

**2007 AMENDMENTS TO THE
UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT**

Approved by the National Conference of Commissioners on Uniform State Laws
at its 2007 Annual Meeting in Pasadena, California

UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT

Prefatory Note

A primary purpose of this act is to establish a robust and redundant system to quickly and efficiently facilitate the deployment and use of licensed practitioners to provide health and veterinary services in response to declared ~~incidents of disasters and emergencies~~. ~~This~~ The act (1) establishes a system for the use of volunteer health practitioners capable of functioning autonomously even when routine methods of communication are disrupted; (2) provides reasonable safeguards to assure that volunteer health practitioners are appropriately licensed and regulated to protect the public's health; ~~and;~~ (3) allows states to regulate, direct, and restrict the scope and extent of services provided by volunteer health practitioners to promote disaster recovery operations; (4) provides limitations on the exposure of volunteer health practitioners to civil liability to create a legal environment conducive to volunteerism; and (5) allows volunteer health practitioners who suffer injury or death while providing services pursuant to this act the option to elect workers' compensation benefits from the host state if such coverage is not otherwise available.

The act was drafted in an expedited manner in the months immediately following the Gulf Coast Hurricanes of 2005 to remedy significant deficiencies in interstate and intrastate procedures used to authorize and regulate the deployment of public and private sector health practitioners to supplement the resources provided by state and local government employees and other first-responders. ~~Issues pertaining to civil liability and workers' compensation protections for volunteer health practitioners have been reserved for future consideration at the 2007 Annual Meeting of the National Conference of Commissioners on Uniform State Laws.~~ With the exception of Sections 11 and 12, which pertain to civil liability and workers' compensation protections for volunteer health practitioners, the act was approved in 2006. Sections 11 and 12 were approved in 2007.

Prior to Hurricanes Katrina and Rita, which in 2005 struck within a few short weeks of each other in Alabama, Florida, Louisiana, Mississippi, and Texas, many states had enacted emergency management laws to allow for emergency waiver or modifications of licensure standards to facilitate the interstate use of licensed health practitioners. Within the public sector, 49 of 50 states had also ratified the provisions of the Emergency Management Assistance Compact ("EMAC") which allowed for the deployment of licensed health practitioners employed by state and local governments to other jurisdictions to provide emergency services without having to be licensed in the affected jurisdictions. Today, all states have ratified EMAC.

The federal government supplemented these provisions of state law by allowing licensed

health practitioners it employs on a permanent or temporary basis to respond to disasters and emergencies without compliance with state professional licensing requirements in the locations where their services are utilized. (10 U.S.C. 1094(d)(1)). Pursuant to federal law, two systems had also been established to facilitate the use of private sector health practitioners in response to emergencies, especially those mobilized ~~by this nation's extraordinary array of~~ charitable non-governmental organizations active in disasters. As authorized by § 2801 of the Public Health Services Act, 42 U.S.C. § 300hh, local Medical Reserve Corps in hundreds of locations throughout the nation are able to recruit, train and promote the deployment of health practitioners in response to emergencies. Funding was also provided under § 319I of the Public Health Services Act, 42 U.S.C. § 247d-7b, to state governments by the ~~Health Resources and Services Administration (HRSA)~~ Department of Health and Human Services (DHHS) to establish Emergency Systems for Advance Registration of Volunteer Health ~~Practitioners~~ Professionals (generally referred to as the "ESAR-VHP Programs"). Through these systems, volunteer health practitioners are recruited and registered in advance at the state level to respond to emergencies or disasters in their state of registration or across the nation. Participation in a local Medical Reserve Corps or registration with a state ESAR-VHP Program, however, does not result in the interstate recognition of licenses issued to volunteer health practitioners or provide other significant legal benefits in all jurisdictions.

When the Gulf Coast Hurricanes struck during 2005, the deficiencies in federal and state programs to facilitate the interstate use of volunteer health practitioners not employed by state or federal agencies became evident. ~~Despite the clear recognition in~~ While federal and state law ~~and interstate compacts that the interstate recognition of licenses issued to~~ recognized the need for interstate licensure reciprocity to fully utilize volunteer health practitioners was critical to ~~emergency response efforts,~~ no uniform and well-understood system existed to effectively link the various public and private sector programs ~~together effectively and to make.~~ Many health practitioners were not available to the large array of non-governmental organizations essential to all disaster relief organizations. For example, while most states issued emergency executive orders or proclamations allowing health practitioners licensed in other states to be used within their boundaries to provide emergency services, each state proceeded somewhat differently to establish and implement these programs. ~~Amid the Hurricanes Katrina and Rita, for example, caused a severe breakdown of routine communications and the chaos caused by the hurricanes, this lack of coordination, resulting in an uncoordinated and ineffective response effort.~~ Moreover, the absence of information regarding the operation of state emergency declarations generated confusion and uncertainty that significantly delayed the deployment of many volunteer health practitioners ~~and seriously limited,~~ thereby limiting the extent to which many others were able to provide valuable needed services. Significant concerns regarding exposure to civil liability and the availability of workers' compensation ~~protections protection~~ also delayed and impeded the recruitment, deployment, and use of volunteers in many critical areas ~~and resulted, resulting~~ in limitations upon the scope of services provided by a substantial number of volunteers, especially physicians and nurses providing services in emergency shelters.

An electronic report posted to the website of the Metropolitan Medical Response System program, part of the federal Department of Homeland Security (DHS), summarizes the types of issues that arose:

Volunteer physicians are pouring in to care for the sick, but red tape is keeping hundreds of others from caring for Hurricane Katrina survivors. The North Carolina mobile hospital waiting to help ... offered impressive state-of-the-art medical care. It was developed with millions of tax dollars through the Office of Homeland Security after 9-11. With capacity for 113 beds, it is designed to handle disasters and mass casualties. It travels in a convoy that includes two 53-foot trailers, which on Sunday afternoon was parked on a gravel lot 70 miles north of New Orleans because Louisiana officials for several days would not let them deploy to the flooded city. 'We have tried so hard to do the right thing. It took us 30 hours to get here,' said one of the frustrated surgeons. That government officials can't straighten out the mess and get them assigned to a relief effort now that they're just a few miles away 'is just mind-boggling,' he said.

This doctor's concerns were echoed by a director of the Northwest Medical Teams, a Seattle based group of volunteer medical personnel ~~who expressed frustration when the deployment of the organization's resources was delayed for several critical, whose resources could not be deployed for several days following Hurricane Katrina because its members could not confirm that their professional licenses would be recognized. These of uncertainty in licensure recognition.~~ The concerns were ~~echoed-reiterated~~ by the Director of Emergency Services in New Orleans, who reported that, "We needed doctors...[and] [i]t was pandemonium in the area." (*State Laws Become Roadblock to Medical Response in Crisis Services to New Orleans*, San Francisco Chronicle, September 2, 2006.)

Rather than treating the injured, sick, and infirm, some qualified physicians, nurses, and other licensed health practitioners ~~found themselves: (1) waiting-waited~~ in long lines in often futile attempts to navigate through a semi-functioning bureaucracy; ~~or (2) providing-provided~~ other forms of assistance, such as general labor, which failed to utilize their desperately needed health skills; ~~or (3) chose not to volunteer at all because of concerns over liability.~~ Others proceeded to treat victims at the risk of violating existing state statutes and potentially facing criminal or administrative penalties or civil liability. Out-of-state practitioners providing medical treatment also faced the real possibility of noncoverage under their medical malpractice policies. These impediments became especially problematic in the aftermath of Hurricane Katrina when, according to the Council of State Governments (CSG), the most pressing need immediately after the storm was the availability of medical volunteers. As reported by a representative of the Louisiana Department of Health and Hospitals:

"The main thing we worked on was allowing out-of-state medical professionals who wanted to volunteer and come help, to waive the requirement of having them licensed in our state if they could show they were validly licensed in the state that they were coming from... We had to keep renewing that executive order because we had so much need for help." (CSG Quarterly, Winter 2006).

Current systems are not sufficient to integrate public health and medical personnel. The Association of State and Territorial Health Officials (ASTHO) reported that the lack of national standards for the deployment and use of public health and medical emergency response personnel complicates the use of volunteer health practitioners for both requesting and deploying

states. *State Mobilization of Health Personnel During the 2005 Hurricanes* 1 (ASTHO, July 2006).

To respond to the lack of an effective system to facilitate the interstate deployment of health practitioners after the Gulf Coast Hurricanes Katrina and Rita made landfall of 2005, a number of different organizations quickly developed and implemented systems to promote the deployment of volunteer health practitioners. These efforts included actions taken by the Federation of State Medical Licensing Boards, the National Council of State Boards of Nursing, the Association of State and Provincial Psychology Licensing Boards, the American Medical Association, the American Nurses Association, the American Psychology Association, the National Association of Social Workers, the American Counseling Association, the National Association of Chain Drug Stores, and the American Veterinary Medicine Association. The American Red Cross was also able to effectively utilize its Disaster Human Resources System that had been previously established to create a network of volunteers available to respond to disasters, including nurses and mental health workers whose licensure status was reviewed and evaluated by the Red Cross prior to their deployment. Notwithstanding the efforts of these groups and organizations, the legal status of many health practitioners remained unclear. Many practitioners and organizations also felt compelled to limit the scope of the services they provided because of concerns about professional licensing sanctions and civil liability.

After the more immediate response efforts associated with Hurricanes Katrina and Rita were complete, the National Conference of Commissioners on Uniform State Laws appointed a Study Committee which convened a meeting in February 2006 (hosted by the American Red Cross) to determine if the development of a uniform state law could help remedy these problems. ~~Participants in the February 2006 meeting~~ included most of the national groups and organizations who helped deploy health practitioners during the disaster, as well as representatives of the National Emergency Management Association, the National Governors' Association, the Association of State and Territorial Health Officials, the American Public Health Association, the Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities, and various sections and committees of the American Bar Association. At the meeting, a unanimous consensus emerged that the National Conference should appoint a Drafting Committee and present proposals for consideration at its 2006 Annual Meeting.

Subsequently, a Drafting Committee was appointed by the ~~National~~ Conference which, after two Drafting Committee ~~Meetings~~ meetings and multiple telephone conferences and informal consultations with its advisors, presented its recommendations to the 2006 Annual Meeting of the Conference. After extensive debate and further revisions to the Committee's recommendations, the Conference waived its usual practice of requiring the consideration of uniform laws at two or more Annual Meetings and approved ~~this the~~ the act, other than Sections 11 and 12, on July 13, 2006. In August 2006, the American Bar Association's House of Delegates added this the act to its agenda for expedited consideration and, after discussion, unanimously endorsed the proposed law after discussion it. Provisions were added to the act dealing with issues of civil liability and workers' compensation by the Conference in 2007.

While the magnitude of the emergency presented by Hurricanes Katrina and Rita exceeded the scope of disasters experienced in this country for many decades, foreseeable

emerging events pose similar threats. Future storms (especially in ~~the New York City and New England area~~ heavily-populated areas); major earthquakes in San Francisco, Los Angeles or other heavily urbanized areas; volcanic eruptions in the Pacific Northwest; tidal waves on the east and west coasts; incidents of terrorism involving weapons of mass destruction, including nuclear, biological and chemical agents; and ~~flu or other pandemics~~ pandemic influenza may overwhelm the resources of local disaster health delivery systems. To help meet patient surge capacity and protect the public's health, reliance on private sector health practitioners and nongovernmental relief organizations ~~may~~ will be needed. This act seeks to remedy defects in current state ~~response systems needed~~ laws to effectively utilize private sector volunteers to meet these needs.

In ~~the development of~~ developing this act, the Drafting Committee and its many advisors sought to pursue the following major policy objectives:

- ~~This~~ The act seeks to make volunteer health practitioners available for deployment in response to emergency declarations as quickly as possible without the necessity for affirmative actions on the part of host states, while still allowing host states to act when necessary to limit, restrict and regulate the use of volunteer health practitioners within their boundaries.
- To protect the public health and safety, ~~this~~ the act requires that, prior to deployment, volunteers must be registered with public or private systems capable of determining that they have been properly licensed and are in good standing with their principal jurisdiction of practice and of communicating this information to host ~~states~~ states' governments and entities ~~in host states using~~ utilizing the services of volunteers. The use of registration systems is intended to (1) discourage the uncoordinated use of "spontaneous volunteers" who may independently travel to the scene of a disaster without the support of public or private emergency response agencies, and ~~to~~ (2) promote the recruitment and training of volunteers in advance of emergency declarations, while also allowing and facilitating additional registrations at the time of an emergency.
- ~~This~~ The act is intended to allow volunteers to register with systems located throughout the country, rather than requiring registration in each affected host state, and to accommodate and facilitate the use of the multiple different types of registration systems that ~~have~~ continue to be developed and are being expanded by public and private agencies, ~~especially those systems that provided critical services in response to the Gulf Coast Hurricanes of 2005~~. Registration systems may be established, however, only by governmental agencies or by private organizations that operate on a national or regional basis in affiliation with disaster relief or healthcare organizations that have demonstrated their ability to responsibly recruit, train and promote the deployment of volunteer health practitioners.
- To alleviate confusion and uncertainty regarding the types of services that may be provided by volunteer health practitioners, ~~this~~ the act requires volunteers to limit their practice to activities for which they are licensed ~~and~~ properly trained, and qualified and to perform. Further, volunteer health practitioners must conform to scope-of-practice authorizations and restrictions imposed by the laws of host states, disaster response

agencies and organizations, and host entities. Coextensively, host states can modify the activities of practitioners as necessary to respond to emergency conditions.

- To properly regulate the activities of volunteer health practitioners, ~~this the~~ act vests authority over out-of-state volunteers in the licensing boards and agencies of host jurisdictions, while also requiring the reporting of unprofessional conduct by host states to licensing jurisdictions ~~and, thereby~~ confirming the ability of licensing jurisdictions to impose sanctions upon professionals for unprofessional conduct that occurs outside of their boundaries. Licensing boards and agencies are required, however, to consider the unique exigent circumstances often created by emergencies and to recognize the limitations upon the communications that may occur which may result in incomplete knowledge regarding any limitations upon the activities of volunteer practitioners.
- Finally, ~~this the~~ act is not intended to supplant state emergency management laws or to establish new systems for the coordination and delivery of emergency response services. Instead, host entities using volunteer health practitioners are required to coordinate their activities with local agencies to the extent and in the manner otherwise required by state law.

In addition to assisting states in utilizing volunteers, the act addresses two additional important topics: (1) whether and to what extent volunteer health practitioners and entities deploying, registering, and using them are responsible for civil claims based on a practitioner's act or omission in providing health or veterinary services (Section 11); and (2) whether and to what extent volunteer health practitioners should receive workers' compensation benefits in the event of injury or death while providing such services (Section 12).

The risk of exposure to liability for malpractice and the availability of workers' compensation benefits are matters of significant concern to all volunteer health practitioners. These issues, however, are particularly important to practitioners providing health or veterinary services amidst the challenging and sub-optimal conditions that exist during emergencies. During emergencies, practitioners often must provide services without access to the resources customarily available to them. They may also have to practice outside their usual fields of expertise and be unable to take all actions reasonably necessary to treat individual patients because of the greater public health need to allocate scarce health care resources efficiently, thereby reducing overall rates of morbidity and mortality.

Practitioners also face greater risks of physical and psychological injuries and death when providing services in emergency settings. In these circumstances, uncertainty regarding interstate variations in expected standards of care, limits of liability, and the availability of workers' compensation coverage may deter qualified practitioners from participating in emergency responses. Even if practitioners are willing to serve, the entities that deploy and use them may be inhibited in doing so by their own liability concerns. The American Red Cross deploys thousands of volunteers each year in response to natural disasters and other public health emergencies. In its pandemic flu planning guidance, the Red Cross reported that, "We are not able to commit Red Cross volunteers to local public health overflow facilities without appropriate worker protections, including *liability coverage and workers safety measures*." (emphasis added). American Red Cross. Pandemic Influenza Planning Guidance: Update on

Worker Safety; Additional Mass Care Planning Tools (2007). Following Hurricanes Katrina and Rita, the Medical Reserve Corps reported that health professionals deployed to Red Cross shelters were unable to provide more than basic health services to shelter residents because of liability concerns. Medical Reserve Corps Response to the 2005 Hurricanes; Final Report, March 13, 2006; 18.

Many existing laws at the federal and state levels recognize the need to provide some civil liability protections or workers' compensation benefits for volunteers. All 50 states have now entered into the Emergency Management Assistance Compact (EMAC), which provides immunity from negligence-based liability claims to state and certain local government employees deployed by one state to another in response to disasters and emergencies. All states have also enacted an array of "Good Samaritan" laws to protect spontaneous volunteers at the scenes of local emergencies. Many states have also granted immunities to other individuals engaged in disaster relief and civil defense activities, and a significant number of states have extended immunities to groups and organizations providing charitable, emergency or disaster relief services.¹ Unfortunately, the applicability of these laws to volunteer health practitioners as defined by the UEVHPA is often unclear, leading to a confusing patchwork of legal protections in limited settings. Hodge, JG, Gable, LA, Calves, S. Volunteer health professionals and emergencies: Assessing and transforming the legal environment. *Biosecurity and Bioterrorism* 2005; 3:3: 216-223.

In determining whether and how best to provide protection from civil liability claims, states must balance and weigh important and competing, legitimate interests. Volunteer health practitioners and the entities that deploy and use them consistently report a need for a legal regime that enables them to provide services during emergencies without excessive concerns over liability. At the same time, persons receiving health services have an expectation of

¹ Many states have extended immunities to groups and organizations providing charitable, emergency or disaster relief services. See e.g., Ala. Code § 6-5-332f (entities engaged in mine rescue operations, persons providing emergency medical care to victims of cardiac arrest, and architectural firms participating in emergency response activities); Del. Code Ann. tit. 10, § 3129 (entities engaged in disaster relief operations pursuant to a government contract); Ga. Code Ann. § 51-1-29.1 (health care providers voluntarily providing services without compensation); Idaho Code Ann. § 46-1017 (entities engaged in civil defense or disaster or emergency relief operations pursuant to a government contract); Iowa Code §135.147 (enacted May 11, 2007) (entities providing emergency care to disaster victims at the request or under orders from emergency management agencies); Kan. Stat. Ann. § 60-42.01 (architectural firms); La. Rev. Stat. Ann. § 9:2793.3 -.7 (designated charitable organizations gratuitously rendering disaster relief services); N.C. Gen. Stat. § 90-21.11, 21.14 and 21.16 (uncompensated volunteer healthcare providers); N.J. Stat. Ann. § 2A:53A-7 (charitable, religious and educational non-profit organizations); 35 Pa. Cons. Stat. §§ 7019, 7021.9, 7704, 42 Pa. Cons. Stat. § 8336 (telephone companies providing emergency notifications, entities under government contracts to provide emergency relief services or who allow the use of real property without compensation for emergency response activities, persons providing uncompensated hazardous materials emergency response services); R.I. Gen. Laws §§ 5-1-16, 5-8-25, 5-51-18, 23-4.1-12, 23-17.6-5, 23-28.20-12 (architectural and engineer firms voluntarily rendering services during disasters, organizations providing emergency medical services, and entities providing uncompensated voluntary services in response to emergencies involving liquefied petroleum gas); Tex. Civ. Prac. & Rem. Code Ann. §§ 74.151, 78.053, 79.002, 79.003 (entities providing uncompensated medical care, volunteer fire departments, and entities providing uncompensated hazardous materials response or disaster relief services); Vt. Stat. Ann., tit. 20, § 20 (entities involved in emergency management activities; and Va. Code Ann. §§ 8.02-225(E), 8.01-255.01(B), 44.126-23 (health care providers administering vaccines, entities credentialing healthcare providers for emergencies, and private agencies engaged in providing emergency services).

reasonable compensation for harms resulting from negligence. Hodge, J.G., Pepe, R.P., Henning, W.H. Voluntarism in the wake of hurricane Katrina: The Uniform Emergency Volunteer Health Practitioners Act. Disaster Medicine and Public Health Preparedness 2007; 1:1: 44-50. Some victims' advocates, while acknowledging the benefits associated with the degree of civil liability relief provided by the federal Volunteer Protection Act, also express the strong belief that volunteers will respond to emergencies regardless of whether additional civil liability protections are provided, that very few claims are asserted against volunteer health practitioners and disaster relief organizations, and that it would be unfair and unreasonable to deprive individuals harmed by negligent acts of access to compensation because of what the advocates consider undocumented allegations about the impact of liability concerns upon relief operations.

After extensive consultation, fact-finding, and discussion, NCCUSL determined that empirical data are generally unavailable upon which to make firm judgments regarding (1) the actual impact of liability concerns upon rates of volunteerism; and (2) whether and to what extent volunteer health practitioners have actually been subject to liability claims. The Conference also determined that such information is unlikely to be generated in any useful and reliable form in the foreseeable future. Nonetheless, because of the widely held consensus that these issues are of vital public importance, the Conference determined that the UEVHPA should clarify the extent to which volunteer health practitioners and the entities engaged in deploying, registering, and using them will be exposed to civil liability. While the Conference concluded that the fundamental policy decision regarding the level of protection to be provided should be left to the states, it also concluded that the failure to include provisions clearly defining the scope of liability exposure would create a significant risk that many highly skilled practitioners with the expertise most needed in effective relief operations would be deterred from volunteering in emergencies. Moreover, such deterrence would create a significant risk that adequate health services needed to reduce morbidity and mortality within affected populations would not be available.

This act provides for some level of liability protection under two alternative sets of rules. Alternative A to Section 11 provides protection to practitioners based upon their negligent acts or omissions in providing health or veterinary services pursuant to the act and also insulates the entities that deploy and use them from vicarious liability for those acts or omissions. Alternative A is based upon the rationale that private sector volunteer health practitioners and entities providing vital health or veterinary services during emergencies deserve the same protections and privileges as states and public employees whose resources and efforts they supplement and complement. Nongovernmental volunteer health practitioners undertake essentially the same risks and provide the same services as their governmental counterparts.

Alternative B clarifies that the protections provided to uncompensated volunteers by the federal Volunteer Protection Act, 42 U.S.C. § 14501 *et seq.*, extend to uncompensated volunteer health practitioners under the UEVHPA. This alternative does not address the issue of vicarious liability of entities, leaving the matter to existing state law.

For each alternative, specific actions of volunteers are excluded from liability protections, including intentional torts, willful misconduct, or wanton, grossly negligent, reckless, or criminal conduct. In addition, each alternative provides some liability protection for persons that operate,

use, or rely upon information provided by a volunteer health practitioner registration system.

In providing a set of alternatives for States to determine the extent to which volunteer practitioners and entities deploying and using them will be exposed to and immune from civil liability, it is NCCUSL's expectation that, over time, the comparative experiences of states adopting different alternatives will result in a more solid base of reliable data upon which more definitive policy recommendations may be developed. However, it is worthy to note that the proposed alternatives in Section 11 are based on existing approaches taken by numerous states or federal policymakers concerning the extension of liability protections to volunteers.

Concerning workers' compensation benefits, after similar consultation, fact-finding, and discussion, the Conference concluded that, as a last resort, some level of benefits should be provided to volunteer health practitioners by the state benefiting from their services. Thus, Section 12 provides that a volunteer health practitioner who provides health or veterinary services pursuant to the act and who is not otherwise entitled to workers' compensation or similar benefits under the laws of any state, including the host state, should be entitled to elect the same workers' compensation or similar benefits as employees of the host state. This includes medical benefits for physical or mental injury and benefits for loss of earnings, provided these benefits would be available to an ordinary employee of the host state.

Under current law, many workers' compensation systems do not cover the activities of volunteers, either because they are not defined as "employees" or because they are acting outside the scope of their employment when volunteering. Although volunteer health practitioners are not employees of the host state in the traditional sense, it is appropriate to extend benefits to them because they are exposed to many of the same risks of harm as ordinary employees of the host state who are providing health or veterinary services during an emergency in the course and scope of their employment.

Most states have statutorily extended workers' compensation coverage to emergency volunteers, principally through emergency, disaster, or public health emergency laws. Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) – Legal and Regulatory Issues, Presentation prepared by the *Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities* for the Department of Health and Human Services. Unfortunately, who may constitute a "volunteer" varies from state to state, and may not include private sector volunteer health practitioners. Coverage may be further limited to volunteers responding solely at the bequest of a state or local government, volunteers working under the close direction of state or local governments, or volunteers who satisfy an array of local registration and certification requirements. As a result, the actual availability of workers' compensation coverage for volunteer health practitioners as defined in the UEVHPA under current law is highly uncertain. Section 12 of this act addresses this lack of uniformity by recommending that all volunteer health practitioners have the protection that host states provide their employees when such benefits are not otherwise available to the practitioners through other workers' compensation plans or protections.

A version of this act with detailed reference notes ("*Annotated UEVHPA*") is available at www.uevhpa.org.

UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT

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SECTION 5. VOLUNTEER HEALTH PRACTITIONER REGISTRATION SYSTEMS.

(a) To qualify as a volunteer health practitioner registration system, a system must:

(1) accept applications for the registration of volunteer health practitioners before or during an emergency;

(2) include information about the licensure and good standing of health practitioners which is accessible by authorized persons;

(3) be capable of confirming the accuracy of information concerning whether a health practitioner is licensed and in good standing before health services or veterinary services are provided under this [act]; and

(4) meet one of the following conditions:

(A) be an emergency system for advance registration of volunteer health-care practitioners established by a state and funded through the ~~Health Resources Services Administration~~ Department of Health and Human Services under Section 319I of the Public Health Services Act, 42 USC Section 247d-7b [as amended];

(B) be a local unit consisting of trained and equipped emergency response, public health, and medical personnel formed pursuant to Section 2801 of the Public Health Services Act, 42 U.S.C. Section 300hh [as amended];

(C) be operated by a:

(i) disaster relief organization;

(ii) licensing board;

(iii) national or regional association of licensing boards or health practitioners;

(iv) health facility that provides comprehensive inpatient and outpatient health-care services, including a tertiary care and teaching hospital; or

(v) governmental entity; or

(D) be designated by [name of appropriate agency or agencies] as a registration system for purposes of this [act].

(b) While an emergency declaration is in effect, [name of appropriate agency or agencies], a person authorized to act on behalf of [name of governmental agency or agencies], or a host entity, may confirm whether volunteer health practitioners utilized in this state are registered with a registration system that complies with subsection (a). Confirmation is limited to obtaining identities of the practitioners from the system and determining whether the system indicates that the practitioners are licensed and in good standing.

(c) Upon request of a person in this state authorized under subsection (b), or a similarly authorized person in another state, a registration system located in this state shall notify the person of the identities of volunteer health practitioners and whether the practitioners are licensed and in good standing.

(d) A host entity is not required to use the services of a volunteer health practitioner even if the practitioner is registered with a registration system that indicates that the practitioner is licensed and in good standing.

Legislative Note: *If this state uses a term other than “hospital” to describe a facility with similar functions, such as an “acute care facility”, the final phrase of subsection ~~(b)(4)~~ (a)(4)(C)(iv) should include a reference to this type of facility – for example, “including a tertiary care, teaching hospital, or acute care facility.”*

Comment

Section 5 authorizes the use of each of the various types of registration systems found to be effective in responding to the Gulf Coast Hurricanes of 2005. These systems include not only federally sponsored local Medical Reserve Corps, ESAR-VHP systems, and other systems expressly created under federal or state laws, but also registration systems established by disaster relief organizations, such as Disaster Human Resources System of the American Red Cross; systems established by associations of the state licensing boards, such as the Federation of State Medical Licensing Boards, the National Council of State Boards of Nursing and the Association of State and Provincial Psychology Licensing Boards; systems established by national associations of health professions, including the American Medical Association, the American Nurses Association, the American Psychology Association, the National Association of Social Workers, the American Counseling Association, the National Association of Chain Drug Stores, and the American Veterinary Medicine Association; and systems established by major tertiary care hospital systems. This act allows each of these various types of organizations to establish and operate registration systems without explicit governmental approval because they have demonstrated the resources, competence and reliability to review and communicate information regarding the professional qualifications of health practitioners. In addition, the act recognizes registration systems operated by state governments or by any other organization granted approval to establish a registration system by any state.

This act does not require or authorize a state to designate or approve registration systems. The experience of the multiple entities that successfully recruited and verified the credentials following the Gulf Coast Hurricanes of 2005 showed that such a requirement is unnecessary and inefficient in deploying and utilizing volunteer health practitioners. Instead, this act empowers and legitimizes the operations of numerous types of public and nongovernmental organizations that have consistently demonstrated their ability to properly recruit, train, deploy and verify the credentials of volunteer health practitioners.

This act designates three core responsibilities of registration systems. Each system must (1) facilitate the registration of volunteer health practitioners *prior* to, or during, the time their services may be needed; (2) maintain organized information about the volunteers that is accessible by authorized personnel; and (3) be capable of being used to verify the accuracy of information concerning whether the volunteers are licensed and in good standing. While registration systems may also perform other types of functions, such as recruiting and training volunteers or coordinating their deployment with states and disaster relief organizations, they are not required to do so to maintain as much flexibility as possible to authorize the operations of diverse types of registration systems able to deliver different types of resources that may be needed in response to emergencies. Similarly, this act does not prohibit or prevent registration systems from establishing additional registration requirements beyond the minimum requirements in subsection (a). For example, this act would not prevent a registration system from requiring specialized training for all individuals registered with a particular system or requiring the affiliation of registrants with one or more public or private disaster relief organizations. Likewise, this act does not require a particular registration system to accept all types of health care practitioners or from exercising its own discretion regarding whether to accept the registration of a particular practitioner.

Under subsection (a)(1), the requirement to facilitate registration prior to, or during, the time services are needed is necessary to (1) discourage the deployment of non-registered “spontaneous volunteers” at the time of a disaster, (2) encourage practitioners to register in advance of emergencies, and (3) give practitioners, if the system so provides, the opportunity to obtain specialized training appropriate to the provision of health or veterinary services in emergencies. This allows volunteers to integrate themselves into the existing response efforts and enables the managing agency to efficiently deploy forces to the appropriate affected areas.

In Oklahoma, shelters were set up to receive up to 5,000 evacuees from areas impacted by Hurricane Katrina in 2005. The Oklahoma State Department of Health, however, did not have the manpower to fully staff these shelters. To meet surge capacity, members of the state’s MRC units were contacted through the state-managed database, issued state identification, and deployed in a single day. *State Mobilization of Health Personnel During the 2005 Hurricanes* 6 (ASTHO, July 2006). Moreover, the state utilized the MRC website to process over 3,000 calls from potential volunteers and track volunteers that had been deployed. This led to their effective utilization. Other examples underscore the vital roles that such organizations play in emergency response efforts.

The National Medical Reserve Corps office reported that one important factor that contributed to its success in response to Hurricane Katrina was that its “teams of volunteers were identified, credentialed, trained, and prepared in advance of the emergency.” *Medical Reserve Corps Hurricane Response Final Report 2* (March 13, 2006). The American Medical Association (AMA) collaborated with Dr. David J. Brailer, National Coordination for Health Information Technology, to expand KatrinaHealth.org, an electronic database of prescription medical records through which authorized pharmacists and physicians can access records of medications evacuees were using before the storm hit, including specific dosages. A report that summarized the implementation challenges in utilizing KatrinaHealth included variations across states and between institutions which can “create havoc when disasters, evacuees, and volunteer providers cross jurisdictional boundaries.” *Lessons from KatrinaHealth* 19 (June 13, 2006). Few mechanisms existed to coordinate the large number of health practitioners willing to volunteer. In Dallas, emergency medical providers ultimately created “a new care network on the fly;” in Houston, they used the medical school’s existing open-source courseware to post messages and exchange information. *Lessons from KatrinaHealth* 20 (June 13, 2006). Despite the publicized numbers of registered federal volunteers, a doctor who worked in three different shelters and makeshift clinics in Mississippi for a total of thirty-four days reported that “these measures did not solve the coordination issues on the ground.” *Lessons from KatrinaHealth* 21 (June 13, 2006).

The National Association of County and City Health Officials (NACCHO) examined the response of five local health departments that assisted evacuees fleeing the Gulf coast in the wake of Hurricane Katrina. Although there were ample volunteers to assist in the recovery efforts, NACCHO observed that their contributions were not sufficiently planned and coordinated. “[P]rior and just-in-time training, assessment of knowledge and skills, and systematic assignments all must improve.” *Shelter from the Storm: Local Public Health Faces Katrina* 22 (NACCHO, February 2006). NACCHO further noted that “a greater national

calamity, such as a smallpox outbreak, would require human resources beyond what public health professionals could deliver on their own.” *Shelter from the Storm: Local Public Health Faces Katrina* 22 (NACCHO, February 2006).

Spontaneous volunteers have, on occasion, stymied emergency response efforts and added to the existing burden facing health practitioners in charge of overseeing a specific disaster site. ~~HRSA~~ DHHS noted that after the attacks on September 11, 2001, thousands of spontaneous volunteers presented themselves at ground zero in New York City to provide medical assistance. In most cases, however, authorities were unable to distinguish qualified personnel from those that were not qualified. See *ESAR-VHP Interim Technical and Policy Guidelines, Standards, and Definitions* Section 1.2 (HRSA, June 2005). The unsolicited presentation of volunteers coupled with the lack of a coordinated mechanism to integrate their services reduced the effectiveness of the overall response effort. A former Director of New York’s Emergency Management Office, observed that “[V]olunteers just show[ed] up ... To accommodate them we had to set up another city. We had to feed them and take care of sanitation and other things. But we just couldn’t use them.” *Id.* Prior registration enables agencies to request, receive, and deploy the necessary volunteer personnel to wherever their services are required and integrate themselves into the ongoing response efforts.

This Act does not, however, mandate prior registration in recognition of the possibility that large scale disasters may create needs for more practitioners than those who register in advance. This is evident from response efforts for Hurricane Andrew in 1993 and the four storms during the hurricane season that struck Florida in 2004. In neither situation were response efforts completely sufficient to alleviate public health and individual health concerns. The large scale mortality and morbidity caused by Hurricane Katrina further demonstrated that what may be perceived as adequate preparation cannot compensate for unforeseeable circumstances. *Katrina as Prelude: Preparing for and Responding to Future Katrina-Class Disturbances in the United States*, p.5, Testimony before the U.S. Senate Homeland Security and Governmental Affairs Committee submitted by Herman B. Leonard and Arnold M. Howitt (March 8, 2006). Therefore, a registration system must be able to allow volunteers to register during an emergency, as well as prior thereto.

ESAR-VHP is listed in subsection (a)(4)(A) as an example of a registration system that provides organized information to ensure an accurate assessment of a volunteer health practitioner’s ability to provide health services during an emergency. These systems have arisen from a federal grant program authorized by Section 107 of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002. Congress directed DHHS to “establish and maintain a system for the advance registration of health professionals, for the purpose of verifying the credentials, licenses, accreditations, and hospital privileges of such professionals when, during public health emergencies, the professionals volunteer to provide health services.” In response, ~~HRSA~~ DHHS created the ESAR-VHP Program to assist states and U.S. territories to develop their emergency registration systems through the provision of grants and guidance. HRSA DHHS has distributed resources to nearly every state and many U.S. territories and developed guidelines and standards for these systems. Jurisdictions are responsible for designing, developing, and administering their respective systems consistent with federal guidelines. Thus, ~~ESAR-VHP is not a federal system, but rather a national system of~~

~~jurisdiction-based emergency volunteer registries.~~

Under subsection (a)(4)(B), a registration system operated by a Medical Reserve Corps (MRCs) is also sufficient. The MRCs program was created in 2002 as a community based and specialized component of Citizen Corps, part of the USA Freedom Corps initiative launched in January, 2002. The program's purpose is to pre-identify, train, and organize volunteer medical and public health practitioners to render services in conjunction with existing local emergency response programs. As of the Fall of 2006, there were 408 MRCs operating across the nation in ten regions. Some states explicitly reference MRC units via statutes that afford protection to volunteer health practitioners during an emergency. These states include Connecticut (Conn. Gen. Stat. § 19a-179b), North Carolina (N.C. Gen. Stat. § 1-539.11), Oklahoma (59 Okl. St. § 493.5, and 76 Okl. St. § 32), Utah (Utah Code. Ann. § 26A-1-126), and Virginia (Va. Code Ann. §§ 2.2-3601, 2.2-3605, 32.1-48.016, and 65.2-101). MRC units consist of personnel with and without a background in health services. The "medical" component of the units does not limit membership to medical professionals. Individuals without medical training are permitted to join and fill essential supporting roles. The protections of this act, however, only extend to volunteer health practitioners who are duly registered under Section 4 and adhere to the scope of practice requirements pursuant to Section 8.

Subsection (a)(4)(C) approves registration systems operated by disaster relief organizations, licensing boards, national and regional associations of licensing boards or health practitioners, or governmental entities. As used here, regional is a subset of national and means a multistate association of licensing boards or health practitioners. The entities listed typically use registration systems in their ordinary course of business or activities.

Subsection (a)(4)(C) also approves registration systems operated by comprehensive health facilities, which include public or private (for-profit or nonprofit) facilities that provide comprehensive inpatient or outpatient services on a regional basis. As used here, regional means that the facility draws from an extensive patient base that exceeds a single, small local community. A comprehensive health facility is distinguishable from a health entity by the breadth of its health services as well as its regional base. As indicated in the act, this includes tertiary care and teaching hospitals. For purposes of this act, a registration system operated by such entities is subject to all the requirements of subsection (a)(1)-(3).

Subsection (a)(4)(D) authorizes the appropriate state agency or agencies to designate for the purposes of this act a registration system other than those set forth in subsections (a)(4)(A)-(C), provided these systems meet the essential requirements in subsection (a)(1)-(3).

Subsection (b) permits a state agency or its designee, or a host entity, to confirm the identity and status within a registration system of a volunteer health practitioner. Confirmation is strongly recommended, but not required, noting that potential exigencies may prevent confirmation in some instances. Confirmation is limited to identification and an assessment of good standing of volunteer health practitioners within the system. This provision is a security safeguard that allows state officials to ensure that volunteer health practitioners capable of providing health or veterinary services during an emergency are appropriately registered with a registration system. Another purpose of this provision is to prevent fraudulent attempts or acts of

unlicensed individuals posing as qualified volunteer health practitioners during emergencies. The primary purpose, however, is to ensure the timely approval of registered volunteer health practitioners to provide health or veterinary services to individuals or populations affected by an emergency.

Subsection (b) does not, however, authorize states to review and approve the credentials and qualifications of individual volunteers or to establish requirements on a state-by-state basis to confirm the registration of volunteers. These authorizations or requirements may undermine a fundamental goal of the act to establish uniformity across states for the recognition of volunteer health practitioners that can function automatically if necessary (*e.g.* communications are disrupted) and access to state officials to secure authorizations is impossible or impractical during an emergency.

Cases may arise where personnel authorized to manage the emergency response are unaware of the identities of volunteer health practitioners and whether they are licensed or in good standing. Subsection (c) mandates any entity that uses a registration system to provide, upon request of an authorized person, the names of all volunteer health practitioners within the system and the most current status of their licensure and standing. This provision empowers authorized personnel to directly acquire information pertaining to the identities and qualifications of volunteers without resorting to additional requests or alternative procedures that may hinder the response efforts.

Subsection (d) grants host entities the authority to choose whether or not they will engage the services of a volunteer health practitioner in response to an emergency declaration. The decision to use a volunteer is not predicated on the mere affirmation of licensure and good standing. There may be many reasons why a host entity chooses not to use the services of a particular practitioner or class of practitioners. This may include, for example, ample availability of existing full-time or part-time employees or volunteers that are required to provide a particular service. As well, a host entity is under no legal obligation to engage the services of a volunteer aside from any pre-existing agreements that may have been entered into by the relevant parties. This act does not set any additional requirements beyond those imposed upon individuals or entities that seek to avail themselves of the privileges and protections of the act.

* * *

SECTION 9. RELATION TO OTHER LAWS.

(a) This [act] does not limit rights, privileges, or immunities provided to volunteer health practitioners by laws other than this [act]. Except as otherwise provided in subsection (b), this [act] does not affect requirements for the use of health practitioners pursuant to the Emergency Management Assistance Compact.

(b) [Name of appropriate governmental agency or agencies], pursuant to the Emergency

Management Assistance Compact, may incorporate into the emergency forces of this state volunteer health practitioners who are not officers or employees of this state, a political subdivision of this state, or a municipality or other local government within this state.

Legislative Note: ~~References~~ If a state adopting this act is a party to ~~other~~ emergency assistance compacts to which the state is a party in addition to the Emergency Management Assistance Compact, references to these other compacts should be added to this section.

* * *

SECTION 10. REGULATORY AUTHORITY. [Name of appropriate governmental agency or agencies] may promulgate rules to implement this [act]. In doing so, [name of appropriate governmental agency or agencies] shall consult with and consider the recommendations of the entity established to coordinate the implementation of the Emergency Management Assistance Compact and shall also consult with and consider rules promulgated by similarly empowered agencies in other states to promote uniformity of application of this [act] and make the emergency response systems in the various states reasonably compatible.

Legislative Note: ~~References~~ If a state adopting this act is a party to ~~other~~ emergency assistance compacts to which the state is a party in addition to the Emergency Management Assistance Compact, references to these other compacts should be added to this section.

Comment

The purpose of this section is to authorize states to adopt regulations reasonably necessary to implement the provisions of this act. For example, a state may adopt rules governing how host entities may coordinate their activities with state emergency management agencies when using volunteer health practitioners as required by Section 5(b). ~~Such regulations could~~ Coordination of the use of emergency volunteer health practitioners is essential to ensure that resources are used effectively, to protect the health and safety of volunteers, to avoid situations in which efforts of spontaneous volunteers disrupt other relief activities, and to more effectively promote the restoration of the operations of regular health care delivery systems.

Regulations implementing this act may require host entities to supply emergency management agencies a list of number and type of volunteer health practitioners recruited by a host entity and the manner in which these personnel are being utilized. This information could then be used by state officials to identify and alleviate gaps in their emergency service delivery network. A state may not, however, impose requirements inconsistent with the provisions of this

act, such as regulations requiring only the use of approved registration systems or requiring the individual review and approval of the qualifications of volunteer health practitioners.

States may also utilize the regulatory authority provided by this section to establish standards to promote the interoperability of registration systems. The minimum data elements of the ESAR-VHP system, for example, include a practitioner's name, contact information, degree(s), hospital(s) in which the individual enjoys privileges, specialty(ies), state license number, state license board check of disciplinary actions taken against the licensee, National Practitioner Databank check of liability actions, date of last reappointment, and status of the license (e.g., active, inactive or retired). Comparable requirements could be imposed upon any registration system seeking to have its registrants used in a state.

In adopting regulations to implement this act, ~~including standards for the interoperability of registration systems, however, state agencies must~~ it is vitally important for state agencies to consult with ~~the intrastate agencies or entities responsible for coordinating and managing emergency responses~~ emergency management officials in other states, along with interstate partners pursuant to existing mutual aid compacts (e.g., the Emergency Management Assistance Compact (EMAC), the Interstate Civil Defense and Disaster Compact (ICDDC), the Nurse Licensure Compact (NLC), and the Southern Regional Emergency Management Assistance Compact) to ensure consistency among regulations and the interoperability of procedures during an emergency. Coordination and consultation of this type are essential to ensure that state regulatory requirements do not inadvertently recreate the very problems which this act seeks to remedy, namely a lack of consistency and uniformity among state systems that may impair the effective and rapid deployment of volunteer health practitioners.

{SECTION 11. LIMITATIONS ON CIVIL LIABILITY FOR VOLUNTEER
HEALTH PRACTITIONERS}; VICARIOUS LIABILITY. ~~RESERVED.~~}

~~Legislative Note: Final action regarding Section 11 of the Act has been deferred until the 2007 Annual Meeting of the National Conference of Commissioners on Uniform State Laws. At that time, the Drafting Committee will present to the Conference for consideration its final recommendations relating to the limitation of civil liability for damages for volunteer health practitioners and organizations that use and maintain registration systems for volunteer health practitioners. Because many States have existing laws pertaining to liability limitations and a uniform approach to liability limitations may play a critical role in promoting the use of volunteer health practitioners, States considering adoption of this Act prior to final action by the National Conference regarding Section 11 should carefully review their existing laws, the laws of other states, provisions of the Emergency Management Assistance Compact, and the work of the Drafting Committee, which is available at <http://www.law.upenn.edu/bll/ulc/ulc.htm>.~~

Alternative A

(a) Subject to subsection (c), a volunteer health practitioner who provides health or veterinary services pursuant to this [act] is not liable for damages for an act or omission of the

practitioner in providing those services.

(b) No person is vicariously liable for damages for an act or omission of a volunteer health practitioner if the practitioner is not liable for the damages under subsection (a).

(c) This section does not limit the liability of a volunteer health practitioner for:

(1) willful misconduct or wanton, grossly negligent, reckless, or criminal conduct;

(2) an intentional tort;

(3) breach of contract;

(4) a claim asserted by a host entity or by an entity located in this or another state which employs or uses the services of the practitioner; or

(5) an act or omission relating to the operation of a motor vehicle, vessel, aircraft, or other vehicle.

(d) A person that, pursuant to this [act], operates, uses, or relies upon information provided by a volunteer health practitioner registration system is not liable for damages for an act or omission relating to that operation, use, or reliance unless the act or omission is an intentional tort or is willful misconduct or wanton, grossly negligent, reckless, or criminal conduct.

[(e) In addition to the protections provided in subsection (a), a volunteer health practitioner who provides health or veterinary services pursuant to this [act] is entitled to all the rights, privileges, or immunities provided by [cite state law.]]

Alternative B

(a) Subject to subsection (b), a volunteer health practitioner who receives compensation of [\$500] or less per year for providing health or veterinary services pursuant to this [act] is not

liable for damages for an act or omission of the practitioner in providing those services.

Reimbursement of, or allowance for, reasonable expenses, or continuation of salary or other remuneration while on leave, is not compensation under this subsection.

(b) This section does not limit the liability of a volunteer health practitioner for:

(1) willful misconduct or wanton, grossly negligent, reckless, or criminal conduct;

(2) an intentional tort;

(3) breach of contract;

(4) a claim asserted by a host entity or by an entity located in this or another state which employs or uses the services of the practitioner; or

(5) an act or omission relating to the operation of a motor vehicle, vessel, aircraft, or other vehicle.

(c) A person that, pursuant to this [act], operates, uses, or relies upon information provided by a volunteer health practitioner registration system is not liable for damages for an act or omission relating to that operation, use, or reliance unless the act or omission is an intentional tort or is willful misconduct or wanton, grossly negligent, reckless, or criminal conduct.

[(d) In addition to the protections provided in subsection (a), a volunteer health practitioner who provides health or veterinary services pursuant to this [act] is entitled to all the rights, privileges, or immunities provided by [cite state law].]

Comment

1. Background and General Purpose.

The principle that some degree of civil liability protection should be provided by volunteer health practitioners in emergency settings has become deeply embedded into state and

federal law. Virtually all states have enacted “Good Samaritan” laws that protect various types of health professionals responding to emergency incidents, such as sudden and unanticipated traumatic injuries, or the onset of life threatening conditions, such as cardiac arrest and seizures, from liability for ordinary negligence. Department of Health and Human Services. Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP): Legal and Regulatory Issues and Solutions. Washington, DC: (May) 2006; Appendix D.

At the federal level, the Volunteer Protection Act, 42 U.S.C. § 14501 *et seq.*, provides that volunteers receiving less than \$500 in compensation (other than reasonable reimbursement or allowances for expenses actually incurred) who provide services through nonprofit organizations or governmental entities are not liable for harm caused by their acts or omissions, provided the volunteers (1) are acting within the scope of their authority on behalf of a nonprofit organization or governmental entity; (2) are properly licensed, certified, or authorized by the appropriate authorities as required by law in the state in which the harm occurred; (3) have not engaged in willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individuals harmed by them; and (4) have not caused the harm by operating a motor vehicle, vessel, aircraft, or other vehicle for which the state requires its operator to possess an operator’s license or maintain insurance. Unless a state makes a statutory election of non-applicability, the federal Volunteer Protection Act preempts inconsistent state laws, except for laws providing additional protection from liability for volunteers. See 42 U.S.C. § 14502.

All 50 states have adopted the Emergency Management Assistance Compact (EMAC), which provides that officers or employees of a party state rendering aid in another state pursuant to the compact are considered “agents of the requesting state” for tort liability and immunity purposes and provides that “no party state or its officers or employees rendering aid in another state pursuant to [the] compact shall be liable on account of any act or omission in good faith on the part of such forces while so engaged or on account of the maintenance or use of any equipment or supplies in connection therewith.” Under EMAC, “good faith” does not include “willful misconduct, gross negligence, or recklessness.”

A substantial number of states have also limited the liability for negligence of volunteers, volunteer organizations, and contractors assisting in emergency or disaster relief efforts. See, e.g., Alaska Stat., § 09.65.091; Cal. Bus. & Pro. Code, § 2395; Cal. Gov. Code, § 8659; 28 Conn. Gen. Stat. § 517-28-13; Del. Code tit. 10, § 3129; D.C. Code § 7-401; Fla. Stat. Ann. §§ 768.1345; Ga. Code Ann. § 51-1-29.1(b); Haw. Rev. Stat. § 128-18; Idaho Code Ann. § 46-1017; 20 Ill. Con. Stat., § 3305/15; Iowa Code Ann. § 135.147; Kan. Stat. Ann. § 48-915; Ky. Rev. Stat. Ann. § 39A-280(3); La. Rev. Stat. Ann. § 9:2793.2-7; Mich. Comp. Laws §§ 30.411(4); N.H. Rev. Stat. Ann. § 21-P(41)(I); Nev. Rev. Stat. § 41.500; N.C. Gen. Stat. § 166A 14; Or. Rev. Stat. § 401.667; 42 Pa. Cons. Stat. § 7704; Tex. Civ. Pro. & Rem. Code Ann. § 79.003; Utah Code Ann., §§ 58-13-12; Va. Code Ann. §§ 58-13-2, 8.01-225.01; Wyo. Stat., § 35-4-114. Similar immunities have also been extended to emergency medical technicians and operators of ambulances and emergency vehicles; individuals and organizations responding to hazardous material and mine rescue incidents; personnel responding to emergencies at school and athletic events; ski patrols; and operators of free clinics. Several states have also adopted volunteer protection acts which mirror or expand the liability relief provided by the Federal Volunteer

Protection Act. *Annotated UEVHPA*, notes 3-9 (The *Annotated UEVHPA* is a version of this act with detailed references notes available at www.uevhpa.org).

The purpose of Section 11 is to provide clear guidance to volunteer health practitioners regarding the extent of their exposure to liability for negligence while providing health or veterinary services pursuant to this act, based upon principles consistent with those currently incorporated into state law. Without such guidance, practitioners will be presented with a confusing array of state and federal laws that will generate substantial uncertainty regarding whether and to what extent they may face exposure to civil liability when responding to emergencies under this act.

Section 11 provides two alternatives that establish different levels of protection. Alternative A provides immunity from liability for ordinary negligence to all volunteer health practitioners and immunity from vicarious liability to the entities engaged in deploying and using them. Alternative B provides immunity from liability for ordinary negligence only to practitioners who are nominally compensated in a manner comparable to the federal Volunteer Protection Act and defers to other state law the question whether the entities deploying and using them may be vicariously liable. While no recommendation is made as to which of these alternatives is more appropriate, it is critical that each state articulate the protections it provides to enable health practitioners to make informed decisions about volunteering.

2. Constitutionality.

Under many state constitutions, provisions ensuring access to the courts have been interpreted as ensuring access to a remedy for injuries. *See, e.g., David Schuman, The Right to a Remedy*, 65 Temple L. Rev. 1197, 1201 (1992). While inconsistent state laws are clearly preempted by the federal Volunteer Protection Act, and the principle that it is appropriate to provide individuals and organizations engaged in disaster relief and emergency response activities with some degree of relief from civil liability is broadly accepted and deeply embedded into current federal and state law, concerns have nonetheless been expressed that by expanding immunity beyond that currently provided by the federal act, Alternative A may impair the right of access unless a substitute remedy, or *quid pro quo*, is provided. *See* Thomas R. Phillips, *The Constitutional Right to a Remedy*, 78 N.Y.U. L. REV. 1309, 1335 (2003); *Cf., PruneYard Shopping Ctr. v. Robins*, 447 U.S. 74, 93-94 (1980) (“there are limits on governmental authority to abolish ‘core’ common law rights, ... at least without a compelling showing of necessity or a provision of a reasonable alternative remedy.”).

The expansion of civil immunity beyond uncompensated individuals to include all volunteer health practitioners and the clear application of immunity from vicarious liability to other persons engaged in the deployment and use of volunteers as provided by Alternative A are premised upon the assumption that it is constitutionally appropriate for a state legislature to conclude that “a compelling showing of necessity” and an appropriate *quid pro quo* are provided by the impact of Alternative A in making emergency healthcare services more readily available to disaster victims. The dearth of precedent striking down Good Samaritan and other state volunteer protection acts illustrates that such legislative determinations satisfy constitutional requirements.

Whether to adopt Alternative B, which confirms that existing federal immunities apply to volunteer health practitioners, or Alternative A, which more expansively grants immunities to facilitate the deployment and use of volunteer health practitioners, is a policy decision that must be made by each state. In making this policy determination, states should consider a variety of factors, including reports that health professionals deployed to mass evacuation shelters during the 2005 hurricanes were generally not permitted by their host entities to provide more than basic health services to shelter residents because of liability concerns. Medical Reserve Corps Response to the 2005 Hurricanes; Final Report, March 13, 2006; 18. Explicit statutory protection from liability may induce entities, such as the American Red Cross and other volunteer organizations active in disaster relief efforts, to expand available services in a manner consistent with the qualifications and skills of the volunteer health practitioners being deployed. Conversely, states may also wish to consider whether measures outside the scope of this act, such as the creation of special disaster relief funds and victims compensation programs, may accomplish comparable objectives with less impact upon remedies available for the negligent provision of healthcare and veterinary services.

To the extent a state concludes that for legal or policy reasons it is not appropriate to adopt Alternative A, Alternative B provides an approach that does not expand the scope of immunity generally available in all jurisdictions under current law, but instead removes potential impediments to the application of existing immunities to volunteer health practitioners providing services under this act. NCCUSL expresses no preference between these alternatives. Rather, it is expected that each state will weigh the relevant policy considerations, make its own constitutional judgment, and select the alternative most appropriate to its circumstances.

3. Certain Conduct Not Protected.

In both Alternatives A and B, liability protections apply only to volunteer health practitioners who are providing health or veterinary services pursuant to this act. These services are distinguishable from services that are of a non-health-related nature and afford no direct health benefit to individuals or populations (e.g., the operation of a non-emergency motor vehicle, the provision of administrative services). The protections are narrowly tailored and do not extend to conduct that exceeds a practitioner's scope of practice as it may be limited by the state or host entity (see UEVHPA Sections 4, 8). For example, a lab technician will be deemed to have exceeded the scope of practice of a similarly situated practitioner by performing unsupervised surgery on an individual during an emergency. Should harm to the patient result, the lab technician will not enjoy the liability protections provided by this act.

Each alternative also contains a provision that limits protection to ordinary negligence. There is no protection for willful misconduct or wanton, grossly negligent, reckless, or criminal conduct, nor is there protection from intentional torts. This is consistent with the approach taken by other laws, including the federal Volunteer Protection Act. Hodge, J.G., Bhattacharya, D., Garcia, A. Assessing criminal liability of volunteer healthcare workers in emergencies. *American Journal of Disaster Medicine* 2006; 1(1):12-17.

Under each alternative, volunteer health practitioners remain liable for their contractual

breaches. They also remain liable for direct claims brought against them by host entities or entities in any state that employ the volunteers or use their services. Thus, host entities are not prevented by this act from seeking redress against volunteer health practitioners for misconduct that may not necessarily have a direct health effect on individuals or populations. Examples may include mismanagement of materials during a response effort or conversion of property or goods provided for the sole purpose of distribution to affected individuals or populations of an emergency. This limitation is not intended, however, to expose the volunteer health practitioner to the very liability from which there is protection under subsection (a). For example, should a host entity be held vicariously liable for a negligent act committed by a protected volunteer health practitioner in a state that adopts Alternative B, the entity should not be permitted to assert an indemnification claim against the practitioner. The protection from liability espoused in subsection (a) of either alternative is intended to insulate volunteer health practitioners from having to pay damages arising from their acts or omissions in providing health or veterinary services, no matter how or by whom a claim for damages is brought.

Pursuant to Alternative A, subsection (c)(5), and Alternative B, subsection (b)(5), a volunteer health practitioner is not exempt from liability for acts or omissions relating to the operation of a vehicle for which the state requires the operator to have either a valid operator's license or liability insurance. The intent is to hold practitioners liable for a type of conduct that is generally outside the scope of their responsibilities as volunteers. Other state laws may, however, provide liability protection to operators of ambulances and other emergency response vehicles, vessels or aircraft. States having such laws should include citations to such laws in subsection (e) of Alternative A or subsection (d) of Alternative B.

4. Protected Conduct.

Subject to the exceptions for unprotected conduct discussed in Comment 3, each alternative begins in subsection (a) with a statement of the level of protection from civil liability being provided to volunteer health practitioners for acts or omissions that occur during the provision of health or veterinary services pursuant to the act. The immunity provided by subsection (a) is limited to volunteer health practitioners and does not extend to host or other entities that may deploy or use them.

Alternative A, subsection (a), contains the broadest protection, immunizing practitioners completely from ordinary negligence. The immunity provided to practitioners by Alternative A is comparable to the immunity provided to state and local government officials and employees deployed to other states in response to declared emergencies under EMAC. Alternative A is premised on the assumption that private sector organizations and volunteers who supplement the efforts of government agencies and employees at no cost to the taxpayers and operate subject to the direction and control of the host state's emergency management officials deserve similar protections.

Alternative B, subsection (a), essentially parallels the liability protections provided by the federal Volunteer Protection Act, 42 U.S.C. § 14501 et seq. It thus applies only to volunteer health practitioners who do not receive compensation in excess of [\$500] per year. "Compensation" for the purposes of this subsection does not include reimbursement of, or

allowance for, reasonable expenses, nor does it include continuation of salary or other remuneration while on leave from an employer. The federal act provides that no volunteer of a nonprofit organization or governmental entity is liable for harm caused by an act or omission of the volunteer on behalf of the organization or entity. 42 U.S.C. § 14503(a). This protection, however, only applies to volunteers who are “properly licensed, certified, or authorized by the appropriate authorities for the activities or practice in the State in which the harm occurred” and who practice “within the scope of the volunteer’s responsibilities in the nonprofit organization or governmental entity.” Under current law, significant issues may arise about whether an out-of-state practitioner is properly licensed, certified, or authorized by the “appropriate authorities” of a state. Likewise, under current law, when a volunteer is dispatched by a nonprofit organization or governmental entity and practices in a health clinic or facility operated during a disaster by another host entity, questions may arise about whether the volunteer is “acting within the scope of the volunteer’s responsibilities in the nonprofit organization or governmental entity.” Alternative B, subsection (a), is intended to resolve such uncertainties.

Each alternative also includes a subsection (subsection (d) in Alternative A and subsection (c) in Alternative B) that protects any person that “operates, uses, or relies upon information provided by a volunteer health practitioner registration system” from liability for an act or omission relating to that conduct. A goal of the act is to require advance registration and deployment of volunteer health practitioners during emergencies so as to ensure that skilled, pre-vetted volunteers are used. However, the exigencies of the circumstances may result in unintentional miscommunications or misinformation concerning prospective volunteers. Thus, a person who operates or uses a registration system or relies on the information provided by a system is not liable for the harm caused by negligent conduct that arises if the data about a volunteer registered with the system are inaccurate, misstated, or miscommunicated. Of course, the protection provided by the subsection does not apply to an intentional tort or to willful misconduct or wanton, grossly negligent, reckless, or criminal conduct.

Finally, each alternative contains a bracketed subsection (subsection (e) in Alternative A and subsection (d) in Alternative B) that permits a state to extend the liability protections of other state laws to volunteer health practitioners. Examples of such other state laws that it may be desirable to specify as applicable to volunteer health practitioners are identified in notes 3, 4, and 9. For example, a state law may protect individuals deployed by disaster relief organizations in response to requests from state and local officials from liability for all types of negligence claims, not merely claims relating to the provision of health or veterinary services. This subsection would allow the state to expressly acknowledge that such immunities apply to volunteer health practitioners who provide health or veterinary services pursuant to this act. This subsection is consistent with the policy expressed in Section 9(a) which provides that, “This [act] does not limit rights, privileges, or immunities provided to volunteer health practitioners by laws other than this [act].”

Alternatives A and B do not exhaust the range of policy choices a state might appropriately make. A state might, for example, select the limited immunities of Alternative B for volunteer health practitioners, yet deem it prudent to provide entities that deploy them and use their services with protection from vicarious liability in order to encourage such entities to provide victims with a broader range of services. To effectuate this policy, a state might

determine that the protection from vicarious liability should extend to the ordinary negligence of all volunteer health practitioners, not just those immunized under Alternative B, subsection (a).

A state might also consider providing additional protection for victims of malpractice by assuming liability for the ordinary negligence of volunteer health practitioners under its tort claims act. This model was followed by Tennessee in its adoption of this act and is consistent with the relief available to tort victims under EMAC and under the laws of several other states. See, e.g., 10 Del. Code, § 3129(d); Iowa Code, § 125.24(4) (as applied to healthcare facilities operating free clinics); Missouri Rev. Stat., §§ 44.125.1 & 105.77; 58 Tenn. Code ch. 2 (P.L. Ch. 579, June 12, 2007); and Wisc. Stat. §§ 165.25 (6), 250.42(4)(b), 893.82 & 895.46.

A state electing to provide state tort claims act coverage for claims against volunteers under this act may substitute the following language for subsections (a) and (b) of Alternative A.

(a) Subject to subsection (c), a volunteer health practitioner who provides health or veterinary services pursuant to this [act] is not liable for the payment of a judgment based on an act or omission of the practitioner in providing those services and may not be named as a defendant in an action based on such an act or omission. However, a volunteer health practitioner is deemed to be an agent or employee of this state under [cite the state tort claims act] while providing health or veterinary services pursuant to this [act], and the state may be named as defendant and is liable for the payment of any judgment based upon an act or omission of the practitioner as provided in [the state tort claims act].

(b) No person other than this state is vicariously liable for payment of a judgment based on the act or omission for an act or omission of a volunteer health practitioner if the practitioner is not liable for the damages under subsection (a).

5. Vicarious Liability.

Subsection (b) of Alternative A directly confers immunity from vicarious liability upon entities that deploy and use volunteer health practitioners. As articulated by Section 7.03(2) of the *Restatement of the Law of Agency*, 3rd, the common-law doctrine of vicarious liability provides that a principal is liable to a third party harmed by an agent's tortious conduct if the agent is an employee who commits the tort while acting within the scope of employment or with apparent authority. Section 7.03(1) of the *Restatement* also provides that a principal is liable directly to a third party harmed by an agent's tortious conduct if (i) the agent acts with actual authority, (ii) the principal ratifies the conduct, (iii) the principal is negligent in selecting, supervising, or otherwise controlling the agent, or (iv) the principal delegates to the agent a duty to use care to protect other persons or their property and the agent fails to perform the duty. Section 11 is limited to vicarious liability and nothing in the section limits the direct liability of a person deploying or using the services of a volunteer health practitioner pursuant to this act.

The extent to which vicarious liability applies to the acts or omissions of volunteer health

practitioners is uncertain because in most circumstances the volunteers are not acting with actual or apparent authority to bind the person that deploys or uses their services, nor are they common-law employees of that person. Under Section 220 of the *Restatement of the Law of Agency*, 2nd, an individual is not a “servant” (or “employee” in contemporary terms) if the person is not employed for a substantial length of time, is not engaged in work as part of the regular business of the putative employer, or if the putative employer is not engaged in a “business.” Because of the uncertainty of application of these principles, subsection (b) of Alternative A provides protection to the extent to which a person that deploys or uses a volunteer health practitioner would otherwise be subject to vicarious liability for the practitioner’s acts or omissions.

Although Section 217 of the *Restatement of the Law of Agency*, 2nd, contains language indicating that vicarious liability may be imposed on a principal even if the agent who commits the tort is immune, there is no significant supporting body of decisional law. The proposition was reduced to a mention in a Reporter’s Note in the *Restatement of the Law of Agency*, 3rd. The cases in which vicarious liability has been imposed notwithstanding an agent’s immunity have tended to turn on the interpretation of a tort claims or other statute rather than on general common-law principles. *See, e.g., Napier v. Town of Windham*, 187 F.3d 177, 191 (1st Cir. 1999) (under Maine tort claims statute, municipality not immunized from vicarious liability because of statutory immunity of police officers but able to claim its own immunity by showing lack of insurance; summary judgment in favor of city denied because of failure to make such a showing); *Regester v. County of Chester*, 797 A.2d 898, 902, 906 (Pa. 2002) (immunity provided under Pennsylvania Emergency Medical Services Act to emergency technicians and municipalities held not to apply to medical center because statute failed clearly to confer such immunity). In any event, nothing prevents, and the cited cases stand for the proposition that, immunity for vicarious (or other) liability may be provided by statute.

The fact that Alternative B does not expressly provide immunity for vicarious liability should not raise an implication that such liability exists. Rather, it represents a policy judgment by NCCUSL that states choosing to limit the immunity provided to volunteer health practitioners to that generally available under federal law might also choose to limit protection from vicarious liability to that generally available under the existing laws of the state. A similar policy judgment was made by Congress in adopting the Volunteer Protection Act, which provides that federal law shall not be deemed inconsistent with any state law which makes a volunteer organization “liable for the acts or omissions of its volunteers to the same extent as an employer is liable for the acts or omissions of its employees.” 42 U.S.C. § 14503(d)(2). As noted in Comment 4, a state adopting Alternative B might nevertheless choose to adopt statutory language clarifying that there is no vicarious liability for the ordinary negligence of volunteer health practitioners. Some state Volunteer Protection Acts make nonprofit organizations expressly liable under the doctrine of respondeat superior for acts of volunteers. *See, e.g., Ala. Code*, § 6-5-336(e); *Ariz. Rev. Stat.*, § 12-982(B); *Fla. Stat. Ann.*, § 768.1355(2); *Haw. Rev. Stat.*, § 662D-2(b); *Kan. Stat. Ann.*, § 60-3601(d); *Me. Rev. Stat.*, tit. 22, § 158. A similar number of jurisdictions, however, take an opposite approach. *See, e.g., Colo. Rev. Stat.*, § 13-21-115.5(4)(ii); *10 Del. Code*, § 8133(e); *Georgia Code Ann.*, § 51-1-29.1; and *Utah Code Ann.*, § 78-19-3.

[SECTION 12. WORKERS' COMPENSATION COVERAGE. Reserved.]

~~Legislative Note: Final action regarding Section 12 of the Act has been deferred until the 2007 Annual Meeting of the National Conference of Commissioners on Uniform State Laws. At that time, the Drafting Committee will present to the Conference for consideration its final recommendations regarding the provision of workers' compensation coverage for volunteer health practitioners without other forms of workers' compensation or disability insurance coverage. Because the establishment of a reasonably uniform system to compensate volunteer practitioners for injuries sustained while responding to emergencies is critical to an effective system of legislation to promote the use of volunteer health practitioners, States considering adoption of this Act prior to final action by the National Conference regarding Section 12 should carefully review the laws of other states providing workers' compensation coverage to volunteers responding to emergencies, provisions of the Emergency Management Assistance Compact, and the work of the Drafting Committee, which is available at <http://www.law.upenn.edu/bll/ulc/ulc.htm>.~~

(a) In this section, "injury" means a physical or mental injury or disease for which an employee of this state who is injured or contracts the disease in the course of the employee's employment would be entitled to benefits under the workers' compensation [or occupational disease] law of this state.

(b) A volunteer health practitioner who dies or is injured as the result of providing health or veterinary services pursuant to this [act] is deemed to be an employee of this state for the purpose of receiving benefits for the death or injury under the workers' compensation [or occupational disease] law of this state if:

(1) the practitioner is not otherwise eligible for such benefits for the injury or death under the law of this or another state; and

(2) the practitioner, or in the case of death the practitioner's personal representative, elects coverage under the workers' compensation [or occupational disease] law of this state by making a claim under that law.

(c) The [name of appropriate governmental agency] shall adopt rules, enter into agreements with other states, or take other measures to facilitate the receipt of benefits for injury

or death under the workers' compensation [or occupational disease] law of this state by volunteer health practitioners who reside in other states, and may waive or modify requirements for filing, processing, and paying claims that unreasonably burden the practitioners. To promote uniformity of application of this [act] with other states that enact similar legislation, the [name of appropriate governmental agency] shall consult with and consider the practices for filing, processing, and paying claims by agencies with similar authority in other states.

Legislative Notes: *The bracketed term “occupational disease” should not be used in states that do not have specific occupational disease laws.*

States should review their workers' compensation and occupational disease laws to determine whether they have appropriate provisions for providing wage loss benefits to volunteer health practitioners. If necessary, an additional subsection cross referencing special provisions included in workers' compensation laws for calculating wage-loss benefits for volunteers, or designating how wage loss benefits for volunteers will be determined, should be added to this section.

States should also review their workers' compensation and occupational disease laws to determine whether current laws may provide more expansive benefits to volunteers than are otherwise provided by this act, such as benefits for injuries or deaths occurring during disaster training or drills. If current state laws provide more expansive benefits and states wish to extend such benefits to volunteer health practitioners under this act, a provision should be added to this section conforming the scope of benefits available under this act to those available under the other laws.

This section defers to other provisions of state law to determine whether and to what extent the option to elect workers' compensation or occupational disease benefits constitutes the exclusive remedy against the state for injuries or death that occurs when acting as a volunteer health practitioner in the state. If existing state laws do not adequately address this topic, states should consider whether appropriate language clarifying whether and to what extent these benefits constitute an exclusive remedy should be added to this section.

Comment

Section 12 is intended to provide redress for injuries or deaths incurred by volunteer health practitioners providing health or veterinary services during an emergency. For the purposes of this protection, subsection (a) stipulates that “injury” includes physical or mental injuries or diseases for which an employee of the state, acting within the course of employment, would be entitled to workers' compensation coverage. Occupational diseases are sometimes covered under legislation other than a state's basic workers' compensation statute, but even so, a volunteer health practitioner is entitled to benefits if a state employee would be so entitled.

The principle that state and local governments should extend workers' compensation coverage to individuals voluntarily performing valuable public services is well recognized under existing state law. For example, virtually all states extend workers' compensation protection to members of volunteer fire departments and most states provide similar benefits to police auxiliaries. In at least 30 jurisdictions, workers' compensation protections have been extended to volunteers participating in disaster response activities, especially health professionals. Because current state law has developed on an *ad hoc* basis without the benefit of any unifying nationwide principles, however, a complex array of local procedural requirements, categorical restrictions, and limitations exist which act as an effective barrier to the reliance upon these laws in the development of integrated nationwide volunteer response efforts. For example, some states limit coverage to volunteers serving pursuant to formal compacts or mutual aid agreements; require the adoption of local ordinances, resolutions, executive orders, or rules before coverage becomes available; limit benefits to the extent of specific appropriations; require loyalty oaths, formal accreditation, or special identification cards; mandate the specific approval or acceptance of volunteers by state officials; require "regular" or "permanent" enrollment; or prohibit any form of material remuneration. *Annotated UEVHPA*, notes 11-17 (The *Annotated UEVHPA* is a version of this act with detailed reference notes available at www.uevhpa.org).

To remedy the lack of consistency and uniformity among the states, subsection (b) allows volunteer health practitioners who are not otherwise eligible for workers' compensation benefits, through their employers or other sources, to elect to be deemed employees of the host state for purposes of workers' compensation claims. This approach has the advantage of treating all volunteers equally and avoiding difficult issues associated with determining whether and to what extent the workers' compensation systems of host states provide coverage for volunteers. As such, Section 12 is based upon the laws of multiple states which provide workers' compensation benefits to all volunteers who are appropriately registered or provide services pursuant to the direction and control or at the request of emergency management officials. *Annotated UEVHPA*, note 18. Section 12 differs from existing state law, however, in that it expressly provides coverage for volunteer health practitioners under this act and takes into account the specialized types of registration systems and practice requirements imposed by this act.

States should consider whether to adopt by reference or add provisions to this section regarding the calculation of wage-loss benefits for volunteer health practitioners. Some prospective volunteer health practitioners may have substantial earnings in the prior year through their existing employers. Others may be retired health professionals who no longer earn significant income. Some states have provisions in their workers' compensation and occupational disease laws clarifying that for volunteers provided workers' compensation or occupational disease benefits, the loss of earnings must be based on the earnings of the practitioner for the previous calendar year from all sources, and not limited to the compensation, if any, received while acting as a volunteer health practitioner, subject to minimum benefits for loss of wages. Many states have adopted specialized rules for determining the wage-loss benefits payable to volunteers. *Annotated UEVHPA*, note 19.

To the extent such provisions are absent from existing state law, a state enacting this act should consider whether to add such a provision to this subsection. For example, an additional

subsection could be added providing that:

“Benefits provided to a volunteer health practitioner under this section for the loss of earnings shall be based upon the total earnings of the practitioner from all sources for the previous calendar year, but may not be less than the statewide average hourly wage for a 40-hour week.”

States should also consider how best to coordinate the scope of benefits provided by this section with benefits that may otherwise be available to all or certain types of volunteers responding to emergencies under other state laws. In several jurisdictions, for example, workers’ compensation benefits may be available for injuries or death occurring during emergency training and drills. See, e.g., Ala. Code § 31-9-16; Ariz. Rev. Stat. § 23-901(n); Ark. Code Ann. § 12-75-129(e)(2); Conn. Gen. Stat. § 28-14; Haw. Rev. Stat. § 127-7; Idaho Code Ann. § 72-205(5); 20 Ill. Comp. Stat. § 3305/10(k); Iowa Code § 85-61; Md. Code, Lab & Emp. § 9-232.1(b)(1); Ohio Rev. Code § 4123.036(c); Or. Rev. Stat., § 401.025(5); 35 Pa. Const. Stat. § 7706; R.I. Gen. Laws § 28-31-12; Wis. Stat. § 166.03(8)(d). Although Section 3 provides that this act only applies to volunteer health practitioners “who provide health or veterinary services in this state for a host entity while an emergency declaration is in effect,” if states wish to apply provisions of other existing laws providing workers’ compensation coverage during drills or training to volunteer health practitioners, a provision to that effect may be added as a separate subsection. The subsection might state that:

“A volunteer health practitioner who dies or is injured while participating in training or drills necessary to respond to emergencies may claim benefits pursuant to this section to the same extent as provided by [cite other applicable state law].”

States without such laws may also, if they deem it appropriate, add comparable provisions to this section. The absence of such a provision would not reduce the benefits provided to volunteers who qualify directly under such laws unless the laws are designated for repeal pursuant to Section 14. See Section 9(a).

Subsection (c) authorizes an appropriate governmental agency to adopt rules, enter into agreements with other states, or take other measures to facilitate the receipt of workers’ compensation benefits by volunteer health practitioners who reside in other states. These practitioners may find it administratively or logistically burdensome to pursue workers’ compensation benefits in the host state. Subsection (c) is intended to reduce these burdens by instructing the host state to take active measures to waive or modify requirements for filing, processing, and paying claims that unreasonably burden the practitioners. To promote uniformity of application, these measures should be taken in consultation with other states that enact similar legislation.

Enactment of this section may expose states to fiscal responsibilities in extending workers’ compensation benefits to volunteer health practitioners. However, the increased costs may potentially be recovered by states through federal reimbursement of disaster related costs and expenses under the federal Robert T. Stafford Disaster Relief and Emergency Assistance

Act, 42 U.S.C. §§ 5121-5206 (2002).

* * *

SECTION 14. REPEALS. The following acts and parts of acts are repealed:

(1)

(2)

Comment

Because the objective of this act is to expand rights, privileges, immunities and benefits available to volunteer health practitioners and entities engaged in their deployment and use, statutes or parts of statutes designated for repeal pursuant to this section should be limited to those that interfere with or are inconsistent with the objectives of this act, such as those which limit the interstate recognition of licenses issued to volunteer health practitioners during emergencies, impose greater degrees of exposure to civil liability upon volunteers or organizations engaged in their deployment or use, or deny workers' compensation benefits to volunteer health practitioners.

* * *