New York State Board for Professional Medical Conduct
433 River Street, Suite 303 • Troy, New York 12180-2299 •(518) 402-0863

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

Dennis P. Whalen
Executive Deputy Commissioner
NYS Department of Health

Dennis J. Graziano, Director
Office of Professional Medical Conduct

PUBLIC

November 4, 2002

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Jerome P. Woodward, M.D.
500-3 Pondview Heights
Rochester, New York 14612

RE: License No. 148690

Dear Dr. Woodward:

Enclosed please find Order #BPMC 02-342 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect November 4, 2002.

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

Sincerely,

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

Enclosure
cc: Edward H. Fox, Esq.
c/o Harris Beach LLP
99 Garney Road
Pittsford, New York 14534

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

IN THE MATTER

OF

JEROME P. WOODWARD, M.D.

SURRENDER ORDER

BPMC No. 02-342

Upon the application of (Respondent) **JEROME P. WOODWARD, M.D.** to Surrender his license as a physician in the State of New York, which is made a part of this Surrender Order, it is

ORDERED, that the Surrender, and its terms, are adopted and SO ORDERED, and it is further

ORDERED, that the name of Respondent be stricken from the roster of physicians in the State of New York; it is further

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

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

SO ORDERED.

DATED: 10/31/02

WILLIAM P. DILLON, 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
JEROME P. WOODWARD, M.D.

SURRENDER
of
LICENSE

JEROME P. WOODWARD, M.D., representing that all of the following statements are true, deposes and says:

That on or about November 20, 1981, I was licensed to practice as a physician in the State of New York, and issued License No. 148690 by the New York State Education Department.

My current address is 500-3 Pondview Heights, Rochester, New York 14612, and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

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

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

I am applying to the State Board for Professional Medical Conduct for permission to surrender my license as a physician in the State of New York on the grounds that I admit to the Twenty-first Specification (Negligence on more than one occasion), and the Twenty-sixth Specification (Failing to maintain adequate records), in full satisfaction of the charges against me.

I ask the Board to accept the Surrender of my License.

I understand that if the Board does not accept this Surrender, none of its

terms shall bind me or constitute an admission of any of the acts of alleged misconduct; this application shall not be used against me in any way and shall be kept in strict confidence; and the Board's denial shall be without prejudice to the pending disciplinary proceeding and the Board's final determination pursuant to the Public Health Law.

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

I ask the Board to accept this Surrender of License of my own free will and not under duress, compulsion or restraint. In consideration of the value to me of the Board's acceptance of this Surrender of License, 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 Surrender Order for which I apply, whether administratively or judicially, and I agree to be bound by the Surrender Order.

DATED 10/14/12

JEROME P. WOODWARD, M.D.
RESPONDENT

The undersigned agree to Respondent's attached Surrender of License and to its proposed penalty, terms and conditions.

DATE: 10/17/02

EDWARD H. FOX, ESQ.
Attorney for Respondent

DATE: 10/21/02

MICHAEL A. HISER, ESQ.
Associate Counsel
Bureau of Professional Medical Conduct

DATE: 10/29/02

/V DENNIS J. GRAZIANO
Director
Office of Professional Medical Conduct

EXHIBIT "B"

GUIDELINES FOR CLOSING A MEDICAL PRACTICE FOLLOWING A REVOCATION, SURRENDER OR SUSPENSION (of 6 months or more) OF A MEDICAL LICENSE

1. Respondent shall immediately cease and desist the practice of medicine in compliance with the terms of the Surrender Order. Respondent shall not represent himself or herself as eligible to practice medicine and shall refrain from providing an opinion as to professional practice or its application.

2. Within fifteen (15) days of the Surrender Order's effective date, Respondent shall notify all patients that he or she has ceased the practice of medicine, and shall refer all patients to another licensed practicing physician for their continued care, as appropriate.

3. Within thirty (30) days of the Surrender Order's effective date, Respondent shall have his or her original license to practice medicine in New York State and current biennial registration delivered to the Office of Professional Medical Conduct (OPMC) at 433 River Street Suite 303, Troy, NY 12180-2299.

4. Respondent shall arrange for the transfer and maintenance of all patient medical records. Within thirty (30) days of the Surrender Order's effective date, Respondent shall notify OPMC of these arrangements, including the name, address, and telephone number of an appropriate contact person, acceptable to the Director of OPMC, who shall have access to these records. Original records shall be retained for patients for at least six (6) years after the last date of service, and, for minors, at least six (6) years after the last date of service or three (3) years after the patient reaches the age of majority, whichever time period is longer. Records shall be maintained in a safe and secure place that is reasonably accessible to former patients. The arrangements shall ensure that all patient information is kept confidential and is available only to authorized persons. When a patient or authorized representative requests a copy of the patient's medical record, or requests that the original medical record be sent to another health care provider, a copy of the record shall be promptly provided or sent at reasonable cost to the patient (not to exceed seventy-five cents per page.) Radiographic, sonographic and like materials shall be provided at cost. A qualified person shall not be denied access to patient information solely because of inability to pay.

5. Within fifteen (15) days of the Order's effective date, if Respondent holds a Drug Enforcement Agency (DEA) certificate, Respondent shall advise the DEA in writing of the licensure action and shall surrender his or her DEA controlled substance certificate, privileges, and any used DEA #222 U.S. Official Order Forms Schedules 1 and 2, to the DEA.

6. Within fifteen (15) days of the Order's effective date, Respondent shall return any unused New York State official prescription forms to the Bureau of Controlled Substances of the New York State Department of Health. Respondent shall have all prescription pads bearing Respondent's name destroyed. If no other licensee is providing services at his practice location, Respondent shall dispose of all medications.

7. Within fifteen (15) days of the Order's effective date, Respondent shall remove from the public domain any representation that Respondent is eligible to practice medicine, including all related signs, advertisements, professional listings whether in telephone directories or otherwise, professional stationery or billings. Respondent shall not share, occupy or use office space in which another licensee

provides health care services.

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

9. If Respondent is a shareholder in any professional service corporation organized to engage in the practice of medicine and Respondent's license is revoked, surrendered or suspended for six (6) months or more pursuant to this Order, Respondent shall, within ninety (90) days of the Order's effective date, divest himself/herself of all financial interest in such professional services corporation in accordance with New York Business Corporation Law. If Respondent is the sole shareholder in a professional services corporation, the corporation must be dissolved or sold within ninety (90) days of the Order's effective date.

10. Failure to comply with the above directives may result in civil or criminal penalties. Practicing medicine when a medical license has been suspended, revoked or annulled is a Class E Felony, punishable by imprisonment for up to four (4) years, under Section 6512 of the Education Law. Professional misconduct may result in penalties including revocation of the suspended license and/or fines of up to $10,000 for each specification of misconduct, under Section 230-a of the Public Health Law.

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

IN THE MATTER

OF

JEROME P. WOODWARD, M.D.

STATEMENT

OF

CHARGES

JEROME P. WOODWARD, M.D., the Respondent, was authorized to practice medicine in New York State on or about November 20, 1981, by the issuance of license number 148690 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided psychiatric medical care to Patient A [patients are identified in the attached Appendix], a female patient 32 years old when first treated, at various times from on or about August 1995 through October, 1999, when Patient A died from a drug overdose. Patient A was treated predominantly at the Respondent's office at 760 Perinton Hills Office Park, Fairport, New York 14450. Patient A was treated for, among others, a bipolar disorder, Attention Deficit Hyperactivity disorder, and an anxiety disorder.

1. Respondent failed to obtain and/or record that he obtained an adequate history of the patient.
2. Respondent failed to perform and/or document that he performed an adequate physical examination of the patient or document that such an examination had been performed.
3. Respondent failed to formulate and implement, and/or record that he formulated and implemented, an adequate treatment plan for the patient.
4. Respondent failed to adequately document the patient's response to the treatment provided, including responses to medications.

5. Respondent, between approximately September 1998 and October 1999, prescribed Darvon and/or Darvocet to Patient A. During this time:

   a. Respondent prescribed these medications without adequate medical justification and/or documenting such justification.

   B. Respondent, during the time he was prescribing Darvon/Darvocet to Patient A, failed to seek adequate medical/surgical consultation or reevaluation.

6. Respondent, from on or about October 24, 1999 through October 27, 1999, prescribed medications for Patient A to be taken concurrently consisting of up to 20 Darvon/Darvocet tablets/day, 40 mg of Sonata/day, and 10 mg of Clonazapam/day.

   a. Respondent's prescribed dosage of these medications for the patient was excessive, in light of the patient's documented condition.

   b. Respondent prescribed these medications without adequate medical justification and/or documenting such justification.

   c. Respondent's prescription of the type and amount of these medications, in light of the patient's recent history of suicidal ideation, was contrary to accepted practice.

7. Respondent failed to maintain an adequate record of his care and treatment of Patient A.

B. Respondent provided psychiatric medical care to a family member, Patient B, at various times from approximately 1994 through April 2001, through the prescription of medications, including controlled substances such as Dexedrine and Dextrostat. Patient B was treated for Attention Deficit Disorder (ADD), as diagnosed by the Respondent.

1. Respondent failed to perform and/or record an adequate evaluation of Patient B's medical condition before providing/prescribing of such drugs.

2. Respondent failed to perform and/or record an adequate evaluation of Patient B's medical condition during his providing/prescribing of such drugs.

3. Respondent failed to maintain adequate medical records of such treatment and/or his provision/prescription of such drugs.

4. Respondent provided medical/ psychiatric care for Patient B, which was inappropriate since the patient was a family member.

C. Respondent provided psychiatric medical care to a family member, Patient C, at various times from approximately January 1999 through April 10, 2001, through the prescription of medications, including controlled substances such as Metadate (Ritalin), Methylphenidate (Ritalin) and Imipramine. Patient C was treated for, among other things, Attention Deficit Disorder (ADD).

1. Respondent failed to perform and/or record an adequate evaluation of Patient C's medical condition before providing/prescribing of such drugs.

2. Respondent failed to perform and/or record an adequate evaluation of Patient C's medical condition during his providing/prescribing of such drugs.

3. Respondent failed to maintain adequate medical records of such treatment and/or his provision/prescription of such drugs.

4. Respondent prescribed such medications for Patient C without the knowledge or consent of the patient's treating physician, Dr. Miriam Halpern.

5. Respondent, on or about January 9, 2001, was interviewed by representatives of the New York State Department of Health regarding the care Respondent provided to Patient C, and regarding allegations Respondent had prescribed medication for Patient C. In the interview, Respondent stated that he had prescribed medications for Patient C only with the knowledge of, and after consulting with, the patient's treating physician, Miriam Halpern, M.D. In fact, Respondent prescribed medications such as Metadate, Methylphenidate (Ritalin) and Imiprimane for Patient C on at least 16 occasions from January of

1999 through January 2001, all without consulting with or the knowledge of Dr. Halpern, and Respondent knew these facts.

6. Respondent provided medical/ psychiatric care for Patient C, which was inappropriate since the patient was a family member.

D. Respondent provided psychiatric medical care to Patient D, a male patient 42 years old when first treated, at various times from late 1999 to at least May 2001. Patient D was treated for, among others, Attention Deficit/Hyperactivity Disorder and an Adjustment Disorder, as diagnosed by the Respondent.

1. Respondent failed to obtain and/or record that he obtained an adequate history of the patient.

2. Respondent failed to perform and/or document that he performed an adequate physical examination of the patient or document that such an examination had been performed.

3. Respondent failed to formulate and implement, and/or record that he formulated and implemented, an adequate treatment plan for the patient.

4. Respondent failed to adequately document the patient's response to the treatment provided, including responses to medications.

5. Respondent provided medications to the patient without adequate medical indication and/or failed to document such medical indication.

E. Respondent provided psychiatric medical care to Patient E; Patient F, her husband, and Patient G, their son, at various times from on or about May 1996 to at least May 2001. Patient E was 44 years old when she was first treated by Respondent in 1996; Patient F was 54 years old when he was first treated in 1998; and Patient G was 14 years old when he was first treated in 1998. All were treated and medicated for, among others, Attention

Deficit/Hyperactivity Disorder, as diagnosed by the Respondent.

Respondent's care of Patient E [see next section for specific allegations related to Patients F and G] was contrary to accepted standards of medical practice in that:

1. Respondent failed to obtain and/or record that he obtained an adequate history of the patient.

2. Respondent failed to perform and/or document that he performed an adequate physical examination of the patient or document that such an examination had been performed.

3. Respondent failed to formulate and implement, and/or record that he formulated and implemented, an adequate treatment plan for the patient.

4. Respondent failed to adequately document the patient's response to the treatment provided, including responses to medications.

5. Respondent provided medications to the patient without adequate medical indication and/or failed to document such medical indication.

6. Respondent's treatment of three family members -- Patients E, F, and G -- at the same time was contrary to generally accepted standards of psychiatric medical practice.

F. Respondent's care of Patient F was contrary to accepted standards of medical practice in that:

1. Respondent failed to obtain and/or record that he obtained an adequate history of the patient.

2. Respondent failed to perform and/or document that he performed an adequate physical examination of the patient or document that such an examination had been performed.

3. Respondent failed to formulate and implement, and/or record that he formulated and implemented, an adequate treatment plan for the patient.

4. Respondent failed to adequately document the patient's response to the treatment provided, including responses to medications.

5. Respondent provided medications to the patient without

adequate medical indication and/or failed to document such medical indication.

6. Respondent's treatment of three family members -- Patients E, F, and G -- at the same time was contrary to accepted standards of psychiatric medical practice.

G. Respondent's care of Patient G was contrary to accepted standards of medical practice in that:

1. Respondent failed to obtain and/or record that he obtained an adequate history of the patient.

2. Respondent failed to perform and/or document that he performed an adequate physical examination of the patient or document that such an examination had been performed.

3. Respondent failed to formulate and implement, and/or record that he formulated and implemented, an adequate treatment plan for the patient.

4. Respondent failed to adequately document the patient's response to the treatment provided, including responses to medications.

5. Respondent provided medications to the patient without adequate medical indication and/or failed to document such medical indication.

6. Respondent's treatment of three family members -- Patients E, F, and G -- at the same time was contrary to accepted standards of psychiatric medical practice.

H. Respondent was affiliated for practice with the Hamilton Associates, a group counseling practice, from approximately March 1997 through September 2000. After Respondent's relationship with Hamilton Associates was ended on or about September 1, 2000, Respondent failed to advise his patients or the staff of Hamilton Associates of his new office address or phone number. On or about September 13, 2000, the father of Patient H contacted the

Rochester office of the Office of Professional Medical Conduct to ask for assistance in locating the Respondent in order to obtain refills of medication for Patient H.

I. Respondent provided psychiatric medical care to Patient I, a female patient 37 years old when first treated, at various times from January 1996 to at least May 2001. Patient I was treated for, among others, major depressive disorder as diagnosed by the Respondent.

1. Respondent failed to obtain and/or record that he obtained an adequate history of the patient.
2. Respondent failed to perform and/or document that he performed an adequate physical examination of the patient or document that such an examination had been performed.
3. Respondent failed to formulate and implement, and/or record that he formulated and implemented, an adequate treatment plan for the patient.
4. Respondent, in his treatment of Patient I in or about April 2001, failed to respond to repeated requests from the patient for medication renewals for Zoloft, until intervention on the patient's behalf by the Rochester Office of the Office of Professional Medical Conduct.
5. Respondent failed to adequately document the patient's response to the treatment provided, including responses to medications.
6. Respondent provided medications to the patient without adequate medical indication and/or failed to document such medical indication.
7. Respondent prescribed excessive dosages of medication for the patient, in light of her documented history and symptoms.

J. Respondent provided psychiatric medical care to Patient J, a male patient 24 years old when first treated, at various times from May 1997 to at least October 2000. Patient J was treated for schizo-affective disorder as diagnosed by the Respondent.

1. Respondent failed to obtain and/or record that he obtained an adequate history of the patient.

2. Respondent failed to perform and/or document that he performed an adequate physical examination of the patient or document that such an examination had been performed.

3. Respondent failed to formulate and implement, and/or record that he formulated and implemented, an adequate treatment plan for the patient.

4. Respondent failed to adequately document the patient's response to the treatment provided, including responses to medications.

5. Respondent provided medications to the patient without adequate medical indication and/or failed to document such medical indication.

SPECIFICATION OF CHARGES
FIRST THROUGH TENTH SPECIFICATION
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:

1. The facts in Paragraphs A and A.1, A. and A.2, A and A.3, A and A.4, A and A.5(a), A and A.5(b), A. and A.6(a), A and A.6(b), A and A.6(c), and/or A and A.7.

2. The facts in Paragraphs B and B.1, B and B.2, B and b.3, and/or B and B.4.

3. The facts in Paragraphs C and C.1, C and C.2, C and C.3, C and C.4, and/or C and C.6.

4. The facts in Paragraphs D and D.1, D and D.2, D and D.3, D and D.4, and/or D and D.5.

5. The facts in Paragraphs E and E.1, E and E.2, E and E.3, E and E.4, E and E. 5, and/or E and E.6.

6. The facts in Paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, and/or F and F.6.

7. The facts in Paragraphs G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, and/or G and G.6.

8. The facts in Paragraph H.

9. The facts in Paragraphs I and I.1, I and I.2, I and I.3, I and I.4, I

and I.5, I and I.6, and/or I and I.7.

10. The facts in Paragraphs J and J.1, J and J.2, J and J.3, J and J.4, and/or J and J.5.

ELEVENTH THROUGH TWENTIETH 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. The facts in Paragraphs A and A.1, A. and A.2, A and A.3, A and A.4, A and A.5(a), A and A.5(b), A. and A.6(a), A and A.6(b), A and A.6(c), and/or A and A.7.

12. The facts in Paragraphs B and B.1, B and B.2, B and b.3, and/or B and B.4.

13. The facts in Paragraphs C and C.1, C and C.2, C and C.3, C and C.4, and/or C and C.6.

14. The facts in Paragraphs D and D.1, D and D.2, D and D.3, D and D.4, and/or D and D.5.

15. The facts in Paragraphs E and E.1, E and E.2, E and E.3, E and E.4, E and E. 5, and/or E and E.6.

16. The facts in Paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, and/or F and F.6.

17. The facts in Paragraphs G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, and/or G and G.6.

18. The facts in Paragraph H.

19. The facts in Paragraphs I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6, and/or I and I.7.

20. The facts in Paragraphs J and J.1, J and J.2, J and J.3, J and J.4, and/or J and J.5.

TWENTY-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:

21. The facts in Paragraphs A and A.1, A. and A.2, A and A.3, A and A.4, A and A.5(a), A. and A.5(b), A and A.6(a), A. and A.6(b), A and A.6(c), A and A.7, B and B.1, B and B.2, B and B.3, B and B.4, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, E and E.1, E and E.2, E and E.3, E and E.4, E and E. 5, E and E.6, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, H, I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6, I and I.7, J and J.1, J and J.2, J and J.3, J and J.4, and/or J and J.5.

TWENTY-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:

22. The facts in Paragraphs A and A.1, A. and A.2, A and A.3, A and A.4, A and A.5(a), A. and A.5(b), A and A.6(a), A. and A.6(b), A and A.6(c), A and A.7, B and B.1, B and B.2, B and B.3, B and B.4, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, E and E.1, E and E.2, E and E.3, E and E.4, E and E. 5, E and E.6, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, H, I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6, I and I.7, J and J.1, J and J.2, J and J.3, J and J.4, and/or J and J.5.

TWENTY-THIRD SPECIFICATION
ABANDONMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(30) by abandoning or neglecting a patient under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care, as alleged in the facts of:

23. The facts in Paragraphs H and/or I and I.4.

TWENTY-FOURTH 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. The facts in Paragraphs C and C.5.

TWENTY-FIFTH 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:

25. The facts in Paragraphs C and C.5.

TWENTY-SIXTH 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:

26. The facts in Paragraphs A and A.1, A. and A.2, A and A.3, A and A.4, A and A.5(a), A and A.6(b), A and A.7, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, C and C.3, D and D.1, D and D.2, D and

D.3, D and D.4, D and D.5, E and E.1, E and E.2, E and E.3, E and E.4, E and E. 5, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, I and I.1, I and I.2, I and I.3, I and I.5, I and I.6, J and J.1, J and J.2, J and J.3, J and J.4, and/or J and J.5.

DATED:
October 21, 2002
Albany, New York

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