

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

Public

April 28, 2011

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Zenaida Reyes-Arguelles, M.D.
1515 Church Avenue
Brooklyn, New York 11226

Mark L. Furman, Esq.
Hoffman, Polland & Furman, PLLC
220 East 42nd Street
New York, New York 10017

Leslie Eisenberg, Esq.
NYS Department of Health
90 Church Street – 4th Floor
New York, New York 10007

RE: In the Matter of Zenaida Reyes-Arguelles, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 11-100) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the Respondent or the Department may seek a review of a committee determination.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

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The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

REDACTED

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

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

COPY

**IN THE MATTER
OF
ZENAIDA REYES-ARGUELLES, MD**

**DETERMINATION
AND
ORDER**

BPMC #11-100

A Notice of Hearing, and Amended Statement of Charges both dated April 16, 2008 were served upon the Respondent **ZENAIDA REYES-ARGUELLES, M.D.**¹ A hearing of this matter was held on March 25, 2011, at the Offices of the New York State Department of Health, 90 Church Street, New York, New York.

Chairperson **SHELDON PUTTERMAN M.D., FLORENCE KAVALER M.D.** and **JOSEPH MADONIA LCSW-R** duly designated members of the State Board of Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. Administrative Law Judge **KIMBERLY A. O'BRIEN ESQ.** served as the Administrative Officer.

The Department of Health appeared by **JAMES E. DERING ESQ.**, General Counsel, by **LESLIE EISENBERG**, of Counsel. The Respondent **ZENAIDA REYES-ARGUELLES, M.D.** appeared in person and by Counsel **MARK L. FURMAN ESQ.**

Evidence was received and argument heard, and transcripts of these proceedings were made.

¹ On or about June 18, 2009, Respondent authorized her Counsel to accept service of the charges on her behalf (Ex. ALJ 2).

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Notice of Hearing & Statement of Charges	June 22, 2009
Pre Hearing Conference	September 23, 2009
Hearing Date	March 25, 2011
Witnesses for Petitioner	None
Witnesses for Respondent ²	Zenaida Reyes-Arguelles M.D.
Final Hearing Transcript Received	April 11, 2011
Deliberations Date	March 25, 2011

CONCLUSIONS OF LAW

The Hearing Committee granted Respondent an adjournment of the first day of hearing and the matter was adjourned to September 30, 2009. A pre hearing conference was held on September 23, 2009. During the conference, it was revealed that Respondent failed to file a written answer to each of the charges ten days prior to the start of the hearing on September 30, 2009. Pursuant to Public Health Law Section 230(10)(c)(2) the administrative law judge deemed the charges admitted. Respondent obtained a stay of the September 30, 2009 hearing, and the matter ultimately proceeded to hearing on March 25, 2011. The sole purpose of the hearing was for the Hearing Committee to determine what if any penalty should be imposed on the Respondent.

STATEMENT OF THE CASE

The State Board of Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York pursuant to Section 230 et seq. of the Public Health

Law of New York. This case was brought by the New York State Department of Health, Office of Professional Medical Conduct (hereinafter "Petitioner" or "Department") pursuant to Section 230 of the Public Health Law. Zenaida Reyes-Arguelles M.D. (hereinafter "Respondent") by virtue of Public Health Law Section 230(10)(c)(2), admitted the factual allegations and fifty-four specifications of misconduct including: negligence on more than one occasion, incompetence on more than one occasion, gross negligence, gross incompetence, unwarranted tests and treatment, fraudulent practice, willfully making or filing a false report(s), failing to maintain patient records, and moral unfitness as set forth in Section 6530 of the Education Law of the State of New York (hereinafter Education Law) and contained in the Notice of Hearing and Statement of Charges, attached hereto and made part of this Decision and Order, and marked as Appendix 1 .

FINDING OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. These findings are based on the application of Public Health Law Section 230(10)(c)(2):

1. On or about April 28, 1986, Zenaida Reyes-Arguelles M.D., the Respondent, was authorized to practice medicine in New York State by the issuance of license number 166048 (Ex. 2).
2. The factual allegations and fifty-four specifications of misconduct set forth in the Statement of Charges are deemed admitted pursuant to Public Health Law Section 230(10)(c)(2) (Ex.1).

DISCUSSION

The Hearing Committee ("Hearing Committee" or "Committee") sustained all the factual allegations and fifty-four (54) specifications of misconduct as set forth in the Statement of Charges in accord with the charges being deemed admitted. The sole purpose of the hearing was for the

Committee to determine what if any penalty should be imposed on Respondent for the acts of misconduct. The Committee's conclusions were unanimous and based on the testimony of the Respondent and the entirety of the record.

The Department did not present any witnesses. The Respondent testified on her own behalf to mitigate any penalty the Committee would assess. The Respondent is a physician who has been practicing medicine in New York State for nearly forty years and she expressed a desire to continue to practice medicine. Since on or about 1986, Respondent has had an office on Church Avenue in Brooklyn, New York ("Church Avenue Practice") where she continues to practice medicine, on a part time basis, treating a small roster of patients most of whom she has been seeing for many years. Respondent testified that up until two years ago she also practiced at a location on Flatbush Avenue in Brooklyn, New York where she saw and treated only patients who had been injured in motor vehicle accidents ("Flatbush Avenue Practice"). Respondent's misconduct was limited to the Flatbush Avenue Practice, and Respondent testified that when she was made aware of the allegations of misconduct she stopped seeing patients there. Throughout Respondent's testimony she repeatedly expressed her frustration that the charges were admitted. While the Committee as a whole found Respondent's obvious and intense frustration about the limitations of the hearing quite understandable, one Committee member, Mr. Madonia, found many of Respondent's tearful displays of emotion to be conveniently timed to deflect answering specific questions. However, after the Committee carefully weighed Respondent's testimony and years of practice against the serious acts of misconduct involving false billing, unwarranted tests and treatment, and failure to keep patient records that accurately reflect the care and treatment of ten patients at the Flatbush Avenue Practice, the Committee unanimously agreed on the penalty determination.

DETERMINATION AS TO PENALTY

After due and careful consideration of the penalties available pursuant to Public Health Law Section 230-a, the Hearing Committee has determined that Respondent benefited financially from the misconduct at the Flatbush Avenue Practice and shall pay a civil penalty in the amount of ten thousand dollars (\$10,000.00). The Committee also concluded that the Respondent's testimony and misconduct reflect weaknesses in her continuing medical education regimen and a need for Respondent to practice in a more structured environment. In order to protect the public the Committee determined that Respondent's license shall be suspended for five years and the suspension shall be stayed, and Respondent shall be on probation for the entire five-year period ("period of probation"). During the period of probation, the Respondent shall only practice medicine in an Article 28 or Veterans Administration facility where she is not responsible for billing, and is subject to oversight of her patient care and receiving regular continuing medical education in her core area of practice. The terms of probation are attached hereto and made a part of this Decision and Order, and marked as Appendix B.

ORDER

Based on the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The factual allegations and the Fifty-Four Specifications set forth in the Statement of Charges (Appendix 1) are **SUSTAINED**;
2. The Respondent shall pay a civil penalty of Ten-Thousand Dollars (\$10,000) within sixty (60) days of the effective date of this Determination and Order;

3. The Respondent's license shall be suspended for five years and the suspension shall be stayed. The Respondent shall be on probation for the five-year period of stayed suspension and shall only practice in an Article 28 or Veterans Administration facility during the entire period of probation (Appendix B);

4. This **ORDER** shall be effective upon service on the Respondent pursuant to Public Health Law Section 230(10)(h).

DATED: April 13, New York, 2011

BY: REDACTED
~~SHELDON PUTTERMAN M.D., Chairperson~~
FLORENCE KAVALER M.D.
JOSEPH MADONIA

To: Zenaida Reyes- Arguelles M.D.
1515 Church Avenue
Brooklyn, New York 11226

Mark L. Furman, Esq.
Hoffman, Polland & Furman PLLC
220 East 42nd Street
New York, New York 10017

Leslie Eisenberg Esq.
NYSDOH -Bureau of Professional Medical Conduct
90 Church Street
New York, New York 10007

APPENDIX B



APPENDIX B
Terms of Probation

1. Respondent shall conduct herself in all ways in a manner befitting her professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his/her profession.
2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.
3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.
4. Respondent shall pay a ten thousand dollar (\$10,000.00) civil penalty within sixty (60) days of the effective date of this Order. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law section 32].
5. The Respondent's license to practice medicine shall be suspended for a period of five years and the suspension shall be stayed. Respondent shall be on probation for the entire five-year period ("period of probation"). During the period of probation, Respondent shall only practice medicine in an Article 28 or Veterans Administration facility. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.
6. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his/her staff at practice locations or OPMC offices.

7. Respondent shall maintain legible and complete medical records that accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.
8. Respondent shall maintain medical malpractice insurance coverage with limits no less than \$2 million per occurrence and \$6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.
9. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.

APPENDIX I



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

IN THE MATTER
OF
ZENAIDA REYES-ARGUELLES, M.D.

NOTICE
OF
HEARING

TO: Zenaida Reyes-Arguelles, M.D.
1468 Flatbush Avenue
Brooklyn, N.Y. 11210

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on July 28, 2009, at 10:00 a.m., at the Offices of the New York State Department of Health, 90 Church Street, 4th Floor, N.Y., N.Y., and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel who shall be an attorney admitted to practice in New York state. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses

and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

YOU ARE HEREBY ADVISED THAT THE ATTACHED CHARGES WILL BE MADE PUBLIC FIVE BUSINESS DAYS AFTER THEY ARE SERVED.

Department attorney: Initial here _____

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. SEAN D. O'BRIEN, DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or

allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A
DETERMINATION THAT YOUR LICENSE TO PRACTICE
MEDICINE IN NEW YORK STATE BE REVOKED OR
SUSPENDED, AND/OR THAT YOU BE FINED OR

SUBJECT TO OTHER SANCTIONS SET OUT IN NEW
YORK PUBLIC HEALTH LAW §§230-a. YOU ARE
URGED TO OBTAIN AN ATTORNEY TO REPRESENT
YOU IN THIS MATTER.

DATED: New York, New York
June 22, 2009

REDACTED

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Leslie Eisenberg
Associate Counsel
Bureau of Professional Medical Conduct
90 Church Street, 4th Floor
New York, N.Y. 10007
212-417-4450

IN THE MATTER
OF
ZENAIDA REYES-ARGUELLES, M.D.

STATEMENT
OF
CHARGES

Zenaida Reyes-Arguelles, M.D., the Respondent, was authorized to practice medicine in New York State on or about April 28, 1986, by the issuance of license number 166048 by the New York State Education Department. From at least April 2007 through January 2008, the time period relevant to the patient cases listed below, Respondent worked at 1468 Flatbush Avenue, Brooklyn, New York and she submitted claims to insurance companies for reimbursement under the name of her personal corporation Arguelles M.D., P.C., located at that same address.

FACTUAL ALLEGATIONS

- A. On or about and between June 1, 2007, and October 22, 2007, Respondent evaluated and treated Patient A, for injuries she reported she sustained in an automobile accident on May 30, 2007. (Patient names are identified in the appendix). Respondent's care and treatment deviated from minimally accepted standards of care in that:
1. Respondent failed to perform and document adequate histories.
 2. Respondent failed to obtain and review Patient A's post-accident hospital records and x-rays from Franklin Hospital.
 3. Respondent failed to perform and document adequate physical examinations.
 4. Respondent inappropriately ordered and/or performed and/or

interpreted:

- a. a Pulmonary Function Test (PFT)
 - b. a Brain Stem Evoked Potential test (BSEP)
 - c. a Somatosensory Evoked Potential test (SSEP)
 - d. Nerve Conduction Velocity tests (NCV) on Patient A's upper and lower extremities
 - e. multiple computerized Range of Motion tests (ROM)
5. Respondent failed to follow-up and/or appropriately document follow-up on test and treatment results, including but not limited to: MRI's, PFT, SSEP, BSEP, NCV, physical therapy, chiropractic therapy, acupuncture and, laser therapy.
 6. Respondent failed to address and/or document abnormal findings in Patient A's test results including but not limited to EKG and PFT.
 7. Respondent failed to adequately establish a medical basis for her diagnoses of Patient A including but not limited to: vertigo, anxiety and nervousness.
 8. Respondent failed to develop and implement an appropriate treatment plan.
 9. Respondent knowingly created the false impression that she performed an orthopedic evaluation on Patient A on June 1, 2007, when in fact, Respondent knew that the documented examination was fabricated, with recorded test values that are identical to the corresponding values recorded on Respondent's medical charts pertaining to the other patient's whose care is addressed by this Statement of Charges.
 - a. Respondent did so with intent to deceive.

10. Respondent ordered or caused to be performed, excessive testing and treatment, not warranted by Patient A's condition.
 - a. These tests and treatment included but were not limited to:
 1. MRI of the Cervical Spine
 2. MRI of the Lumbar Spine
 3. MRI of the Left shoulder
 4. acupuncture
 5. durable goods including: cervical collar, cervical pillow, LSO, lumbosacral cushion, thermophore, egg crate mattress and bed board
 6. physical therapy
 7. chiropractic treatment
 8. synaptic/bioelectric treatment
 9. low level cold laser therapy
 10. Pulmonary Function Test (PFT)
 11. Brain Stem Evoked Potential (BSEP)
 12. Somatosensory Evoked Potential test (SSEP)
 13. Nerve Conduction Velocity tests (NCV)
 14. computerized Range of Motion tests (ROM)
 - b. Respondent submitted claim forms to Progressive Insurance Company for the treatment and tests set forth in a) 6-14 above, with intent to deceive.
11. Respondent falsely billed for her initial meeting with Patient A as a consultation, knowing that her evaluation did not meet the billing criteria for a consultation. Respondent did so with intent to deceive.
12. Respondent failed to maintain a record that accurately reflects the care and treatment of Patient A.

- B. On or about and between April 19, 2007, and September 5, 2007, Respondent evaluated and treated Patient B for injuries he reported he sustained in an automobile accident on March 21, 2007. Respondent's care and treatment deviated from minimally accepted standards of care in that:
1. Respondent failed to perform and document adequate histories.
 2. Respondent failed to perform and document adequate physical examinations.
 3. Respondent inappropriately ordered and/or performed and/or interpreted:
 - a. a Pulmonary Function Test (PFT)
 - b. a Brain Stem Evoked Potential test (BSEP)
 - c. Somatosensory Evoked Potential tests (SSEP) on Patient B's upper and lower extremities
 - d. Nerve Conduction Velocity tests (NCV)
 4. Respondent failed to follow-up and/or appropriately document follow-up on test and treatment results, including but not limited to: MRI's, SSEP, BSEP, physical therapy, chiropractic therapy, acupuncture and, laser therapy.
 5. Respondent failed to adequately establish a medical basis for her diagnoses of Patient B including but not limited to: vertigo, anxiety and nervousness.
 6. Respondent failed to develop and implement an appropriate treatment plan.
 7. Respondent knowingly created the false impression that she performed an orthopedic evaluation on Patient B on April 19, 2007, when in fact, Respondent knew that the documented examination was

fabricated, with recorded test values that are identical to the corresponding values recorded on Respondent's medical charts pertaining to the other patient's whose care is addressed by this Statement of Charges.

- a. Respondent did so with intent to deceive.
8. Respondent ordered or caused to be performed, excessive testing and treatment, not warranted by Patient B's condition.
- a. These tests and treatment include but were not limited to:
 1. MRI of the Cervical Spine
 2. MRI of the Thoracic Spine
 3. MRI of the Left shoulder
 4. acupuncture
 5. durable goods including: cervical collar, cervical pillow, LSO, lumbosacral cushion, thermophore, egg crate mattress and bed board
 6. Pulmonary Function test (PFT)
 7. Nerve Conduction Velocity (NCV)
 8. physical therapy
 9. chiropractic treatment
 10. synaptic/bioelectric treatment
 11. low level cold laser therapy
 12. Brain Stem Evoked Potential (BSEP)
 13. Somatosensory Evoked Potential (SSEP)
 - b. Respondent submitted claim forms to GEICO Insurance Company for the treatments and tests set forth in a) 8-13 above, with intent to deceive.
9. Respondent falsely billed for her initial meeting with Patient B as a

consultation, knowing that her evaluation did not meet the billing criteria for a consultation. Respondent did so with intent to deceive.

10. Respondent failed to maintain a record that accurately reflects the care and treatment of Patient B.

C. On or about and between September 4, 2007, and October 23, 2007, Respondent evaluated and treated Patient C, a 9 year old boy, for injuries he reported he sustained in an automobile accident on August 29, 2007. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent failed to perform and document an adequate history.
2. Respondent failed to perform and document an adequate physical examination.
3. Respondent failed to perform and document an adequate neurologic evaluation of Patient C, as was indicated by abnormal findings noted in the record.
4. Respondent failed to follow-up and/or appropriately document follow-up on treatment results, including but not limited to: physical therapy, chiropractic therapy and, laser therapy.
5. Respondent failed to adequately establish a medical basis for her diagnoses of Patient C including but not limited to: vertigo, anxiety, nervousness and chest pain.
6. Respondent failed to develop and implement an appropriate treatment plan.
7. Respondent knowingly created the false impression that she performed an orthopedic evaluation on Patient C on September 4,

2007, when in fact, Respondent knew that the documented examination was fabricated, with recorded test values that are identical to the corresponding values recorded on Respondent's medical charts pertaining to the other patient's whose care is addressed by this Statement of Charges.

a. Respondent did so with intent to deceive.

8. Respondent ordered or caused to be performed, excessive testing and treatment, not warranted by Patient C's condition.

a. These tests and treatment include but were not limited to:

1. physical therapy
2. chiropractic treatment
3. synaptic/bioelectric treatment
4. cold laser therapy
5. durable goods including: cervical collar, cervical pillow, LSO, lumbosacral cushion, thermophore, egg crate mattress and, knee and ankle supports

b. Respondent submitted claim forms to GEICO Insurance Company for the tests and treatment set forth in a) 1-4 above, with intent to deceive.

9. Respondent falsely billed for her initial meeting with Patient C as a consultation, knowing that her evaluation did not meet the billing criteria for a consultation. Respondent did so with intent to deceive.

10. Respondent failed to maintain a record that accurately reflects the care and treatment of Patient C.

D. On or about and between April 19, 2007, and August 9, 2007, Respondent evaluated and treated Patient D for injuries he reported he sustained in an

automobile accident on March 21, 2007. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent failed to perform and document adequate histories.
2. Respondent failed to perform and document adequate physical examinations.
3. Respondent inappropriately ordered and/or performed and/or interpreted:
 - a. a Pulmonary Function Test (PFT)
 - b. a Brain Stem Evoked Potential test (BSEP)
 - c. a Somatosensory Evoked Potential test (SSEP)
 - d. Nerve Conduction Velocity tests (NCV)
4. Respondent failed to follow-up and/or appropriately document follow-up on test and treatment results, including but not limited to: MRI's, PFT, SSEP, BSEP, physical therapy, chiropractic therapy, acupuncture and, laser therapy.
5. Respondent failed to address and/or document abnormal findings in Patient D's test results including but not limited to EKG and PFT.
6. Respondent failed to adequately establish a medical basis for her diagnoses of Patient D including but not limited to: vertigo, anxiety and nervousness.
7. Respondent failed to develop and implement an appropriate treatment plan.
8. Respondent knowingly created the false impression that she performed an orthopedic evaluation on Patient D on April 19, 2007, when in fact, Respondent knew that the documented examination was fabricated, with recorded test values that are identical to the

corresponding values recorded on Respondent's medical charts pertaining to the other patient's whose care is addressed by this Statement of Charges.

- a. Respondent did so with intent to deceive.
9. Respondent ordered or caused to be performed, excessive testing and treatment, not warranted by Patient D's condition.
- a. These tests and treatment include but were not limited to:
 1. MRI of the Cervical Spine
 2. MRI of the Lumbar Spine
 3. MRI of the Right shoulder
 4. MRI of the Left knee
 5. acupuncture
 6. Nerve Conduction Velocity (NCV)
 7. durable goods including: cervical collar, cervical pillow, LSO, lumbosacral cushion, thermophore, egg crate mattress, bed board and knee support
 8. Physical therapy
 9. chiropractic treatment
 10. synaptic/bioelectric treatment
 11. low level cold laser therapy
 12. Pulmonary Function Test (PFT)
 13. Brain Stem Evoked Potential (BSEP)
 14. Somatosensory Evoked Potential (SSEP)
 - b. Respondent submitted claim forms to GEICO Insurance Company for the treatment and tests set forth in a) 8-14 above, with intent to deceive
10. Respondent falsely billed for her initial meeting with Patient D as a

consultation, knowing that her evaluation did not meet the billing criteria for a consultation. Respondent did so with intent to deceive.

11. Respondent failed to maintain a record that accurately reflects the care and treatment of Patient D.

E. On or about and between August 28, 2007, and January 24, 2008, Respondent evaluated and treated Patient E for injuries she reported she sustained in an automobile accident on August 25, 2007. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent failed to perform and document adequate histories.
2. Respondent failed to perform and document adequate physical examinations.
3. Respondent inappropriately ordered and/or performed and/or interpreted:
 - a. a Pulmonary Function Test (PFT)
 - b. a Brain Stem Evoked Potential test (BSEP)
 - c. a Somatosensory Evoked Potential test (SSEP) on Patient E's upper and lower extremities
 - d. Nerve Conduction Velocity tests (NCV) on Patient E's upper and lower extremities
 - e. multiple computerized range of motion tests (ROM)
4. Respondent failed to follow-up and/or appropriately document follow-up on test and treatment results, including but not limited to: MRI's, PFT, SSEP, BSEP, NCV, physical therapy, chiropractic therapy, acupuncture and, laser therapy.
5. Respondent failed to address and/or document abnormal findings in

- Patient E's test results including but not limited to PFT and EKG.
6. Respondent failed to adequately establish a medical basis for her diagnoses of Patient E including but not limited to: vertigo, anxiety and nervousness.
 7. Respondent failed to develop and implement an appropriate treatment plan.
 8. Respondent knowingly created the false impression that she performed an orthopedic evaluation on Patient E on August 28, 2007, when in fact, Respondent knew that the documented examination was fabricated, with recorded test values that are identical to the corresponding values recorded on Respondent's medical charts pertaining to the other patient's whose care is addressed by this Statement of Charges.
 - a. Respondent did so with intent to deceive.
 9. Respondent ordered or caused to be performed, excessive testing and treatment, not warranted by Patient E's condition.
 - a. These tests and treatment include but were not limited to:
 1. MRI of the Cervical Spine
 2. MRI of the Thoracic Spine
 3. MRI of the Lumbar Spine
 4. acupuncture
 5. durable goods including: cervical collar, cervical pillow, LSO, lumbosacral cushion, thermophore, egg crate mattress and bed board
 6. physical therapy
 7. chiropractic treatment
 8. synaptic/bioelectric treatment

9. low level cold laser therapy
 10. Pulmonary Function Test (PFT)
 11. Brain Stem Evoked Potential (BSEP)
 12. Somatosensory Evoked Potential (SSEP)
 13. Nerve Conduction Velocity tests (NCV)
 14. computerized Range of Motion tests (ROM)
- b. Respondent submitted claim forms to GEICO Insurance Company for the treatments and tests set forth in a) 6-14 above, with intent to deceive.
10. Respondent falsely billed for her initial meeting with Patient E as a consultation, knowing that her evaluation did not meet the billing criteria for a consultation. Respondent did so with intent to deceive.
11. Respondent failed to maintain a record that accurately reflects the care and treatment of Patient E.

F. On or about and between July 19, 2007, and December 4, 2007, Respondent evaluated and treated Patient F for injuries he reported he sustained in an automobile accident on July 17, 2007. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent failed to perform and document adequate histories.
2. Respondent failed to perform and document adequate physical examinations.
3. Respondent inappropriately ordered and/or performed and/or interpreted:
 - a. a Pulmonary Function Test (PFT)
 - b. a Brain Stem Evoked Potential test (BSEP)

4. Respondent failed to follow-up and/or appropriately document follow-up on test and treatment results, including but not limited to: MRI's, PFT, BSEP, physical therapy, chiropractic therapy, acupuncture and, laser therapy.
5. Respondent failed to address and/or document abnormal findings in Patient F's test results including but not limited to PFT.
6. Respondent failed to adequately establish a medical basis for her diagnoses of Patient F including but not limited to: anxiety and nervousness.
7. Respondent failed to develop and implement an appropriate treatment plan.
8. Respondent ordered or caused to be performed, excessive testing and treatment, not warranted by Patient F's condition.
 - a. These tests and treatment include but were not limited to:
 1. MRI of the Left knee
 2. acupuncture
 3. durable goods including: thermophore and, knee support
 4. physical therapy
 5. chiropractic treatment
 6. synaptic/bioelectric treatment
 7. low level cold laser therapy
 8. Pulmonary Function Test (PFT)
 9. Brain Stem Evoked Potential (BSEP)
 - b. Respondent submitted claim forms to GEICO Insurance Company for the treatments and tests set forth in a) 4-9 above, with intent to deceive.
9. Respondent falsely billed for her initial meeting with Patient F as a

consultation, knowing that her evaluation did not meet the billing criteria for a consultation. Respondent did so with intent to deceive.

10. Respondent failed to maintain a record that accurately reflects the care and treatment of Patient F.

G. On or about and between May 15, 2007, and August 1, 2007, Respondent evaluated and treated Patient G for injuries he reported he sustained in an automobile accident on May 6, 2007. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent failed to perform and document adequate histories.
2. Respondent failed to perform and document adequate physical examinations.
3. Respondent inappropriately ordered and/or performed and/or interpreted:
 - a. a Pulmonary Function Test (PFT)
 - b. a Brain Stem Evoked Potential test (BSEP)
 - c. a Somatosensory Evoked Potential test (SSEP)
 - d. Nerve Conduction Velocity tests (NCV) on Patient G's upper and lower extremities
4. Respondent failed to follow-up and/or appropriately document follow-up on test and treatment results, including but not limited to: MRI's, PFT, BSEP, physical therapy, chiropractic therapy, acupuncture and laser therapy.
5. Respondent failed to address and/or document abnormal findings in Patient G's test results including but not limited to EKG and PFT.
6. Respondent failed to adequately establish a medical basis for her

diagnoses of Patient G including but not limited to: vertigo, anxiety and nervousness.

7. Respondent failed to develop and implement an appropriate treatment plan.
8. Respondent knowingly created the false impression that she performed an orthopedic evaluation on Patient G on May 15, 2007, when in fact, Respondent knew that the documented examination was fabricated, with recorded test values that are identical to the corresponding values recorded on Respondent's medical charts pertaining to the other patient's whose care is addressed by this Statement of Charges.
 - a. Respondent did so with intent to deceive.
9. Respondent ordered or caused to be performed, excessive testing and treatment, not warranted by Patient G's condition.
 - a. These tests and treatment include but were not limited to:
 1. MRI of the Cervical Spine
 2. MRI of the Lumbar Spine
 3. MRI of the Right elbow
 4. MRI of the Right knee
 5. acupuncture
 6. durable goods including: cervical collar, cervical pillow, LSO, lumbosacral cushion, thermophore, egg crate mattress, bed board and knee support
 7. Somatosensory Evoked Potential (SSEP)
 8. Nerve Conduction Velocity tests (NCV)
 9. physical therapy
 10. chiropractic treatment

11. synaptic/bioelectric treatment
 12. low level cold laser therapy
 13. Pulmonary Function Test (PFT)
 14. Brain Stem Evoked Potential (BSEP)
- b. Respondent submitted claim forms to Nationwide Insurance Company for the treatments and tests set forth in a) 9-14 above, with intent to deceive.
10. Respondent falsely billed for her initial meeting with Patient G as a consultation, knowing that her evaluation did not meet the billing criteria for a consultation. Respondent did so with intent to deceive.
11. Respondent failed to maintain a record that accurately reflects the care and treatment of Patient G.
- H. On or about and between May 14, 2007, and September 25, 2007, Respondent evaluated and treated Patient H for injuries she reported she sustained in an automobile accident on May 7, 2007. Respondent's care and treatment deviated from minimally accepted standards of care in that:
1. Respondent failed to perform and document adequate histories.
 2. Respondent failed to perform and document adequate physical examinations.
 3. Respondent inappropriately ordered and/or performed and/or interpreted:
 - a. a Pulmonary Function Test (PFT)
 - b. a Brain Stem Evoked Potential test (BSEP)
 - c. a Somatosensory Evoked Potential test (SSEP) on Patient H's upper and lower extremities

- d. Nerve Conduction Velocity tests (NCV) on Patient H's upper extremities
 - e. multiple computerized range of motion tests (ROM)
4. Respondent failed to follow-up and/or appropriately document follow-up on test and treatment results, including but not limited to: MRI's, PFT, SSEP, BSEP, NCV, physical therapy, chiropractic therapy, acupuncture and, laser therapy.
 5. Respondent failed to address and/or document abnormal findings in Patient H's test results including but not limited to a markedly abnormal EKG, PFT and, SSEP.
 6. Respondent failed to adequately establish a medical basis for her diagnoses of Patient H including but not limited to: vertigo, anxiety and nervousness.
 7. Respondent failed to develop and implement an appropriate treatment plan.
 8. Respondent knowingly created the false impression that she performed an orthopedic evaluation on Patient H on May 14, 2007, when in fact, Respondent knew that the documented examination was fabricated, with recorded test values that are identical to the corresponding values recorded on Respondent's medical charts pertaining to the other patient's whose care is addressed by this Statement of Charges.
 - a. Respondent did so with intent to deceive.
 9. Respondent ordered or caused to be performed, excessive testing and treatment, not warranted by Patient H's condition.
 - a. These tests and treatments include but were not limited to:
 1. MRI of the Cervical Spine

2. MRI of the Thoracic Spine
 3. MRI of the Lumbar Spine
 4. acupuncture
 5. durable goods including: cervical collar, cervical pillow, LSO, lumbosacral cushion, thermophore, egg crate mattress and bed board
 6. physical therapy
 7. chiropractic treatment
 8. synaptic/bioelectric treatment
 9. low level cold laser therapy
 10. Pulmonary Function Test (PFT)
 11. Brain Stem Evoked Potential (BSEP)
 12. Somatosensory Evoked Potential (SSEP)
 13. Nerve Conduction Velocity tests (NCV)
 14. computerized Range of Motion tests (ROM)
- b. Respondent submitted claim forms to Nationwide Insurance Company for the treatments and tests set forth in a) 6-14 above, with intent to deceive.
10. Respondent falsely billed for her initial meeting with Patient H as a consultation, knowing that her evaluation did not meet the billing criteria for a consultation. Respondent did so with intent to deceive.
 11. Respondent failed to maintain a record that accurately reflects the care and treatment of Patient H.
- I. On or about and between July 19, 2007, and December 4, 2007, Respondent evaluated and treated Patient I for injuries he reported he sustained in an automobile accident on July 17, 2007. Respondent's care

and treatment deviated from minimally accepted standards of care in that:

1. Respondent failed to perform and document adequate histories.
2. Respondent failed to perform and document adequate physical examinations.
3. Respondent inappropriately ordered and/or performed and/or interpreted:
 - a. a Pulmonary Function Test (PFT)
 - b. a Brain Stem Evoked Potential test (BSEP)
 - c. a Somatosensory Evoked Potential test (SSEP) on Patient I's upper and lower extremities
 - d. Nerve Conduction Velocity tests (NCV) on Patient I's upper and lower extremities
4. Respondent failed to follow-up and/or appropriately document follow-up on test and treatment results, including but not limited to: MRI's, PFT, EKG, SSEP, BSEP, NCVs, physical therapy, chiropractic therapy, acupuncture and, laser therapy.
5. Respondent failed to address and/or document abnormal findings in Patient I's test results including but not limited to EKG and PFT.
6. Respondent failed to adequately establish a medical basis for her diagnoses of Patient I including but not limited to: vertigo, anxiety and nervousness.
7. Respondent failed to develop and implement an appropriate treatment plan.
8. Respondent knowingly created the false impression that she performed an orthopedic evaluation on Patient I on July 19, 2007, when in fact, Respondent knew that the documented examination was

fabricated, with recorded test values that are identical to the corresponding values recorded on Respondent's medical charts pertaining to the other patient's whose care is addressed by this Statement of Charges.

- a. Respondent did so with intent to deceive.
9. Respondent ordered or caused to be performed, excessive testing and treatment, not warranted by Patient I's condition.
- a. These tests and treatment include but were not limited to:
 1. MRI of the Cervical Spine
 2. MRI of the Lumbar Spine
 3. MRI of the Right knee
 4. acupuncture
 5. durable goods including: cervical collar, cervical pillow, LSO, lumbosacral cushion, orthopedic car seat support, thermophore, egg crate mattress and knee support
 6. physical therapy
 7. chiropractic treatment
 8. synaptic/bioelectric treatment
 9. low level cold laser therapy
 10. Pulmonary Function Test (PFT)
 11. Brain Stem Evoked Potential (BSEP)
 12. Somatosensory Evoked Potential (SSEP)
 13. Nerve Conduction Velocity tests (NCV)
 - b. Respondent submitted claim forms to GEICO Insurance Company for the treatments and tests set forth in a) 6-13 above, with intent to deceive.
10. Respondent falsely billed for her initial meeting with Patient I as a

consultation, knowing that her evaluation did not meet the billing criteria for a consultation. Respondent did so with intent to deceive.

11. Respondent failed to maintain a record that accurately reflects the care and treatment of Patient I.

J. On or about and between May 21, 2007, and September 7, 2007, Respondent evaluated and treated Patient J for injuries she reported she sustained in an automobile accident on May 19, 2007. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent failed to perform and document adequate histories.
2. Respondent failed to perform and document adequate physical examinations.
3. Respondent failed to perform an EKG even though there was a medical basis to do so indicated in the record.
4. Respondent inappropriately ordered and/or performed and/or interpreted:
 - a. a Pulmonary Function Test (PFT)
 - b. a Brain Stem Evoked Potential test (BSEP)
 - c. a Somatosensory Evoked Potential test (SSEP) on Patient J's upper and lower extremities
 - d. Bilateral Nerve Conduction Velocity tests (NCV) on Patient J's upper and lower extremities
 - e. multiple computerized range of motion tests (ROM)
5. Respondent failed to follow-up and/or appropriately document follow-up on test and treatment results, including but not limited to: MRI's, SSEP, BSEP, NCV, ROM tests, physical therapy, chiropractic therapy,

acupuncture and, laser therapy.

6. Respondent failed to adequately establish a medical basis for her diagnoses of Patient J including but not limited to: vertigo, anxiety and nervousness.
7. Respondent failed to develop and implement an appropriate treatment plan.
8. Respondent knowingly created the false impression that she performed an orthopedic evaluation on Patient J on May 21, 2007, when in fact, Respondent knew that the documented examination was fabricated, with recorded test values that are identical to the corresponding values recorded on Respondent's medical charts pertaining to the other patient's whose care is addressed by this Statement of Charges.
 - a. Respondent did so with intent to deceive.
9. Respondent ordered or caused to be performed, excessive testing and treatment, not warranted by Patient J's condition.
 - a. These tests and treatment include but were not limited to:
 1. MRI of the Cervical Spine
 2. MRI of the Thoracic Spine
 3. MRI of the Lumbar Spine
 4. acupuncture
 5. durable goods including: cervical collar, cervical pillow, LSO, lumbosacral cushion, thermophore, egg crate mattress and bed board
 6. Pulmonary Function Test (PFT)
 7. physical therapy
 8. chiropractic treatment

9. synaptic/bioelectric treatment
 10. low level cold laser therapy
 11. Brain Stem Evoked Potential (BSEP)
 12. Somatosensory Evoked Potential (SSEP)
 13. Nerve Conduction Velocity tests (NCV)
 14. computerized Range of Motion tests (ROM)
- b. Respondent submitted claim forms to GEICO Insurance Company for the treatments and tests set forth in a) 8-15 above, with intent to deceive.
10. Respondent falsely billed for her initial meeting with Patient J as a consultation, knowing that her evaluation did not meet the billing criteria for a consultation. Respondent did so with intent to deceive.
 11. Respondent failed to maintain a record that accurately reflects the care and treatment of Patient J.

SPECIFICATION OF CHARGES

FIRST 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:

1. Paragraph A, A1-8, A12 and, Paragraph B, B1-6, B10 and, Paragraph C, C1-6, C10 and, Paragraph D, D1-7, D11 and,

Paragraph E, E1-7, E11 and, Paragraph F, F1-7, F10 and,
Paragraph G, G1-7, G11 and, Paragraph H, H1-7, H11 and,
Paragraph I, I1-7, I11 and, Paragraph J; J1-7 and J11.

SECOND 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:

2. Paragraph A, A1-8, A12 and, Paragraph B, B1-6, B10 and, Paragraph C, C1-6, C10 and, Paragraph D, D1-7, D11 and, Paragraph E, E1-7, E11 and, Paragraph F, F1-7, F10 and, Paragraph G, G1-7, G11 and, Paragraph H, H1-7, H11 and, Paragraph I, I1-7, I11 and, Paragraph J, J1-7 and J11.

THIRD THROUGH TWELFTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

3. Paragraph A, A1-8 and A12.
4. Paragraph B, B1-6 and B10.
5. Paragraph C, C1-6 and C10.

6. Paragraph D, D1-7 and D11.
7. Paragraph E, E1-7 and E11.
8. Paragraph F, F1-7 and F10.
9. Paragraph G, G1-7 and G11.
10. Paragraph H, H1-7 and H11.
11. Paragraph I, I1-7 and I11.
12. Paragraph J, J1-7 and J11.

THIRTEENTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

13. Paragraph A, A1-8, A12 and, Paragraph B, B1-6, B10 and, Paragraph C, C1-6, C10 and, Paragraph D, D1-7, D11 and, Paragraph E, E1-7, E11 and, Paragraph F, F1-7, F10 and, Paragraph G, G1-7, G11 and, Paragraph H, H1-7, H11 and, Paragraph I, I1-7, I11 and, Paragraph J, J1-7 and J11.

FOURTEENTH THROUGH TWENTY-THIRD SPECIFICATIONS

UNWARRANTED TESTS/TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(35) by ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient, as alleged in the

facts of:

14. Paragraph A, A10 and A10a1-14.
15. Paragraph B, B8 and B8a1-13.
16. Paragraph C, C8 and C8a1-5.
17. Paragraph D, D9 and D9a1-14.
18. Paragraph E, E9 and E9a1-14.
19. Paragraph F, F9 and F8a1-9.
20. Paragraph G, G9 and G9a1-14.
21. Paragraph H, H9 and H9a1-14.
22. Paragraph I, I9 and I9a1-13.
23. Paragraph J, J9 and J9a1-15.

TWENTY-FOURTH THROUGH THIRTY-THIRD SPECIFICATIONS
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:

24. Paragraph A, A9 and A9a, A10, A10a1-14, A10b and A11.
25. Paragraph B, B7 and B7a, B8, B8a1-13, B8b and B9.
26. Paragraph C, C7 and C7a, C8, C8a1-5, C8b and C9.
27. Paragraph D, D8 and D8a, D9, D9a1-14, D9b and D10.
28. Paragraph E, E8 and E8a, E9, E9a1-14, E9b and E10.
29. Paragraph F, F9, F8a1-9, F8b and F9.
30. Paragraph G, G8 and G8a, G9, G9a1-14, G9b and G10.

31. Paragraph H, H8 and H8a, H9, H9a1-14, H9b and H10.
32. Paragraph I, I8 and I8a, I9, I9a1-13, I9b and I10.
33. Paragraph J, J8 and J8a, J9, J9a1-15, J9b and J10.

THIRTY-FOURTH THROUGH FORTY-THIRD SPECIFICATIONS

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by wilfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of:

34. Paragraph A, A9 and A11.
35. Paragraph B, B7 and B10.
36. Paragraph C, C7 and C10.
37. Paragraph D, D8 and D11.
38. Paragraph E, E8 and E11.
39. Paragraph F and F10.
40. Paragraph G, G8 and G11.
41. Paragraph H, H8 and H11.
42. Paragraph I, I8 and I11.
43. Paragraph J, J8 and J11.

FORTY-FOURTH THROUGH FIFTY-THIRD SPECIFICATIONS

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:

44. Paragraph A and A12.
45. Paragraph B and B10.
46. Paragraph C and C10.
47. Paragraph D and D11.
48. Paragraph E and E11.
49. Paragraph F and F10
50. Paragraph G and G11.
51. Paragraph H and H11.
52. Paragraph I and I11
53. Paragraph J and J11.

FIFTY-FOURTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

54. Paragraph A, A9 and A9a, A10, A10a1-14, A10b, A11 and, Paragraph B, B7 and B7a, B8, B8a1-13, B8b, B9 and, Paragraph C, C7 and C7a, C8, C8a1-5, C8b, C9 and, Paragraph D, D8 and D8a, D9, D9a1-14, D9b, D10 and, Paragraph E, E8 and E8a, E9, E9a1-14 and E9b, E10 and, Paragraph F, F8, F8a1-9 and F8b, F9 and, Paragraph G, G8 and

G8a, G9, G9a1-14, G9b, G10 and, Paragraph H, H8 and H8a, H9,
H9a1-14, H9b, H10 and, Paragraph I, I8 and I8a, I9, I9a1-13, I9b, I10
and, Paragraph J, J8 and J8a, J9, J9a1-15, J9b and J10.

DATE: June 22, 2009
New York, New York

REDACTED

Roy Nerberson
Deputy Counsel
Bureau of Professional Medical Conduct