSA 1978.

The 2005 amendment, effective June 17, 2005, changes the definition of Indian child to mean an Indian child as defined in the federal Indian Child Welfare Act of 1978.

24-22-3. Leaving an infant.

A. A person may leave an infant with the staff of a hospital without being subject to criminal prosecution for abandonment or abuse if the infant was born within ninety days of being left at the hospital, as determined within a reasonable degree of medical certainty, and if the infant is left in a condition that would not constitute abandonment or abuse of a child pursuant to Section 30-6-1 NMSA 1978.

B. A hospital may ask the person leaving the infant for the name of the infant's biological father or biological mother, the infant's name and the infant's medical history, but the person leaving the infant is not required to provide that information to the hospital.

C. The hospital is deemed to have received consent for medical services provided to an infant left at a hospital in accordance with the provisions of the Safe Haven for Infants Act [24-22-1 NMSA 1978] or in accordance with procedures developed between the children, youth and families department and the hospital.

History: Laws 2001, ch. 31, § 3 and Laws 2001, ch. 132, § 3; 2005, ch. 26, § 4.

ANNOTATIONS

Duplicate laws. — Laws 2001, ch. 31, § 3, effective March 14, 2001, and Laws 2001, ch. 132, § 3, effective April 2, 2001, enact identical new sections of the law. Both have been compiled as 24-22-3 NMSA 1978.

The 2005 amendment, effective June 17, 2005, provides that a person may leaves an infant at a hospital without being subject to criminal prosecution for abandonment or abuse under circumstances stated in this section.

24-22-4. Hospital procedures.

A. A hospital shall accept an infant who is left at the hospital in accordance with the provisions of the Safe Haven for Infants Act [24-22-1 NMSA 1978].

B. In conjunction with the children, youth and families department, a hospital shall develop procedures for appropriate staff to accept and provide necessary medical services to an infant left at the hospital and to the person leaving the infant at the hospital, if necessary.

C. Upon receiving an infant who is left at a hospital in accordance with the provisions of the Safe Haven for Infants Act, the hospital may provide the person leaving the infant with:

(1) information about adoption services, including the availability of private adoption services;

(2) brochures or telephone numbers for agencies that provide adoption services or counseling services; and

(3) written information regarding whom to contact at the children, youth and families department if the parent decides to seek reunification with the infant.

D. A hospital shall ask the person leaving the infant whether the infant has a parent who is either a member of an Indian tribe or is eligible for membership in an Indian tribe, but the person leaving the infant is not required to provide that information to the hospital.

E. Immediately after receiving an infant in accordance with the provisions of the Safe Haven for Infants Act, a hospital shall inform the children, youth and families department that the infant has been left at the hospital. The hospital shall provide the children, youth and families department with all available information regarding the child and the parents, including the identity of the child and the parents, the location of the parents and the child's medical records.

History: Laws 2001, ch. 31, § 4 and Laws 2001, ch. 132, § 4; 2005, ch. 26, § 5.

ANNOTATIONS

Duplicate laws. — Laws 2001, ch. 31, § 4, effective March 14, 2001, and Laws 2001, ch. 132, § 4, effective April 2, 2001, enact identical new sections of the law. Both have been compiled as 24-22-4 NMSA 1978.

The 2005 amendment, effective June 17, 2005, provides that a hospital shall ask the person leaving an infant whether the infant has a parent who is a member of an Indian tribe or is eligible for membership in an Indian tribe, but the person leaving the infant is not required to give the information and requires the hospital to immediately provide the children, youth and families department with all available information about the child and the parents of the child.

24-22-5. Responsibilities of the children, youth and families department.

A. The children, youth and families department shall be deemed to have emergency custody of an infant who has been left at a hospital according to the provisions of the Safe Haven for Infants Act [24-22-1 NMSA 1978].

B. Upon receiving a report of an infant left at a hospital pursuant to the provisions of the Safe Haven for Infants Act, the children, youth and families department shall

immediately conduct an investigation, pursuant to the provisions of the Abuse and Neglect Act [32A-4-1 NMSA 1978].

C. When an infant is taken into custody by the children, youth and families department, the department shall make reasonable efforts to determine whether the infant is an Indian child. If the infant is an Indian child:

(1) the child's tribe shall be notified as required by Section 32A-1-14 NMSA 1978 and the federal Indian Child Welfare Act of 1978; and

(2) pre-adoptive placement and adoptive placement of the Indian child shall be in accordance with the provisions of Section 32A-5-5 NMSA 1978 regarding Indian child placement preferences.

D. The children, youth and families department shall perform public outreach functions necessary to educate the public about the Safe Haven for Infants Act, including developing literature about that act and distributing it to hospitals.

E. An infant left at a hospital in accordance with the provisions of the Safe Haven for Infants Act shall presumptively be deemed eligible and enrolled for medicaid benefits and services.

History: Laws 2001, ch. 31, § 5 and Laws 2001, ch. 132, § 5; 2005, ch. 26, § 6.

ANNOTATIONS

Duplicate laws. — Laws 2001, ch. 31, § 5, effective March 14, 2001, and Laws 2001, ch. 132, § 5, effective April 2, 2001, enact identical new sections of the law. Both have been compiled as 24-22-5 NMSA 1978.

The 2005 amendment, effective June 17, 2005, provides that if the infant is an Indian child, the child’s tribe shall be notified as required by 32A-1-14 NMSA 1978 and the federal Indian Child Welfare Act of 1978.

24-22-6. Repealed.

History: Laws 2001, ch. 31, § 6 and Laws 2001, ch. 132, § 6; repealed by Laws 2005, ch. 26, § 8.

ANNOTATIONS

Repeals. — Laws 2005, ch. 26, § 8 repeals 24-22-6 NMSA 1978, relating to confidentiality, effective June 17, 2005. For provisions of former section, *see* New Mexico One Source of Law DVD..

24-22-7. Procedure if reunification is sought.

A. A person established as a parent of an infant previously left at a hospital shall have standing to participate in all proceedings regarding the child pursuant to the provisions of the Abuse and Neglect Act [32A-4-1 NMSA 1978].

B. If a person not previously established as a parent seeks reunification with an infant previously left at a hospital and the person's DNA indicates parentage of the infant, that person shall have standing to participate in all proceedings regarding the infant pursuant to the provisions of the Abuse and Neglect Act.

History: Laws 2001, ch. 31, § 7 and Laws 2001, ch. 132, § 7; 2005, ch. 26, § 7.

ANNOTATIONS

Duplicate laws. — Laws 2001, ch. 31, § 7, effective March 14, 2001, and Laws 2001, ch. 132, § 7, effective April 2, 2001, enact identical new sections of the law. Both have been compiled as 24-22-7 NMSA 1978.

The 2005 amendment, effective June 17, 2005, provides that the parent of an infant shall have standing to participate in all proceedings regarding the child pursuant to the Abuse and Neglect Act; provides that if a person not previously established as a parent seeks reunification with an infant and the persons DNA indicated parentage of the infant, then the person has standing to participate in proceedings regarding the infant; and eliminates the provision that provides there is no presumption of abuse or neglect of against a person who seeks reunification.

24-22-8. Immunity.

A hospital and its staff are immune from criminal liability and civil liability for accepting an infant in compliance with the provisions of the Safe Haven for Infants Act [24-22-1 NMSA 1978] but not for subsequent negligent medical care or treatment of the infant.

History: Laws 2001, ch. 31, § 8 and Laws 2001, ch. 132, § 8.

ANNOTATIONS

Duplicate laws. — Laws 2001, ch. 31, § 8, effective March 14, 2001, and Laws 2001, ch. 132, § 8, effective April 2, 2001, enact identical new sections of the law. Both have been compiled as 24-22-8 NMSA 1978.

ARTICLE 23
Administration of Opioid Antagonists

24-23-1. Authority to administer opioid antagonists; release from liability.

A. A person authorized under federal, state or local government regulations, other than a licensed health care professional permitted by law to administer an opioid antagonist, may administer an opioid antagonist to another person if:

(1) he, in good faith, believes the other person is experiencing a drug overdose; and

(2) he acts with reasonable care in administering the drug to the other person.

B. A person who administers an opioid antagonist to another person pursuant to Subsection A of this section shall not be subject to civil liability or criminal prosecution as a result of the administration of the drug.

History: Laws 2001, ch. 228, § 1.

ANNOTATIONS

Emergency clauses. — Laws 2001, ch. 228, § 3 makes the act effective immediately, approved April 3, 2001.

24-23-2. Health care professionals; release from liability.

A licensed health care professional who is permitted by law to prescribe an opioid antagonist, if acting with reasonable care, may prescribe, dispense, distribute or administer an opioid antagonist without being subject to civil liability or criminal prosecution.

History: Laws 2001, ch. 228, § 2.

ANNOTATIONS

Emergency clauses. — Laws 2001, ch. 228, § 3 makes the act effective immediately. Approved April 3, 2001.

ARTICLE 24
Child Care Facility Loan

24-24-1. Short title.

This act [24-24-1 to 24-24-4 NMSA 1978] may be cited as the "Child Care Facility Loan Act".

History: Laws 2003, ch. 316, § 1.

ANNOTATIONS

Emergency clauses. — Laws 2003, ch. 316, § 5 makes the act effective April 8, 2003.

24-24-2. Purpose.

The purpose of the Child Care Facility Loan Act [24-24-1 NMSA 1978] is to support the physical improvement, repair, safety and maintenance of licensed child care facilities throughout New Mexico by providing long-term, low-interest funding through a revolving loan fund so as to ensure availability of healthy and safe teaching environments.

History: Laws 2003, ch. 316, § 2.

ANNOTATIONS

Emergency clauses. — Laws 2003, ch. 316, § 5 makes the act effective immediately April 8, 2003.

24-24-3. Definitions.

As used in the Child Care Facility Loan Act [24-24-1 NMSA 1978]:

A. "department" means the children, youth and families department;

B. "facility" means a child care facility operated by a provider, including both family home-based and center-based programs, licensed by the department to provide care to infants, toddlers and children;

C. "fund" means the child care facility revolving loan fund; and

D. "provider" means a person licensed by the department to provide child care to infants, toddlers and children pursuant to Section 9-2A-8 NMSA 1978.

History: Laws 2003, ch. 316, § 3.

ANNOTATIONS

Emergency clauses. — Laws 2003, ch. 316, § 5 makes the act effective April 8, 2003.

24-24-4. Fund created; administration.

A. The "child care facility revolving loan fund" is created in the New Mexico finance authority to provide low-interest, long-term loans to providers to make health and safety improvements in their facilities. The fund shall consist of appropriations, gifts, grants and donations to the fund, which shall be invested as provided in the New Mexico Finance Authority Act [6-21-1 NMSA 1978]. Money in the fund shall not revert and is appropriated to the department, which shall utilize the fund for the purposes of the Child

Care Facility Loan Act [24-24-1 NMSA 1978]. Administrative costs of the authority may be paid from the fund. Expenditures from the fund for loans to providers shall be made upon warrants of the secretary of finance and administration pursuant to vouchers signed by the secretary of children, youth and families or his authorized representative.

B. Money in the fund shall be used to make loans to providers that demonstrate the need to make health and safety improvements, including space expansion, in order to maintain an adequate and appropriate environment for their clients. Loans from the fund are to be made at the lowest legally permissible interest rates for the longest amount of time in order to allow the providers the maximum opportunity to maintain the business while repaying the loan.

C. No more than twenty percent of the fund may be loaned to a single provider in a single loan. A provider that has received a loan from the fund in the immediately preceding five years or that has not completed repayment of a previous loan from the fund is ineligible for a new loan. The department shall give priority for loans to facilities of providers that serve proportionately high numbers of state-subsidized clients and low-income families.

D. The department, in conjunction with the New Mexico finance authority, shall adopt rules to administer and implement the Child Care Facility Loan Act . The rules shall become effective when filed in accordance with the State Rules Act [14-4-1 NMSA 1978].

History: Laws 2003, ch. 316, § 4.

ANNOTATIONS

Emergency clauses. — Laws 2003, ch. 316, § 5 makes the act effective April 8, 2003.

ARTICLE 25
New Mexico Telehealth Act

24-25-1. Short title.

This act [24-25-1 to 24-25-5 NMSA 1978] may be cited as the "New Mexico Telehealth Act".

History: Laws 2004, ch. 48, § 1.

ANNOTATIONS

24-25-2. Findings and purpose.

A. The legislature finds that:

(1) lack of primary care, specialty providers and transportation continue to be significant barriers to access to health services in medically underserved rural areas;

(2) there are parts of this state where it is difficult to attract and retain health professionals, as well as support local health facilities to provide a continuum of health care;

(3) many health care providers in medically underserved areas are isolated from mentors and colleagues and from the information resources necessary to support them personally and professionally;

(4) using information technology to deliver medical services and information from one location to another is part of a multifaceted approach to address the problems of provider distribution and the development of health systems in medically underserved areas by improving communication capabilities and providing convenient access to up-to-date information, consultations and other forms of support;

(5) the use of telecommunications to deliver health services has the potential to reduce costs, improve quality, change the conditions of practice and improve access to health care in rural, medically underserved areas; and

(6) telehealth will assist in maintaining or improving the physical and economic health of medically underserved communities by keeping the source of medical care in the local area, strengthening the health infrastructure and preserving health-care-related jobs.

B. The purpose of the New Mexico Telehealth Act [24-25-1 NMSA 1978] is to provide a framework for health care providers to follow in providing telehealth to New Mexico citizens when it is impractical for those citizens to receive health care consultations face-to-face with health care providers.

History: Laws 2004, ch. 48, § 2.

ANNOTATIONS

24-25-3. Definitions.

As used in the New Mexico Telehealth Act [24-25-1 NMSA 1978]:

A. "health care provider" means a person licensed to provide health care to patients in New Mexico, including:

(1) an optometrist;

(2) a chiropractic physician;

(3) a dentist;

(4) a physician;

(5) a podiatrist;

(6) an osteopathic physician;

(7) a physician assistant;

(8) a certified nurse practitioner;

(9) a physical therapist;

(10) an occupational therapist;

(11) a speech-language pathologist;

(12) a doctor of oriental medicine;

(13) a nutritionist;

(14) a psychologist;

(15) a certified nurse-midwife;

(16) a clinical nurse specialist;

(17) a registered nurse;

(18) a dental hygienist; or

(19) a pharmacist;

B. "originating site" means a place where a patient may receive health care via telehealth. An originating site may include:

(1) a licensed inpatient center;

(2) an ambulatory surgical or treatment center;

(3) a skilled nursing center;

(4) a residential treatment center;

(5) a home health agency;

(6) a diagnostic laboratory or imaging center;

(7) an assisted living center;

(8) a school-based health program;

(9) a mobile clinic;

(10) a mental health clinic;

(11) a rehabilitation or other therapeutic health setting; or

(12) the patient's residence; and

C. "telehealth" means the use of electronic information, imaging and communication technologies, including interactive audio, video, data communications as well as store-and-forward technologies, to provide and support health care delivery, diagnosis, consultation, treatment, transfer of medical data and education when distance separates the patient and the health care provider.

History: Laws 2004, ch. 48, § 3.

ANNOTATIONS

24-25-4. Telehealth authorized; procedure.

The delivery of health care via telehealth is recognized and encouraged as a safe, practical and necessary practice in New Mexico. No health care provider or operator of an originating site shall be disciplined for or discouraged from participating in telehealth pursuant to the New Mexico Telehealth Act [24-25-1 NMSA 1978]. In using telehealth procedures, health care providers and operators of originating sites shall comply with all applicable federal and state guidelines and shall follow established federal and state rules regarding security, confidentiality and privacy protections for health care information.

History: Laws 2004, ch. 48, § 4.

ANNOTATIONS

24-25-5. Scope of act.

A. The New Mexico Telehealth Act [24-25-1 NMSA 1978] does not alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

B. Although the use of telehealth is strongly encouraged, nothing in the New Mexico Telehealth Act requires a health insurer, health maintenance organization, managed care organization, provider service organization or the state's medical assistance program to include telehealth within the scope of the plan or policy offered by that entity.

History: Laws 2004, ch. 48, § 5.

ANNOTATIONS

ARTICLE 26
Patient Care Monitoring Act

24-26-1. Short title.

This act [24-26-1 to 24-26-12 NMSA 1978] may be cited as the "Patient Care Monitoring Act".

History: Laws 2004, ch. 53, § 1.

ANNOTATIONS

24-26-2. Definitions.

As used in the Patient Care Monitoring Act [24-26-1 NMSA 1978]:

A. "agency" means the state agency on aging;

B. "facility" means a long-term care facility licensed pursuant to the provisions of Section 24-1-5 NMSA 1978, other than an intermediate care facility for the mentally retarded, and may also include:

(1) a skilled nursing facility;

(2) an intermediate care nursing facility;

(3) a nursing facility;

(4) an adult residential shelter care home;

(5) a boarding home;

(6) any adult care home or adult residential care facility; and

(7) any swing bed in an acute care facility or extended care facility;

C. "monitoring device" means a surveillance instrument that broadcasts or records activity, but does not include a still camera;

D. "patient" means a person who is a resident of a facility;

E. "program" means the New Mexico long-term care ombudsman program; and

F. "surrogate" means a legal guardian or a legally appointed substitute decision-maker who is authorized to act on behalf of a patient.

History: Laws 2004, ch. 53, § 2.

ANNOTATIONS

24-26-3. Monitoring device; authorization and use.

A. A patient or a surrogate may authorize installation and use of a monitoring device in a facility provided that:

(1) the facility is given notice of the installation;

(2) if the monitoring device records activity visually, such recording shall include a record of the date and time;

(3) the monitoring device and all installation and maintenance costs are paid for by the patient; and

(4) written consent is given by each patient or surrogate of each patient occupying the same room.

B. The patient may establish and the facility shall accommodate limits on the use, including the time of operation, direction, focus or volume, of a monitoring device.

History: Laws 2004, ch. 53, § 3.

ANNOTATIONS

24-26-4. Monitoring device option; installation; accommodation by facility.

A. At the time of admission to a facility, a patient shall be offered the option to have a monitoring device, and a record of the patient's authorization or choice not to have a monitoring device shall be kept by the facility and shall be made accessible to the program.

B. After authorization, consent and notice, a patient or surrogate may install, operate and maintain a monitoring device in the patient's room at the patient's expense.

C. The facility shall cooperate to accommodate the installation of the monitoring device, provided the installation does not place undue burden on the facility.

History: Laws 2004, ch. 53, § 4.

ANNOTATIONS

24-26-5. Consent; waiver.

A. Consent to the authorization for the installation and use of a monitoring device may be given only by the patient or the surrogate.

B. Consent to the authorization for the installation and use of a monitoring device shall include a release of liability for the facility for a violation of the patient's right to privacy insofar as the use of the monitoring device is concerned.

C. A patient or the surrogate may reverse a choice to have or not have a monitoring device installed and used at any time, after notice to the facility and to the program upon a form prescribed by the agency.

History: Laws 2004, ch. 53, § 5.

ANNOTATIONS

24-26-6. Authorization form; contents.

The form for the authorization of installation and use of a monitoring device shall provide for:

A. consent of the patient or the surrogate authorizing the installation and use of the monitoring device;

B. notice to the facility of the patient's installation of a monitoring device and specifics as to its type, function and use;

C. consent of any other patient or that patient's surrogate sharing the same room;

D. notice of release from liability for privacy violation through the use of the monitoring device; and

E. waiver of the patient's right to privacy in conjunction with the use of the monitoring device.

History: Laws 2004, ch. 53, § 6.

ANNOTATIONS

24-26-7. Immunity; unauthorized use.

A. In any civil action against the facility, material obtained through the use of a monitoring device may not be used if the monitoring device was installed or used without the knowledge of the facility or without the prescribed form.

B. Compliance with the provisions of the Patient Care Monitoring Act [24-26-1 NMSA 1978] shall be a complete defense against any civil or criminal action brought against the patient, surrogate or facility for the use or presence of a monitoring device.

History: Laws 2004, ch. 53, § 7.

ANNOTATIONS

24-26-8. Notice to current patients.

Within six months of the effective date of the Patient Care Monitoring Act [24-26-1 NMSA 1978], all facilities shall provide to each patient or surrogate a form prescribed by the agency explaining the provisions of the Patient Care Monitoring Act and giving each patient or surrogate a choice to have a monitoring device installed in the patient's room. Copies of the completed form shall be kept by the facility and shall be made accessible to the program.

History: Laws 2004, ch. 53, § 8.

ANNOTATIONS

24-26-9. Notice.

The facility shall post a notice in a conspicuous place at the entrance to a room with a monitoring device that a monitoring device is in use in that room of the facility.

History: Laws 2004, ch. 53, § 9.

ANNOTATIONS

24-26-10. Rules.

The agency shall adopt rules necessary to implement the provisions of the Patient Care Monitoring Act [24-26-1 NMSA 1978].

History: Laws 2004, ch. 53, § 10.

ANNOTATIONS

24-26-11. Prohibited acts.

No person or patient shall be denied admission to or discharged from a facility or be otherwise discriminated against or retaliated against because of a choice to authorize installation and use of a monitoring device. Any person who violates this section shall be subject to the provisions of Section 28-17-19 NMSA 1978.

History: Laws 2004, ch. 53, § 11.

ANNOTATIONS

24-26-12. Criminal acts.

Any person other than a patient or surrogate found guilty of intentionally hampering, obstructing, tampering with or destroying a monitoring device or a recording made by a monitoring device installed in a facility pursuant to the Patient Care Monitoring Act [24-26-1 NMSA 1978] is guilty of a fourth degree felony and shall be sentenced pursuant to Section 31-18-15 NMSA 1978.

History: Laws 2004, ch. 53, § 12.

ANNOTATIONS

ARTICLE 27
Umbilical Cord Blood Banking Act

24-27-1. Short title.

This act may be cited as the "Umbilical Cord Blood Banking Act".

History: Laws 2005, ch. 43, § 1.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 43, § 8 makes the act effective July 1, 2005.

24-27-2. Purpose of act.

The purpose of the Umbilical Cord Blood Banking Act [24-27-1 NMSA 1978] is to educate pregnant women regarding the potential benefits of umbilical cord blood

donations and to provide opportunities for the donation and storage of umbilical cord blood when desired by a pregnant woman.

History: Laws 2005, ch. 43, § 2.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 43, § 8 makes the act effective July 1, 2005.

24-27-3. Definitions.

As used in the Umbilical Cord Blood Banking Act [24-27-1 NMSA 1978]:

A. "health care facility" means an institution providing health care services, including a hospital, clinic or other inpatient center, outpatient facility or diagnostic or treatment center that is licensed by the department of health;

B. "health care provider" means a person who is licensed, certified or otherwise authorized by law to provide or render health care services to pregnant women in New Mexico in the ordinary course of business or practice of a profession, but is limited to a medical physician, osteopathic physician, doctor of oriental medicine, certified nurse practitioner and certified nurse-midwife; and

C. "umbilical cord blood" means the blood that remains in the umbilical cord and placenta after the birth of a newborn child.

History: Laws 2005, ch. 43, § 3.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 43, § 8 makes the act effective July 1, 2005.

24-27-4. Dissemination of information.

A. All health care providers providing health care services to a pregnant woman during the last trimester of her pregnancy, which health care services are directly related to her pregnancy, shall advise her of options to donate umbilical cord blood following the delivery of a newborn child. Provision in a timely manner of publications prepared by the department of health pursuant to Section 5 of the Umbilical Cord Blood Banking Act [24-27-5 NMSA 1978] shall constitute compliance with this subsection.

B. Nothing in this section imposes an obligation upon a health care provider to inform a pregnant woman regarding the option of umbilical cord blood donations if such information conflicts with bona fide religious beliefs of the health care provider.

History: Laws 2005, ch. 43, § 4.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 43, § 8 makes the act effective January 1, 2006.

24-27-5. Informational publications.

The department of health shall, by January 1, 2006, prepare and distribute to health care providers written publications that include the following information:

A. the medical processes involved in the collection of umbilical cord blood;

B. the medical risks to a mother and her newborn child of umbilical cord blood collection;

C. the current and potential future medical uses and benefits of umbilical cord blood collection to a mother, her newborn child and her biological family;

D. the current and potential future medical uses and benefits of umbilical cord blood collection to persons who are not biologically related to a mother or her newborn child;

E. any costs that may be incurred by a pregnant woman who chooses to make an umbilical cord blood donation;

F. options for ownership and future use of the donated material; and

G. the availability in this state of umbilical cord blood donations.

History: Laws 2005, ch. 43, § 5.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 43, § 8 makes the act effective July 1, 2005.

24-27-6. Donation of umbilical cord blood.

A. Unless it is medically inadvisable, all health care facilities and health care providers treating a pregnant woman during the delivery of a newborn child shall, if requested by that woman, permit her to arrange for an umbilical cord blood donation.

B. Nothing in this section imposes an obligation upon a health care facility or health care provider to permit an umbilical cord blood donation if in the professional judgment of a health care provider the donation of umbilical cord blood would threaten the health of the mother or newborn child.

C. Nothing in this section imposes an obligation upon a health care facility or health care provider to permit an umbilical cord blood donation if the donation conflicts with bona fide religious beliefs of the health care facility or health care provider. If a health care facility or health care provider declines to engage in umbilical cord blood donation, that fact shall be made known to pregnant patients of that facility or provider as soon as reasonably feasible.

History: Laws 2005, ch. 43, § 6.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 43, § 8 makes the act effective January 1, 2006.

24-27-7. Severability.

If any part or application of the Umbilical Cord Blood Banking Act [24-27-1 NMSA 1978] is held invalid, the remainder or its application to other situations or persons shall not be affected.

History: Laws 2005, ch. 43, § 7.

ANNOTATIONS

Effective dates. — Laws 2005, ch. 43, § 8 makes the act effective July 1, 2005.