Ohio Administrative Code

Rule 3701-22-23 Level III service standards.

Effective: August 31, 2025

(A) Obstetric license. A level III obstetrical service will provide antepartum, intrapartum and postpartum care for obstetrical patients, including:

(1) All low-risk patients;

(2) All uncomplicated patients with higher-risk conditions;

(3) All high-risk patients;

(4) Patients with more complex maternal or fetal conditions as identified by the service, such as patients:

(a) With suspected placenta accreta or placenta previa with prior uterine surgery;

(b) With suspected placenta percreta;

(c) With adult respiratory syndrome; or

(d) Requiring expectant management of early severe preeclampsia at less than thirty-four weeks of gestation;

(5) Intensive care through an on-site intensive care unit that is equipped to:

(a) Provide labor and delivery in the intensive care unit;

(b) Provide medical and surgical care of complex obstetrical conditions; and

(c) Bring intensive care unit services to the obstetrical unit;

(6) The management of unanticipated complications of labor and delivery; and

(7) The management of emergencies.

(B) Obstetric transfer. A level III obstetrical service will transfer to a level IV obstetric service care any pregnant woman for intrapartum care:

(1) With a complex medical condition that requires critical care or intensive care beyond that which the facility can provide; or

(2) If the newborn is anticipated to need advanced medical and surgical care beyond that which the transferring service is licensed to provide.

(a) The mother is having contractions; and

(b) When, in the clinical judgment of a qualified obstetrical practitioner working under that practitioner's scope of practice:

(i) There is inadequate time to effect a safe transfer of the mother to an appropriate higher level hospital before delivery; or

(ii) The transfer will pose a threat to the health or safety of either the mother or the fetus.

(3) Exception: A level III obstetric service may provide care where an emergency medical condition exists as defined by the Emergency Medical Treatment and Labor Act, 42 U.S.C. 1395dd (2012), and is evidenced by the following:

(C) When considering a woman's condition and the likelihood of pregnancy-related complications, paragraphs (A) and (B) of this rule do not preclude the admission of:

(1) A pregnant woman to the maternity unit for care or services for a non-obstetrical issue, but that may require monitoring of the health of the mother, the fetus, or both;

(2) Women for antepartum care at any stage of the maternity cycle where labor is not imminent;

(3) Non-infectious gynecologic patients; or

(4) Non-infectious female surgical patients in accordance with policies and procedures approved by the service's director.

(D) Neonatal license. A level III neonatal care service will provide intensive, intermediate and routine care to newborns, including to:

(1) All low risk newborns;

(2) All complicated newborns;

(3) Extremely low birth weight infants;

(4) Newborns requiring advanced respiratory care, other than extracorporeal membrane oxygenation, including high-frequency ventilation and inhaled nitric oxide and/or therapeutic hypothermia or the provider will have policies and procedures in place to facilitate neonatal transfer to a higher level of care. This paragraph notwithstanding, a level III neonatal care service that was providing pulmonary extracorporeal membrane oxygenation that did not require cardiac intervention under rule 3701-22-24 of the Administrative Code, may continue to provide extracorporeal membrane oxygenation that does not require cardiac intervention;

(5) Newborns requiring major surgery as identified by the service, other than newborns requiring immediate surgical repair of serious congenital cardiac malformations that require cardiopulmonary bypass, as designated by the service, either on-site or at a nearby, closely-related institution; and

(6) Newborns that require emergency resuscitation or stabilization for transport.

(E) Newborn transfers. When a level III obstetric service cannot timely transfer a pregnant woman pursuant to paragraph (B)(2) of this rule, the level III neonatal care service will transfer a newborn to

a level IV neonatal care service if the newborn is anticipated to need advanced medical or surgical care beyond that which the transferring service is licensed to provide, unless all of the following are met:

(1) The level III neonatal care service has identified a neonatal transport program to facilitate the transport of the newborn to a higher level neonatal facility;

(2) The level III neonatal care service has in place a valid memorandum of agreement with one or more level IV neonatal care services, providing for consultation on the retention of the infant between the level III neonatal care service attending physician and the neonatologist on the staff of the level IV neonatal care service;

(3) The consultation with, and the concurrence of, the neonatologist on the staff of the level IV neonatal care service is documented by the level III neonatal care service in the patient medical record and as otherwise may be determined by the service; and

(4) The risks and benefits to the newborn for both retention at the level III neonatal care service and transfer of the newborn to a level IV neonatal care service are discussed with the parent, parents, or legal guardian of the newborn and appropriately documented.

(F) Informed consent. When discussing transfer of a pregnant woman or a newborn to another facility in accordance with this rule, the transferring service will document and provide the patient or patient's legal guardian with:

(1) The recommendations from any consultations with a level IV service;

(2) The risks and benefits associated with the patient's transfer or retention; and

(3) Any other information required by the hospital's policies and procedures.

(G) In the event the patient or patient's legal guardian refuses transfer to a recommended hospital, the service will document the refusal of transfer and provide treatment to the patient or patients in accordance with hospital policies and procedures. The service will update the patient or patient's

legal guardian as the patient's condition warrants.

(H) Written service plan. Each provider will, using licensed health care professionals acting within their scopes of practice, develop a written service plan for the care and services to be provided by the service. The written service plan will be in accordance with the "Guidelines for perinatal care" or other applicable professional standard and address, at minimum:

(1) The more complex maternal or fetal conditions for which the care will be provided based on the:

(a) Patient population;

(b) Acuity of patients;

(c) Volume of patients; and

(d) Competency of staff;

(2) Criteria for determining those conditions that can be routinely managed by the service;

(3) Admission to the service;

(4) Discharge from the service;

(5) Patient care in accordance with accepted professional standards;

(6) Referrals for obtaining public health, dietetic, genetic, and toxicology services not available in-house;

(7) Minimum competency standards for staff in accordance with recognized national standards and ensure that all staff are competent to perform services based on education, experience and demonstrated ability;

(8) Administration of blood and blood products;

(9) Provision of phototherapy;

(10) Provision of respiratory therapy;

(11) Unit-based surgeries and surgical suite-based surgeries;

(12) Post-mortem care;

(13) A formal education program for staff including, at minimum:

(a) A nursing orientation that incorporates didactic education, simulation, skills verification, and competency and is tailored to the individual needs of each nurse based on clinical experience;

(b) The neonatal resuscitation program. The service will ensure all labor and delivery registered nurses and any other practitioner likely to attend to a neonate at a high risk of a more complicated delivery will receive training in the neonatal resuscitation program;

(c) A post- resuscitation program. The service will ensure individuals caring for newborns receive training in a post resuscitation program to include, at minimum:

(i) The identification and treatment of signs and symptoms related to hypoglycemia, hypothermia, and pneumothorax;

(ii) Blood pressure (normal ranges, factors that can impair cardiac output);

(iii) Lab work, including perinatal and postnatal risks factors and clinical signs of sepsis;

(iv) Principles of assisted ventilation, continuous positive airway pressure, positive pressure ventilation, assisting and securing endo-tracheal tube insertion, and chest x-rays;

(v) Emotional support to parents with sick infants; and

(vi) Quality improvement to identify problems and the importance of debriefing to evaluate care in the post-resuscitation period; and

(d) Ongoing continuing education that includes:

(i) An annual educational needs assessment to determine the educational needs of the clinical nursing staff and ancillary team members;

(ii) Annual nursing education that addresses the annual needs assessment and incorporates simulation and skills verification of low-volume, high-risk procedures consistent with the types of care provided in the obstetric and neonatal care services and includes education related to serious safety events; and

(iii) Nursing staff participation in annual simulation and skills verification, including low-volume, high-risk procedures consistent with the types of care provided in the obstetric and neonatal care services.

(14) Provision of care by direct care staff to individuals in other areas of the hospital, including, but not limited to the emergency department and the intensive care unit;

(15) Risk assessment of obstetric and neonatal patients to ensure identification of appropriate consultation requirements for or referral of high-risk patients;

(16) A formal process for the on-site provision of services or the referral of patients to follow-up services, as appropriate, for the following:

(a) Developmental screening;

(b) Ophthalmology;

(c) Audiology;

(d) Child life specialist;

(e) Lactation clinical care, education, and support;

(f) Neonatal therapists to address the six core practice domains of environment, family or psychosocial health support, sensory system, neurobehavioral system, neuromotor and musculoskeletal systems, and oral feeding and swallowing by providers with neonatal experience, including:

(i) Physical therapy,

(ii) Occupational therapy; and

(iii) Speech therapy.

(17) Education for mothers regarding personal care and nutrition, newborn care and nutrition, and newborn feeding;

(18) Infection control, consistent with current infection control guidelines issued by the United States centers for disease control and prevention;

(19) Consultation for and referral of both obstetric and neonatal transports;

(20) The coordination and facilitation, on a twenty-four hour basis, of both obstetric and neonatal transports, which may include the reverse transport of newborns;

(21) Consultation for maternal-fetal medicine on a twenty-four hour basis;

(22) Developmental follow-up of at-risk newborns in the service or referral of such newborns to appropriate programs;

(23) Provision of ongoing education for referring hospitals;

(24) Provision of opportunities for graduate medical education such as pediatric residencies or

obstetrics-gynecology residencies, neonatal fellowships or maternal-fetal medicine fellowships, provided either directly or through an agreement with a hospital providing co-located newborn services;

(25) Provision of opportunities for clinical experience for purposes of graduate nursing education, or continuing education, or both;

(26) Participation, on an ongoing basis, in basic or clinical obstetrics or neonatology research;

(27) Provision of multi-disciplinary planning relating to management and therapy through the postpartum period; and

(28) A process to appropriately identify infants at risk for retinopathy of prematurity to guarantee timely examination and treatment by having:

(a) Documented policies and procedures for the monitoring, treatment, and follow-up of retinopathy of prematurity; and

(b) The ability to perform on-site retinal examinations, or off-site interpretation of digital photographic retinal images, by a pediatric ophthalmologist or retinal specialist with expertise in retinopathy of prematurity.

(I) Each provider will, in accordance with accepted professional standards, develop and follow written policies and procedures to implement the written service plan set forth in paragraph (H) of this rule.

(J) Each provider will have the ability to perform all of the following:

(1) An emergency cesarean delivery in accordance with facility policy, but no later than thirty minutes from the time that the decision is made to perform the procedure;

(2) Fetal monitoring; and

(3) Resuscitation and stabilization of newborns and emergency care for the mother and newborn in each delivery room.

(K) Support services (on-site). Each provider will have the following staff and services on-site on a twenty-four hour basis:

(1) Clinical laboratory, capable of providing any necessary testing, including:

(a) Blood typing, crossmatch, and antibody testing;

(b) Neonatal blood gas monitoring; and

(c) Analysis of small volume samples;

(i) Low-volume specialty laboratory services may be provided by an outside laboratory, but the facility will have policies and procedures in place to verify timely and direct communication of all critical value results; and

(d) Access to perinatal pathology services, if applicable, may be provided on-site or by arrangement.

(2) A blood bank capable of providing blood, blood products, substitutes, blood component therapy and irradiated, leukoreduced or cytomegalovirus (CMV)-negative blood;

(3) Diagnostic imaging, including:

(a) X-ray; and

(b) Computed tomography;

(4) Portable ultrasound visualization equipment for diagnosis and evaluation;

(5) Each provider will have at least one registered pharmacist with experience in neonatal and/or pediatric pharmacology who will:

(a) Complete continuing education requirements specific to pediatric and neonatal pharmacology;

(b) Participate in multidisciplinary care, including participation in patient care rounds;

(c) Ensure that neonatal appropriate total parenteral nutrition (TPN) is available twenty-four hours a day and that written policies and procedures for the proper preparation and delivery of TPN are in place;

(d) Have policies and procedures in place to address drug shortages and to verify medications are appropriately allocated to the neonatal care service; and

(e) Have policies and procedures in place to verify neonatal competency for pharmacy staff supporting and preparing medications for neonatal patients.

(f) A pediatric/neonatal trained hospital pharmacist available by telephone or telehealth on a twenty-four-hour day basis. This requirement can be provided directly or by an agreement with a children's hospital.

(6) Respiratory therapy and pulmonary. The respiratory therapy service will:

(a) Have a full-time credentialed respiratory care practitioner, with education, training, or experience in neonatal respiratory care who:

(i) Has sufficient time allocated to provide direction and guidance as needed, of the respiratory therapists who provide care in the level III neonatal care service; and

(ii) Provide oversight of an annual simulation and skills verification of staff, including neonatal respiratory care modalities and low-volume, high-risk neonatal respiratory procedures;

(b) Develop a written staffing plan for respiratory therapists that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of respiratory therapy staff to a care situation, attend to a safe and high-quality work environment, and

be operationally reviewed annually for adherence and to verify respiratory therapy staffing is adequate for patient care need;

(c) Maintain appropriate staffing ratios for infants receiving supplemental oxygen and positive pressure ventilation; and

(d) Ensure that respiratory therapy practitioners:

(i) Have documented education, training, or experience in the respiratory support of newborns and infants;

(ii) Will be on-site, in the same hospital building, twenty-four hours a day, seven days a week and remain available to supervise assisted ventilation, assist in resuscitation, and attend deliveries;

(iii) Are current on neonatal resuscitation program training;

(iv) Have their credentials reviewed by the respiratory care leader annually; and

(v) Participate in annual simulation and respiratory skills verification, including low-volume, high-risk procedures consistent with the types of respiratory care provided in the neonatal care service.

(7) Anesthesia, including an anesthesiologist with the ability to:

(a) Respond to the bedside within one hour of request or identified need;

(b) Act as the primary responsible anesthesia provider for all infants; and

(c) Be physically present for all neonatal surgical procedures for which they serve as the primary responsible anesthesia provider; and

(8) Neonatal nutrition:

(a) Provide a specialized area or room, with limited access and away from the bedside, to

accommodate mixing of formula or additives to human milk;

(b) Develop standardized feeding protocols for the advancement of feedings based on the availability of, and family preference for human milk, donor human milk, fortification of human milk and formula; and

(c) Have policies and procedures in place for accurate verification and administration of human milk and formula, and to avoid misappropriation.

(L) Support services (on-call). On a twenty four hour basis, each provider will have the following services on-site, with staff necessary to provide the services on-call:

(1) Magnetic resonance imaging;

(2) Fluoroscopy: If fluoroscopy is not offered on-site at the facility, policies and procedures will be in place to facilitate transfer of an infant to a higher level of care;

(3) The ability to provide timely imaging interpretation by radiologists with pediatric expertise as requested;

(4) Personnel appropriately trained in ultrasonography, including cranial ultrasonography, to perform advanced imaging as requested;

(5) Echocardiography, including the ability to consult with a pediatric cardiologist for timely echocardiography interpretation as requested; and

(6) Biomedical engineering.

(M) Unit management: Each provider will have qualified individuals on-staff appropriate for the services provided, including:

(1) A board-certified obstetrician and a board-certified neonatologist as co-directors for the obstetric and neonatal care service. The co-directors will coordinate and integrate the following:

(a) A system for consultation;

(b) In-service education programs;

(c) Coordination and communication with support services and other obstetrical services;

(d) Defining and establishing, in collaboration with other members of the obstetric team, appropriate protocols and procedures for obstetric patients; and

(e) Treatment of patients in the neonatal intensive care unit who are not under the care of other physicians;

(2) A board-certified maternal-fetal medicine subspecialist to serve as director of the maternal-fetal medicine service;

(3) Obstetric nurse leader: A single, designated registered nurse with a bachelor's degree in nursing and a master's degree responsible for leading the organization and supervising the nursing services in the obstetrical service;

(4) Neonatal nurse leader: A single, designated registered nurse with a bachelor's degree in nursing and a master's degree, who has experience and expertise in neonatal nursing and conditions, responsible for leading the organization and supervising the nursing services of a level III neonatal care service, who will:

(a) Be responsible for inpatient activities in the neonatal care service and, as appropriate, obstetrical, well newborn, and/or pediatric units;

(b) Coordinate with respective neonatal, pediatric, and obstetric care services, as appropriate;

(c) Provide oversight of annual neonatal-specific education which includes low-volume, high-risk procedures consistent with the care provided in the level III neonatal care service;

(d) Foster collaborative relationships with multidisciplinary team members, facility leadership, and higher-level facilities to create a diverse, equitable, and inclusive environment to improve the quality of care and patient care outcomes; and

(e) If the neonatal nurse leader is involved with providing care to the neonatal patient, the neonatal nurse leader must be current on neonatal resuscitation.

(5) Neonatal nurse specialist: A registered nurse with bachelor's degree in nursing and a master's degree, who has current neonatal nursing certification and demonstrated expertise in neonatal care to:

(a) Foster continuous quality improvement in nursing care;

(b) Develop and educate staff to provide evidence-based nursing care;

(c) Be responsible for mentoring new staff and developing team building skills;

(d) Provide leadership to multidisciplinary teams;

(e) Facilitate case management of high-risk neonatal patients;

(f) Cultivate collaborative relationships with multidisciplinary team members and facility leadership to improve the quality of care and patient care outcomes;

(g) If the neonatal nurse specialist is involved with providing care to the neonatal patient, the neonatal nurse specialist must be current on neonatal resuscitation; and

(h) The roles and responsibilities of the nurse specialist can be allocated to multiple individuals or provided by a co-located hospital to perform this role.

(6) Nurse educator: A registered nurse with a bachelor's degree in nursing and a master's degree, who has sufficient time allocated to perform the roles and responsibilities of the role who is responsible for:

(a) Cultivating collaborative relationships with the obstetric nurse leader and the neonatal nurse leader and facility leadership to improve the quality of care and patient care outcomes;

(b) Evaluating the educational needs of the clinical staff, developing didactic and skill-based educational tools, overseeing education and skills verification, and evaluating retention of content, critical thinking skills, and competency relevant to obstetric and neonatal care services; and

(c) A registered nurse employed as a nurse educator as of October 1, 2024, who has not obtained a master's degree will have five years from that date to complete a master's degree program.

(7) A director of obstetric anesthesia services who is a board-eligible or board-certified anesthesiologist;

(8) A geneticist or genetics counselor who is certified by the American college of medical genetics or eligible for such certification to:

(a) Identify families at risk for genetic abnormalities;

(b) Obtain family genetic history;

(c) Provide genetic counseling in complicated cases; and

(d) If necessary, refer complicated cases to an on-staff medical geneticist.

(N) Specialists. Each provider will have medical, surgical, radiological and pathology specialists either on-site or on-call based on the medical needs of the patients.

(O) Sub-specialists. Each provider will have qualified sub-specialists available for consultation, and, if necessary, patient care either on-site or at a nearby closely related hospital or institution, appropriate for the services provided and based upon the medical needs of the patient, that may include:

(1) Medical-surgical:

(a) Maternal-fetal medicine;

(b) Critical care;

(c) General surgery;

(d) Infectious disease;

(e) Hematology;

(f) Cardiology;

(g) Nephrology; and

(h) Neurology;

(2) Pediatric:

(a) Hematology;

(b) Nephrology;

(c) Metabolic;

(d) Endocrinology;

(e) Gastroenterology;

(f) Nutrition;

(g) Immunology;

(h) Ophthalmology; and

(i) Pharmacology; and

(3) Pediatric surgical:

(a) Orthopedic surgeons;

(b) Urologic surgeons; and

(c) Otolaryngologic surgeons.

(P) Deliveries:

(1) For every anticipated low-risk delivery or uncomplicated delivery with higher-risk conditions, each provider will have an obstetrician, physician, or certified nurse midwife acting within their scope of practice and under a standard care arrangement with a collaborating physician, in attendance; or

(2) For an unanticipated high-risk delivery, every attempt will be made to secure a second physician, certified nurse practitioner acting within their scope of practice and under a standard care arrangement with a collaborating physician to care for the neonate, or a physician assistant acting within their scope of practice and under a supervisory agreement with a physician, to care for the neonate.

(Q) For every anticipated high-risk delivery, each provider will have in attendance:

(1) An obstetrician or physician;

(2) A second physician, certified nurse practitioner acting within their scope of practice and under a standard care arrangement with a collaborating physician to care for the neonate, or a physician assistant acting within their scope of practice and under a supervisory agreement with a physician, to

care for the neonate; and

(3) Members of the multi-disciplinary team set forth in paragraph (T) of this rule, one of whom can initiate resuscitation, and one of whom can complete full resuscitation. This can be the same individual.

(R) For every delivery with more complex maternal or fetal conditions, each provider will have in attendance:

(1) An obstetrician or maternal fetal medicine specialist capable of performing a cesarean section;

(2) A neonatologist or physician to attend to the neonate;

(3) A maternal-fetal medicine or fetal surgeon, as appropriate, during operative procedures; and

(4) Members of the multi-disciplinary team set forth in paragraph (T) of this rule, one of whom can initiate resuscitation, and one of whom can complete full resuscitation. This can be the same individual.

(S) Each provider will ensure every newborn requiring mechanical ventilation or continuous positive airway pressure has an initial evaluation by a physician, certified nurse practitioner, or physician assistant acting within their scope of practice. If stable, qualified staff with experience in newborn airway management and diagnosis and management of air leaks will be on-site to care for such newborns.

(T) Each provider will have on-duty, qualified staff appropriate for the services provided including at minimum:

(1) Registered nurse staffing, including:

(a) At least two registered nurses competent in obstetric and neonatal care for labor and delivery;

(b) A registered nurse with obstetric and neonatal experience for each patient in the second stage of

labor;

(c) A registered nurse to circulate for the cesarean section deliveries;

(d) Additional registered nurses with the appropriate education and demonstrated competence, commensurate with the acuity and volume of patients served, to provide direct supervision of newborns; and

(e) Additional registered nurses with the appropriate education and demonstrated competence, commensurate with the acuity and volume of patients served, to provide direct supervision of obstetric patients.

(2) At least one member of the nursing staff to attend to newborns when they are not with the mother or her designee; and

(3) A multi-disciplinary team, each of whom have successfully completed the neonatal resuscitation and can initiate resuscitation. One member of the multi-disciplinary team is obligated to be capable of completing full resuscitation.

(U) Other disciplines. Each provider will have:

(1) A master's prepared social worker. Individuals employed in this position on the effective date of these rules who do not meet the qualifications of this rule shall have five years from the effective date of this rule to come into compliance with the certification requirement. Additional social workers will be provided based upon the size and needs of the patient population. Social workers will:

(a) Provide assessments, family support services, and medical social work;

(b) Have a written description that clearly identifies the responsibilities and functions of the obstetric and neonatal care services social worker;

(c) Have social services available for each family with an infant in the neonatal care service as

needed.

(2) A licensed dietitian with knowledge of maternal and newborn nutrition and knowledge of parenteral/enteral nutrition management of at-risk newborns who will:

(a) Collaborate with the medical team to establish feeding protocols, develop patient-specific feeding plans, and help determine nutritional needs at discharge;

(b) Establish policies and procedures to verify proper preparation and storage of human milk and formula;

(c) Participate in multidisciplinary care, including participation in patient care rounds; and

(d) Ensure that policies and procedures are in place for dietary consultation for infants in the neonatal care service; and

(3) Personnel with the knowledge and skills to support lactation including:

(a) A certified lactation consultant, as defined in rule 3701-22-01 of the Administrative Code, available for on-site consultation on weekdays and certified lactation consultant services will be accessible by telehealth or telephone twenty-four hours a day, seven days a week. After-hours and weekend consultation can be provided by free services available to healthcare providers and their patients through other avenues such as a hotline. Individuals employed in this position on the effective date of these rules who do not meet the qualifications of this rule shall have five years from the effective date of this rule to come into compliance with the certification requirement;

(b) Lactation support may be provided under the direction of the certified lactation consultant by lactation counselor/education staff or registered nurse staff educated and trained on how to provide lactation support to the mother; and

(c) The provider will ensure that certified lactation consultant staff maintain continuing education and certification requirements, as applicable, and ensure adequately trained lactation coverage is available based on the specific need and volume of the neonatal population served.

(V) If the provider utilizes licensed practical nurses (LPNs) or nonlicensed direct care providers to support the clinical nursing staff, the facility will:

(1) Have written criteria that define the LPN's or nonlicensed direct care provider's scope of obstetric and neonatal care;

(2) Provide annual education specific to the care of the obstetric and neonatal population served; and

(3) Have a written staffing plan that establishes collaborative work assignments in accordance with the facility's policies and procedures.

(W) If the provider utilizes physician assistants (PA):

(1) Physician supervision for the PA will be provided by:

(a) A neonatologist or a board certified pediatrician when the PA is providing care to a neonate; or

(b) An obstetrician or maternal-fetal medicine physician when the PA is providing care to the obstetric patient.

(2) The PA will have appropriate education and demonstrated competence, commensurate with the acuity and volume of patients served, to provide direct supervision of newborns and/or obstetric patients;

(3) The PA is responsible for maintaining clinical expertise and knowledge of current therapy by participating in continuing medical education and scholarly activities;

(4) The PA will maintain national certification, including one hundred hours of continuing medical education every two years and a recertification exam given by the "National Commission on Certification of Physician Assistants" every ten years;

(5) The level III service will maintain written criteria that define the PA's scope of obstetric or

neonatal care; and

(6) If the PA is involved with providing care to the neonatal patient, the PA must be current on neonatal resuscitation.