NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

June 16, 2017

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Daniel Cameron, M.D.
657 Main Street
Mt. Kisco, New York 10549

Re: License No. 161183

Dear Dr. Cameron:

Enclosed is a copy of the New York State Board for Professional Medical Conduct (BPMC) Order No. 17-169. This order and any penalty provided therein goes into effect June 23, 2017.

Please direct any questions to: Board for Professional Medical Conduct, Riverview Center, 150 Broadway, Suite 355, Albany, New York 12204, telephone # 518-402-0846.

Sincerely,

[redacted]

Robert A. Catalano, M.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

cc: Jacques G. Simon, Esq.
Attorney at Law
100 Jericho Quadrangle, Suite 208
Jericho, New York 11753

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

BPMC No. 17-169

IN THE MATTER OF DANIEL CAMERON, M.D.	CONSENT ORDER

Upon the application of (Respondent) DANIEL CAMERON, 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 it is further

ORDERED, that this Consent 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.

DATE: 6/15/2017

[redacted]

Carmela Torrelli
Vice Chair
State Board for Professional Medical Conduct

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

IN THE MATTER OF DANIEL CAMERON, M.D.	CONSENT AGREEMENT

DANIEL CAMERON, M.D., represents that all of the following statements are true:

That on or about January 14, 1985, I was licensed to practice as a physician in the State of New York, and issued License No. 161183 by the New York State Education Department.

My current address is 657 Main St. Mt. Kisco NY 10549, 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 (Board) has charged me with one or more specifications of professional misconduct, as set forth in a Statement of Charges, marked as Exhibit "A", attached to and part of this Consent Agreement.

I assert that I cannot successfully defend against at least one of the acts of misconduct alleged, in full satisfaction of the charges against me, and agree to the following penalty:

Pursuant to N.Y. Pub. Health Law § 230-a(9), I shall be placed on probation for a period of 3 years, subject to the terms set forth in attached Exhibit "B."

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

That Respondent shall comply with each and every penalty imposed by this Order pursuant to N.Y. Pub. Health Law § 230-a.

That Respondent shall, regarding each patient of Respondent's medical practice after the effective date of this order:

- Communicate fully to the patient the nature of the medical role that Respondent is undertaking, whether as a physician with primary care responsibility for that patient's general medical condition(s), or, in the alternative, as a consultant for a defined or limited purpose and/or a practitioner of a particular medical specialty, whether or not universally accepted treatment modalities are contemplated. Respondent shall document his role and this communication fully in the patient's record.
- Obtain written informed consent specifically addressing all aspects of treatment modalities to be used by Respondent in performance of the medical role undertaken and as addressed above. The language of the consent forms shall be determined by the

Respondent and his appropriately qualified counsel. Exemplars of each consent form prepared and used for this purpose shall be provided to the Office of Professional Medical Conduct for inclusion in its files but not for acceptance or rejection. Respondent shall provide the initial set of informed consent forms to OPMC no later than 45 days after the effective date of this Order.

- Include in the patient record all written informed consent forms duly obtained and full documentation of all discussions with the patient concerning the nature and scope of Respondent's evaluation and treatment, and of the patient's need to pursue conventional medical care elsewhere, if indicated, at the patient's informed option.
- Document in the patient record all histories obtained and physical examinations performed on the patient by Respondent and/or Respondent's staff.
- For all new patients first seen after the effective date of the Order and for all continuing patients for whom it is medically appropriate, attempt to get the patient's written consent to obtain the patient's medical records from prior or concurrently treating physicians or facilities, and to enable Respondent to communicate with those physicians or facilities, as necessary. Respondent shall maintain these medical records, and/or documentation related to requests

for these records, in the patient medical record. Respondent shall document appropriately his review of any records received from other treating physicians or facilities. Alternatively, if the patient refuses to grant written consent after being fully advised of the reason for it, Respondent shall document Respondent's advice and the patient's refusal.

- Refer the patient to appropriate primary care physicians, specialists, or consultants for further evaluation and/or treatment where medically warranted and beyond the scope of Respondent's role with regard to the patient. Respondent, who states and affirmatively represents that making such referrals as specified above is already his standard practice, shall note all referrals in the patient's medical record to the extent that such referrals are made. Respondent shall provide the physician receiving the referral with all patient information known to Respondent that is significant in relation to the purpose of the consultation, unless the physician receiving the referral declines to receive it; this information shall include, but not be limited to, all treatment modalities in use. If the patient refuses the referral after being fully advised of the reason for it, Respondent shall document the Respondent's advice and the patient's refusal.

The above condition and all of its terms shall take effect 60 days after the effective date of the Consent Order and will continue so long as Respondent remains a Licensee in New York State; and

That Respondent shall remain in continuous compliance with all requirements of N.Y. Educ Law § 6502 including but not limited to the requirements that a Respondent shall register and continue to be registered with the New York State Education Department (except during periods of actual suspension) and that a Respondent shall pay all registration fees. Respondent shall not exercise the option provided in N.Y. Educ. Law § 6502(4) to avoid registration and payment of fees. This condition shall take effect 120 days after the Consent Order's effective date and will continue so long as Respondent remains a Licensee in New York State; and

That Respondent shall remain in continuous compliance with all requirements of N.Y. Pub. Health Law § 2995-a(4) and 10 NYCRR 1000.5, including but not limited to the requirements that a Respondent shall: report to the department all information required by the Department to develop a public physician profile for the Respondent; continue to notify the department of any change in profile information within 30 days of any change (or in the case of optional information, within 365 days of such change); and, in addition to such periodic reports and notification of any changes, update his or her profile information within six months prior to the expiration date of the

Respondent's registration period. Respondent shall submit changes to his or her physician profile information either electronically using the department's secure web site or on forms prescribed by the department, and Respondent shall attest to the truthfulness, completeness and correctness of any changes Respondent submits to the department. This condition shall take effect 30 days after the Order's effective date and shall continue so long as Respondent remains a Licensee in New York State. Respondent's failure to comply with this condition, if proven and found at a hearing pursuant to N.Y. Pub. Health Law § 230, shall constitute professional misconduct as defined in N.Y. Educ. Law § 6530(21) and N.Y. Educ. Law § 6530(29). Potential penalties for failure to comply with this condition may include all penalties for professional misconduct set forth in N.Y. Pub. Health Law § 230-a, including but not limited to: revocation or suspension of license, Censure and Reprimand, probation, public service and/or fines of up to $10,000 per specification of misconduct found; and

That Respondent shall provide the Director, Office of Professional Medical Conduct (OPMC), Riverview Center, 150 Broadway, Suite 355, Albany, New York 12204-2719, with the following information, in writing, and ensure that this information is kept current: a full description of Respondent's employment and practice; all professional and residential addresses and telephone numbers within and outside New York State; and all investigations,

arrests, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility. Respondent shall notify OPMC, in writing, within 30 days of any additions to or changes in the required information. This condition shall take effect 30 days after the Order's effective date and shall continue at all times until Respondent receives written notification from the Office of Professional Medical Conduct, Physician Monitoring Program, that OPMC has determined that Respondent has fully complied with and satisfied the requirements of the Order, regardless of tolling; and

That Respondent shall cooperate fully with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Consent 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 Consent 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.

I stipulate that my failure to comply with any conditions of this Consent Order shall constitute misconduct as defined by N.Y. Educ. 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 N.Y. Pub. 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 Consent 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. The Consent Order, this agreement, and all attached Exhibits shall be public documents, with only patient identities or other confidential information, if any, redacted. As public documents, they may be posted on the Department's website. OPMC shall report this action to the National Practitioner Data Bank and the Federation of State Medical Boards, and any other entities that the Director of OPMC shall deem appropriate.

I stipulate that the proposed sanction and Consent Order are authorized by N.Y. Pub. Health Law §§ 230 and 230-a, and that the Board and OPMC have the requisite

powers to carry out all included terms. 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 I ask that the Board adopt this Consent Agreement.

I understand and agree that the attorney for the Department, the Director of OPMC and the Chair of the Board each retain complete discretion either to enter into the proposed agreement and Consent Order, based upon my application, or to decline to do so. I further understand and agree that no prior or separate written or oral communication can limit that discretion.

DATE 6-15-17

[redacted]

DANIEL CAMERON, M.D.
RESPONDENT

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

DATE: [redacted]

JACQUES G. SIMON, ESQ.
Attorney for Respondent

DATE: 6/15/17 [redacted]

LESLIE A. EISENBERG
Associate Counsel
Bureau of Professional Medical Conduct

DATE: 6/15/17 [redacted]

KEITH W. SERVIS
Director
Office of Professional Medical Conduct

EXHIBIT "A"

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

IN THE MATTER OF DANIEL CAMERON, MD	STATEMENT OF CHARGES

Daniel Cameron, M.D., the Respondent, was authorized to practice medicine in New York State on or about January 14, 1985, by the issuance of license number 161183 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, a 41-year-old woman, from on or about January 28, 1997, through in or about June 2008. At the initial visit, the Patient reported leg pain, poor sleep and, that she had been evaluated by numerous physicians, for various joint complaints, with no definitive diagnosis. In March 1999, the Patient was admitted to a psychiatric facility for narcotic detoxification and upon discharge, returned to Respondent for continued treatment. In August 1999, based on ongoing complaints of poor concentration and fatigue, the Patient was evaluated at Helen Hayes Hospital and was diagnosed with Bipolar Disorder/Personality Disorder and Narcotic Abuse. In or about July 2003, the Patient moved to Florida. Respondent continued to provide the Patient with prescriptions for narcotics through 2005. (Patient names are identified in

the Appendix). Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent repeatedly failed to take and/or note an adequate history of present illness.

2. Respondent repeatedly failed to perform and/or note an appropriate physical examination.

3. Respondent failed to appropriately construct a differential diagnosis and pursue a thorough diagnostic evaluation.

4. Respondent treated the Patient inappropriately with an ongoing and escalating antibiotic regimen without appropriate sequential physical examinations and clinical re-assessments for consideration of any alternative diagnoses and/or treatment.

5. Respondent failed to follow-up, in a timely fashion, when the Patient developed possible adverse reactions to administered therapy.

6. Respondent inappropriately prescribed narcotics for the Patient.

7. Respondent inappropriately prescribed medication to the Patient without appropriate medical indications.

8. Respondent failed to maintain a record that accurately reflects the care and treatment rendered to the Patient.

B. Respondent treated Patient B, a 38-year-old woman, from on or about October 15, 1998, through on or about March 7, 2008, for complaints that included severe fatigue,

disturbed sleep, irritability, joint pains, frequent sore throats, nausea and diarrhea. At her initial visit, the Patient reported that 9 years earlier she had been told she had a borderline Lyme test and was treated with antibiotics and, that in the past 5 years she had frequent bouts of fatigue and was diagnosed with Chronic Fatigue Syndrome. In December 1998, the Patient was seen by a neurologist who, based on an abnormal MRI, recommended a lumbar puncture but one was not done. In June 1999, the patient had an abnormal brain SPECT. In January 2002, the patient had her first and only physical examination in Respondent's practice. In January 2008, ten years after the initial MRI, the Patient had a second MRI, which was again abnormal and, a neurologist performed a lumbar puncture. The results of the lumbar puncture were negative for Lyme disease but revealed positive oligoclonal band proteins which are consistent with the diagnosis of Multiple Sclerosis. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent repeatedly failed to take and/or note an adequate history of present illness.

2. Respondent failed to obtain and/or review prior medical records to confirm the earlier diagnoses and treatment.

3. Respondent repeatedly failed to perform and/or note an appropriate physical examination.

4. Respondent failed to appropriately construct a differential diagnosis and pursue a thorough diagnostic evaluation.

5. Respondent treated the Patient inappropriately with an ongoing and escalating antibiotic regimen without appropriate sequential physical examinations and clinical re-assessments for consideration of any alternative diagnoses and/or treatment.

6. Respondent inappropriately prescribed medication to the patient without appropriate medical indications.

7. Respondent failed to order and/or perform a lumbar puncture to evaluate the Patient, based on ongoing complaints, an abnormal MRI and, an abnormal SPECT scan.

8. Respondent failed to reconsider a broad differential diagnosis based upon radiographic studies and ongoing complaints that included among other symptoms: slurred speech, memory loss, fatigue, headaches and worsening symptoms in the warm weather, thereby depriving the patient of an accurate diagnosis and years of effective therapy for her progressive disease.

9. Respondent failed to follow-up, in a timely fashion, when the Patient experienced possible adverse reactions to administered therapy.

10. Respondent failed to maintain records that accurately reflect the care and treatment rendered to the Patient.

C. Respondent treated Patient C, a 47-year-old male, from in or about January 1995, through in or about May 2009. The Patient suffered from morbid obesity and diabetes. In June 1999, the Patient presented with a diagnosis of phlebitis of his right leg.

Respondent began treating the Patient with parenteral antibiotics and thereafter, Respondent added the diagnosis of Lyme disease. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent repeatedly failed to take and/or note an adequate history of present illness.

2. Respondent repeatedly failed to perform and/or note an appropriate physical examination.

3. Respondent failed to appropriately construct a differential diagnosis and pursue a thorough diagnostic evaluation.

4. Respondent treated the Patient inappropriately with an ongoing antibiotic regimen without further medical or surgical investigation of chronic venous insufficiency.

5. Respondent failed to maintain records that accurately reflects the care and treatment rendered to the Patient.

D. Respondent treated Patient D, a 49-year-old woman, from on or about October 10, 1997, through in or about February 2005. Respondent saw the Patient for evaluation of possible Lyme disease. At her initial visit, the Patient complained of problems with concentration, fatigue and, multiple joint pains. The Patient reported that she had previously been seen by a neurologist and had a normal MRI and CT scan. In December 1998, a neurologist recommended that Respondent order and/or perform

spinal fluid analysis but, this was not done. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent repeatedly failed to take and/or note an adequate history of present illness.

2. Respondent repeatedly failed to perform and/or note an appropriate physical examination.

3. Respondent failed to appropriately construct a differential diagnosis and pursue a thorough diagnostic evaluation.

4. Respondent failed to appropriately evaluate the Patient, based on complaints of ongoing dizziness.

5. Respondent treated the Patient inappropriately with an ongoing and escalating antibiotic regimen without appropriate sequential physical examinations and clinical re-assessments for consideration of any alternative diagnoses and/or treatment.

6. Respondent failed to maintain records that accurately reflects the care and treatment rendered to the Patient.

E. Respondent treated Patient E, a 46-year-old woman, from on or about July 8, 2008, through in or about August, 2008. At her initial visit, the Patient reported that she had been diagnosed with Parkinson's disease in May 2008, and that in early May 2008, she had a tick bite, a bull's eye rash and had been treated with antibiotics and intra muscular injections for approximately seven weeks. Respondent ordered a PICC

line for the administration of parenteral antibiotics, which was placed on July 17, 2008. One week later, the Patient complained of pain in her neck and shoulder. On July 31, 2008, the Patient reported extreme pain. The Patient had a venous Doppler study which indicated deep vein thrombosis. The Patient was admitted to Northern Westchester Hospital where the PICC line was removed and the patient was placed on anticoagulant therapy. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent repeatedly failed to take and/or note an appropriate history.

2. Respondent failed to obtain and/or review prior medical records to confirm the earlier diagnosis and treatment.

3. Respondent repeatedly failed to perform and/or note an appropriate physical examination.

4. Respondent failed to appropriately construct a differential diagnosis and pursue a thorough diagnostic evaluation.

5. Respondent inappropriately treated the Patient with an antibiotic regimen without appropriate physical examinations and clinical re-assessments for consideration of any alternative diagnoses and/or treatment.

6. Respondent ordered and/or prescribed a PICC line and parenteral antibiotics without medical necessity.

7. Respondent failed to appropriately evaluate the Patient, in a timely fashion, when she complained of pain associated with the PICC line.

8. Respondent failed to maintain a record that accurately reflects the care and treatment rendered to the Patient.

F. Respondent treated Patient F, a 36-year-old woman, on February 19, 2008, and May 5, 2008. The Patient reported that her recent medical history included a termination of pregnancy in October 2007, diverticulitis in November 2007 and, a diagnosis of Lyme disease for which she was treated with a five-week course of antibiotics in January 2008. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent repeatedly failed to take and/or note an appropriate history.

2. Respondent failed to obtain and/or review prior medical records to confirm the earlier diagnosis and treatment.

3. Respondent repeatedly failed to perform and/or note an appropriate physical examination.

4. Respondent failed to appropriately construct a differential diagnosis and pursue a thorough diagnostic evaluation including but not limited to other infections or inflammatory processes.

5. Respondent failed to appropriately follow-up on abnormal laboratory results including abnormal liver function tests and an elevated sedimentation rate.

6. Respondent failed to evaluate the Patient by ordering a CT scan of the abdomen and pelvis as well as additional blood testing.

7. Respondent failed to maintain a record that accurately reflects the care and treatment rendered to the Patient.

G. Respondent treated Patient G, a 28-year-old man, from on or about August 11, 2009, through on or about September 28, 2010. The Patient presented for evaluation of possible Lyme disease with complaints of headache, fatigue, memory loss, myalgia and back and neck pain. The Patient had a history of bipolar disorder for which he was under the care of a psychiatrist and, he had been diagnosed with and treated for Lyme disease 16 years earlier. A previous evaluation by a neurologist included negative MRI and MRA of the brain. Respondent's care and treatment of the Patient deviated from minimally accepted standards of care in that:

1. Respondent repeatedly failed to take and/or note an adequate history of present illness.

2. Respondent repeatedly failed to perform and/or note an appropriate physical examination.

3. Respondent failed to appropriately construct a differential diagnosis and pursue a thorough diagnostic evaluation.

4. Respondent failed to appropriately evaluate the Patient based on his ongoing complaints of chronic headaches and cognitive dysfunction.

5. Respondent treated the Patient inappropriately with an ongoing and escalating antibiotic regimen without appropriate sequential physical examinations

and clinical re-assessments for consideration of any alternative diagnoses and/or treatment.

6. Respondent inappropriately prescribed medications without appropriate medical indications and/or without considering possible drug interactions.

7. Respondent failed to follow-up, in a timely fashion, when the Patient experienced possible side effects.

8. Respondent failed to follow-up appropriately on abnormal test results.

9. Respondent failed to maintain records that accurately reflects the care and treatment rendered to the Patient.

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:

1. Paragraph A and its subparagraphs and/or Paragraph B and its subparagraphs and/or Paragraph C and its subparagraphs and/or Paragraph D and its subparagraphs and/or Paragraph E and its

subparagraphs and/or Paragraph F and its subparagraphs and/or Paragraph G and its subparagraphs.

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:

2. Paragraph A and its subparagraphs and/or Paragraph B and its subparagraphs and/or Paragraph C and its subparagraphs and/or Paragraph D and its subparagraphs and/or Paragraph E and its subparagraphs and/or Paragraph F and its subparagraphs and/or Paragraph G and its subparagraphs.

THIRD THROUGH NINTH 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 and its subparagraphs.

4. Paragraph B and its subparagraphs.

5. Paragraph C and its subparagraphs.

6. Paragraph D and its subparagraphs.

7. Paragraph E and its subparagraphs.

8. Paragraph F and its subparagraphs.

9. Paragraph G and its subparagraphs.

TENTH 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:

10. Paragraph A and its subparagraphs and/or Paragraph B and its subparagraphs and/or Paragraph C and its subparagraphs and/or Paragraph D and its subparagraphs and/or Paragraph E and its subparagraphs and/or Paragraph F and its subparagraphs and/or Paragraph G and its subparagraphs.

ELEVENTH 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:

11. Paragraph A and A (8) and/or Paragraph B and B(10) and/or Paragraph C and C(5) and/or Paragraph D and D(6) and/or Paragraph E and E(8) and/or Paragraph F and F(7) and/or Paragraph G and G(9).

DATE: April 27, 2017
New York, New York

[redacted]

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct

EXHIBIT "B"

Terms of Probation

1) Respondent's conduct shall conform to moral and professional standards of conduct and governing law. Any act of professional misconduct by Respondent as defined by N.Y. Educ. Law §§ 6530 or 6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to N.Y. Pub. Health Law § 230(19).

2) Respondent shall cooperate fully with, and respond in a timely manner to, OPMC requests to provide written periodic verification of Respondent's compliance with the terms of this Consent Order. Upon the Director of OPMC's request, Respondent shall meet in person with the Director's designee.

3) The probation period shall toll when Respondent is not engaged in active medical practice in New York State for a period of 30 consecutive days or more. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in, or intends to leave, active medical practice in New York State for a consecutive 30 day period. Respondent shall then notify the Director again at least 14 days before returning to active practice. Upon Respondent's return to active practice in New York State, the probation period shall resume and Respondent shall fulfill any unfulfilled probation terms and such additional requirements as the Director may impose as reasonably relate to the matters set forth in Exhibit "A" or as are necessary to protect the public health.

4) The Director of OPMC may review Respondent's professional performance. This review may include but shall not be limited to: a review of office records, patient records, hospital charts, and/or electronic records; and interviews with or periodic visits with Respondent and staff at practice locations or OPMC offices.

5) Respondent shall adhere to federal and state guidelines and professional standards of care with respect to infection control practices. Respondent shall ensure education, training and oversight of all office personnel involved in medical care, with respect to these practices.

6) Respondent shall maintain complete and legible medical records that accurately reflect the evaluation and treatment of patients and contain all information required by State rules and regulations concerning controlled substances.

7) Within thirty days of the Consent Order's effective date, Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty considering Respondent's specialty of practice, who is familiar with the diagnostic and treatment modalities practiced and offered by Respondent ("practice monitor"). Practice monitor shall be proposed by Respondent and subject to the written

approval of the Director of OPMC. Such written approval shall not be unreasonably withheld.

a) Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no fewer than 20) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is prudent and competent, given all of the conditions and circumstances of the patient, the medical role of Respondent as made know to the patient, and referrals made. Any perceived deviation from prudent and competent care as set forth above, or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

b) Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

c) Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

d) 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.

8) Respondent shall enroll in and successfully complete a continuing education program in an area or areas as directed by the Office of Professional Medical Conduct. This continuing education program is subject to the Director of OPMC's prior written approval and shall be successfully completed within the first 90 days of the probation period.

9) Respondent shall comply with this Consent Order and all its terms, and shall bear all associated compliance costs. Upon receiving evidence of noncompliance with, or a violation of, these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding, and/or any other such proceeding authorized by law, against Respondent.