Department of Health

ANDREW M. CUOMO
Governor

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

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

November 2, 2017

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Chetan Sati, D.O.
South Shore Family Practice
1000 Park Boulevard
Massapequa Park, New York 11762

Re: License No. 218705

Dear Dr. Sati:

Enclosed is a copy of the New York State Board for Professional Medical Conduct (BPMC) Order No. 17-320. This order and any penalty provided therein goes into effect November 9, 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: Barbara Ryan, Esq.
Aaronson, Rappaport, Feinstein & Deutsch, LLP.
600 Third Avenue
New York, New York 10016

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

BPMC No. 17-320

IN THE MATTER OF CHETAN SATI, D.O.	CONSENT ORDER

Upon the application of (Respondent) CHETAN SATI, D.O. 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: 11/02/2017

Carmela Torrelli
Vice Chair
State Board for Professional Medical Conduct

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

IN THE MATTER OF CHETAN SATI, D.O.	CONSENT AGREEMENT

CHETAN SATI, D.O., represents that all of the following statements are true:

That on or about August 3, 2000, I was licensed to practice as a physician in the State of New York, and issued License No. 218705 by the New York State Education Department.

My current address is 1000 Park Blvd Mass Pk NY 11762, 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(3), my license to practice medicine in New York State shall be limited to preclude all ordering, prescribing, distributing or administering of controlled substances.

Pursuant to N.Y. Pub. Health Law § 230-a(9), I shall be placed on probation for a period of 36 months, 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 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 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 licensee shall: report to the department all information required by the Department to develop a public physician profile for the licensee; 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 licensee's registration period. Licensee 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 licensee shall attest to the truthfulness, completeness and correctness of any changes licensee 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.

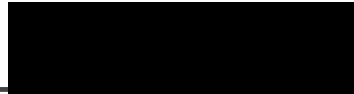
7

DATE 10/20/17

CHETAN SATI, D.O.
RESPONDENT

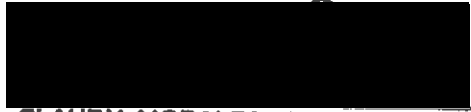
The undersigned agree to Respondent's attached Consent Agreement and to its proposed penalty, terms and conditions.

DATE: 10/20/17



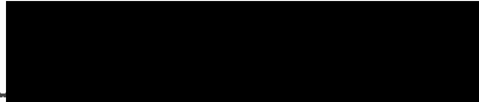
BARBARA RYAN, ESQ.
Attorney for Respondent

DATE: 10/24/17



CLAUDIA MORALES BLOCH
Associate Counsel
Bureau of Professional Medical Conduct

DATE: 10/31/17



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 CHETAN SATI, D.O.	STATEMENT OF CHARGES

CHETAN SATI, D.O., the Respondent, was authorized to practice medicine in New York State on or about August 3, 2000, by the issuance of license number 218705 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent undertook the care and treatment of Patient A (the identity of all patients herein charged is set forth in Appendix "A") from on or about January 17, 2012 through on or about January 17, 2017 at his office, South Shore Family Practice, P.C., located at 1000 Park Blvd., Rear Annex, Massapequa Park, NY 11762, (hereinafter referred to as "his office"). Patient A had a history of opioid addiction and enrollment in a methadone maintenance program. He was treated by Respondent for complaints of pain associated with orthopedic hardware in his leg, back pain, insomnia, hypertension, and GERD. Throughout his care and treatment of Patient A, Respondent continuously prescribed a controlled substance, Oxycodone, to Patient A, as well as maintaining him on Zolpidem. Respondent's care and treatment of Patient A deviated from accepted standards of care in that Respondent:

1. Failed to obtain and/or note a complete, accurate and appropriate past medical/surgical history for Patient A.
2. On multiple occasions, failed to obtain and/or note an appropriate history of the patient's presenting and/or ongoing complaints and/or condition(s).

3. On multiple occasions, failed to perform and/or note an appropriate physical examination.

4. Inappropriately prescribed Oxycodone and Zolpidem to Patient A, in that Respondent:

   a. Failed to provide and/or note the appropriate management of the patient's use of controlled substances, to wit: failed to apply appropriate risk evaluations and mitigation strategies (REMS) over the course of his treatment with controlled substances;

   b. Failed to appropriately and timely respond to and manage the patient's exhibited signs of substance abuse;

   c. Continually renewed these prescriptions without the appropriate inquiry into the patient's symptoms, functional status nor response to the controlled substances and/or failed to note the responses to these inquiries.

   d. Failed to maintain a clear and accurate account of prescription dates, pill counts, and refill intervals.

   e. Failed to adequately and appropriately pursue conservative therapies for Patient A's complaints prior to the use of controlled substances.

5. Failed to maintain an appropriate and complete record which accurately reflects the care, evaluation and treatment rendered Patient A.

B. Respondent undertook the care and treatment of Patient B at his office from on or about January 17, 2012 through on or about January 17, 2017, the same time period Respondent was treating Patient A. Patient B is Patient A's mother and they live in the same household. Patient B suffered from multiple co-morbid medical problems, and while under Respondent's care, had multiple hospitalization for, inter alia, shortness of breath, chest pain, exacerbation of congestive heart failure and falls. Throughout his care and treatment of Patient B, Respondent continuously prescribed a controlled substance, Oxycodone, to Patient B as well as maintaining her on Zolpidem. Respondent also prescribed Fentanyl on/or about 3 occasions. Respondent's care and treatment of Patient B deviated from accepted standards of care in that Respondent:

1. Failed to obtain and/or note a complete, accurate and appropriate past medical/surgical history for Patient B.
2. On multiple occasions, failed to obtain and/or note an appropriate history of the patient's presenting and/or ongoing complaints and/or condition(s).
3. On multiple occasions, failed to perform and/or note an appropriate physical examination.
4. Inappropriately prescribed Oxycodone, Fentanyl and Zolpidem to Patient B, in that:

a. Failed to provide and/or note the appropriate management of the patient's use of controlled substances, to wit: failed to apply appropriate risk evaluations and mitigation strategies (REMS) over the course of his treatment with controlled substances;

b. Failed to appropriately respond to and manage the markedly elevated risk of diversion of prescribed controlled substances to her son, Patient A.

c. Continually renewed these prescriptions without the appropriate inquiry into the patient's symptoms, functional status nor response to the controlled substances and/or failed to note the responses to these inquiries.

d. Failed to maintain a clear and accurate account of prescription dates, pill counts, and refill intervals.

e. Failed to adequately and appropriately pursue conservative therapies for Patient B's complaints prior to the use of controlled substances.

5. Failed to maintain an appropriate and complete record which accurately reflects the care, evaluation and treatment rendered Patient B.

C. Respondent undertook the care and treatment of Patient C at his office from on or about July 12, 2007 through on or about January 9, 2017. Throughout his care and treatment, Respondent treated Patient C with high doses of opioids, (Vicodin, Percocet and Oxycodone) for numerous pain complaints to his neck, back, shoulder, knee and ankle, and, simultaneously, with benzodiazepines (Alprazolem and Diazepam) for anxiety. Respondent's care and treatment of Patient C deviated from accepted standards of care in that Respondent:

1. Failed to obtain and/or note a complete, accurate and appropriate past medical/surgical history for Patient C.
2. On multiple occasions, failed to obtain and/or note an appropriate history of the patient's presenting and/or ongoing complaints and/or condition(s).
3. On multiple occasions, failed to perform and/or note an appropriate physical examination.
4. Inappropriate prescribed opioids and benzodiazepines to Patient C, in that Respondent:

   a. Failed to provide and/or note the appropriate management of the patient's use of controlled substances, to wit: failed to apply appropriate risk evaluations and mitigation strategies (REMS) over the course of his treatment with controlled substances;

   b. Failed to appropriately and timely respond to and manage the patient's exhibited signs of substance abuse;

   c. Continually renewed these prescriptions without the appropriate inquiry into the patient's symptoms, functional status nor response to the controlled substances and/or failed to note the responses to these inquiries.

   d. Inappropriately escalated doses of controlled substance without medical indication nor justification, and/or without noting same.

   e. Failed to maintain a clear and accurate account of prescription dates, pill counts, and refill intervals.

   f. Failed to adequately and appropriately pursue conservative therapies for Patient C's complaints prior to the use of controlled substances.

5. Failed to maintain an appropriate and complete record which accurately reflects the care, evaluation and treatment rendered Patient C.

D. Respondent undertook the care and treatment of Patient D at his office from on or about June 16, 2009 through on or about January 12, 2017. Throughout his care and treatment, Respondent simultaneously treated Patient D with multiple controlled substances, to wit: Hydrocodone, for pain; Alprazolam for anxiety; Ambien for insomnia

and Amphetamines for Attention Deficit Disorder ("ADD"). Respondent's care and treatment of Patient D deviated from accepted standards of care in that Respondent:

1. Failed to obtain and/or note a complete, accurate and appropriate past medical/surgical history for Patient D.
2. On multiple occasions, failed to obtain and/or note an appropriate history of the patient's presenting and/or ongoing complaints and/or condition(s).
3. On multiple occasions, failed to perform and/or note an appropriate physical examination.
4. Inappropriate prescribed Hydrocodone, Alprazolam, Ambien and Amphetamines to Patient D, in that Respondent:

    a. Failed to provide and/or note the appropriate management of the patient's use of controlled substances, to wit: failed to apply appropriate risk evaluations and mitigation strategies (REMS) over the course of his treatment with controlled substances;

    b. Failed to appropriately and timely respond to and manage the patient's exhibited signs of substance abuse;

    c. Continually renewed these prescriptions without the appropriate inquiry into the patient's symptoms, functional status nor response to the controlled substances and/or failed to note the responses to these inquiries.

    d. Inappropriately escalated doses of controlled substance without medical indication nor justification, and/or without noting same.

    e. Failed to maintain a clear and accurate account of prescription dates, pill counts, and refill intervals.

    f. Failed to adequately and appropriately pursue conservative therapies for Patient D's complaints prior to the use of controlled substances.

5. Failed to maintain an appropriate and complete record which accurately reflects the care, evaluation and treatment rendered Patient D.

E. Respondent undertook the care and treatment of Patient E at his office from on or about May 24, 2012 through on or about March 17, 2014. Throughout his care and treatment, Respondent treated Patient E with Oxycodone for complaints of back and

joint pain; Alprazolam for anxiety and Amphetamines for ADD. Patient E also presented, on occasion, with complaints of headache and palpitations. Respondent's care and treatment of Patient E deviated from accepted standards of care in that Respondent:

1. Failed to obtain and/or note a complete, accurate and appropriate past medical/surgical history for Patient E.
2. On multiple occasions, failed to obtain and/or note an appropriate history of the patient's presenting and/or ongoing complaints and/or condition(s).
3. On multiple occasions, failed to perform and/or note an appropriate physical examination.
4. Inappropriate prescribed Oxycodone, Alprazolam and Amphetamines to Patient E, in that Respondent:

   a. Failed to provide and/or note the appropriate management of the patient's use of controlled substances, to wit: failed to apply appropriate risk evaluations and mitigation strategies (REMS) over the course of his treatment with controlled substances;

   b. Continually renewed these prescriptions without the appropriate inquiry into the patient's symptoms, functional status nor response to the controlled substances and/or failed to note the responses to these inquiries.

   c. Inappropriately escalated doses of controlled substance without medical indication nor justification, and/or without noting same.

   d. Failed to maintain a clear and accurate account of prescription dates, pill counts, and refill intervals.

   e. On multiple occasions, inappropriately provided Patient E with early prescription refills for Oxycodone and Adderall.

   f. Failed to adequately and appropriately pursue conservative therapies for Patient D's complaints prior to the use of controlled substances.

5. Failed to maintain an appropriate and complete record which accurately reflects the care, evaluation and treatment rendered Patient E.

F. Respondent has failed, since 2004, to update his Physician Profile in violation of Pub. Health Law Section 2995-a(4) and 10 NYCRR 1000.5.

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. Paragraphs A, A.1 – A.3, A.4 and subparagraphs, A.5, B, B.1 – B.3, B.4 and subparagraphs, B.5, C, C.1 – C.3, C.4 and subparagraphs, C.5, D, D.1 – D.3, D.4 and subparagraphs, D.5, E, E.1 – E.3, E.4 and subparagraphs, E.5

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. Paragraphs A, A.1 – A.3, A.4 and subparagraphs, A.5, B, B.1 – B.3, B.4 and subparagraphs, B.5, C, C.1 – C.3, C.4 and subparagraphs, C.5, D, D.1 – D.3, D.4 and subparagraphs, D.5, E, E.1 – E.3, E.4 and subparagraphs, E.5

THIRD THROUGH SEVENTH 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:

3. Paragraphs A, A.1 – A.3, A.4 and subparagraphs, A.5
4. Paragraphs B, B.1 – B.3, B.4 and subparagraphs, B.5
5. Paragraphs C, C.1 – C.3, C.4 and subparagraphs, C.5
6. Paragraphs D, D.1 – D.3, D.4 and subparagraphs, D.5
7. Paragraph E, E.1 – E.3, E.4 and subparagraphs, E.5

EIGHTH 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:

8. Paragraphs A, A.1 – A.3, A.4 and subparagraphs, A.5, B, B.1 – B.3, B.4 and subparagraphs, B.5, C, C.1 – C.3, C.4 and subparagraphs, C.5, D, D.1 – D.3, D.4 and subparagraphs, D.5, E, E.1 – E.3, E.4 and subparagraphs, E.5

NINTH THROUGH THIRTEENTH 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 evaluation and treatment of the patient, as alleged in the facts of:

9. Paragraphs A.1 – A.3, A.4.a, A.4.c, A.4.d, A.5
10. Paragraphs B.1 – B.3, B.4.a, B.4.c, B.4.d, B.5
11. Paragraphs C.1 – C.3, C.4.a, C.4.c, C.4.e, C.5
12. Paragraphs D.1 – D.3, D.4.a, D.4.c, D.4.d, D.4.e, D.5
13. Paragraphs E.1 – E.3, E.4.a – E.4.d, E.5

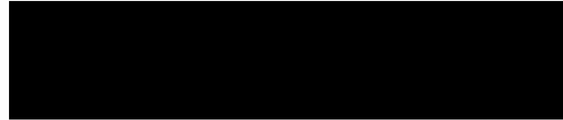
FOURTEENTH SPECIFICATION

FAILING TO FILE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by willfully making or filing a false report, or failing to file a report required by law or by the Department of Health or the Education Department, as alleged in the facts of paragraph:

14. Paragraph F

DATE: August 24, 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) 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].

4) 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.

5) 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.

6) 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.

7) 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.

8) 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, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. Any medical practice in violation of this term shall constitute the unauthorized practice of medicine.

   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 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.

   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.

9) Respondent shall enroll in and successfully complete a continuing education program; this 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.

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.