



New York State Board for Professional Medical Conduct

433 River Street, Suite 303 • Troy, New York 12180-2299 • (518) 402-0863

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
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NYS Department of Health*

Dennis P. Whalen
*Executive Deputy Commissioner
NYS Department of Health*

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Office of Professional Medical Conduct

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Michael A. Gonzalez, R.P.A.
Vice Chair

Ansel R. Marks, M.D., J.D.
Executive Secretary

PUBLIC

April 8, 2005

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Nellie Mitchell, M.D.
345 Highland Avenue
Rochester, NY 14620

Re: License No. 080277

Dear Dr. Mitchell:

Enclosed is a copy of Order #BPMC 05-67 of the New York State Board for Professional Medical Conduct. This order and any penalty provided therein goes into effect April 15, 2005.

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order to the Board for Professional Medical Conduct, New York State Department of Health, Hedley Park Place, Suite 303, 433 River Street, Troy, New York 12180.

Sincerely,

Ansel R. Marks, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

cc: Rudolph C. Gabriel, Esq.
Kern, Augustine & Schoppmann, P.C.
420 Lakeville Road
Lake Success, NY 11042

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER
OF
NELLIE MITCHELL, M.D.

CONSENT
ORDER

BPMC No. 05-67

Upon the application of NELLIE MITCHELL, M.D. in the attached Consent Agreement and Order, which is made a part of this Consent Order, it is

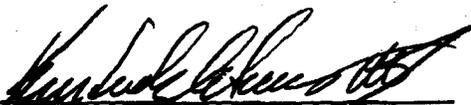
ORDERED, that the Consent Agreement; and its terms, are adopted and
SO ORDERED, and it is further

ORDERED, that this Order shall be effective upon issuance by the Board, either

- by mailing of a copy of this Consent Order, either by first class mail to Respondent at the address in the attached Consent Agreement or by certified mail to Respondent's attorney, OR
- upon facsimile transmission to Respondent or Respondent's attorney, Whichever is first.

SO ORDERED.

DATED: 4-7-05


KENDRICK A. SEARS, M.D.
Chair
State Board for Professional Medical Conduct

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER
OF
NELLIE MITCHELL, M.D.

CONSENT
AGREEMENT
AND
ORDER

NELLIE MITCHELL, M.D., representing that all of the following statements are true, deposes and says:

That on or about December 16, 1957, I was licensed to practice as a physician in the State of New York, and issued License No. 080277 by the New York State Education Department.

My current address is 345 Highland Avenue, Rochester, New York, and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

I understand that the New York State Board for Professional Medical Conduct has charged me with 19 specifications of professional misconduct.

A copy of the Statement of Charges, marked as Exhibit "A", is attached to and part of this Consent Agreement.

I do not contest the Fifteenth and Eighteenth Specifications in full satisfaction of the charges against me, and agree to the following penalty:

My license to practice medicine shall be limited, pursuant to §230-a of the Public Health Law, to preclude patient contact and any practice of medicine, clinical or otherwise. I shall be precluded from diagnosing, treating, operating, or prescribing for any human disease, pain, injury deformity, or physical condition.

I further agree that the Consent Order for which I hereby apply shall impose the following conditions:

- That Respondent shall, within 30 days of the issuance of the Consent Order, notify the New York State Education Department, Division of Professional Licensing Services, that Respondent's license status is "inactive," and shall provide proof of such notification to the Director of OPMC within 30 days thereafter; and
- That Respondent shall return any and all official New York State prescriptions to the Bureau of Controlled Substances, and shall surrender Respondent's Controlled Substance Registration Certificate to the United States Department of Justice, Drug Enforcement Administration, within 15 days of the effective date of this Order. Further, within 30 days of returning said prescriptions and surrendering said registration, Respondent shall provide documentary proof of such transaction(s) to the Director of OPMC; and

I further agree that the Consent Order shall impose the following conditions:

That Respondent shall cooperate fully with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Order and in its investigations of matters concerning Respondent. Respondent shall respond in a timely manner to all OPMC requests for written periodic verification of Respondent's compliance with this Order. Respondent shall meet with a person designated by the Director of OPMC, as directed. Respondent shall respond promptly and provide all documents and information within Respondent's control, as directed. This condition shall take

effect upon the Board's issuance of the Consent Order and will continue so long as Respondent remains licensed in New York State; and

Respondent shall comply with all conditions set forth in Exhibit "B" ("Guidelines for Closing a Medical Practice") which is attached.

I stipulate that my failure to comply with any conditions of this Order shall constitute misconduct as defined by New York State Education Law §6530(29).

I agree that if I am charged with professional misconduct in future, this Consent Agreement and Order shall be admitted into evidence in that proceeding.

I ask the Board to adopt this Consent Agreement.

I understand that if the Board does not adopt this Consent Agreement, none of its terms shall bind me or constitute an admission of any of the acts of alleged misconduct; this Consent Agreement shall not be used against me in any way and shall be kept in strict confidence; and the Board's denial shall be without prejudice to the pending disciplinary proceeding and the Board's final determination pursuant to the Public Health Law.

I agree that, if the Board adopts this Consent Agreement, the Chair of the Board shall issue a Consent Order in accordance with its terms. I agree that this Order shall take effect upon its issuance by the Board, either by mailing of a copy of the Consent Order by first class mail to me at the address in this Consent Agreement, or to my attorney by certified mail, OR upon facsimile transmission to me or my attorney, whichever is first.

I ask the Board to adopt this Consent Agreement of my own free will and not under duress, compulsion or restraint. In consideration of the value to me of

the Board's adoption of this Consent Agreement, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive my right to contest the Consent Order for which I apply, whether administratively or judicially, I agree to be bound by the Consent Order, and ask that the Board adopt this Consent Agreement.

DATED 3/24/05

Nellie L. Mitchell, M.D.

NELLIE MITCHELL, M.D.
RESPONDENT

The undersigned agree to Respondent's attached Consent Agreement and to its proposed penalty, terms and conditions.

DATE: 3/24/05


RUDOLPH C. GABRIEL
Attorney for Respondent

DATE: 3/28/05


MICHAEL A. HISER
Bureau of Professional Medical Conduct

DATE: 4/05/05


DENNIS J. GRAZIANO
Director
Office of Professional Medical Conduct

IN THE MATTER
OF
NELLIE MITCHELL, M.D.

**FIRST
AMENDED
STATEMENT**
OF
CHARGES

NELLIE MITCHELL, M.D., the Respondent, was authorized to practice medicine in New York State on or about December 16, 1957 and issued license number 080277, by the New York State Education Department.

FACTUAL ALLEGATIONS

- A. Respondent provided medical care as a psychiatrist to Patient A [patients are identified in the attached Appendix], a female patient born in 1956, at various times from on or about January 1986 to at least on or about November 2002 at Respondent's office at 345 Highland Avenue, Rochester, New York ["Respondent's office"] or other hospital locations. Respondent's care and treatment of Patient A failed to meet acceptable standards of care in that:
1. Respondent, from 1995 onward, failed to timely and adequately document her evaluation and treatment of the patient, including ongoing assessments of the patient's mental status, responses to treatment, and treatment plan.
 2. Respondent, despite having knowledge of Patient A's history of substance abuse, prescribed medications and/or controlled substances, including opioids, narcotics and benzodiazepines to the patient on numerous occasions between July 1995 and October 2002, without adequate medical indications, and/or for excessive periods of time, and/or failed to document such adequate medical indication.
 3. Respondent failed to adequately evaluate and treat the patient's substance abuse.
 4. Respondent, between 1994 and October 2002, undertook to treat the patient's complaints of pain with, among other things, Percocet, Lortab, and Tylox, without first performing an adequate medical evaluation or consulting with appropriate specialists and/or failed to document such evaluations or

consultations.

5. Respondent inappropriately prescribed anti-psychotic medications such as Seroquel to Patient A without adequate medical justification and/or for an excessive period of time.
6. Respondent inappropriately evaluated and treated Patient A's report of "command hallucinations" on June 28, 2002 and/or failed to document such.
7. Respondent, on or about March 4, 2002, fraudulently presented medical records to the Office of Professional Medical Conduct, New York State Department of Health, that purported to be Respondent's transcription of handwritten progress notes for Patient A, but which added medically relevant information not contained in the original handwritten notes.
8. Respondent failed to maintain a medical record for the patient that accurately reflects her evaluation and treatment of the patient.

B. Respondent provided medical care as a psychiatrist to Patient B, a female patient 27 years old when first treated, at various times from November, 1984 to on or about November 2002, at Respondent's office or other hospital locations. Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care in that:

1. Respondent, from 1993 onward, failed to timely and adequately document her evaluation and treatment of the patient, including ongoing assessments of the patient's mental status, responses to treatment, and treatment plan.
2. Respondent, despite having knowledge about the patient's history of, and ongoing problems with, alcohol abuse and polysubstance abuse and dependence, repeatedly and inappropriately prescribed opioids, narcotics and/or benzodiazepines to the patient between at least 1993 through 2002 without adequate medical indications, and/or for excessive periods of time.
3. Respondent failed to adequately evaluate and treat the patient's substance abuse.
4. Respondent, between at least 1993 and 2002, undertook to treat the patient's complaints of pain with, among others, Percocet, Toradol, Tylenol #3, and Tylenol #4, without performing an adequate medical evaluation or consulting with appropriate specialists and/or failed to document such evaluations or consultations.
5. Respondent, at various times between January 1993 and May 2001,

inappropriately prescribed medications such as Dilantin, Neurontin, Toradol, Percocet, Valium, to Patient B, without adequate medical indication and/or in improper combinations and/or failed to document such adequate medical indication.

6. Respondent, prior to prescribing such medications and controlled substances as Dilantin, Neurontin, Toradol, Percocet, Valium, Tylenol #3, and Tylenol #4 to Patient B, failed to adequately explore alternative treatment modalities, and/or failed to document such.
7. Respondent, although aware on or about April 17, 2002 that the patient had stopped taking her 400 mg/day dose of Dilantin, did not take appropriate steps to protect the patient from the medical implications of stopping such Dilantin therapy, and/or did not document that she took such appropriate steps.
8. Respondent, in or about February 2002, fraudulently presented medical records to the Office of Professional Medical Conduct, New York State Department of Health, that purported to be Respondent's transcription of handwritten progress notes for Patient B, but which added medically relevant information not contained in the original handwritten notes.
9. Respondent failed to maintain a medical record for the patient that accurately reflects her evaluation and treatment of the patient.

C. Respondent provided medical care as a psychiatrist to Patient C, a female patient born in 1970, at various times beginning on or about March 2000. Respondent's care and treatment of Patient C failed to meet acceptable standards of care in that:

1. Respondent, from 2000 onward, failed to timely and adequately document her evaluation and treatment of the patient, including ongoing assessments of the patient's mental status, responses to treatment, and treatment plan.
2. Respondent, despite having knowledge about the patient's history of, and ongoing problems with, benzodiazepine, stimulant, and prescription opiate abuse, repeatedly and inappropriately prescribed medications and controlled substances, including opioids and benzodiazepines to the patient between March 2000 and February 2001, and then again between January and March 2002, without adequate medical indications, and/or for excessive periods of time.
3. Respondent failed to adequately evaluate and treat the patient's substance abuse.
4. Respondent, between March 2000 and February 2001, and again from January 2002 through March 2002, prescribed numerous opioids and benzodiazepines for Patient A without adequate [or any] consultation with Patient C's primary care physician or other health care providers, and/or

without documenting such consultations.

5. Respondent, between April 2000 and February 2001, and then again in March 2002, prescribed Adderall to the patient at the same time that she also prescribed Klonopin, which concurrent prescriptions and/or course of treatment was not indicated.
6. Respondent, on various occasions between June 8, 2000, and September 6, 2000, documented in her medical record that she prescribed the medication "Judgment" for the patient in the amount of 1 mg, varying between three to four times a day. In fact, there is no known psychiatric medication named "Judgment".
7. Respondent, on or about September 20, 2000, inappropriately prescribed Neurontin to Patient C as an antidepressant, without adequate medical indication and/or without documenting such adequate medical indication.
8. Respondent failed to adequately evaluate and treat Patient C's report of "tactile hallucinations" on or about February 8, 2001, and/or failed to document an adequate evaluation and/or treatment.
9. Respondent failed to maintain a medical record for the patient that accurately reflects her evaluation and treatment of the patient.

D. Respondent provided medical care as a psychiatrist to Patient D, a female patient 42 years old, at various times beginning on or about August 1997 at Respondent's office. Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care in that:

1. Respondent, from 1997 onward, failed to timely and adequately document her evaluation and treatment of the patient, including ongoing assessments of the patient's mental status, responses to treatment, and treatment plan.
2. Respondent, despite having knowledge about the patient's history of, and ongoing problems with, alcohol dependence, repeatedly and inappropriately prescribed opioids, narcotics and/or benzodiazepines to the patient, Percodan, Tylenol #s 3 and 4, Percocet, morphine sulfate, and acetaminophen with codeine, between at least March 1998 and October 2002, without adequate medical indications, and/or for excessive periods of time.
3. Respondent failed to adequately evaluate and treat the patient's substance abuse.
4. Respondent, between approximately January 2000 and December 2001, on numerous occasions prescribed Ritalin and Klonopin to the patient at the same time, without adequate medical indication and/or without documenting such indication.

5. Respondent, between approximately January 2001 and October 2001, prescribed Trilafon to Patient D in the amount of 64 mg/day, without adequate medical indications for such an excessive dose and/or without documenting such medical indications.
6. Respondent, on numerous occasions between approximately August 1997 and October 2002, prescribed medications for the patient without adequately documenting the type, the dose or the frequency of administration of the medication, the rationale for such treatment and/or rationale for changes in treatment.
7. Respondent failed to maintain a medical record for the patient that accurately reflects her evaluation and treatment of the patient.

E. Respondent provided medical care as a psychiatrist to Patient E, a female patient 39 years old when first treated, at various times from 1997 to at least October 2002.

Respondent's care and treatment of Patient E failed to meet acceptable standards of care in that:

1. Respondent, despite having knowledge about the patient's history of, and ongoing problems with, cocaine, heroin and alcohol abuse and/or dependence, repeatedly and inappropriately prescribed numerous opioids and benzodiazepines, including valium, Tylenol #4, and/or percocet to the patient between March 1998 and October 2002, without adequate medical indications, and/or for excessive periods of time, and/or without documenting such adequate medical indication.
2. Respondent failed to adequately evaluate and treat the patient's substance abuse.
3. Respondent, on numerous occasions between approximately March 1998 and October 2002, prescribed numerous opioids and benzodiazepines for Patient A without adequate [or any] consultation with Patient E's primary care physician or other health care providers concerning Respondent's prescription of such substances.
4. Respondent failed to obtain baseline lab studies before treating the patient with Lithium, and/or failed to obtain periodic lab studies after beginning to treat the patient with Lithium, and/or failed to adequately document that she had obtained such studies.
5. Respondent, on numerous occasions between approximately March 1998 and October 2002, prescribed medications for the patient without adequately documenting the type, the dose or the frequency of administration of the medication, the rationale for such treatment and/or rationale for changes in treatment.

6. Respondent failed to maintain a medical record for the patient that accurately reflects her evaluation and treatment of the patient.

F. Respondent provided medical care as a psychiatrist to Patient F, a male patient approximately 48 years old when first treated, at various times in 1998.

Respondent's care and treatment of Patient F failed to meet acceptable standards of care in that:

1. Respondent began treating the patient without first obtaining and/or documenting an adequate history of the patient.
2. Respondent began treating the patient without first developing and/or documenting an adequate treatment plan.
3. Respondent, on numerous occasions in 1998 and 1999, inappropriately prescribed Methadone using the generic name "Dolophine" to Patient F without adequate medical indications.
4. Respondent, on numerous occasions in 1998 and 1999, inappropriately prescribed Methadone using the generic name "Dolophine" to Patient F, despite the fact that the Respondent was not prescribing this medication as a physician in an approved methadone treatment clinic.
5. Respondent, in or about February 1999, was contacted by the patient's methadone clinic treatment physician, who advised Respondent that the patient was receiving Methadone in an established clinic program, and thus the Respondent should not be prescribing it to him. Respondent told the clinic physician that she had never prescribed Methadone to the patient. Respondent also denied that she had ever prescribed Klonopin [also known as clonazepam] to the patient.
6. Respondent, on or about March 19, 1999, wrote a letter to the patient's methadone clinic treatment physician treating physician, acknowledging that she had written prescriptions for the medication "Dolophine" for the patient, but Respondent (1) denied knowing when she wrote the prescription that Dolophine was the same as Methadone, and (2) indicated that she learned from "a patient" that Methadone and Dolophine were the same medication.
7. Respondent failed to maintain a medical record for the patient that accurately reflects her evaluation and treatment of the patient.

G. Respondent provided medical care as a psychiatrist to Patient G, a male patient 36

years old when first treated, at various times from December 1996 to at least October 2003. Respondent's care and treatment of Patient G failed to meet acceptable standards of care in that:

1. Respondent, despite having knowledge about the patient's history of, and ongoing problems with, marijuana abuse, alcohol, and polysubstance abuse and/or dependence, repeatedly and inappropriately prescribed numerous opioids and benzodiazepines, including Percodan, Percocet, Oxycontin, Klonopin, and/or Valium, to the patient between approximately July 1997 and October 2003, without adequate medical indications, and/or for excessive periods of time.
2. Respondent failed to adequately evaluate and treat the patient's substance abuse.
3. Respondent, on numerous occasions between approximately July 1997 and October 2003, prescribed numerous opioids and benzodiazepines for Patient G without adequate [or any] consultation with Patient G's primary care physician or other health care providers concerning Respondent's prescription of such substances.
4. Respondent failed to appropriately respond to the patient's non-compliance with the prescribed medication regimen.
5. Respondent, in late 2003, was requested by representatives of the Office of Professional Medical Conduct in Rochester to provide a certified copy of her medical record relating to her care of Patient G. Respondent thereafter created a medical record of newly typed progress notes. On or about January 18, 2004, Respondent forwarded the newly typed progress notes to her attorney. Respondent requested that the attorney "make any corrections or recommendations and I [Respondent] will do another copy along with the notarization for you to forward on [to OPMC]."
6. Respondent failed to maintain a medical record for the patient that accurately reflects her evaluation and treatment of the patient.

H. Respondent submitted a "Re-Appointment Application, Medical/Dental Staff" to the Rochester General Hospital ["Rochester General Application"], 1425 Portland Avenue, Rochester, New York 14621, on or about April 27, 1993. Respondent had last been appointed to the Rochester General Medical Staff on or about February 28, 1992.

1. Respondent, on her Rochester General Application, dated and signed by the Respondent on or about "4/27/93", falsely answered "no" to the following question, numbered "8":

"Since your last re-appointment application in 1991, have any medical staff memberships, privileges, associations, or employment been voluntarily or involuntarily suspended, limited, denied or reduced at any other hospitals or health care organizations?"

In fact, Respondent's association as a physician provider with Preferred Care, a Rochester area health maintenance organization, had been terminated and/or reduced on or about January 12, 1993 through Preferred Care's refusal to renew her privileges after concerns had been raised about the Respondent's care of numerous patients, and after Respondent had demanded a hearing, and Respondent knew such facts.

2. Respondent, on her Rochester General Application, dated and signed by the Respondent on or about "4/27/93", falsely answered "no" to the following question, numbered "13":

"Since your last re-appointment in 1991:

(I) Have you been denied staff appointment or had privileges suspended, revoked, limited, or not renewed?"

In fact, Respondent's association as a physician provider with Preferred Care, a Rochester area health maintenance organization, had been terminated and/or reduced on or about January 12, 1993 through Preferred Care's refusal to renew her privileges after concerns had been raised about the Respondent's care of numerous patients, and after Respondent had demanded a hearing, and Respondent knew such facts.

- I. Respondent, on or about June 10, 2004, July 20, 2004, August 3, 2004, and October 19, 2004, was sent written demands for medical records of certain of her patients [Patients C, D, E, F, G, H, I, J, K, and L], from the New York State Department of Health, in accordance with New York Public Health Law Section 230. Respondent failed to provide such records. Thereafter, effective on or about November 8, 2004, Respondent stipulated to having been personally served with a written demand for such medical records. Despite more than 30 days having lapsed since then, Respondent has failed to respond or make available such medical records.

SPECIFICATION OF CHARGES
FIRST THROUGH SEVENTH SPECIFICATIONS
GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Education Law § 6530(3) by practicing the profession of medicine with gross negligence on more than one occasion as alleged in the facts of two or more of the following:

1. The facts in paragraphs A and A.2, A and A.3, A and A.4, A and A.5, A and A.6.
2. The facts in paragraphs B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, and/or B and B.7.
3. The facts in paragraphs C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, and/or C and C.8.
4. The facts in paragraphs D and D.2, D and D.3, D and D.4, D and D.5, and/or D and D.6.
5. The facts in paragraphs E and E.1, E and E.2, E and E.3, E and E.4, and/or E and E.5.
6. The facts in paragraphs F and F.3, F and F.4, and/or F and F.5.
7. The facts in paragraphs G and G.1, G and G.2, G and G.3, and/or G and G.4.

EIGHTH THROUGH FOURTEENTH SPECIFICATIONS
GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Education Law § 6530(5) by practicing the profession of medicine with gross incompetence on more than one occasion as alleged in the facts of two or more of the following:

8. The facts in paragraphs A and A.2, A and A.3, A and A.4, A and A.5, A and A.6.

9. The facts in paragraphs B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, and/or B and B.7.
10. The facts in paragraphs C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, and/or C and C.8.
11. The facts in paragraphs D and D.2, D and D.3, D and D.4, D and D.5, and/or D and D.6.
12. The facts in paragraphs E and E.1, E and E.2, E and E.3, E and E.4, and/or E and E.5.
13. The facts in paragraphs F and F.3, F and F.4, and/or F and F.5.
14. The facts in paragraphs G and G.1, G and G.2, G and G.3, and/or G and G.4.

FIFTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

15. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8, C and C.9, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, G and G.1, G and G.2, G and G.3, G and G.4, and/or G and G.6.

SIXTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y.

Educ. Law §6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

16. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8, C and C.9, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, G and G.1, G and G.2, G and G.3, G and G.4, and/or G and G.6.

SEVENTEENTH SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

17. The facts in paragraphs A and A.7, B and B.8, F and F.5, F and F.6, G and G.5, H and H.1, and/or H and H.2.

EIGHTEENTH SPECIFICATION

FAILING TO MAKE MEDICAL RECORDS AVAILABLE IN 30 DAYS

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(28) by failing to respond and make available medical records within 30 days of having been personally served with a demand for such records, as alleged in the facts of the following:

18. The facts in paragraph I.

NINETEENTH SPECIFICATION
FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

19. The facts in paragraphs A and A.1, A and A.2, A and A.4, A and A.6, A and A.7, A and A.8, B and B.1, B and B.2, B and B.3, B and B.7, B and B.8, B and B.9, C and C.1, C and C.4, C and C.6, C and C.7, C and C.8, C and C.9, D and D.1, D and D.4, D and D.5, D and D.6, D and D.7, E and E.1, E and E.4, E and E.5, E and E.6, and/or F and F.7.

DATED: February **3**, 2005
Albany, New York


Peter D. Van Buren
Deputy Counsel
Bureau of Professional
Medical Conduct

EXHIBIT "B"

GUIDELINES FOR CLOSING A MEDICAL PRACTICE

1. Respondent shall immediately cease and desist from engaging in the practice of medicine in accordance with the terms of the Order. In addition, Respondent shall refrain from providing an opinion as to professional practice or its application and from representing himself as being eligible to practice medicine.
2. Respondent shall have delivered to the Office of Professional Medical Conduct (OPMC) at 433 River Street Suite 303, Troy, NY 12180-2299 his current biennial registration within thirty (30) days of the effective date of the Order.
3. Respondent shall, within 30 days of the issuance of the Consent Order, notify the New York State Education Department, Division of Professional Licensing Services, that Respondent's license status is "inactive," and shall provide proof of such notification to the Director of OPMC within 30 days thereafter.
4. Respondent shall make arrangements for the transfer and maintenance of the medical records of his patients. Within thirty days of the effective date of the Order, Respondent shall notify OPMC of these arrangements including the appropriate and acceptable contact person's name, address, and telephone number who shall have access to these records. Original records shall be retained for at least six years after the last date of service rendered to a patient or, in the case of a minor, for at least six years after the last date of service or three years after the patient reaches the age of majority whichever time period is longer. Records shall be maintained in a safe and secure place which is reasonably accessible to former patients. The arrangements shall include provisions to ensure that the information on the record is kept confidential and made available only to authorized persons. When a patient or and/or his or her representative requests a copy of the patient's medical record or requests that the original medical record be forwarded to another health care provider, a copy of the record shall be promptly provided or forwarded at a reasonable cost to the patient (not to exceed seventy-five cents per page.) Radiographic, sonographic and like materials shall be provided at cost. A qualified person shall not be denied access to patient information solely because of their inability to pay.
5. In the event that Respondent holds a Drug Enforcement Agency (DEA) certificate, Respondent shall within fifteen (15) days advise the DEA in writing of the licensure action and shall surrender his DEA controlled substance privileges to the DEA. Respondent shall promptly surrender any unused DEA #222 U.S. Official Order Forms Schedules 1 and 2 to the DEA.
6. Respondent shall within fifteen (15) days return any unused New York State official prescription forms to the Bureau of Controlled Substances of the New York State Department of Health. Respondent shall cause all prescription pads bearing his name to be destroyed. If no other licensee is providing services at his practice location, all medications shall be properly disposed.
7. Respondent shall not share, occupy or use office space in which another licensee provides health care services. Respondent shall cause all signs to be removed within fifteen (15) days and stop all advertisements, professional listings whether in telephone directories or otherwise, professional stationery or billings by which his eligibility to practice is represented.

8. Respondent shall not charge, receive or share any fee or distribution of dividends for professional services rendered by himself or others while barred from engaging in the practice of medicine. Respondent may be compensated for the reasonable value of services lawfully rendered and disbursements incurred on a patient's behalf prior to the effective date of this Order.

9. If Respondent is a shareholder in any professional service corporation organized to engage in the practice of medicine and if his license is revoked, surrendered or suspended for a term of six months or more under the terms of this Order, Respondent shall divest himself of all financial interest in the professional services corporation in accordance with New York Business Corporation Law. Such divestiture shall occur within 90 days. If Respondent is the sole shareholder in a professional services corporation, the corporation must be dissolved or sold within ninety (90) days of the effective date of this Order.

10. Failure to comply with the above directives may result in a civil penalty or further criminal penalties as may be authorized pursuant to the law. Under Section 6512 of the Education Law it is a Class E Felony, punishable by imprisonment of up to 4 years, to practice the profession of medicine when such professional license has been suspended, revoked or annulled. Such punishment is in addition to the penalties for professional misconduct set forth in section 230-a of the Public Health Law, which includes fines of up to \$10,000 for each specification of charges of which the Respondent is found guilty and may include revocation of a suspended license.