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.
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NYS Department of Health

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NYS Department of Health

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Office of Professional Medical Conduct

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Denise M. Bolan, R.P.A.
Vice Chair

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

September 28, 1999

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Susan Mary Levine
889 Lexington Avenue
New York, NY 10021

RE: License No.: 150459

Dear Dr. Levine:

Enclosed please find Order #BPMC 99-246 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect **September 28, 1999.**

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: Mark Barnes, Esq.
Proskauer Rose LLP
1585 Broadway
New York, NY 10036-8299

Ann Gayle, Esq.

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

IN THE MATTER
OF
SUSAN MARY LEVINE, M.D.

CONSENT
AGREEMENT
AND
ORDER
BPMC #99-246

STATE OF NEW YORK)
COUNTY OF NEW YORK) ss.:

SUSAN MARY LEVINE, M.D., (Respondent) being duly sworn, deposes and says:

That on or about July 1, 1982, I was licensed to practice as a physician in the State of New York, having been issued License No. 150459, by the New York State Education Department.

My current office address is 889 Lexington Avenue, New York, NY 10021, and I will advise the Director of the Office of Professional Medical Conduct of any change of my office address, to coincide with the period of probation in this Order.

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

A copy of the Amended Statement of Charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

A hearing regarding the aforesaid charges commenced on December 10, 1998; after ten days of hearing, the matter was adjourned indefinitely while I was evaluated at the Albany Medical College, following which I met with members of the Board for Professional Medical Conduct and physicians affiliated with the Office of Professional Medical Conduct to discuss the aforesaid charges, the aforesaid evaluation, and other aspects of my medical practice. Following said meeting, it was agreed that I would enter into this Consent Agreement.

I admit guilt to the SEVENTH THROUGH SIXTEENTH SPECIFICATIONS to the extent of Paragraphs A and A7, B and B7, C and C7, D and D10, E and E7, F and F9, G and G9, H and H6, I and I4, and J and J4, I assert that I cannot successfully defend against the FIRST SPECIFICATION to the extent of Paragraphs C and C1, 2, 3, and 7, E and E1, 2, 3, and 7, G and G1, 2, and 9, and I and I2 and 4, in full satisfaction of the charges against me. I hereby agree to the following penalty:

A suspension of my license for a period of three years, with said suspension stayed.
Probation for a period of three years, the terms of which are enumerated in Exhibit "B".
I further agree that the Consent Order for which I hereby apply shall impose the following conditions:

That, except during periods of actual suspension, revocation, or surrender, Respondent shall maintain current registration of Respondent's license with the New York State Education Department Division of Professional Licensing Services, and pay all registration fees. This condition shall be in effect beginning thirty days after the effective date of the Consent Order and will continue while the licensee possesses her license; and

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

investigation of all matters regarding Respondent. Respondent shall respond in a timely manner to each and every request by OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall meet with a person designated by the Director of OPMC as directed. Respondent shall respond promptly and provide any and all documents and information within Respondent's control and relating to Respondent's practice of medicine and/or possible professional misconduct upon the direction of OPMC. This condition shall be in effect beginning upon the effective date of the Consent Order and will continue while the licensee possesses her license.

I hereby stipulate that any failure by me to comply with such conditions shall constitute misconduct as defined by New York State Education Law §6530(29)(McKinney Supp 1999).

I agree that in the event I am charged with professional misconduct in the future, this agreement and order shall be admitted into evidence in that proceeding.

I hereby make this Application to the State Board for Professional Medical Conduct (the Board) and request that it be granted.

I understand that, in the event that this Application is not granted by the Board, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such Application shall not be used against me in any way and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary

proceeding; and such denial by the Board shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by the Board pursuant to the provisions of the Public Health Law.

I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with same. I agree that such order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Consent Order to me at the address set forth in this agreement, or to my attorney, or upon transmission via facsimile to me or my attorney, whichever is earliest.

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner. In consideration of the value to me of the acceptance by the Board of this Application, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive any right I may have to contest the Consent Order for which I hereby apply, whether administratively or judicially, and ask that the Application be granted.

DATED 9/23/99

SUSAN MARY LEVINE, M.D.
RESPONDENT

Sworn to before me
on this 23 day of
September, 1999

NOTARY

ISABELLA PIERGIOVANNI
Notary Public, State of New York
No. 01PI5088253
Qualified in Queens County
Commission Expires Nov. 17, 1999

The undersigned agree to the attached application of the Respondent and to the proposed penalty based on the terms and conditions thereof.

DATE: 9/23/99

Mark Barnes (by LHF)
MARK BARNES, ESQ.
Attorney for Respondent

DATE: 9-23-99

Ann Gayle
ANN GAYLE
Associate Counsel
Bureau of Professional
Medical Conduct

DATE: 9/27/99

Anne Saile
ANNE F. SAILE
Director
Office of Professional
Medical Conduct

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

IN THE MATTER
OF
SUSAN MARY LEVINE, M.D.

CONSENT
ORDER

Upon the proposed agreement of Susan Mary Levine, M.D. (Respondent) for Consent Order, which application is made a part hereof, it is agreed to and

ORDERED, that the application and the provisions thereof are hereby adopted and so ORDERED, and it is further

ORDERED, that this order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Consent Order to Respondent at the address set forth in this agreement or to Respondent's attorney by certified mail, or upon transmission via facsimile to Respondent or Respondent's attorney, whichever is earliest.

SO ORDERED.

DATED: 9/27/99

Denise M. Bolan, RPA-C

~~WILLIAM P. DILLON, M.D.~~ Denise M. Bolan, RPA-C
~~Chair~~ Vice-Chair
State Board for Professional
Medical Conduct

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

IN THE MATTER

OF

SUSAN MARY LEVINE, M.D.

AMENDED
STATEMENT
OF
CHARGES

SUSAN MARY LEVINE, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 1, 1982, by the issuance of license number 150459, by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, a then 32 year old female, at her office, locate at 889 Lexington Avenue, and/or 200 West 86th Street, and/or 2 West 86th Street, and/or 171 East 74th Street, New York, New York, and ordered treatment in Patient A's home, for a chronic yeast infection and chronic fatigu syndrome, from approximately August 11, 1995 to June 30, 1997.

1. Repeatedly throughout the course of treatment, Respondent failed to take an adequate history from Patient A or to note such history in the chart.
2. Repeatedly throughout the course of treatment, Respondent failed to perform an adequate physical examination and/or to obtain/perform other necessary examinations/evaluations upon Patient A or to note such physical and other examinations/evaluations in the chart.
3. Respondent inappropriately administered and/or prescribed intravenous Amphotericin B to Patient A without any indication for same, without appropriate follow up, and without any notation in

the chart regarding follow up.

4. Respondent failed to appropriately follow up on findings from laboratory and other examinations which were performed upon Patient A or to note such follow up in the chart.

5. Respondent inappropriately administered and/or prescribed gamma globulin to Patient A without any indication for same, without appropriate follow up, and without any notation in the chart regarding follow up.

6. Respondent inappropriately administered and/or prescribed Vitamin B12 to Patient A without any indication for same, without appropriate follow up, and without any notation in the chart regarding follow up.

7. Respondent failed to maintain a record for Patient A which accurately reflects the care and treatment provided to Patient A.

B. Respondent treated Patient B, a then 54 year old female, at her office, locatec at 889 Lexington Avenue, or 200 West 86th Street, or 2 West 86th Street, or 171 East 74th Street, New York, New York, for fibromyalgia, on or about September 26, 1996.

1. Respondent failed to take an adequate history from Patient B or to note such history in the chart.

2. Respondent failed to perform an adequate physical examination upon Patient B or to note such physical examination in the chart.

3. Respondent inappropriately prescribed Xanax to Patient B and failed to note such prescription in the chart.

4. Respondent inappropriately prescribed Vitamin B-12 and syringes to Patient B without any indication for same and without appropriate instructions.

5. Respondent inappropriately prescribed Ultram to Patient B without any indication for same and failed to note such prescription in the chart.

6. Respondent inappropriately prescribed Cylert to Patient B without any indication for same and failed to note such prescription in the chart.

7. Respondent failed to maintain a record for Patient B which accurately reflects the care and treatment provided to Patient B.

C. Respondent treated Patient C, a then 30 year old female, at her office, located at 889 Lexington Avenue, and/or 200 West 86th Street, and/or 2 West 86th Street, and/or 171 East 74th Street, New York, New York, for mild chronic fatigue syndrome, from approximately January 31, 1994 to September 29, 1994 or August 7, 1996.

1. Repeatedly throughout the course of treatment, Respondent failed to take an adequate history from Patient C or to note such history in the chart.

2. Repeatedly throughout the course of treatment, Respondent failed to perform an adequate physical examination and/or to obtain/perform other necessary examinations/evaluations upon Patient C or to note such physical and other examinations/evaluations in the chart.

3. Respondent failed to appropriately follow up on findings from laboratory and other examinations which were performed upon Patient C or to note such follow up in the chart.

4. Respondent failed to appropriately diagnose Patient C's condition.

5. Respondent inappropriately administered and/or prescribed

gamma globulin to Patient C without any indication for same, without appropriate follow up, and without any notation in the chart regarding follow up.

6. Respondent inappropriately administered or prescribed Kutapressin SQ to Patient C without any indication, without appropriate instructions, and without appropriate follow up for same, and without noting such instructions and/or follow up in the chart.

7. Respondent failed to maintain a record for Patient C which accurately reflects the care and treatment provided to Patient C.

D. Respondent treated Patient D, a then 40 year old female, at her office, located at 889 Lexington Avenue, and/or 200 West 86th Street, and/or 2 West 86th Street, and/or 171 East 74th Street, New York, New York, for Epstein-Barr Virus since 1978, possible Lyme disease, chronic fatigue syndrome, and fibromyalgia, from approximately January 3, 1992 to February 28, 1997.

1. Repeatedly throughout the course of treatment, Respondent failed to take an adequate history from Patient D or to note such history in the chart.

2. Repeatedly throughout the course of treatment, Respondent failed to perform an adequate physical examination and/or to obtain/perform other necessary examinations/evaluations upon Patient D or to note such physical and other examinations/evaluations in the chart.

3. Respondent failed to appropriately diagnose Patient D's condition.

4. Respondent failed to appropriately follow up on findings from laboratory and other examinations which were performed upon

Patient D or to note such follow up in the chart.

5. Respondent inappropriately administered and/or prescribed gamma globulin to Patient D without any indication for same, without appropriate follow up, and without any notation in the chart regarding follow up.

6. Respondent inappropriately administered and/or prescribed Vitamin B12 to Patient D without any indication for same, without appropriate follow up, and without any notation in the chart regarding follow up.

7. Respondent inappropriately administered or prescribed Kutapressin SQ to Patient D without any indication, without appropriate instructions, and without appropriate follow up for same, and without noting such instructions and/or follow up in the chart.

8. Respondent inappropriately administered and/or prescribed magnesium to Patient D without any indication for same, without appropriate follow up, and without any notation in the chart regarding follow up.

9. Respondent inappropriately administered and/or prescribed Xanax to Patient D without any indication for same, without appropriate follow up, and without any notation in the chart regarding follow up.

10. Respondent failed to maintain a record for Patient D which accurately reflects the care and treatment provided to Patient D.

E. Respondent treated Patient E, a then 25 year old female, at her office, located at 889 Lexington Avenue, and/or 200 West 86th Street, and/or 2 West 86th Street, and/or 171 East 74th Street, New York, New York, for chronic fatigue

syndrome and fibromyalgia, from approximately December 30, 1993 to January 25, 1996.

1. Repeatedly throughout the course of treatment, Respondent failed to take an adequate history or to appropriately follow up on the history taken from Patient E or to note such history and/or follow up in the chart.
2. Repeatedly throughout the course of treatment, Respondent failed to perform an adequate physical examination and/or to obtain/perform other necessary examinations/evaluations upon Patient E or to note such physical and other examinations/evaluations in the chart.
3. Respondent failed to appropriately follow up on findings from laboratory and other examinations which were performed upon Patient E or to note such follow up in the chart.
4. Respondent inappropriately administered or prescribed Kutapressin SQ to Patient E without any indication, without appropriate instructions, and without appropriate follow up for same, and without noting such instructions and/or follow up in the chart.
5. Respondent inappropriately administered and/or prescribed Vitamin B12 to Patient E without any indication for same, without appropriate follow up, and without any notation in the chart regarding follow up.
6. Respondent inappropriately administered and/or prescribed magnesium to Patient E without any indication for same, without appropriate follow up, and without any notation in the chart regarding follow up.

7. Respondent failed to maintain a record for Patient E which accurately reflects the care and treatment provided to Patient E.

F. Respondent treated Patient F, a then 40 year old female, at her office, located at 889 Lexington Avenue, and/or 200 West 86th Street, and/or 2 West 86th Street, and/or 171 East 74th Street, New York, New York, for chronic fatigue syndrome, from approximately April 9, 1991 to September 21, 1994 or June 15, 1995.

1. Repeatedly throughout the course of treatment, Respondent failed to take an adequate history from Patient F or to note such history in the chart.
2. Repeatedly throughout the course of treatment, Respondent failed to perform an adequate physical examination and/or to obtain/perform other necessary examinations/evaluations upon Patient F or to note such physical and other examinations/evaluations in the chart.
3. Respondent failed to appropriately follow up on findings from laboratory and other examinations which were performed upon Patient F or to note such follow up in the chart.
4. Respondent inappropriately administered and/or prescribed ACTH to Patient F without any indication for same, without appropriate follow up, and without any notation in the chart regarding follow up.
5. Respondent inappropriately administered and/or prescribed gamma globulin to Patient F without any indication for same, without appropriate follow up, and without any notation in the chart regarding follow up.
6. Respondent inappropriately administered or prescribed

Kutapressin SQ to Patient F without any indication, without appropriate instructions, and without appropriate follow up for same, and without noting such instructions and/or follow up in the chart.

7. Respondent inappropriately administered and/or prescribed Vitamin B12 to Patient F without any indication for same, without appropriate follow up, and without any notation in the chart regarding follow up.

8. Respondent inappropriately administered and/or prescribed Cylert to Patient F without any indication for same, without appropriate follow up, and without any notation in the chart regarding follow up.

9. Respondent failed to maintain a record for Patient F which accurately reflects the care and treatment provided to Patient F.

G. Respondent treated Patient G, a then 59 year old female, at her office, located at 889 Lexington Avenue, and/or 200 West 86th Street, and/or 2 West 86th Street, and/or 171 East 74th Street, New York, New York, for chronic fatigue syndrome and fibromyalgia, from approximately ~~April 4, 1991~~ October 20, 1992 to February 4, 1997.

Amended 2/18/99

1. Repeatedly throughout the course of treatment, Respondent failed to perform an adequate physical examination and/or to obtain/perform other necessary examinations/evaluations upon Patient G or to note such physical and other examinations/evaluations in the chart.

2. Respondent failed to appropriately follow up on findings from laboratory and other examinations which were performed upon Patient G or to note such follow up in the chart.

3. Respondent failed to appropriately diagnose Patient G's condition.

4. Respondent inappropriately administered and/or prescribed Cylert to Patient G without any indication for same, without appropriate follow up, and without any notation in the chart regarding follow up.

5. Respondent inappropriately administered and/or prescribed gamma globulin to Patient G without any indication for same, without appropriate follow up, and without any notation in the chart regarding follow up.

6. Respondent inappropriately administered or prescribed Vitamin B-12 to Patient G without any indication, without appropriate instructions, and without appropriate follow up for same, and without noting such instructions and/or follow up in the chart.

7. Respondent inappropriately administered or prescribed magnesium to Patient G without any indication, without appropriate instructions, and without appropriate follow up for same, and without noting such instructions and/or follow up in the chart.

8. Respondent inappropriately administered or prescribed Kutapressin SQ to Patient G without any indication, without appropriate instructions, and without appropriate follow up for same, and without noting such instructions and/or follow up in the chart.

9. Respondent failed to maintain a record for Patient G which accurately reflects the care and treatment provided to Patient G.

H. Respondent treated Patient H, a then 44 year old female, at her office, located at 889 Lexington Avenue, and/or 200 West 86th Street, and/or 2 West 86th Street, and/or 171 East 74th Street, New York, New York, for chronic fatigue syndrome, from approximately September 10, 1990 to January 19, 1995.

1. Repeatedly throughout the course of treatment, Respondent failed to take an adequate history from Patient H or to note such history in the chart.
2. Repeatedly throughout the course of treatment, Respondent failed to perform an adequate physical examination and/or to obtain/perform other necessary examinations/evaluations upon Patient H or to note such physical and other examinations/evaluations in the chart.
3. Respondent failed to appropriately follow up on findings from laboratory and other examinations which were performed upon Patient H or to note such follow up in the chart.
4. Respondent inappropriately administered and/or prescribed Cylert to Patient H without any indication for same, without appropriate follow up, and without any notation in the chart regarding follow up.
5. Respondent inappropriately administered and/or prescribed gamma globulin to Patient H without any indication for same, without appropriate follow up, and without any notation in the chart regarding follow up.
6. Respondent failed to maintain a record for Patient H which accurately reflects the care and treatment provided to Patient H.

I. Respondent treated Patient I, a then 23 year old male, at her office, located a 889 Lexington Avenue, and/or 200 West 86th Street, and/or 2 West 86th

Street, and/or 171 East 74th Street, New York, New York, for swelling, from approximately January 30, 1995 to February 1, 1995.

w/drawn 1. Respondent failed to take an adequate history from Patient I or to note such history in the chart.

4/30/99 w/drawn 2. ~~Repeatedly throughout the course of treatment~~, Respondent failed to perform an adequate physical examination and/or to obtain/perform other necessary examinations/evaluations upon Patient I or to note such physical and other examinations/evaluations in the chart.

3. Respondent inappropriately administered or prescribed Keflex to Patient I without any indication for same.

4. Respondent failed to maintain a record for Patient I which accurately reflects the care and treatment provided to Patient I.

J. Respondent treated Patient J, a then 35 year old female, at her office, locate at 889 Lexington Avenue, and/or 200 West 86th Street, and/or 2 West 86th Street, and/or 171 East 74th Street, New York, New York, for chronic fatigue syndrome, on or about August 14, 1991 and continuing to approximately 1994.

1. Repeatedly throughout the course of treatment, Respondent failed to perform an adequate physical examination and/or to obtain/perform other necessary examinations/evaluations upon Patient J or to note such physical and other examinations/evaluations in the chart.

2. Respondent inappropriately administered and/or prescribed Cylert to Patient J, despite Patient J's cardiac condition and without any indication for same.

3. Respondent inappropriately administered or prescribed

Kutapressin SQ to Patient J without any indication, without appropriate instructions, and without appropriate follow up for same, and without noting such instructions and/or follow up in the chart.

amended 2/18/99

4. Respondent failed to maintain a record for Patient J which accurately reflects the care and treatment provided to Patient J.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1998) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. Paragraphs A and A1, 2, 3, 4 and/or 7, B and B1, 2, 3, 4, 5, 6 and/or 7, C and C 1, 2, 3, 4 and/or 7, D and D 1, 2, 3, 4 and/or 10, E and E 1, 2, 3 and/or 7, F and F 1, 2, 3, 4 and/or 9, G and G 1, 2, 3 and/or 9, H and H 1, 2, 3 and/or 6, I and I 1, 2, 3 and/or 4, and/or J and J 1, 2 and/or 4.

SECOND THROUGH FOURTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined N.Y. Educ. Law §6530(4)(McKinney Supp. 1998) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

2. Paragraphs A and A1, 2, 3, 4, 5, 6 and/or 7.
3. Paragraphs B and B1, 2, 3, 4, 5, 6 and/or 7.

4. Paragraphs J and J 1, 2, 3 and/or 4.

FIFTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1998) 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:

5. Paragraphs A and A1, 2, 3, 4, 5, 6 and/or 7, B and B1, 2, 3, 4, 5, 6 and/or 7, C and C 1, 2, 3, 4, 5, 6 and/or 7, D and D 1, 2, 3, 4, 5, 6, 7, 8, 9 and/or 10, E and E 1, 2, 3, 4, 5, 6 and/or 7, F and F 1, 2, 3, 4, 5, 6, 7, 8 and/or 9, G and G 1, 2, 3, 4, 5, 6, 7, 8 and/or 9, H and H 1, 2, 3, 4, 5 and/or 6, I and I 1, 2, 3 and/or 4, and/or J and J 1, 2, 3 and/or 4.

SIXTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined ir N.Y. Educ. Law §6530(6)(McKinney Supp. 1998) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

6. Paragraphs A and A1, 2, 3, 4, 5, 6 and/or 7, B and B1, 2, 3, 4, 5, 6 and/or 7, C and C 1, 2, 3, 4, 5, 6 and/or 7, D and D 1, 2, 3, 4, 5, 6, 7, 8, 9 and/or 10, E and E 1, 2, 3, 4, 5, 6 and/or 7, F and F 1, 2, 3, 4, 5, 6, 7, 8 and/or 9, G and G 1, 2, 3, 4, 5, 6, 7, 8 and/or 9, H and H 1, 2, 3, 4, 5 and/or 6, I and I1, 2, 3 and/or 4, and/or J and J 1, 2, 3 and/or 4.

SEVENTH THROUGH SIXTEENTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §(32)(McKinney Supp. 1998) 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:

7. Paragraphs A and A1, 2, 3, 4, 5, 6 and/or 7.
8. Paragraphs B and B1, 2, 3, 5, 6 and/or 7.
9. Paragraphs C and C 1, 2, 3, 5, 6 and/or 7.
10. Paragraphs D and D 1, 2, 4, 5, 6, 7, 8, 9 and/or 10.
11. Paragraphs E and E 1, 2, 3, 4, 5, 6 and/or 7.
12. Paragraphs F and F1, 2, 3, 4, 5, 6, 7, 8 and/or 9.
13. Paragraphs G and G 1, 2, 4, 5, 6, 7, 8 and/or 9.
14. Paragraphs H and H 1, 2, 3, 4, 5 and/or 6.
15. Paragraphs I and I1, 2 and/or 4.
16. Paragraphs J and J 1, 3 and/or 4.

DATED: November 18, 1998
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

EXHIBIT "B"

Terms of Probation

1. Respondent shall conduct herself in all ways in a manner befitting her professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by her profession.

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director of the Office of Professional Medical Conduct, New York State Department of Health, 433 River Street, Suite 303, Troy, NY 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Civil penalties, if any arise pursuant to or are provided for in this Consent Agreement and Order, not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law section 32].

4. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

PRACTICE MONITOR

5. Beginning no more than thirty days after the issuance of this order, Respondent shall practice medicine only when monitored by a physician licensed in the State of New York, board certified in internal medicine, ("monitor") proposed by Respondent, and subject to the written approval of the Director of OPMC, which 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 monitor shall visit Respondent's medical practice at each and every location, on a weekly basis for the first three months of monitoring pursuant to this Consent Order, then on a random unannounced basis at least monthly for the remainder of the monitoring period and shall examine a selection (no less than 20) of records maintained by Respondent, including patient records,

prescribing information and office records. At the end of each year the Respondent may request of the Director a reduction in the minimum number of records to be reviewed by the Monitor. The review will determine whether the Respondent's practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC. Such deviation may constitute a violation of probation under this agreement as shall any deviation of any of the other terms of probation set forth in this Order.

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 monitor to report monthly during the first three months of monitoring and then quarterly thereafter, 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 no more than thirty days after the effective date of this Order.

MENTORING

6. Respondent shall fully participate in, cooperate with, and successfully complete a mentoring program.

7. Respondent, within thirty days of the effective date of this Order, shall secure a practice position at a clinic or physician's private office for not less than 8 hours per week for the first twenty-four months, subject to release or reduction, at the discretion of the Director of OPMC, at the end of the first twelve months. Said clinic or physician's private office shall be proposed by Respondent, and subject to the written approval of the Director of OPMC, which approval shall not be unreasonably withheld.

8. Respondent's practice at said clinic or physician's private office shall include supervision by an assigned preceptor who shall be board certified in an appropriate specialty. Said preceptor shall be subject to the written approval of the Director of OPMC. Respondent shall not supervise or instruct other physicians at said clinic or physician's private office.

9. The preceptor assigned to Respondent shall:

a. Submit quarterly reports to OPMC certifying whether Respondent is fully participating in the mentoring program.

b. Report immediately to the Director of OPMC if Respondent withdraws from the program and report promptly to OPMC any significant pattern of non-compliance by Respondent.

c. At the conclusion of the mentoring program, submit to the Director of OPMC a detailed assessment of the progress made by Respondent toward remediation of all identified deficiencies, if any.

10. Respondent shall practice medicine outside the setting set forth in Paragraph 7 only when monitored (as described above in Paragraph 5).

11. Respondent shall ensure that the monitor(s) and preceptor(s) are familiar with all aspects of the terms of this Order. Respondent shall cause the monitor(s) and preceptor(s) to report any deviation from compliance with the terms of this Order to OPMC. Respondent shall cause the monitor(s) and preceptor(s) to submit required reports on a timely basis.

12. Respondent shall complete continuing medical education with regard to medical recordkeeping. Said course shall commence within three months of the effective date of the Consent Order. Said course shall be proposed by Respondent, and shall be subject to the written approval of the Director of OPMC, which approval shall not be unreasonably withheld.

13. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and her staff at practice locations or OPMC offices.

14. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

15. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.