ANDREW M. CUOMO
Governor

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

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

October 23, 2017

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Bernard D. Raxlen, M.D.
566 Seventh Avenue, Suite 502
New York, New York 10018

Re: License No. 170256

Dear Dr. Raxlen:

Enclosed is a copy of the New York State Board for Professional Medical Conduct (BPMC) Order No. 17-303. This order and any penalty provided therein goes into effect October 30, 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,

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

Enclosure

cc: Jacques Simon, Esq.
100 Jericho Quadrangle, Suite 208
Jericho, New York 11753

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

BPMC No. 17-303

IN THE MATTER OF BERNARD RAXLEN, M.D.	CONSENT ORDER

Upon the application of (Respondent) BERNARD RAXLEN, 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: 10/21/2017

ARTHUR S. HENGERER, 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 BERNARD RAXLEN, M.D.	CONSENT AGREEMENT

BERNARD RAXLEN, M.D., represents that all of the following statements are true:

That on or about June 30, 1987, I was licensed to practice as a physician in the State of New York, and issued License No. 170256 by the New York State Education Department.

My current address is 566 Seventh Avenue, Suite 502, New York, NY 10018, 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.

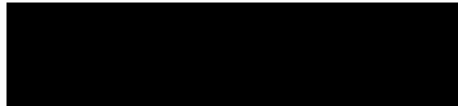
I agree that, if the Board adopts this Consent Agreement, the Chair of the Board shall issue a Consent Order in accordance with its terms. I agree that this Consent Order shall take effect upon its issuance by the Board, either by mailing of a copy of the Consent Order by first class mail to me at the 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.

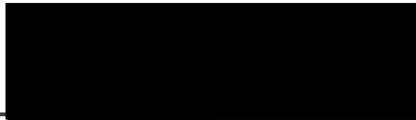
DATE *Oct 13/2017*



BERNARD RAXLEN, M.D.
RESPONDENT

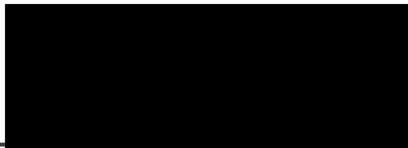
The undersigned agree to Respondent's attached Consent Agreement and to its proposed penalty, terms and conditions.

DATE: 10/13/17



JACQUES G. SIMON, ESQ.
Attorney for Respondent

DATE: 10-16-17



LESLIE A. EISENBERG
Associate Counsel
Bureau of Professional Medical Conduct

DATE: 10/19/17

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 BERNARD RAXLEN, M.D.	STATEMENT OF CHARGES

Bernard Raxlen, M.D., the Respondent, was authorized to practice medicine in New York State on or about June 3, 1987, by the issuance of license number 170256 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, from on or about 8/28/08 through on or about 12/29/10. Patient A presented to Respondent complaining of a variety of symptoms including but not limited to freezing, burning, air hunger, weakness, fatigue, neck pain and intestinal pain. Patient A reported prior treatment by multiple doctors including prolonged courses of antibiotics and other treatments. (Patient names are identified in the Appendix.) Respondent's care and treatment deviated from minimally accepted standards of care in that Respondent:

1. Repeatedly failed to perform and/or note a comprehensive history, including psychiatric history, appropriate physical examinations, neuropsychological testing and/or mental health status examinations.
2. Failed to construct a differential diagnosis and pursue a thorough diagnostic evaluation prior to arriving at a diagnosis and treatment plan.
3. Inappropriately prescribed medications without appropriate medical indications.
4. Failed to present and/or note potential risks, benefits, side effects and safe use of prescribed medications.

5. Treated inappropriately with an ongoing and/or escalating medication regimen without appropriate sequential physical examinations and clinical reassessments for consideration of alternative diagnoses and/or treatment.
6. Failed to appropriately identify, address and/or follow-up on potential side effects.
7. Failed to appropriately identify, address and/or follow up on a potentially life threatening circumstance when the patient was severely dehydrated.
8. Failed to maintain a record that accurately reflects the care and treatment of the patient.

B. Respondent treated Patient B, from on or about 1/20/10 through on or about 5/25/11. Prior to the initial visit with Respondent, Patient B, a 14-year-old, had experienced depression and suicidal ideation and was hospitalized after he developed a severe headache and left-sided Bell's Palsy. Respondent's care and treatment deviated from minimally accepted standards of care in that Respondent:

1. Repeatedly failed to perform and/or note a comprehensive history, including psychiatric history, appropriate physical examinations, neuropsychological testing and/or mental health status examinations.
2. Failed to construct a differential diagnosis and pursue a thorough diagnostic evaluation prior to arriving at a diagnosis and treatment plan.
3. Inappropriately prescribed medications without appropriate medical indications and/or without considering potential drug interactions.
4. Failed to present and/or note potential risks, benefits, side effects and safe use of prescribed medications.
5. Treated inappropriately with an ongoing and/or escalating medication regimen without appropriate sequential physical examinations and clinical reassessments for consideration of alternative diagnosis and/or treatment.
6. Failed to appropriately identify, address and/or follow-up on potential side effects.

7. Failed to maintain a record that accurately reflects the care and treatment of the patient.

C. Respondent treated Patient C, from on or about 5/25/11 through on or about 1/13/12. Patient C presented with a history of lobular carcinoma in situ (LCIS) and symptoms that included breast pain, rib pain and visual issues. Respondent's care and treatment deviated from minimally accepted standards of care in that Respondent:

1. Repeatedly failed to perform and/or note a comprehensive history, including psychiatric history, appropriate physical examinations, neuropsychological testing and/or mental health status examinations.
2. Failed to construct a differential diagnosis and pursue a thorough diagnostic evaluation prior to arriving at a diagnosis and treatment plan.
3. Inappropriately prescribed medications without appropriate medical indications including but not limited to inappropriately prescribing Rifampin while the patient was on Tamoxifen.
4. Failed to present and/or note potential risks, benefits, side effects and safe use of prescribed medications.
5. Treated inappropriately with an ongoing and/or escalating medication regimen without appropriate sequential physical examinations and clinical reassessments for consideration of alternative diagnosis and/or treatment.
6. Failed to appropriately identify, address and/or follow-up on potential side effects.
7. Failed to maintain a record that accurately reflects the care and treatment of the patient.

D. Respondent treated Patient D, from on or about 12/4/98 through in or about May 2011. Patient D presented to Respondent reporting a history of hypothyroidism, depression and anxiety. Respondent continued to treat Patient D even after she moved from Connecticut to Myrtle Beach in or around December 2005. Respondent's

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

1. Repeatedly failed to perform and/or note a comprehensive history including a psychiatric history, appropriate physical examinations and/or mental health status examinations.
2. Failed to construct a differential diagnosis and pursue a thorough diagnostic evaluation.
3. Inappropriately prescribed medications without appropriate medical indications and/or without appropriate patient assessment.
4. Failed to appropriately identify, address and/or follow-up on potential side effects.
5. Treated inappropriately with an ongoing and/or escalating medication regimen without appropriate sequential physical examinations and clinical reassessments for consideration of alternative diagnoses and/or treatment.
6. Failed to present and/or note potential risks, benefits and side effects for prescribed medications including a controlled substance.
7. Failed to maintain a record that accurately reflects the care and treatment of the patient.

E. Respondent treated Patient E, from on or about 5/25/11 through on or about 7/27/12. Patient E presented to Respondent complaining of an increase in symptoms that included but were not limited to fatigue, migraines, neck pain, joint pain, numbness and tingling, irritability, sound, light and temperature sensitivity and, nonrestorative sleep. Respondent's care and treatment deviated from minimally accepted standards of care in that Respondent:

1. Repeatedly failed to perform and/or note a comprehensive history, including psychiatric history, appropriate physical examinations and/or mental status examinations.
2. Failed to construct a differential diagnosis and pursue a thorough diagnostic evaluation prior to arriving at a diagnosis and treatment plan.

3. Inappropriately prescribed medications without appropriate medical indications and/or at inappropriate doses.
4. Inappropriately treated the patient with Xanax before arriving at a diagnosis of anxiety disorder and/or considering non-addictive therapeutic treatment first.
5. Failed to present and/or note potential risks, benefits and side effects and safe use of prescribed medications.
6. Treated inappropriately with an ongoing and/or escalating medication regimen without appropriate sequential physical examinations and clinical reassessments for consideration of alternative diagnoses and/or treatment.
7. Failed to appropriately identify, address and/or follow-up on potential side effects.
8. Failed to maintain a record that accurately reflects the care and treatment of the patient.

F. Respondent treated Patient F, from on or about 9/7/07 through on or about 9/24/12. Patient F presented to Respondent reporting a tick bite one month prior and complaining of symptoms that included but were not limited to headaches, burning, tingling, mood swings, anxiety and, an eating disorder. Respondent's care and treatment deviated from minimally accepted standards of care in that Respondent:

1. Failed to construct a differential diagnosis and pursue a thorough diagnostic evaluation prior to treating the patient, despite her initial presentation and prior treatment.
2. Repeatedly failed to perform and/or note a comprehensive history including a psychiatric history, appropriate physical examinations and/or mental health status examinations.
3. Inappropriately prescribed medications without appropriate medical indications and/or at inappropriate doses.
4. Inappropriately treated the patient with anti-depressants and anti-anxiety medications, including controlled substances, before arriving at a diagnosis and/or considering non-addictive therapeutic treatment first.

5. Failed to present and/or note potential risks, benefits and side effects of prescribed medications.
6. Treated inappropriately with an ongoing and/or escalating medication regimen without appropriate sequential physical examinations and clinical reassessments for consideration of alternative diagnoses and/or treatment.
7. Failed to appropriately identify, address and/or follow-up on potential side effects.
8. Failed to maintain a record that accurately reflects the care and treatment of the patient.

G. Respondent treated Patient G, from in or about 7/24/00 through in or about 10/2/12. Patient G presented to Respondent reporting a variety of symptoms including but not limited to back pain, abdominal pain, feet pain, extremity weakness, anxiety, depression and mood swings. Respondent's care and treatment deviated from minimally accepted standards of care in that Respondent:

1. Repeatedly failed to perform and/or note a comprehensive history including a psychiatric history, appropriate physical examinations and/or mental health status examinations.
2. Failed to construct a differential diagnosis and pursue a thorough diagnostic evaluation prior to arriving at a diagnosis and treatment plan.
3. Inappropriately prescribed monthly narcotic analgesics for the patient.
4. Inappropriately prescribed medications including but not limited to benzodiazepines and opiates, without appropriate medical indications.
5. Failed to present and/or note potential risks, benefits and side effects of prescribed medications.
6. Treated inappropriately with an ongoing and/or escalating medication regimen without appropriate sequential physical examinations and clinical reassessments for consideration of alternative diagnoses and/or treatment.
7. Failed to appropriately identify, address and/or follow-up on potential side effects.

8. Failed to maintain a record that accurately reflects the care and treatment of the patient.

H. Respondent treated Patient H, who was referred by her dentist, from on or about 4/25/14 through in or about 8/14. Patient H presented with a 8-year history of incapacitating mouth, teeth and jaw pain as well as a variety of symptoms including but not limited to confusion, forgetfulness, irritability and mood swings. Respondent's care and treatment deviated from minimally accepted standards of care in that Respondent:

1. Repeatedly failed to perform and/or note a comprehensive history including a psychiatric history, appropriate physical examinations and/or mental health status examinations.
2. Failed to construct a differential diagnosis and pursue a thorough diagnostic evaluation prior to arriving at a diagnosis or treatment plan.
3. Inappropriately relied upon Applied Kinesiology to formulate a diagnosis.
4. Inappropriately prescribed medications, without appropriate medical indications.
5. Failed to present and/or note potential risks, benefits and side effects of prescribed medications.
6. Treated Inappropriately with an ongoing and/or escalating medication regimen without appropriate sequential physical examinations and clinical reassessments for consideration of alternative diagnoses and/or treatment.
7. Inappropriately ordered the placement of a Hickman catheter, without medical necessity.
8. Inappropriately administered antibiotics, including but not limited to intravenous Invanz, Clindamycin and Flagyl and, Rifampin, Minocycline, Mepron, Plaquenil and Bactrim, without medical indication.
9. Failed to appropriately identify, address and/or follow-up on potential side effects.
10. Failed to maintain a record that accurately reflects the care and treatment of 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 and/or Paragraph H 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 and/or Paragraph H and its subparagraphs.

THIRD-TENTH 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.
10. Paragraph H and its subparagraphs.

ELEVENTH 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:

11. 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 and/or Paragraph H and its subparagraphs.

TWELFTH-NINETEENTH 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 evaluation and treatment of the patient, as alleged in the facts of:

12. Paragraph A and its subparagraphs.
13. Paragraph B and its subparagraphs.
14. Paragraph C and its subparagraphs.

15. Paragraph D and its subparagraphs.

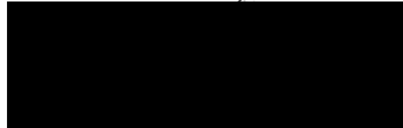
16. Paragraph E and its subparagraphs.

17. Paragraph F and its subparagraphs.

18. Paragraph G and its subparagraphs.

19. Paragraph H and its subparagraphs.

DATE: September 5, 2017
New York, New York



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.