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

Kendrick A. Sears, M.D.
Chair

Keith W. Servis, Director
Office of Professional Medical Conduct

Michael A. Gonzalez, R.P.A.
Vice Chair

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

February 13, 2007

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Edward Kowalski, Jr., M.D.
6815 Honeysuckle Trail
Bradenton, FL 34202

Re: License No. 186824

Dear Dr. Kowalski:

Enclosed is a copy of Order #BPMC 07-35 of the New York State Board for Professional Medical Conduct. This order and any penalty provided therein goes into effect February 20, 2007.

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

Sincerely,

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

Enclosure

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

IN THE MATTER

OF

EDWARD KOWALSKI, JR., MD

CONSENT
ORDER

BPMC No. #07-35

Upon the application of (Respondent) EDWARD KOWALSKI, JR., 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: 2-13-2007

KENDRICK A. SEARS, 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

EDWARD KOWALSKI, JR., M.D.

CONSENT AGREEMENT AND ORDER

EDWARD KOWALSKI, JR., M.D., representing that all of the following statements are true, deposes and says:

That on or about September 6, 1991, I was licensed to practice as a physician in the State of New York, and issued License No. 186824 by the New York State Education Department.

My current address is 6815 Honeysuckle Trail, Bradenton, Florida, 34202, 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 2 specifications of professional misconduct.

A copy of the Statement of Charges, marked as Appendix A, is attached to and part of this Consent Agreement.

I cannot successfully defend the charges against me, and agree to the following penalty:

1. Three years suspension, stayed;
2. Three years probation with practice monitor, and;
3. Restricted from prescribing controlled substances.

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

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 licensee shall register and continue to be registered with the New York State Education Department (except during periods of actual suspension) and that a licensee 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 30 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 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 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, if any, redacted. As public documents, they may be posted on the Department's website.

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 1/23/07

EDWARD KOWALSKI, JR., M.D.
RESPONDENT

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

DATE: 1/29/07

Amy B. Merklen, Esq.
Assistant Counsel
Bureau of Professional Medical Conduct

DATE: 2/8/07

Keith W. Servis
Director
Office of Professional Medical Conduct

APPENDIX A

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

IN THE MATTER

OF

EDWARD KOWALSKI, JR., M.D.

STATEMENT
OF
CHARGES

EDWARD KOWALSKI, JR, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 6, 1991, by the issuance of license number 186824 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided care and treatment for Patient A from on or about May 2004 to approximately June 2005. Respondent care and treatment failed to meet accepted standards of care, in that:

1. Respondent prescribed medication for Patient A without adequate medical indication(s) and/or documentation.
2. Respondent failed to perform and/or document an adequate physical exam.
3. Respondent failed to obtain and/or document an adequate medical history.
4. Respondent failed to adequately diagnose and/or treat Patient A and/or document a diagnosis and/or treatment plan.
5. Respondent failed to document numerous prescriptions for Patient A.
6. Respondent failed to maintain an adequate medical record accurately reflecting the care and treatment provided.

B. Respondent provided care and treatment for Patient B from on or about April 2001 to approximately June 2005. Respondent care and treatment failed to meet accepted standards of care, in that:

1. Respondent prescribed medication(s) for Patient B without adequate medical indication(s) and/or documentation.
2. Respondent failed to perform and/or document an adequate physical exam.
3. Respondent failed to obtain and/or document an adequate medical history.
4. Respondent failed to adequately diagnose and/or treat Patient A and/or document a diagnosis and/or treatment plan.
5. Respondent failed to document numerous prescriptions.
6. Respondent failed to maintain an adequate medical record accurately reflecting the care and treatment provided.

C. Respondent provided care and treatment for Patient C from on or about June 2003 to approximately June 2005. Respondent care and treatment failed to meet accepted standards of care, in that:

1. Respondent prescribed narcotics for Patient C without adequate medical indication(s) and/or documentation.
2. Respondent failed to perform and/or document an adequate physical exam.
3. Respondent failed to obtain and/or document an adequate medical history.
4. Respondent failed to adequately diagnose and/or treat Patient A and/or document a diagnosis and/or treatment plan.
5. Respondent failed to document numerous prescriptions.
6. Respondent failed to maintain an adequate medical record

accurately reflecting the care and treatment provided.

D. Respondent provided care and treatment for Patient from on or about April 2003 to approximately June 2005. Respondent care and treatment failed to meet accepted standards of care, in that:

1. Respondent prescribed medication(s) for Patient D without adequate medical indication(s) and/or documentation.
2. Respondent failed to perform and/or document an adequate physical exam.
3. Respondent failed to obtain and/or document an adequate medical history.
4. Respondent failed to adequately diagnose and/or treat Patient A and/or document a diagnosis and/or treatment plan.
5. Respondent failed to document numerous prescriptions.
6. Respondent failed to maintain an adequate medical record accurately reflecting the care and treatment provided.

E. Respondent provided care and treatment for Patient E from on or about September 1994 to approximately June 2005. Respondent care and treatment failed to meet accepted standards of care, in that:

1. Respondent prescribed narcotics for Patient E without adequate medical indication(s) and/or documentation.
2. Respondent failed to perform and/or document an adequate physical exam.
3. Respondent failed to obtain and/or document an adequate medical history.
4. Respondent failed to adequately diagnose and/or treat Patient A and/or document a diagnosis and/or treatment plan.
5. Respondent failed to document numerous prescriptions.

6. Respondent failed to maintain an adequate medical record accurately reflecting the care and treatment provided.

F. Respondent provided care and treatment for Patient F from on or about 1998 to approximately June 2005. Respondent care and treatment failed to meet accepted standards of care, in that:

1. Respondent prescribed medication(s) for Patient F without adequate medical indication(s) and/or documentation.
2. Respondent failed to perform and/or document an adequate physical exam.
3. Respondent failed to obtain and/or document an adequate medical history.
4. Respondent failed to adequately diagnose and/or treat Patient A and/or document a diagnosis and/or treatment plan.
5. Respondent failed to document numerous prescriptions.
6. Respondent failed to maintain an adequate medical record accurately reflecting the care and treatment provided.

G. Respondent provided care and treatment for Patient G from on or about May 2004 to approximately June 2005. Respondent care and treatment failed to meet accepted standards of care, in that:

1. Respondent prescribed medication(s) for Patient G without adequate medical indication(s) and/or documentation.
2. Respondent failed to perform and/or document an adequate physical exam.
3. Respondent failed to obtain and/or document an adequate medical history.
4. Respondent failed to adequately diagnose and/or treat Patient A and/or document a diagnosis and/or treatment plan.

5. Respondent failed to document numerous prescriptions.

6. Respondent failed to maintain an adequate medical record accurately reflecting the care and treatment provided.

H. Respondent provided care and treatment for Patient H from on or about May 2004 to approximately June 2005. Respondent care and treatment failed to meet accepted standards of care, in that:

1. Respondent prescribed medication(s) for Patient H without adequate medical indication(s) and/or documentation.

2. Respondent failed to perform and/or document an adequate physical exam.

3. Respondent failed to obtain and/or document an adequate medical history.

4. Respondent failed to adequately diagnose and/or treat Patient A and/or document a diagnosis and/or treatment plan.

5. Respondent failed to document numerous prescriptions.

6. Respondent failed to maintain an adequate medical record accurately reflecting the care and treatment provided.

I. Respondent provided care and treatment for Patient from on or about May 2004 to approximately June 2005. Respondent care and treatment failed to meet accepted standards of care, in that:

1. Respondent prescribed medication(s) for Patient I without adequate medical indication(s) and/or documentation.

2. Respondent failed to perform and/or document an adequate physical exam.

3. Respondent failed to obtain and/or document an adequate medical history.

4. Respondent failed to adequately diagnose and/or treat Patient A and/or document a diagnosis and/or treatment plan.
5. Respondent failed to document numerous prescriptions.
6. Respondent failed to maintain an adequate medical record accurately reflecting the care and treatment provided.

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

1. The facts as alleged in paragraphs A - A6, B - B6, C - C6, D - D6, E - E6, F - F6, G - G6, H - H6, and/or I - I6.

SECOND 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:

2. The facts as alleged in paragraphs A - A6, B - B6, C - C6, D - D6, E - E6, F - F6, G - G6, H - H6, and/or I - I6.

DATE: January 29, 2007
Albany, New York

Peter D. Van Buren
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 maintain active registration of Respondent's license (except during periods of actual suspension) with the New York State Education Department Division of Professional Licensing Services, and shall pay all registration fees.

3. Respondent shall provide the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299 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.

4. 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.

5. Respondent's failure to pay any monetary penalty by the prescribed date shall subject Respondent to all provisions of law relating to debt collection by New York State, including but 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 § 171(27); State Finance Law § 18; CPLR § 5001; Executive Law § 32].

6. 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.

7. 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.

8. 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.

9. [redacted]

10. 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.