FLORIDA HOUSE OF REPRESENTATIVES
BILL ANALYSIS

This bill analysis was prepared by nonpartisan committee staff and does not constitute an official statement of legislative intent.

BILL #: CS/HB 733	**COMPANION BILL:** None
TITLE: Department of Health	**LINKED BILLS:** None
SPONSOR(S): Gerwig	**RELATED BILLS:** CS/CS/SB 902 (Garcia)

Committee References

Health Professions & Programs	➤	Health Care Budget	➤	Health & Human Services
18 Y, 0 N		13 Y, 0 N		14 Y, 5 N, As CS

SUMMARY

Effect of the Bill:
HB 733 revises several sections of law relating to Florida's health care workforce, health care services, and health care practitioner licensure and regulation related to the Department of Health (DOH). The bill:

- Revises the definition of low-THC and emergency rulemaking authority for the medical marijuana program;
- Adds Infantile Krabbe Disease to the newborn screening program;
- Creates a Neurofibromatosis Grant Program;
- Requires DOH to develop a pamphlet on neonate nutrition;
- Requires DOH to develop procedures and protocols for various Early Steps functions;
- Expands eligibility for the UF Center for Autism and Neurodevelopment autism micro-credential;
- Allows a home health aide for medically fragile children to administer certain medication;
- Requires DOH to designate certain specialty licensed children's hospitals as pediatric trauma centers;
- Requires practitioner advertisements include the practitioners full name and license number;
- Revises the degree program accreditation requirements for marriage & family therapist licensure;
- Extends sovereign immunity under the Access to Health Care Act to dental and dental hygiene students;
- Expands the populations dentists and dental hygienists may serve under a loan repayment program;
- Allows dental hygienists to use lasers for teeth cleaning under the direct supervision of a dentist;
- Requires DOH to immediately suspend the license of a practitioner who has been arrested for murder;
- Prohibits marriage between first cousins.

Fiscal or Economic Impact:
None

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ANALYSIS

EFFECT OF THE BILL:

CS/HB 733 amends numerous provisions of law related to public health and the functions of the Department of Health (DOH).

Medical Marijuana

Qualified Physicians and Medical Directors

The bill revises the certification course renewal process for qualified physicians and medical directors to expressly state that the required certification course must be renewed biennially. According to DOH, the phrasing of current law may be construed to tie the course renewal cycle to either the practitioner's or MMTC's license renewal

period,[1] which would result in a length of time greater than two years between course renewals. The revision specifies that the certification course must be renewed every two years regardless of when the practitioner's or MMTC's license renewal occurs. (Section 2).

Low-THC Cannabis

The bill revises the definition of "low-THC cannabis" to include all forms of cannabis product, except for edibles. The bill also modifies the potency requirements for low-THC cannabis by reducing the required percentage of cannabidiol (CBD) from more than 10 percent in the form of dried flower, to more than two percent CBD in the final product.[2] The revisions allow DOH to track the dispensing of low-THC cannabis products based on the potency of the final product being dispensed, rather than the potency of the dried flower from which the product was derived. (Section 2).

Medical Marijuana Emergency Rulemaking Authority

The bill requires DOH to initiate nonemergency rulemaking by July 15, 2026, to replace all previously adopted medical marijuana emergency rules and to publish the proposed nonemergency rules by July 30, 2026. The bill expressly prohibits the extension of this timeframe and repeals the express authority in s. 381.986 for DOH to adopt medical marijuana emergency rules. (Sections 16, 17, & 18).

Rare Diseases

Screening for Infantile Krabbe Disease

The bill requires DOH to adopt rules requiring the Newborn Screening Program (NBS Program) screen newborns for Infantile Krabbe Disease (IKD). Subject to legislative appropriation, the NBS Program must begin screening for IKD by January 1, 2027. (Section 4).

Neurofibromatosis Disease Grant Program

The bill establishes the Neurofibromatosis Disease Grant Program (Grant Program), subject to an appropriation, within DOH. Under the Grant Program, DOH will award grants to universities or established research institutes in the state for scientific and clinical research to further the search for new diagnostics, treatments, and cures for neurofibromatosis.

The bill requires DOH to consult with the Rare Disease Advisory Council (RDAC) to award grants through a competitive, peer-reviewed process. The bill establishes an express preference for grant proposals which foster collaboration among institutions, researchers, and community practitioners.

DOH must appoint peer review panels of independent, scientifically qualified individuals to review the scientific merit of each proposal and establish its priority score, which will be used by RDAC to make funding recommendations. The bill requires RDAC and peer-review panels to establish and follow rigorous guidelines for ethical conduct and adhere to a strict policy in regard to conflict of interest. (Section 3).

Neonatal Nutrition Pamphlet

The bill requires DOH to develop an evidence-based, educational pamphlet on neonate nutrition for the parents and guardians of preterm infants receiving care in hospital neonatal intensive care units (NICUs).

[1] Department of Health, *2026 Agency Legislative Bill Analysis for HB 733* (2026), page 3. On file with the Health & Human Services Committee.
[2] Under current law, the potency requirement for "low-THC cannabis" is 0.8 percent THC and 10 percent CBD of the *dried flower* from which the final product was derived, and does not necessarily reflect the potency of the final product. *See*, s. 381.986(1)(f), F.S.

The pamphlet must include information on the following subjects:

- The nutritional needs of preterm infants;
- The health risks of nutritional deficits and the potential need for nutritional supplementation;
- Different nutritional sources for infants, including maternal breast milk, pasteurized human donor milk, infant formula, and human-milk-derived fortifiers, and bovine-milk-derived fortifiers and the recommended uses for each;
- The importance of maternal breast milk for meeting the nutritional and developmental needs of infants, and the alternative of pasteurized human donor milk if maternal breast milk is not available;
- The potential risks associated with the use of infant formula, including preterm infant formula, as a sole or primary nutrition source; and
- Necrotizing enterocolitis (NEC), the associated risk factors, and the potential for a human-milk-based diet, including maternal and pasteurized donor breast milk and human-milk-derived infant fortifiers, to reduce the risk of developing NEC.

The bill requires DOH to make the pamphlet available to hospitals with NICUs[3] by January 1, 2027. (Section 4).

Child Health

Early Steps Program

The bill replaces detailed, locally-executed, directives for the Early Steps Program in current law with a general directive for DOH to establish statewide uniform protocols and procedures for transition to a school district program for children with disabilities or another program as part of the individual family support plan (IFSP) pursuant to Part C of the federal Individuals with Disabilities Education Act (IDEA).[4] The prescriptive requirements in current law create redundancies that overlap, but do not fully align with federal law and can cause confusion for service providers. According to DOH, simplifying the statutory provisions will streamline the federal approval process for program policies and ensures that relevant state agencies have the flexibility to timely update policies with appropriate public participation and stakeholder input.[5] (Sections 5 & 6).

The bill makes early intervention services providers credentialed by Early Steps eligible for the University of Florida Center for Autism and Neurodevelopment's autism micro-credential. This expands access to the micro-credential beyond the instructional personnel, prekindergarten instructors, and child care personnel who are currently eligible for the micro-credential under current law.[6] (Section 15).

Pediatric Trauma Centers

The bill requires DOH to designate children's hospitals as pediatric trauma centers, if they have certificates of trauma center verification from the American College of Surgeons (ACS). (Section 7).

There are currently four licensed children's hospitals in Florida, three of which are designated as pediatric trauma centers.[7] The bill will allow for the fourth, Nemours Children's Hospital, to be designated as a pediatric trauma center if it obtains ACS verification.

[3] Hospitals are licensed by the Agency for Health Care Administration under ch. 395, F.S.; See, s. 395.1055(h), F.S., and Rule 59A-3.249, F.A.C. regarding the licensure requirements for hospital NICUs.
[4] *See*, 34 CFR Part 303
[5] Department of Health, *2026 Agency Legislative Bill Analysis for HB 733* (2026), page 7. On file with the Health & Human Services Committee.
[6] S. 1004.551, F.S.
[7] John Hopkins All Childrens Hospital, Nicklaus Children's Hospital, Wolfson Children's Hospital, and Nemours Children's Hospital are the four licensed specialty children's hospitals in the state; all but Nemours Children's Hospital are designated pediatric trauma centers. *See*, Department of Health, *Florida Designated Trauma Centers* (2025). Available at https://www.floridahealth.gov/wp-content/uploads/2025/08/florida-trauma-centers-map.pdf (last visited February 25, 2026).

Home Health Aides to Medically Fragile Children

The bill authorizes a registered nurse to delegate to a home health aide for medically fragile children the administration of a Schedule IV controlled substance prescribed for the emergency treatment of an active seizure to a medically fragile child. (Section 10).

Health Care Practitioner Licensure & Regulation

Practitioner Advertising

The bill requires health care practitioners to include their full name, the type of license they possess, and license number, in any advertisement for health care services that is for a specific practitioner. This applies to all advertising mediums, including, but not limited to, promotional materials, websites, and social media. Practitioners who violate these requirements may be subject to discipline by DOH or the applicable professional board. (Section 8).

Emergency Suspension of Practitioner License

The bill requires DOH issue an emergency order suspending the license of a health care practitioner who has been arrested for committing or attempting, soliciting, or conspiring to commit murder.[8] This expands DOH's authority to issue an emergency suspension for murder, which is currently limited to conviction. (Section 9).

Marriage and Family Therapist Licensure

The bill revises the marriage and family therapist licensure requirements by extending the date by which an individual must have attained a master's degree from a program that is accredited by either the Commission on Accreditation for Marriage and Family Therapy Education of the Council on Accreditation of Counseling and Related Educational Programs, from September 1, 2027, to September 1, 2032.

The bill allows master's-degree-holders who possess a degree conferred prior to September 1, 2032, to be eligible for licensure as a marriage and family therapist if the degree is from an otherwise institutionally accredited college or university with graduate courses approved by the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling. By delaying the requirement for programmatic accreditation by five years, the bill creates the opportunity for an institutionally accredited college or university to establish a new marriage and family graduate program and obtain accreditation by ensuring that the graduates of such a program will be eligible for licensure. (Section 12).

Access to Health Care Act – Sovereign Immunity

The bill extends eligibility for sovereign immunity under the Access to Health Care Act (Act) to students enrolled in an accredited dental or dental hygiene program.

This extends to dental and dental hygiene students sovereign immunity protection currently provided under the Act to students enrolled allopathic, osteopathic, chiropractic, and podiatric physician, registered nurse, licensed practical nurse, advanced practice registered nurse, and midwife programs who work under a contract with a governmental contractor[9] and provide volunteer, uncompensated health care services to low-income individuals.[10] (Section 14).

Dental Student Loan Repayment Program

[8] *See*, s. 782.04, F.S.
[9] A governmental contractor is the DOH, a county health department, a special taxing district having health care responsibilities, or a hospital owned and operated by a governmental entity. S. 766.1115(3)(c), F.S.
[10] S. 766.1115, F.S.

The bill broadens the eligibility for participation in the Dental Student Loan Repayment (DSLR) Program by allowing dentists and dental hygienists to qualify for the DSLR Program by serving all low-income[11] patients, rather than only Medicaid patients. This change allows for dentists employed in facilities that are ineligible for Medicaid enrollment, such as free clinics or prisons,[12] or otherwise employed in private practices that serve low-income clients but do not accept Medicaid, to be eligible for the DSLR Program.

The bill aligns the definition of "dental health professional shortage area" with the federal definition to include an area with a special population or a facility designated by the federal Department of Health and Human Services, in addition to geographic areas. This will expand the number of shortage areas that DOH is able to identify in the state and allow more dentists to participate in the DSLR program.

The bill also expands the settings in which a DSLR Program participant can complete their volunteer service requirement beyond only state-operated programs by allowing the requirement to be satisfied by participation in volunteer programs operated by non-profit programs in the state. (Section 1).

Dental Hygiene

The bill authorizes licensed dental hygienists to use dental diode lasers in the practice of dental hygiene under the direct supervision of a dentist, if the dental hygienist has obtained the required certification. A dentist must have a minimum of 12 hours of education and training on the use of lasers in a dental setting in order supervise the use of lasers by a dental hygienist. The bill specifies that a dental hygienist may only use a laser for the purpose of bacterial reduction or the disinfection of gingival sulcus, in a manner with the dental hygienists' scope of practice.

Prior to using laser in the practice of dental hygiene, a dental hygienist must complete an in-person course in the operation of lasers in a dental setting. The course must be a minimum of 12 hours, of which three hours must include clinical simulation laser training. The course must be provided or recognized by the Commission on Dental Accreditation of the American Dental Association, or an organization approved by the Board of Dentistry (BOD). A dental hygienist must biennially complete two hours of continuing education on the use of dental diode lasers in order to maintain their certification. The dental hygienist must submit evidence of completing the required course and the biennial continuing education hours to the BOD and prominently display the certification at the location where they are authorized to use dental diode lasers. (Section 11).

Cousin Marriage

The bill prohibits marriage between first cousins. The state will not recognize, for any purpose, marriages between first cousins that are entered into after July 1, 2026. (Section 13).

The bill provides an effective date of July 1, 2026. (Section 19).

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Medical Marijuana

[11] Under s. 766.1115(3), F.S., "low-income" means a person who is one of the following: Medicaid-eligible under Florida law, a person who is without health insurance and whose family income does not exceed 300% of the federal poverty line, or any client of DOH who voluntarily chooses to participate in a DOH program and meets the program eligibility requirements.
[12] Department of Health, *2026 Agency Legislative Bill Analysis for HB 733* (2026), pages 2-3. On file with the Health & Human Services Committee.

The Office of Medical Marijuana Use (OMMU), within DOH, regulates Florida's medical marijuana program. This includes the oversight and licensure of medical marijuana treatment centers (MMTCs).

Qualified Physicians

Only a qualified physician may certify a patient for medical use of marijuana. A qualified physician is a Florida-licensed allopathic physician or osteopathic physician, who holds an active, unrestricted license and has completed a 2-hour educational course and exam offered by the Florida Medical Association (FMA) or the Florida Osteopathic Medical Association (FOMA).[13] MMTCs are required to employ a medical director who is qualified physician. Current law requires each qualified physician and medical director to complete the 2-hour course be taken before each licensure renewal;[14] however, the law doesn't expressly specify whether the course must be completed in conjunction with the renewal of the physician's license to practice, or the MMTC's license.

Low-THC Cannabis

"Low-THC cannabis" is a marijuana product with trace amounts of tetrahydrocannabinol (THC) and higher amounts of cannabidiol (CBD). The 2014 Compassionate Medical Cannabis Act[15] authorized specified physicians to order low-THC cannabis for qualified patients. In 2017, the OMMU was established and the use of medical marijuana was expanded for use by patients suffering from certain qualifying conditions. Low-THC cannabis remained in law, maintaining the availability of low-THC cannabis for patients. MMTCs are required to produce and make available for purchase at least one "low-THC cannabis" product.[16]

Under current law, low-THC cannabis is a plant of the genus *Cannabis*, the dried flowers of which contain 0.8 percent or less of THC and more than 10 percent of CBD weight for weight; the seeds thereof; the resin extracted from any part of such plant; or any compound, manufacture, salt, derivative, mixture, or preparation of such plant or its seeds or resin that is dispensed from an MMTC.[17]

MMTCs are required under current law to test the potency of marijuana products after processing, before the product is dispensed.[18] While the definition of low-THC cannabis includes the compounds, manufactures, salts, derivatives, mixtures, and other preparations of the dried flower that can be dispensed as a final product, current law bases the potency requirement for low-THC cannabis on the dried flower, rather than the final product being dispensed. This discrepancy between regulatory testing and the statutory definition of low-THC cannabis has presented difficulties for tracking through DOH's seed-to-sale tracking system which was implemented in 2024, as well as enforcement challenges for OMMU.[19]

Medical Marijuana Emergency Rulemaking Authority

On November 7, 2016, Florida voters approved Amendment 2, Use of Marijuana for Debilitating Medical Conditions as Art. X, Sec. 29 of the Florida Constitution. The amendment authorizes patients with a debilitating medical condition to obtain medical marijuana and required DOH to adopt regulations by July 3, 2017 for:

- Patient and caregiver identification cards;
- Caregiver qualifications;
- MMTC registration process and operational regulations; and

[13] S. 381.986(3), F.S.
[14] *Id.*
[15] *See* ch. 2014-157, L.O.F., ch. 2016-123, L.O.F. and s. 381.986, F.S.
[16] S. 381.986(8), F.S.
[17] S. 381.986(1), F.S.
[18] S. 381.986(8)(e), F.S.
[19] Department of Health, *2026 Agency Legislative Bill Analysis for HB 733* (2026), p. 4. On file with the Health & Human Services Committee.

- The amount of marijuana reasonably presumed to be an adequate supply for medical use by a patient, based on best available evidence.

In 2017, the Legislature enacted a statutory framework to regulate the medical marijuana program, including granting DOH general rulemaking authority under the Administrative Procedures Act (ch. 120) and limited emergency rulemaking authority to accommodate the constitutionally imposed deadlines and implement the OMMU program.[20] The law exempts DOH from the standard for emergency rulemaking that there be an immediate danger to the public health, safety, or welfare, and from the requirement to issue a statement of estimated regulatory costs. The law also exempts the emergency rules from the 90-day expiration in ch. 120, instead allowing the emergency rules to remain in effect until DOH replaces them with non-emergency rules.

The law required DOH to initiate nonemergency rulemaking to replace all emergency rules adopted under this authority by January 1, 2018. The bill also expressly prohibited DOH from adopting emergency rules pursuant to this authority after January 1, 2018. However, for the past seven years DOH has refused to adopt nonemergency rules, and the Legislature has annually extended this deadline to avoid expiration of the emergency rules without nonemergency rules in place (which would result in an unregulated program).

In 2025, the Legislature revised the emergency rulemaking authority to require DOH and the applicable boards to initiate nonemergency rulemaking to replace all emergency rules adopted under this authority by September 1, 2025, and expressly prohibited DOH and the applicable boards from adopting emergency rules pursuant to this authority after December 31, 2025.[21] In compliance, DOH published its notice of initiating nonemergency rulemaking on August 29, 2025, to replace the following emergency rules:[22]

- 64ER20-31 Definitions;
- 64ER20-32 MMTC Packaging and Labeling;
- 64ER20-35 Standards for Production of Edibles;
- 64ER21-10 MMTC Authorization Procedures;
- 64ER21-13 MMTC Solvent-Based Extraction;
- 64ER22-1 MMTC Financial Assurance;
- 64ER22-2 MMTC Trade Name and Logo;
- 64ER22-7 MMTC Websites and Website Purchasing;
- 64ER22-8 Dosing and Supply Limits for Medical Marijuana;
- 64ER22-9 Application for MMTC Licensure;
- 64ER23-2 Caregiver Background Screening and Request for Close Relative Status;
- 64ER24-1 MMTC Seed-to-Sale Tracking System Integration;
- 64ER24-2 MMTC STS Tracking System Procedures; and
- 64ER25-1 Renewal Application Requirements for MMTCs.

However, DOH has not completed adoption of these rules. Under ch. 120, agencies must publish proposed rules within 180 days of a notice of initiating rulemaking, unless they provide the Joint Administrative Procedures Committee (JAPC) a concise statement identifying the reasons for the delay at least 7 days before the end of the 180 days.[23] On January 20, 2026, and February 13, 2026, DOH submitted the required statements to JAPC indicating that it would be unable to publish the above rules within the 180-day timeframe; however, DOH did not identify the reasons for its delay.[24] Current law requires DOH to update this statement each quarter, but does not require DOH to publish the proposed rules.[25]

[20] Section 14 of chapter 2017-232, Laws of Florida.
[21] Section 15 of chapter 2025-199, Laws of Florida.
[22] *See Notice,* Office of Medical Marijuana Use. Available at https://knowthefactsmmj.com/notices/ (last viewed February 25, 2026).
[23] S. 120.54(2)(a)2.
[24] Letters from Amanda Bush, Chief Legal Counsel, and B. Levi Gallian, Senior Attorney, Department of Health, re: Statement Required to Extend 180-day Timeframe, January 20, 2026, and February 13, 2026 (respectively), on file with the Health and Human Services Committee.
[25] *Id.*

On February 25, 2026, DOH published the proposed nonemergency rule for Caregiver Background Screening and Request for Close Relative Status and MMTC Authorization Procedures.[26] To date, DOH has not published any other proposed rules.[27]

Newborn Health

Nutritional Needs of Preterm Infants

Infants born prior to 37 weeks of gestation are considered preterm. Preterm infants often have significant medical needs requiring stays in neonatal intensive care units (NICUs) that are equipped to give the infant the best chance of survival. Preterm infants have special feeding needs, from both oral motor and nutritional perspectives, during their NICU stay and after being discharged. The last few weeks of a pregnancy are a vital phase for nutrient absorption and oral motor development for a fetus; as a result, preterm infants experience nutritional deficits and struggle to coordinate sucking, swallowing, and breathing.[28]

An infant's mother's own milk is the preferred base for an infant's diet, regardless of whether or not an infant is born preterm. Maternal milk provides the full range of nutritional, immunologic, enzymatic, and growth factors specific to the infant. Due to their increased nutritional need, preterm infants often require nutritional fortification in order to optimize growth, bone health, and development.[29] When an infant's mother's own milk is not available, donor human milk is the preferred alternative. Early feeding with human milk, standardized feeding protocols, avoidance of formula, fortification of mother's milk, infant-led oral feeding progression strategies, and clear nutrition plans at hospital discharge are the best practice for the treatment of preterm infants in the NICU. Infants who receive such care see better growth during periods of rapid brain growth, lower rates of necrotizing enterocolitis,[30] less infection, shorter number of central line days, shorter hospital stays, lower rates of sudden unexpected infant death, and fewer hospital readmissions after leaving the NICU.[31]

Newborn Screening

Newborn screening is a preventive public health service provided in every state to identify, diagnose, and manage newborns at risk for selected disorders that, without detection and treatment, can lead to permanent developmental and physical damage or death. Newborn screening is evidence-based and has been shown to be effective at reducing infant morbidity and mortality.[32] The federal government produces a list of conditions that it

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[26] See *Notice,* Office of Medical Marijuana Use. Available at https://knowthefactsmmj.com/notices/ (last viewed February 25, 2026).
[27] DOH also adopted three new emergency rules shortly before the expiration of emergency rulemaking authority on December 31, 2025. (See 64 ER25-6 MMTC Advertising and Marketing, 64 ER25-5 Marijuana Delivery Devices and 64 ER25-4 MMTC Harvest Failures and Wholesale Transfers.) DOH has not initiated nonemergency rulemaking for these rules. Because the emergency rulemaking authority and the procedural exceptions in prior law expired January 1, 2026, legal authority to maintain these rules is unclear.
[28] Stellagen, L., Kim, J., Hurst, N. (2020). *Neonatology for Primary Care, Chapter 10: Optimizing Nutrition for the Preterm, Very Low-Birth-Weight Infant After Discharge from Neonatal Intensive Care*. American Academy of Pediatrics. Available at https://publications.aap.org/first1000days/module/27506/section/b941fe12-6cf2-410b-9a1a-a4f60a054f32?target=module-content?autologincheck=redirected (last visited February 25, 2026).
[29] *Id*.
[30] Necrotizing enterocolitis (NEC) is a deadly gastrointestinal disease that primarily occurs in preterm infants. Its onset is sudden and the smallest, most premature infants are the most vulnerable. Necrotizing enterocolitis is a costly disease, accounting for nearly 20% of NICU costs annually. Necrotizing enterocolitis survivors requiring surgery often stay in the NICU more than 90 days and are among those most likely to stay more than 6 months. *See*, Gephart, S.M., et al., *Necrotizing Enterocolitis Risk: State of the Science*. (2012). Advances in Neonatal Care 12(2):p 77-87. DOI: 10.1097/ANC.0b013e31824cee94
[31] Stellagen, L., Kim, J., Hurst, N. (2020). *Neonatology for Primary Care, Chapter 10: Optimizing Nutrition for the Preterm, Very Low-Birth-Weight Infant After Discharge from Neonatal Intensive Care*. American Academy of Pediatrics. Available at https://publications.aap.org/first1000days/module/27506/section/b941fe12-6cf2-410b-9a1a-a4f60a054f32?target=module-content?autologincheck=redirected (last visited February 25, 2026).
[32] Yusuf, C., Sontag, M. K., Miller, J., Kellar-Guenther, Y., McKasson, S., Shone, S., Singh, S., & Ojodu, J. (2019). *Development of National Newborn Screening Quality Indicators in the United States*. International Journal of Neonatal Screening, 5(3), 34. https://doi.org/10.3390/ijns5030034; Watson, S., Lloyd-Puryear, M., & Howell, R. (2022). *The Progress and Future of US Newborn Screening*. International Journal of Neonatal Screening, 8:41, https://doi.org/10.3390/ijns8030041.

recommends every newborn be screened for, but each state determines the conditions newborns are screened for under their respective state's newborn screening program.[33]

Florida Newborn Screening Program

The Florida Newborn Screening (NBS) Program was initially established in 1965 to screen newborns for a single condition, phenylketonuria.[34] The NBS Program has since evolved to screen for a wide range of congenital conditions. The NBS program is housed within the DOH and serves to promote the screening of all newborns for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect.[35] The NBS Program attempts to screen all newborns to identify, diagnose, and manage newborns at risk for select disorders that, without detection and treatment, can lead to permanent developmental and physical damage or death.[36] Parents and guardians may elect to decline the screening.[37]

The Florida Genetics and Newborn Screening Advisory Council (GNASC) advises DOH on disorders to be included in the panel of screened disorders and the procedures for collecting and transmitting specimens.[38] The NBS Program currently screens for 60 different conditions, nearly all of which are screened for through the collection and testing of blood spots. Hearing screening, critical congenital heart disease, and targeted testing for congenital cytomegalovirus are completed at the birthing facility through point of care testing.[39]

Under current law, when a new condition is added to the federal Recommended Uniform Screening Panel,[40] GNASC is required to consider the condition and make a recommendation to DOH as to whether the condition should be included in the NBS Program panel within one year.[41]

GNASC reviews the recommendation to ensure:[42]

- The state's readiness to screen, diagnose, and treat the condition;
- The condition is known to result in significant impairment in health, intellect, or functional ability if not treated before clinical signs appear;
- The condition can be detected using screening methods which are accepted by current medical practice;
- The condition can be detected prior to the infant becoming 2 weeks of age, or at the appropriate age as indicated by accepted medical practice;

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[33] Health Resources & Services Administration, *History of the ACHDNC*. Available at https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/heritable-disorders/hrsa-timeline-interactive.pdf (last visited February 26, 2026).

[34] *See*, Tatiana Wing, R.C. Philips Research and Education Unit, *Newborn Screening Update* (2020). Available at https://genetics.pediatrics.med.ufl.edu/wordpress/files/2019/11/RCPU-Newborn-screening-update.pdf (last visited February 26, 2026); Watson, S., Lloyd-Puryear, M., & Howell, R. (2022). *The Progress and Future of US Newborn Screening*. International Journal of Neonatal Screening, 8:41, https://doi.org/10.3390/ijns8030041. Phenylketonuria (PKU) is a rare inherited disorder that causes an amino acid called phenylalanine to build up in the body resulting in dangerous symptoms unless a specific diet is adhered to. PKU was the first inheritable condition for which a relatively simple and repeatable blood test was able to be conducted at a high enough throughput to enable population-level screening.

[35] S. 383.14(1), F.S.

[36] Florida Department of Health, *Florida Newborn Screening 2022 Guidelines*. Available at https://floridanewbornscreening.com/wp-content/uploads/NBS-Protocols-2022-FINAL.pdf (last visited February 26, 2026).

[37] *See*, s. 383.14(4), F.S., and Rule 64C-7.008, F.A.C.; The health care provider must attempt to get a written statement of objection to be placed in the medical record.

[38] S. 383.14(5), F.S.

[39] Florida Newborn Screening, Conditions: *What is Screened*. Available at https://floridanewbornscreening.com/conditions/core-secondary-conditions/ (last visited February 26, 2026).

[40] The Recommended Uniform Screening Panel (RUSP) is a list of disorders that the Secretary of HHS recommends states screen for as part of their newborn screening program. *See*, Health Resources & Services Administration, *Recommended Uniform Screening Panel* (2024). Available at https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp (last visited February 26, 2026); Health Resources & Services Administration, *Newborn Screening Programs* (2025). Available at https://mchb.hrsa.gov/programs/newborn-screening (last visited February 26, 2026).

[41] S. 383.14(6), F.S.

[42] Department of Health, Agency Analysis of HB 1089 (2025). On file with the Health & Human Services Committee.

- After screening for the disorder, reasonable cost benefits can be anticipated through a comparison of tangible program costs with those medical, institutional, and special educational costs likely to be incurred by an undetected population; and
- When screening for a condition, sufficient pediatric medical infrastructure is available.

NBS Program Screening Process

The NBS Program involves coordination across several entities, including the Bureau of Public Health Laboratories Newborn Screening Laboratory (state laboratory), DOH Children's Medical Services (CMS) Newborn Screening Follow-up Program, and referral centers, birthing centers, and physicians throughout the state.[43] Health care providers in hospitals, birthing centers, perinatal centers, county health departments, and school health programs provide screening as part of the multilevel NBS Program screening process.[44]

Health care providers in hospitals and birthing centers collect drops of blood from the newborn's heel on a standardized specimen collection card which is then sent to the state laboratory for testing.[45] Point-of-care testing is used at the birthing facility to screen for the conditions which cannot be screened for with blood spot testing: pulse oximetry tests for critical congenital heart defect and hearing screening to detect hearing loss. Screening results are released to the newborn's health care provider; in the event of an abnormal result, the baby's health care provider, or a nurse or specialist from the Follow-up Program provides follow-up services and referrals for the child and his or her family.[46]

DOH is authorized to charge and collect a fee not to exceed $15 per live birth occurring in a hospital or birth center to administer the NBS Program.[47] DOH must calculate the annual assessment for each hospital and birth center, and then quarterly generate and mail each hospital and birth center a statement of the amount due.[48] DOH bills hospitals and birth centers quarterly using vital statistics data to determine the amount to be billed.[49] DOH is authorized to bill third-party payers for the screening tests and bills insurers directly for the cost of the screening.[50] DOH does not bill families that do not have insurance coverage.[51]

Rare Diseases

Rare Disease Advisory Council

The Legislature established the Rare Disease Advisory Council (RDAC) in 2021 to assist DOH in providing recommendations to improve health outcomes for individuals with rare diseases residing in the state.[52] The establishment of RDACs across the country is an initiative spearheaded by the National Organization for Rare

[43] S. 383.14, F.S.
[44] *Id.*
[45] Florida Newborn Screening Program, *What is Newborn Screening?* Available at https://floridanewbornscreening.com/parents/what-is-newborn-screening/ (last visited May 6, 2025). *See also,* Florida Newborn Screening, *Specimen Collection Card*, http://floridanewbornscreening.com/wp-content/uploads/Order-Form.png (last visited February 26, 2026).
[46] Department of Health, *Agency Analysis of HB 499* (2024). On file with the Health & Human Services Committee.
[47] S. 383.145(3)(g)1., F.S.
[48] *Id.*
[49] S. 383.145(3)(g), F.S.
[50] S. 383.145(3)(h), F.S.
[51] S. 383.14, F.S.
[52] S. 381.99, F.S.

Disorders (NORD),[53] a national nonprofit group advocating for individuals and families affected by rare diseases.[54] Florida was the 19th state to establish a RDAC through legislation.[55]

Florida's RDAC is directed to:[56]

- Consult with experts on rare diseases and solicit public comment to assist in developing recommendations on improving the treatment of rare diseases in Florida;
- Develop recommended strategies for academic research institutions in Florida to facilitate continued research on rare diseases;
- Develop recommended strategies for health care providers to be informed on how to more efficiently recognize and diagnose rare diseases in order to effectively treat patients; and
- Provide input and feedback in writing to DOH, the Medicaid program, and other state agencies on matters that affect people who have been diagnosed with rare diseases.

Neurofibromatosis

Neurofibromatosis (NF) refers to a group of genetic conditions that cause tumors to form on nerves throughout the body, including those in the brain, spinal cord, and nervous system.[57] There are an estimated 4 million[58] people worldwide are living with Neurofibromatosis.

NF is not a single disorder and includes Neurofibromatosis type 1 (*NF1*), and all types of Schwannomatosis (*SWN*), including NF2-related schwannomatosis (*NF2-SWN*).[59] NF1, is the most common, occurring in approximately 1 in 2,500 births. NF2-related schwannomatosis (NF2-SWN) is significantly less common, affecting about 1 in 25,000 births, and the other forms of schwannomatosis occur in roughly 1 in 70,000 births.[60]

Neurofibromatosis Type 1 (NF 1)[61]

Neurofibromatosis Type 1 (*NF1*) is the most common form of the condition and is usually diagnosed in childhood. Symptoms of *NF1* include:[62]

- Flat, light brown spots on the skin ("café au lait" spots);
- Freckling in the armpits or the groin;
- Soft, pea-sized bumps called neurofibromas;
- Plexiform neurofibromas;
- Growths on the iris of the eye (known as Lisch nodules or iris hamartomas);
- A tumor of the optic pathway (optic pathway glioma);
- Bone deformities;
- Shorter than average height and a larger head size; and

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[53] National Organization for Rare Disorders (NORD). *Project RDAC Year One* (2021). Available at https://rarediseases.org/wp-content/uploads/2021/11/NRD-2200-RDAC-Year1-Highlights_FNL.pdf (last visited February 25, 2026).
[54] National Organization for Rare Disorders (NORD). *About Us*. Available at https://rarediseases.org/about-us/ (last visited February 25, 2026).
[55] Department of Health, *Rare Disease Advisory Council: Legislative Report, Fiscal Year 2022-2023* (2023). Available at https://www.floridahealth.gov/wp-content/uploads/2025/08/Rare-Disease-Advisory-Council-Legislative-Report_2022.pdf (last visited February 25, 2026).
[56] *Id*; S. 381.99(4), F.S.
[57] National Institute of Neurological Disorders & Stroke, *Neurofibromatosis*, National Institute of Health. Available at https://www.ninds.nih.gov/health-information/disorders/neurofibromatosis (last visited February 25, 2026)
[58] Children's Tumor Foundation, *Understanding NF.* Available at https://www.ctf.org/about-nf/ (last visited February 8, 2026).
[59] *Id.*
[60] *Id.*
[61] National Institute of Neurological Disorders & Stroke, *Neurofibromatosis*, National Institute of Health, available at https://www.ninds.nih.gov/health-information/disorders/neurofibromatosis (last visited February 25, 2026)
[62] *Id.*

- Learning difficulties and attention deficit hyperactivity disorder.

Complications of NF1 include various vascular conditions, more common and aggressive scoliosis and increased risk of gastrointestinal stromal tumors, among others. Additionally, children with NF1 have a higher risk for learning disabilities.[63]

Neurofibromatosis Type 2 (NF2-SWN)[64]

NF2-Schwannomatosis (*NF2-SWN*) is usually diagnosed in young adulthood and up to age 30, although they can begin at any age. The most common features of *NF-2* include benign, slow-growing tumors affecting cranial, spinal and peripheral nerves and the covering of the brain and spinal cord.[65]

Complications of NF2-SWN include:[66]

- Hearing loss or ringing in the ears and problems with balance related to vestibular schwannomas;
- Vision problems such as cataracts;
- Peripheral neuropathy; and,
- Schwannomas[67] on the skin.

Treatment for Neurofibromatosis

Currently, there is no cure for neurofibromatosis, but treatments are available to help manage symptoms and other conditions that may develop. People with neurofibromatosis are recommended to get regular screenings through routine eye and physical exams and be seen regularly by a specialist.[68] Children with NF1 have a higher risk for learning disabilities and are recommended to undergo neuropsychological assessments. Cochlear implants, hearing aids, auditory brain stem implants, mobility devices, and corrective eyewear may help individuals with NF2-SWN manage hearing, movement, and vision problems.[69]

Research

The National Institute of Neurological Disorders and Stroke (NINDS) is the leading federal funder of NF research. NINDS supports new and innovative research to understand, prevent, diagnose, and treat NF.[70] NF research is also supported at the federal level through the Department of Defense's Congressional Directed Medical Research Programs[71], which administers the Neurofibromatosis Research Program to advance studies in tumor biology, biomarker development, and clinical therapeutics.

Infantile Krabbe Disease

Krabbe disease is a rare genetic condition that affects approximately 1 out of every 100,000 individuals. It's an inherited condition caused by a mutated GALC gene – the mutation leads to an enzyme (GALC) deficiency and the

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[63] *Id.*
[64] *Id.*
[65] *Id.*
[66] *Id.*
[67] A schwannoma is a tumor that develops from Schwann cells in your peripheral nervous system or nerve roots. *Schwannoma*, Cleveland Clinic, available at https://my.clevelandclinic.org/health/diseases/17877-schwannoma (last viewed February 9, 2026).
[68] National Institute of Neurological Disorders & Stroke, *Neurofibromatosis*, National Institute of Health, available at https://www.ninds.nih.gov/health-information/disorders/neurofibromatosis (last visited February 25, 2026)
[69] *Id.*
[70] *Id.*
[71] Neurofibromatosis Research Program (NFRP), *Congressional Directed Medical Research Programs*, U.S. Department of Defense, available at https://cdmrp.health.mil/nfrp/default (last visited February 7, 2026).

build-up of neurotoxins (psychosine) which cause rapidly progressing neurological deterioration and ultimately leads to death.[72]

There are several subtypes of Krabbe disease that depend on the age of symptom onset, but the most common form is infantile Krabbe disease (IKD). Clinical symptoms of IKD begin to present at 4 to 6 months of age with restlessness, irritability, vomiting, feeding difficulty, hypersensitivity and failure to thrive. The disease progresses rapidly and is generally fatal by age 2.[73]

Treatment

There is no cure for IKD. The most appropriate treatment depends on several factors, such as the severity of symptoms at the time of diagnosis.

Hematopoietic stem cell transplant (HSCT) is the most effective treatment for IKD. HSCT is not a cure for IKD, but when provided in the first 4-6 weeks of life, it can lower the risk of death in early childhood and reduce the severity of symptoms. HSCT does come with its own risks – there is a 10% risk of death within 100 days of receiving treatment, and affected individuals can still have significant functional impairment.[74]

For symptomatic infants who are not candidates for HSCT, treatment is generally focused on increasing the quality of life and avoiding complications. Such treatments include muscle relaxants, anticonvulsants, physical, occupational, and speech therapy, depending on the symptoms.[75]

Screening for Infantile Krabbe Disease

Accurate screening of newborns for IKD requires a two-tier methodology. The first-tier screening method measures GALC enzyme activity using dried blood spots commonly collected for newborn screening (NBS) programs. Low GALC enzyme activity indicates a higher risk for IKD, but is not sufficient to diagnose IKD. Second-tier screening typically measures blood psychosine levels, which can be taken from the original dried blood spot specimen or a subsequent sample. Very elevated concentration of psychosine would indicate a presumptive positive result for IKD; further testing and consultation with relevant specialists is necessary for a confirmed positive diagnosis.

Diagnosing IKD in asymptomatic infants early enough to significantly affect health outcomes is a time-critical endeavor requiring significant coordination between components of a state's NBS program. IKD is currently included in 18 other states' newborn screening panel.[76] Florida's Genetics and Newborn Screening Advisory Council (GNASC) considered IKD for inclusion in the state NBS panel in June, 2025, but voted not to begin screening for IKD at that time.[77]

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[72] Health and Resources and Services Administration, Maternal and Child Health Bureau, *Newborn Screening for Infantile Krabbe Disease: A Summary of the Evidence and Advisory Committee Decision* (2024). Available at https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/heritable-disorders/rusp/infantile-krabbe-disease-brief-report.pdf (last visited February 26, 2026).
[73] Orsini J.J., et al., *Krabbe Disease*. (2018).. In: Adam MP, Bick S, Mirzaa GM, et al., editors. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2026. Available at https://www.ncbi.nlm.nih.gov/books/NBK1238/ (last visited February 26, 2026).
[74] Kwon, J,M., et al., *Consensus Guidelines for Newborn Screening, Diagnosis and Treatment of Infantile Krabbe Disease* (2018). Orphanet Journal of Rare Diseases, 13:30, DOI 10.1186/s13023-018-0766-x Available at https://link.springer.com/content/pdf/10.1186/s13023-018-0766-x.pdf (last visited February 26, 2026).
[75] Jain, M. & De Jesus, O., *Krabbe Disease* (2023). StatPearls Publishing. Available at https://www.ncbi.nlm.nih.gov/books/NBK562315/ (last visited February 26, 2026).
[76] KrabbeConnect, Krabbe Disease Newborn Screening. Available at https://krabbeconnect.org/krabbe-disease/krabbe-disease-newborn-screening/ (last visited February 26, 2026).
[77] Florida Newborn Screening Program, *Genetics and Newborn Screening Advisory Council Meeting Minutes for June 27, 2025*. (2025). Available at https://floridanewbornscreening.com/wp-content/uploads/Final-Minutes-GNSAC-6-27-25.pdf (last visited February 26, 2026).

The Individuals with Disabilities Education Act & Florida's Early Steps Program

The Individuals with Disabilities Education Act (IDEA)[78] is the main federal statute governing special education and early intervention services for children with disabilities from birth through age 21. The IDEA makes available a free, appropriate public education to eligible children with disabilities and ensures special education and related services to those children. The IDEA governs how states and public agencies provide early intervention, special education, and related services to more than eight million (as of school year 2022-23) eligible infants, toddlers, children, and youth with disabilities.[79]

IDEA Part C

Part C of the IDEA awards grants to assist states in implementing statewide systems of coordinated, comprehensive, multidisciplinary, interagency programs and making early intervention services (EIS) available to children with disabilities, aged birth through two, and their families,[80] usually as provided pursuant to an individualized family support or service plan (IFSP). An IFSP is a document or written plan that contains information on the child's present level of development in all areas, outcomes for the child and family, and services the child and family will receive to help them achieve the outcomes.[81]

EIS provides for the early identification and treatment of children under age three (36 months), who are at risk[82] of having, or who have, developmental delays or related conditions.[83] The IDEA requires that state programs provide EIS, to the maximum extent appropriate, in natural environments, such as the home or community settings where children would be participating if they did not have a disability; these services can be provided in another setting only when EIS cannot be achieved satisfactorily for the infant or toddler in a natural environment.[84]

The Early Steps Program

The Early Steps Program is Florida's implementation of the IDEA Part C. As such, Early Steps is governed by and must comply with all Federal policies that are related and relevant to IDEA Part C.[85] Early Steps is an early intervention program for infants and toddlers who are at risk of developmental delays or have a developmental disability. Early Steps is administered by DOH and operates on a multidisciplinary, family-focused model where services are delivered in home and community-based settings within the context of everyday routines, activities, and places the family frequents.[86]

DOH works in conjunction with the Department of Education (DOE) and the Agency for Health Care Administration (AHCA) to administer the Early Steps program. Early Steps works in partnership with DOE to transition the child from Part C (early intervention services) to Part B (school-based services) of the IDEA program and AHCA facilitates reimbursements for early intervention services delivered to Medicaid-eligible children. AHCA maintains

[78] The Education for All Handicapped Children Act became law in 1975 and was reauthorized as the Individuals with Disabilities Education Act.
[79] US Department of Education, *About IDEA: History of the IDEA.* Available at https://sites.ed.gov/idea/about-idea/#IDEA-History (last visited February 21, 2026).
[80] U.S. Department of Education, *Early Intervention Program for Infants and Toddlers with Disabilities, Purpose.* Available at https://www2.ed.gov/programs/osepeip/index.html (last visited February 21, 2026).
[81] *See*, Early Childhood Technical Assistance Center (ECTA), *Part C of IDEA Overview* (2025). Available at https://ectacenter.org/~pdfs/partc/ecta-part-c-overview.pdf (last visited February 21, 2026, 2026).
[82] 34 C.F.R. s. 303.5.
[83] Agency for Health Care Administration, *Florida Medicaid Early Intervention Services Coverage Policy* (2023). Available at https://ahca.myflorida.com/content/download/5946/file/59G-4.085_EIS_Coverage_Policy_9.22.2023.pdf (last visited February 21, 2026).
[84] U.S. Department of Education, *Early Intervention Program for Infants and Toddlers with Disabilities, Purpose*. Available at https://www2.ed.gov/programs/osepeip/index.html (last visited February 21, 2026).
[85] *Id.*
[86] Department of Health, *2026 Agency Legislative Bill Analysis for HB 733* (2026), p. 4. On file with the Health & Human Services Committee.

the Early Intervention Services (EIS) Coverage Policy and associated fee schedule for Early Steps services delivered to Medicaid-eligible children.[87]

Early Steps Extended Option

In 2025, the Legislature created the Early Steps Extended Option, requiring DOH to establish an option for eligible children to continue to receive Early Steps services after the child ages-out or turns three years old.[88] DOH is required to apply for federal approval to extend eligibility for services by July 1, 2026.[89]

The implementation of the Early Steps Extended Option necessitates significant changes to the policies and program model of the Early Steps Program, which must go through a public participation process and be submitted to the federal Office of Special Education Programs for approval to ensure alignment with CFR language. Current law includes detailed, locally-executed directives that overlap with, but do not completely align with federal law. These redundancies create confusion for local service providers and may slow the application and approval process.[90]

University of Florida Center for Autism and Neurodevelopment

The University of Florida Center for Autism and Neurodevelopment (UF CAN) is operated within the University of Florida's College of Medicine. The mission of UF Can is to:[91]

- Provide centralized and state of the art transdisciplinary diagnostic and clinical treatment services for children and adults with neurodevelopmental disorders.
- Use basic, clinical, and translational science approaches to answer key questions and accelerate research about autism and other neurodevelopmental disorders.
- Inform, expand, and facilitate innovative university training programs in assessment, treatment, and education of individuals with neurodevelopmental disorders among medical, nursing, psychology, education, and other professionals.
- Empower families to partner with clinicians and researchers to expand community outreach, increase advocacy efforts, and extend the care of individuals with neurodevelopmental disorders throughout their lifespan.
- Create an inclusive local community by providing support during the transition to adulthood for an individual's autism and neurodevelopmental disorders.

In 2025, the Legislature tasked UF CAN with developing an autism micro-credential to provide both certified and noncertified instructional personnel, prekindergarten instructors, and child care personnel with the knowledge and skills needed to support children and students with autism.[92] The autism micro-credential must require competency in:[93]

- Identifying behaviors associated with autism.
- Supporting the learning environment in a general education or specialized classroom setting.
- Promoting the use of assistive technologies.
- Applying evidence-based instructional practices.

[87] Agency for Health Care Administration, *Florida Medicaid Early Intervention Services Coverage Policy* (2023). Available at https://ahca.myflorida.com/content/download/5946/file/59G-4.085_EIS_Coverage_Policy_9.22.2023.pdf (last visited February 21, 2026).
[88] *See*, Ch. 2025-95, L.O.F.
[89] S. 391.3081, F.S.
[90] Department of Health, *2026 Agency Legislative Bill Analysis for HB 733* (2026), p. 5. On file with the Health & Human Services Committee.
[91] University of Florida, Center for Autism and Neurodevelopment, *About Overview*. Available at https://autism.psychiatry.ufl.edu/about-overview/ (last visited January 30, 2026).
[92] Ch. 2025-95, L.O.F.
[93] S. 1004.551, F.S.

The micro-credential must be provided at no cost to eligible participants and be competency based, allowing participants to complete the credentialing process either in person or online. Under current law, eligible participants include instructional personnel, prekindergarten instructors, and child care personnel.[94] Early intervention service providers credentialed through the Early Steps Program are not currently eligible for the micro-credential. Enrollment for the micro-credential is expected to open in the summer of 2026.[95]

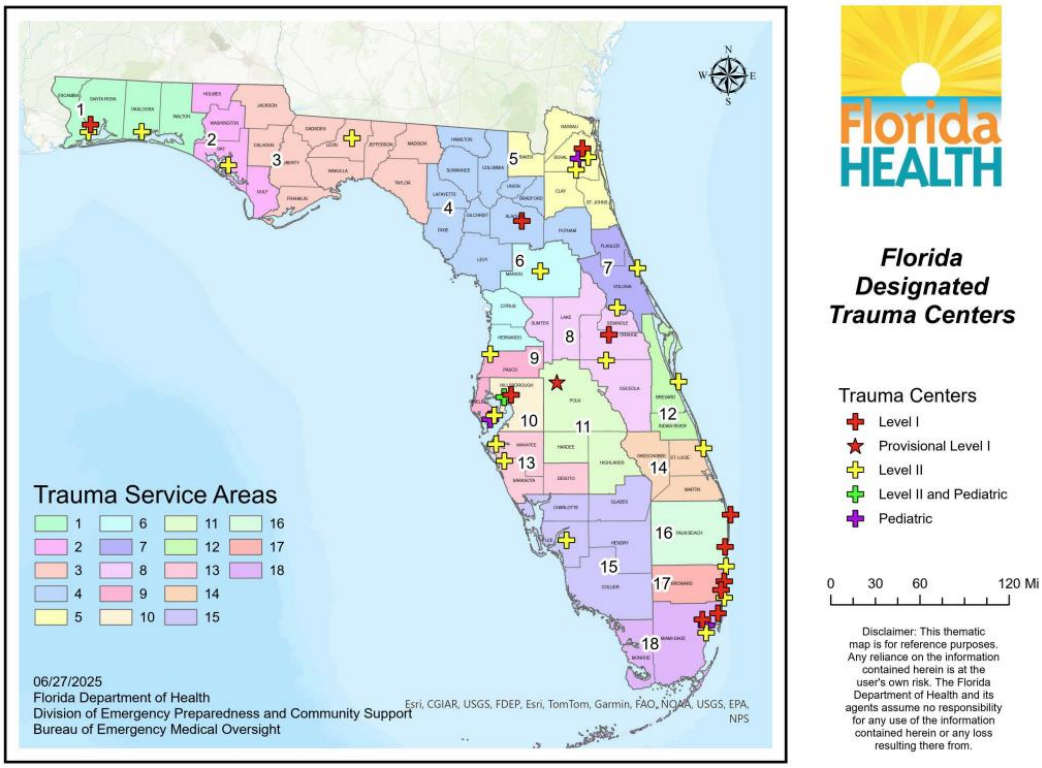
Pediatric Trauma Centers

Florida's Trauma System

A trauma center is a type of hospital that provides trauma surgeons, neurosurgeons, and other surgical and non-surgical specialists and medical personnel, equipment, and facilities for immediate or follow-up treatment of severely injured patients who have sustained a single or multisystem injury due to blunt or penetrating means or burns.[96] Care of trauma patients at a designated trauma center leads to better outcomes and significantly reduces mortality risk following traumatic injuries than care at a non-designated facility.[97]

DOH is responsible for designating trauma centers in each of the state's 18 Trauma Service Areas (TSAs).[98] Current law requires each TSA have a minimum number of trauma centers based primarily on the TSAs population.[99]

Florida's Trauma Service Areas[100]



[94] *See*, s. 1004.551, F.S.
[95] University of Florida, Center for Autism and Neurodevelopment, Florida Senate Bill 112 – Children with Developmental Disabilities. Available at https://autism.psychiatry.ufl.edu/advocacy/florida-senate-bill-112/ (last visited January 30, 2026).
[96] Smith, S., & Scantling, D. R. (2025). Improving care and equity in the American trauma system: past, present and future. *Trauma surgery & acute care open*, *10*(2), e001729. https://doi.org/10.1136/tsaco-2024-001729
[97] Southern, A.P., Celik, D.H., EMS: *Trauma Center Designation* (2025). In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available at https://www.ncbi.nlm.nih.gov/books/NBK560553/ (last visited January 31, 2026).
[98] S. 395.4001, F.S.
[99] S. 395.402, F.S.
[100] Department of Health, *Florida Designated Trauma Centers* (2025). Available at https://www.floridahealth.gov/wp-content/uploads/2025/08/florida-trauma-centers-map.pdf (last visited February 25, 2026).

Each TSA must have at least one Level I or Level II trauma center. DOH may not designate an existing Level II trauma center as a new pediatric trauma center or designate an existing Level II trauma center as a Level I trauma center in a trauma service area that already has an existing Level I or pediatric trauma center.[101]

Florida Trauma Center Levels[102]	
Type	Description
Level I	• Treats both adult and pediatric trauma victims.[103] • Clinical capabilities may exceed those of a Level II. • Must have a formal research program. • Serves as a resource facility to Level II trauma centers, pediatric trauma centers, and general hospitals.
Pediatric	• Treats primarily pediatric trauma victims. • Must have a formal research program.
Level II	• Treats primarily adult trauma victims.

Specialty Children's Hospitals and Pediatric Trauma Centers

AHCA licenses specialty children's hospitals that provide the full range of medical services offered by general hospitals, but are specialized in providing such care to children.[104] There are four hospitals currently licensed as specialty children's hospitals in the state: John Hopkins All Childrens Hospital, Nicklaus Children's Hospital, Wolfson Children's Hospital, and Nemours Children's Hospital.[105]

Severely injured children require unique resources and specialized care due to immature anatomical features and developing psychological functions. Hospitals that have pediatric-specific equipment and staff who are experienced in providing care for injured children are the best qualified to meet the needs of pediatric trauma victims.[106]

A pediatric trauma center is hospitals that DOH has verified to be in substantial compliance with pediatric trauma center standards as established by DOH rule and has been approved by DOH to operate as a pediatric trauma center. There are currently three specialty children's hospitals designated as pediatric trauma centers in the state:[107]

- John Hopkins All Children's Hospital;
- Nicklaus Children's Hospital; and
- Wolfson Children's Hospital.

[101] Except as otherwise provided in s. 395.4025(16), F.S.; S. 395.402, F.S.
[102] Florida Trauma System Advisory Council, *Comparative Study: Florida Pediatric Trauma Center Verification* (2018). Available at https://www.floridahealth.gov/wp-content/uploads/2025/08/comparative-study-florida-pediatric-trauma-center-verification.pdf (last visited February 25, 2026).
[103] The Florida Trauma Center Standards require Level 1 trauma centers to have the resources to treat injured children. *See*, Florida Trauma System Advisory Council, *Comparative Study: Florida Pediatric Trauma Center Verification* (2018). Available at https://www.floridahealth.gov/wp-content/uploads/2025/08/comparative-study-florida-pediatric-trauma-center-verification.pdf (last visited February 25, 2026).
[104] *See*, Rule 59A-3.252, F.A.C.; S. 395.002(28), F.S.
[105] *See*, Agency for Health Care Administration, *Health Care Transparency: Facility/Provider Location Search*. Available at https://quality.healthfinder.fl.gov/Facility-Search/FacilityLocateSearch (last visited February 26, 2026). Input: Facility/Provider Type: Hospital and Classification *: Class 2 Hospital for Children and submit search.
[106] Florida Trauma System Advisory Council, *Comparative Study: Florida Pediatric Trauma Center Verification* (2018). Available at https://www.floridahealth.gov/wp-content/uploads/2025/08/comparative-study-florida-pediatric-trauma-center-verification.pdf (last visited February 25, 2026).
[107] Department of Health, *Florida Trauma Centers* (2025). Available at https://www.floridahealth.gov/wp-content/uploads/2025/08/Florida-Trauma-Centers.pdf (last visited February 25, 2026).

Home Health Aides for Medically Fragile Children

The Legislature created the Home Health Aide for Medically Fragile Children (HHAMFC) Program in 2023 to allow family caregivers to be paid for providing home care for their medically fragile children.[108] The HHAMFC Program is intended to alleviate the effects of the national home health care staffing shortage on medically fragile children and their family caregivers, and provide an opportunity for family caregivers to receive training and gainful employment. Hours of service provided by family caregivers offset the number of hours ordered for private duty nursing.

The HHAMFC Program allows a family caregiver to be reimbursed by Medicaid for providing care to a relative who is 21 years old or younger with an underlying physical, mental, or cognitive impairment that prevents him or her from safely living independently. The medically fragile child must be eligible to receive skilled care or respite care services under the Medicaid program.[109] Under the HHAMFC Program, AHCA is required to reimburse a home health agency for services provided by a HHAMFC Program family caregiver at a rate of $25 per hour for up to 8 hours per day.[110]

In order to participate, a family caregiver must be at least 18 years old, demonstrate a minimum ability to read and write, and successfully pass background screening requirements. The family caregiver must also complete an approved training program or have graduated from an accredited prelicensure nursing education program[111] and are waiting to take the nurse licensing exam.[112]

Authorized Tasks

A family caregiver in the HHAMFC Program is authorized to perform certain tasks if delegated by a registered nurse, including medication administration and tasks associated with:[113]

- Activities of daily living, including bathing, dressing, eating, maintaining continence, toileting, and transferring;
- Maintaining mobility;
- Nutrition and hydration;
- Assistive devices;
- Safety and cleanliness;
- Data gathering;
- Reporting abnormal signs and symptoms;
- Postmortem care;
- End-of-life care;
- Patient socialization and reality orientation;
- Cardiopulmonary resuscitation and emergency care;
- Residents' or patients' rights;
- Documentation of services performed;
- Infection control;
- Safety and emergency procedures;
- Hygiene and grooming;
- Skin care and pressure sore prevention;
- Wound care;

[108] Ch. 2023-183, Laws of Fla.
[109] S. 400.462(12), F.S.
[110] S. 400.4765(9), F.S.
[111] *See*, s. 464.019, F.S.
[112] S. 400.4765(2), F.S.
[113] S. 400.462(18), F.S.

- Portable oxygen and other respiratory procedures;
- Tracheostomy care;
- Enteral care and therapy; and
- Peripheral intravenous assistive activities and alternative feeding methods.

Services provided by a family caregiver must not duplicate private duty nursing services provided to an eligible recipient and must result in a reduction in the number of private duty nursing service hours provided to an eligible recipient.[114]

Current law prohibits a family caregiver in the HHAMFC Program from administering any controlled substance listed in Schedule II, Schedule III, or Schedule IV medications.[115]

Health Care Practitioner Licensure and Regulation

The Division of Medical Quality Assurance (MQA), within DOH has general regulatory authority over health care practitioners.[116] The MQA works with 22 professional boards and four councils to license and regulate seven types of health care facilities and more than 40 health care professions. Each health care profession is regulated by chapter 456, F.S., which provides general regulatory and licensure authority for the MQA, as well as a profession- or field-specific practice act.[117]

Health Care Practitioner Discipline

The typical process for disciplinary proceedings against a licensed health care practitioner begins when a complaint is filed. DOH investigates complaints for legal sufficiency,[118] and if a complaint is determined to be legally sufficient, all investigative findings must be submitted to a panel to be assessed for probable cause.[119] Upon a finding of probable cause, DOH is required to file a formal complaint, and may choose to prosecute the complaint pursuant to Chapter 120, F.S.[120] Professional boards and DOH may issue a reprimand or letter of concern, assess fines, suspend or restrict licenses, or revoke licenses, among other penalties, based on the nature of the violation.[121]

Under current law, any advertisement for health care services naming the practitioner must identify the type of license that the practitioner holds.[122] Failure for a practitioner to do so constitutes grounds for discipline.[123] However, there is no requirement for a practitioner to include their full name and license number in advertisements.

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[114] S. 400.4765(7), F.S.
[115] S. 464.0156, F.S.
[116] Pursuant to s. 456.001(4), F.S., health care practitioners are defined to include acupuncturists, physicians, physician assistants, chiropractors, podiatrists, naturopaths, dentists, dental hygienists, optometrists, nurses, nursing assistants, pharmacists, midwives, speech language pathologists, nursing home administrators, occupational therapists, respiratory therapists, dieticians, athletic trainers, orthotists, prosthetists, electrologists, massage therapists, clinical laboratory personnel, medical physicists, dispensers of optical devices or hearing aids, physical therapists, psychologists, social workers, mental health counselors, and psychotherapists, among others.
[117] Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, FY 2024-25* (2025). Available at https://www.floridahealth.gov/wp-content/uploads/2026/01/2025.10.31.FY24-25MQAAR-FINAL1-1.pdf (last visited February 24, 2026).
[118] S. 456.073(1), F.S.; a complaint is legally sufficient if it contains ultimate facts that show that a violation of Ch. 456, F.S., of any of the practice acts relating to the professions regulated by the department, or of any rule adopted by the department or a regulatory board in the department has occurred.
[119] S. 456.073(4), F.S.
[120] *Id.*
[121] *See*, s. 456.072, F.S.
[122] This requirement does not apply to practitioners providing services in facilities licensed under chs. 394, 395, 400, or 429, F.S.; see, 456.072(1)(t), F.S.
[123] *See*, s. 456.072(2), F.S.

Emergency Suspensions

DOH may issue an emergency license suspension, sometimes referred to as a summary suspension, if necessary to protect the public. There are two types of emergency actions DOH may take: mandatory and discretionary. Mandatory emergency suspensions are those suspensions the Department is required to take by law, typically for criminal offenses. Discretionary emergency actions are authorized when the Department finds that a licensee poses an immediate serious danger to the public health, safety, or welfare. All emergency actions are subject to appeal; however, discretionary emergency actions are subject to strict judicial review to ensure the order is necessary and only uses the minimum amount of restriction necessary to protect the public. The procedure for issuing an emergency suspension must meet the following criteria.[124]

- The procedure must provide at least the same procedural protection as is given by other statutes, the state Constitution, or the United States Constitution;
- DOH must take only that action necessary to protect the public interest under the emergency procedure; and
- DOH must state in writing at the time of, or prior to, its action the specific facts and reasons for finding an *immediate danger to the public health, safety, or welfare* and its reasons for concluding that the procedure used is fair under the circumstances.

Mandatory suspension applies to certain criminal convictions and arrests. DOH is required to immediately suspend the license of any health care practitioner who has plead guilty or nolo contendere to or has been *convicted* of the following offenses:[125]

- Felony Medicare or Medicaid fraud under ch. 409, F.S.;
- Felony fraud under ch. 817, F.S.;
- Felony drug offenses under ch. 893, F.S., and equivalent charges under federal law;
- Misdemeanors or felonies under federal law relating to the Medicaid program;
- Felonies under s. 784.086, F.S., relating to reproductive battery;[126] and
- Felonies under ch. 782, F.S., relating to homicide.

DOH is also required to suspend the license of any health care practitioner who has been convicted of *or arrested for* committing or attempting, soliciting, or conspiring to commit any act that would constitute a violation of 34 enumerated felony crimes, including sexual battery, kidnapping, lewd or lascivious offenses, and racketeering.

Current law does not require DOH to suspend the license of a practitioner who has been arrested for committing or attempting, soliciting, or conspiring to commit murder.[127] DOH is aware of 31 licensed health care practitioners arrested for murder between July 1, 2021 and June 5, 2025, however, DOH was unable to take emergency action on these practitioners upon arrest.[128] DOH would have to exercise discretionary authority to take emergency action in these cases, and each case may not meet the public danger standard for such actions.

[124] S. 120.60(6), F.S.
[125] S. 456.074(1), F.S.
[126] *See*, s. 786.086(2), F.S.; reproductive battery refers to a criminal act wherein a health care practitioner intentionally transfers into the body of a patient reproductive material of a donor knowing that the patient has not consented to the use of reproductive material from that donor.
[127] S. 456.074(5), F.S.
[128] Department of Health, *2026 Agency Legislative Bill Analysis for HB 733* (2026). On file with the Health Professions & Programs Subcommittee.

Marriage & Family Therapist Licensure

The practice of marriage and family therapy incorporates psychotherapy, hypnotherapy, sex therapy, counseling, behavior modification, consultation, client-centered advocacy, crisis intervention, and the provision of needed information and education to clients.[129]

To qualify for licensure as a marriage and family therapist, an applicant must:[130]

- Possess a master's degree from a program accredited by either:
  - The Commission on Accreditation for Marriage and Family Therapy Education;
  - The Council on Accreditation of Counseling and Related Educational Programs with coursework with an emphasis in marriage and family therapy and approved by the board; or
  - For master's degrees conferred before September 1, 2027, programs may be institutionally accredited with graduate courses approved by the board.
- Pass a board-approved examination;[131] and
- Demonstrate knowledge of laws and rules governing the practice.[132]

DOH may also issue a dual license in marriage and family therapy to anyone who meets the following requirements:[133]

- Holds a valid, active license as a psychologist,[134] a clinical social worker or mental health counselor,[135] or is a licensed advanced practice registered nurse with a specialty in psychiatric nursing;[136]
- Has held a valid, active license for at least three years; and
- Has passed the examination required for licensure as a marriage and family therapist.

There are approximately 3,713 marriage and family therapists with active licenses to practice in Florida.[137]

Access to Health Care Act – Sovereign Immunity

The "Access to Health Care Act" (Act), established by s. 766.1115, F.S., was enacted in 1992 to encourage health care providers to provide care to low-income persons.[138] DOH administers the Act through the Volunteer Health Services Program, which works with DOH entities and community and faith-based health care providers to promote access to quality health care for the medically underserved and uninsured in this state.[139] A contract under the Act must pertain to volunteer, uncompensated services for which the provider may not receive compensation from the governmental contractor for any services provided under the contract and must not bill or

[129] S. 491.003(9), F.S.
[130] S. 491.005(3), F.S. An individual may qualify for a dual license in marriage and family therapy if he or she passes an examination in marriage and family therapy and has held an active license for at least three years as a psychologist, clinical social worker, mental health counselor, or advanced registered nurse practitioner who is determined by the Board of Nursing to be a specialist in psychiatric mental health (s. 491.0057, F.S.)
[131] Rule 64B4-3.003, F.A.C., establishes the examination developed by the Examination Advisory Committee of the Association of Marital and Family Therapy Regulatory Board as the approved exam.
[132] Rule 64B4-3.0035, F.A.C., requires licensure applicants complete a course on the laws and rules of Florida as they pertain to the relevant profession. The course must include a testing mechanism on which the applicant must obtain a passing score of at least 80 percent.
[133] s. 491.0057, F.S.
[134] Psychologists are licensed under ch. 490, F.S.
[135] Clinical social workers and mental health counselors are licensed under ch. 491, F.S.
[136] Advanced practice registered nurses are licensed under s. 464.012, F.S.
[137] Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, FY 2024-25* (2025). Available at https://www.floridahealth.gov/wp-content/uploads/2026/01/2025.10.31.FY24-25MQAAR-FINAL1-1.pdf (last visited February 24, 2026).
[138] Under s. 766.1115(3), F.S., "low-income" means a person who is one of the following: Medicaid-eligible under Florida law, a person who is without health insurance and whose family income does not exceed 300% of the federal poverty line, or any client of DOH who voluntarily chooses to participate in a DOH program and meets the program eligibility requirements.
[139] Department of Health, *Volunteer Health Services*. Available at https://www.floridahealth.gov/provider-and-partner-resources/volunteer-health-services-opportunities/index.html (last visited March 26, 2025).

accept compensation from the recipient or any public or private third-party payor for the specific services provided to the low-income recipients covered by the contract.[140] The governmental contractor must provide written notice to each patient, or the patient's legal representative, receipt of which must be acknowledged in writing, that the provider is covered under s. 768.28, F.S., for purposes of legal actions alleging medical negligence.[141]

The Act grants sovereign immunity[142] to health care providers who execute a contract with a governmental contractor[143] and who, as agents of the state, provide volunteer, uncompensated health care services to low-income individuals. Health care providers included under the Act are allopathic, osteopathic, chiropractic, and podiatric physicians, registered nurses, licensed practical nurses, advanced practice registered nurses, midwifes, dentists, dental hygienists, and students currently enrolled in any accredited program preparing students for one of the listed professions, except for dental and dental hygiene students.[144]

Dental Student Loan Repayment Program

Dental Health Professional Shortage Areas

In the U.S., the dental care workforce is primarily composed of dentists and allied professionals including dental hygienists and dental assistants who provide dental care and oral health education to patients in a variety of settings. Unfortunately, there are not enough dental professionals to serve the needs of the U.S. population, and the majority of dental professionals are disproportionately concentrated in urban and suburban areas.[145]

The U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas (HPSAs). A HPSA is a geographic area, population group, or health care facility that has been designated by the HRSA as having a shortage of health professionals. There are three categories of HPSA: primary care, dental health, and mental health.[146] HPSAs can be designated as geographic areas; areas with a specific group of people such as low-income populations, homeless populations, and migrant farmworker populations; or as a specific facility that serves a population or geographic area with a shortage of providers.[147]

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[140] S. 766.1115(3)(a), F.S.
[141] S. 766.1115(5), F.S.
[142] The legal doctrine of sovereign immunity prevents a government from being sued in its own courts without its consent. According to United States Supreme Court Justice Oliver Wendell Holmes, citing the noted 17th century Hobbes work, *Leviathan*, "a sovereign is exempt from suit, not because of any formal conception or obsolete theory, but on the logical and practical ground that there can be no legal right as against the authority that makes the law on which the right depends." State governments in the United States, as sovereigns, inherently possess sovereign immunity. Article X, section 13 of the Florida Constitution recognizes the concept of sovereign immunity and gives the Legislature the power to waive immunity in part or in full by general law. S. 768.28, F.S., contains the limited waiver of sovereign immunity applicable to the state. Under this statute, officers, employees, and agents of the state will not be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function. However, personal liability may result from actions committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. When an officer, employee, or agency of the state is sued, the state steps in as the party litigant and defends against the claim. A person may recover no more than $200,000 for one incident and the total for all recoveries related to one incident is limited to $300,000. The sovereign immunity recovery caps do not prevent a plaintiff from obtaining a judgment in excess of the caps, but the plaintiff cannot recover the excess damages without action by the Legislature. *See* Black's Law Dictionary, 3rd Pocket Edition, 2006; *Kawananakoa v Polyblank*, 205 U.S. 349, 353 (1907); Fla. Jur. 2d, Government Tort Liability, Sec. 1.; S. 768.28, F.S.
[143] A governmental contractor is the DOH, a county health department, a special taxing district having health care responsibilities, or a hospital owned and operated by a governmental entity. S. 766.1115(3)(c), F.S.
[144] S. 766.1115(3), F.S.,
[145] *Id.*
[146] National Health Service Corps, *Health Professional Shortage Areas (HPSAs) and Your Site.* Available at https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/workforce-shortage-areas/nhsc-hpsas-practice-sites.pdf, (last visited January 30, 2026).
[147] HRSA, *What is a Shortage Designation?* Available at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas, (last visited January 30, 2026).

As of December 31, 2024, 5,907,517 Floridians live in one of the 274 dental HPSAs in the state. The state would need 1,256 dentists appropriately distributed throughout the state to eliminate these shortage areas.[148] Florida dentists are disproportionately concentrated in the most populous areas of the state, while rural areas are significantly underserved. Two counties, Dixie and Gilchrist, have no licensed dentists, while other counties have more than 80 dentists per 100,000 residents.[149]

DSLR Eligibility

In 2019, the Legislature established the DSLR Program under DOH in order to support the state Medicaid program and promote access to dental care by supporting qualified dentists and dental hygienists who treat medically underserved populations.

Under the program, a Florida-licensed dentist or dental hygienist is eligible to participate if they:

- Maintain active employment in a public health program[150] or private practice that serves Medicaid recipients and other low-income patients and is located in a dental HPSA[151] or a medically underserved area; and
- Volunteer 25 hours per year providing dental services in a free clinic that is located in a dental health professional shortage area or a medically underserved area, through another volunteer program operated by the state pursuant to part IV of chapter 110, or through a pro bono program approved by the Board of Dentistry.[152]

The amount of the award is equal to 20 percent of the principal loan amount owed by the participating dentist or dental hygienist, but may not exceed $50,000 per year, up to a maximum of $250,000 over five years.[153] The Loan Program may only cover loans to pay the costs of tuition, books, dental equipment and supplies, uniforms, and living expenses and must be made directly to the holder of the loan. All repayments are contingent upon continued proof of eligibility and the state is not responsible for the collection of any interest charges or other remaining loan balances.[154]

Dental Hygienists

A dental hygienist provides education, preventive, and delegated therapeutic dental services under varying levels of supervision by a licensed dentist.[155] To be licensed as a dental hygienist, a person must apply to DOH and meet the following requirements:[156]

- Be 18 years of age or older;
- Be a graduate of an accredited dental hygiene college or school;[157] and

[148] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, *Designated Health Professional Shortage Areas Statistics, Fourth Quarter of Fiscal Year 2023* (Sept. 30, 2023), available at https://data.hrsa.gov/topics/health-workforce/health-workforce-shortage-areas?hmpgtile=hmpg-hlth-srvcs (last visited January 30, 2026). To generate the report, select "Designated HPSA Quarterly Summary."
[149] Department of Health, FL Health Charts: Dentists (DMD, DDS). Available at https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=NonVitalIndNoGrp.Dataviewer&cid=0326 (last visited January 30, 2026).
[150] Section 381.4019 defines a "public health program" as a county health department, the Children's Medical Services program, a federally funded community health center, a federally funded migrant health center, or other publicly funded or nonprofit health care program designated by DOH.
[151] Current law specifies that a dental HPSA is limited to a geographic area as designated by the federal government and does not encompass the complete federal definition of a HPSA. *See*, 381.4019(1), F.S.
[152] S. 381.4019, F.S.
[153] *Id.*
[154] *Id.*
[155] Ss. 466.003(4), F.S., and 466.003(5), F.S.
[156] S. 466.007, F.S.

- Obtain a passing score on the:
  - Dental Hygiene National Board Examination;
  - Dental Hygiene Licensing Examination developed by the American Board of Dental Examiners, Inc., which is graded by a Florida-licensed dentist or dental hygienist employed by DOH for such purpose; and
  - A written examination on Florida laws and rules regulating the practice of dental hygiene.

Dental Hygiene Scope

A supervising dentist may delegate certain tasks to a dental hygienist, such as removing calculus deposits, accretions, and stains from exposed surfaces of the teeth and from the gingival sulcus and the task of performing root planning and curettage.[158] A dental hygienist may also expose dental X-ray films, apply topical preventive or prophylactic agents, and delegated remediable tasks.[159] Remediable tasks are intra-oral tasks which do not create an unalterable change in the oral cavity or contiguous structures, are reversible, and do not expose the patient to risk, including but not limited to:

- Fabricating temporary crowns or bridges inter-orally;
- Selecting and pre-sizing orthodontic bands;
- Preparing a tooth service by applying conditioning agents for orthodontic appliances;
- Removing and re-cementing properly contoured and fitting loose bands that are not permanently attached to any appliance;
- Applying bleaching solution, activating light source, and monitoring and removing in-office bleaching solution;
- Placing or removing rubber dams;
- Making impressions for study casts which are not being made for the purpose of fabricating any intra-oral appliances, restorations, or orthodontic appliances;
- Taking impressions for passive appliances, occlusal guards, space maintainers, and protective mouth guards; and
- Cementing temporary crowns and bridges with temporary cement.

A dental hygienist may perform additional remediable tasks as delegated by the supervising dentist if they have received additional training in a pre-licensure course, other formal training, or on-the-job training.[160] Dental hygienists are not authorized to use lasers in the provision of patient care under current law. The BOD considered the use of lasers by dental hygienists as a remedial task in 2021, and ultimately rejected the proposal due to lack of evidence of the efficacy of such laser treatments and patient safety concerns.[161]

A qualified dental hygienist may, under the direct supervision of a dentist, administer local anesthesia to non-sedated, adult patients. In order to be qualified to administer local anesthesia, a dental hygienist must obtain a certificate from DOH which indicates that they are certified in basic or advanced cardiac life support and have completed an accredited or BOD-approved course[162] consisting of a minimum of 60 hours of instruction relating to the administration of local anesthesia. A dental hygienist must display this certificate prominently at the location where the dental hygienist is authorized to administer local anesthesia. Dental hygienists are required to notify the

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[157] If the school is not accredited, the applicant must have completed a minimum of 4 years of postsecondary dental education and received a dental school diploma which is comparable to a D.D.S. or D.M.
[158] S. 466.023, F.S.
[159] Ss. 466.023, F.S., and 466.024, F.S.
[160] *See*, ss. 466.023, F.S., 466.0235, F.S., and 466.024, F.S.; and Rule 64B5-16, F.A.C.
[161] See, Board of Dentistry, Rules Hearing Meeting Minutes: May 21, 2021 (2021). Available at https://floridasdentistry.gov/Meetings/Minutes/2021/05-may/05212021-rules-minutes.pdf (last visited April 22, 2025).
[162] *See*, s. 466.017(5), F.S. The course must include at least 30 hours of didactic instruction and 30 hours of clinical instruction and cover the following subjects: the theory of pain control, selection-of-pain-control modalities, anatomy, neurophysiology, pharmacology of local anesthetics, pharmacology of vasoconstrictors, psychological aspects of pain control, systematic complications, techniques of maxillary anesthesia, techniques of mandibular anesthesia, infection control, and medical emergencies involving local anesthesia.

BOD by registered mail within 48 hours after any adverse incident related to the administration of local anesthesia.[163]

Dental hygienists are authorized to perform dental charting without dentist supervision. Dental charting includes the recording of visual observations of clinical conditions of the oral cavity without the use of X-rays, laboratory tests, or other diagnostic methods or equipment, except the instruments necessary to record visual restorations, missing teeth, suspicious areas, and periodontal pockets.[164] Dental charting is not a substitute for a comprehensive dental examination, and each patient who receives dental charting by a dental hygienist must be informed of the limitations of dental charting.[165] Dental hygienists performing dental charting without dentist supervision are required to maintain their own medical malpractice insurance or other proof of financial responsibility.[166]

Dental hygienists are not required to maintain professional liability insurance and must be covered by the supervising dentist's liability insurance,[167] unless they are providing services without dental supervision, in which case they must maintain their own medical malpractice insurance or other proof of financial responsibility.[168]

Dentist Supervision

Dental care teams are generally comprised of dentists and allied professionals including dental hygienists and dental assistants who are trained to provide specific oral health care services under the supervision of a dentist. There are three levels of supervision that a dental hygienist and dental assistant may be subject to:[169]

Level of Supervision	Requirements
Direct Supervision	A licensed dentist examines the patient, diagnose a condition to be treated, authorize the procedure to be performed, be on the premises while the procedure is performed, and approve the work performed prior to the patient's departure from the premises.
Indirect Supervision	A licensed dentist examines the patient, diagnose a condition to be treated, authorize the procedure to be performed, and be on the premises while the procedure is performed.
General Supervision	A licensed dentist authorizes the procedures to be performed but need not be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the dentist's usual place of practice.

The level of supervision required is dependent upon on the specific task being performed, the education and training of the dental hygienist or dental assistant, and the discretion of the supervising dentist. Supervisory standards are outlined in current law and rule prescribed by the BOD.[170]

Cousin Marriage

Current law prohibits marriage between a man and a woman who are related by lineal consanguinity; that is, a man cannot marry a woman to whom he is directly related, such as his sister, aunt, or niece.[171] However, first

[163] S. 466.017(11), F.S.
[164] S. 466.0235, F.S.; Dental hygienists may only perform periodontal probing as a part of dental charting if the patient has received medical clearance from a physician or dentist.
[165] Rule 64B5-16.0075, F.A.C
[166] Rule 64B5-17.011(4), F.A.C.
[167] Rule 64B5-17.011(4), F.A.C.
[168] *Id.*; *see also*, s. 466.024(5), F.S.
[169] Rule 64B5-16.001, F.A.C.
[170] S. 466.024, F.S., and Rule 64B5-16, F.A.C.
[171] S. 741.21, F.S.

cousins, or individuals who share a grandparent, are not included in the prohibition, and may be married in the state.

Marriage between first cousins is illegal, or largely illegal,[172] in 32 US states.[173] There are potential adverse health effects for children born from consanguineous unions.[174] The more closely related two people are, the more likely it is that a child born from the union will inherit a recessive genetic disorder. The prevalence and specific conditions that appear depend upon the genetic background and the frequency of particular recessive genes within the population; however, there is a consistently increased risk of infant and childhood mortality for the children of such unions.[175]

OTHER RESOURCES:

Department of Health, Trauma Center Standards (Pamphlet 150-9)

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[172] Some states allow marriage between first cousins on a limited basis; for example, if both individuals are over 65 years old.
[173] Paul, D. B., & Spencer, H. G. (2008). "*It's Ok, We're Not Cousins by Blood": The Cousin Marriage Controversy In Historical Perspective*. PLoS biology, 6(12), 2627–2630. https://doi.org/10.1371/journal.pbio.0060320; see also, Riess, R., (2024). *Tennessee Legislature Passes Bill Banning Marriages Between First Cousins*. CNN. Available at https://www.cnn.com/2024/04/12/us/tennessee-first-cousin-marriage-bill (last visited February 25, 2026).
[174] Consanguineous marriages are unions between individuals who are second cousins or closer. *Id. See also*, Heidari, F., et al. (2014). *Prevalence and Risk Factors of Consanguineous Marriage*. Eur J Gen Med 2014; 11(4):248-255. DOI : 10.15197/sabad.1.11.81
[175] Glover-Thomas N. (2025). *Consanguineous Marriage: Law and Public Health*. Health care analysis: HCA: Journal Of Health Philosophy And Policy, 33(4), 321–336. https://doi.org/10.1007/s10728-025-00541-2; The effectiveness of banning consanguineous marriage as a public health measure is debated.

BILL HISTORY

COMMITTEE REFERENCE	ACTION	DATE	STAFF DIRECTOR/ POLICY CHIEF	ANALYSIS PREPARED BY
Health Professions & Programs Subcommittee	18 Y, 0 N	1/29/2026	McElroy	Osborne
Health Care Budget Subcommittee	13 Y, 0 N	2/5/2026	Clark	Day
Health & Human Services Committee	14 Y, 5 N, As CS	2/24/2026	Calamas	Osborne

THE CHANGES ADOPTED BY THE COMMITTEE:

- Deleted proposed limits on future MMTC facility locations.
- Revised OMMU emergency rulemaking authority.
- Created a Neurofibromatosis Grant Program.
- Added Infantile Krabbe Disease to the newborn screening program.
- Required DOH to develop a pamphlet on neonate nutrition (fortified human breast milk) for parents and guardians of preterm infants in hospital NICUs.
- Allowed dental hygienists to use lasers for teeth cleaning under the direct supervision of a dentist.
- Revised marriage and family therapist licensure requirements to require all applicants after 2032 to have graduated from an accredited program.
- Required advertisements for health care services to include the full name and license number of the practitioner.
- Extended sovereign immunity under the Access to Health Care Act to dental and dental hygiene students.
- Required DOH to designate specialty licensed children's hospitals as pediatric trauma centers, if they have certificates of trauma center verification from the American College of Surgeons.
- Allowed an RN to delegate the administration of a Schedule IV controlled substance to a home health aide for medically fragile children for emergency treatment of an active seizure.
- Prohibited marriage between first cousins.

THIS BILL ANALYSIS HAS BEEN UPDATED TO INCORPORATE ALL OF THE CHANGES DESCRIBED ABOVE.
