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.
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NYS Department of Health

Dennis P. Whalen
Executive Deputy Commissioner
NYS Department of Health

Dennis J. Graziano, Director
Office of Professional Medical Conduct

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

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

PUBLIC

June 28, 2004

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Mark A. Nercessian, M.D.
5434 Country Club Lane
Hamburg, NY 14075

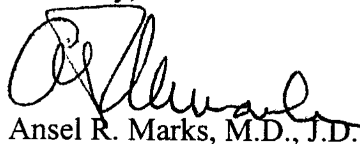
Re: License No. 202684

Dear Dr. Nercessian:

Enclosed please find Order #BPMC 04-139 of the New York State Board for Professional Medical Conduct. This order and any penalty provided therein goes into effect July 5, 2004.

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 the 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: Brian J. Weidner, Esq.
Brown & Tarantino, LLP
1500 Rand Building
14 Lafayette Square
Buffalo, NY 14203

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

IN THE MATTER OF MARK NERCESSIAN, M.D.	SURRENDER ORDER
	BPMC No. 04-139

Upon the application of (Respondent) MARK NERCESSIAN, 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: 6/25/04

MICHAEL A. GONZALEZ, R.P.A.
Vice Chair
State Board for Professional Medical Conduct

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

IN THE MATTER OF MARK NERCESSIAN, M.D.	SURRENDER of LICENSE

MARK NERCESSIAN, M.D., representing that all of the following statements are true, deposes and says:

That on or about April 12, 1996, I was licensed to practice as a physician in the State of New York, and issued License No. 202684 by the New York State Education Department.

My current address is 5434 Country Club Lane, Hamburg, New York 14075, 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 Thirty-one 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 the Third Specification [negligence on more than one occasion] to the extent of allegations A and A.2, A and A.4, E and E.1, E and E.2, and E and E.3. I do not contest the Seventh through Ninth Specifications [fraud in the practice of medicine] solely to the extent of allegations A and A.3, G and G.1, and H and H.1, and I do not contest the Nineteenth through Twenty-first Specifications [moral unfitness] also solely to the extent of allegations A and A.3,

G and G.1, and H and H.1, all 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.

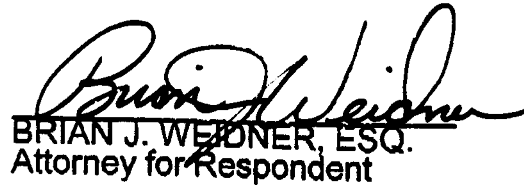
I ask the Board to accept this Surrender of License of my own free will and not under duress, compulsion or restraint. In consideration of the value to me of the Board's acceptance of this Surrender of License, allowing me to resolve this matter without the various risks and burdens of a hearing on the 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 6/15/04

Mark Nercessian M.D.
MARK NERCESSIAN, M.D.
RESPONDENT

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

DATE: June 15, 2004



BRIAN J. WEIDNER, ESQ.
Attorney for Respondent

DATE: 6/16/04

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

DATE: 6/23/04

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

EXHIBIT A

IN THE MATTER OF MARK NERCESSIAN, M.D.	**STATEMENT OF CHARGES**

MARK NERCESSIAN, M.D., the Respondent, was authorized to practice medicine in New York State on or about April 12, 1996, by the issuance of license number 202684 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A [patients are identified in the attached appendix], a 45 year old female, at the Emergency Room of the Mount St. Mary's Hospital, 5300 Military Road, Lewiston, New York 14092, on January 3, 2001. Patient A was admitted with multiple open skull fractures and an intracerebral hemorrhage secondary to head trauma, among others. Respondent's care of Patient A failed to meet minimum standards of medical care in that:

1. Respondent failed to obtain an adequate history of the nature and extent of the patient's medical history and injuries.
2. Respondent failed to conduct an adequate physical examination of the patient in light of her presenting condition.
3. Respondent documented that he conducted aspects of a physical examination of Patient A [for example, an evaluation of the patient's ears] that he did not in fact perform.
4. Respondent failed to adequately evaluate and/or treat the patient, and/or document such evaluation or treatment.

B. Respondent provided medical care to Patient B, a 24 year old female, at the Lake Shore Hospital, 845 Routes 5 and 20, Irving, New York, 14081, at various times from August 20-22, 1996. Patient B was admitted to the hospital on 8/19/96 with complaints of a 2 to 3 day history of abdominal pain and nausea. Patient B expired at approximately 6:30 a.m. on 8/22/96 with an immediate cause of death listed as necrotizing pancreatitis. Respondent's care of Patient B failed to meet minimum standards of medical care in that:

1. Respondent, at approximately 11:00 a.m. on 8/20/96, failed to evaluate and treat Patient B's pancreatitis in an adequate and timely manner, and/or failed to document such evaluation and treatment.

2. Respondent, beginning at approximately 11:00 a.m. on 8/20/96, failed to order adequate and timely oversight of the patient's medical condition, and/or failed to document such orders.

3. Respondent, at approximately 8:00 a.m. on 8/21/96, failed to evaluate and treat Patient B's pancreatitis in an adequate and timely manner, and/or failed to document such evaluation and treatment.

4. Respondent, despite being informed at approximately 5:00 p.m. on 8/21/96 that the patient's clinical condition had deteriorated, including elevated pulse and respiration rates, mottling of her back and legs, and diaphoresis, failed to evaluate and treat the patient in an adequate and timely manner, and/or failed to document such evaluation and treatment.

5. Respondent, despite being informed at approximately 8:30 p.m. on 8/21/96 that the patient's clinical condition remained deteriorated, including elevated pulse and respiration rates, persistent mottling of her back and legs, diaphoresis, and abnormally low urine output, failed to evaluate and treat the patient in an adequate and timely manner, and/or failed to document such evaluation and treatment.

6. Respondent, despite being informed at approximately 1:45 a.m. on 8/22/96 of the patient's clinical condition, including the appearance of respiratory distress and other relevant clinical and laboratory results, failed to evaluate and treat the patient in an adequate and timely manner, and/or failed to document such evaluation and treatment.

7. Respondent, despite being informed at approximately 3:00 a.m. on 8/22/96 of the patient's clinical condition, including markedly elevated pulse and respiration rates, altered mental status, lowered oxygen saturation, and persistent mottling of her back and legs, and despite being specifically requested to come to the hospital by the nursing supervisor, failed to evaluate and treat the patient in an adequate and timely manner, and/or failed to document such evaluation and treatment.

8. Respondent, despite being informed at approximately 4:15 a.m. on 8/22/96 of the patient's clinical condition, and despite being specifically requested to come to the hospital by nursing staff, failed to evaluate and treat the patient in an adequate and timely manner, and/or failed to document such evaluation and treatment.

9. Respondent, despite being informed at approximately 5:15 a.m. on 8/22/96 of the patient's clinical condition, failed to evaluate and treat the patient in an adequate and timely manner, and/or failed to document such evaluation and treatment.

C. Respondent provided medical care to Patient C, a 56 year old male, at the Emergency Room of the Niagara Falls Memorial Medical Center, 621 Tenth Street, Niagara Falls, New York 14302, on December 17, 2001. Patient C was admitted with complaints of difficulty breathing, coughing, and upper abdominal pain. Respondent's care of Patient C failed to meet minimum standards of medical care in that:

1. Respondent failed to adequately evaluate and treat Patient C in light of the patient's history of illness, presenting symptoms, and emergency room EKG that demonstrated an "abnormal ECG", with an "Acute M[yocardial] In[farction]".

D. Respondent provided medical care to Patient D, a 4 year old male, at the Emergency Room of the Ira Davenport Memorial Hospital, 7571 State Route

54, Bath, New York 14810, [Ira Davenport Hospital], on or about February 12, 2003. Patient D was treated in the emergency department with complaint of severe abdominal pain. Respondent's care of Patient D failed to meet minimum standards of medical care in that:

1. Respondent failed to conduct an appropriate physical exam of the patient, including a testicular exam, and/or document such an exam.
2. Respondent failed to order a urinalysis for the patient, despite medical indications.
3. Respondent, despite the patient showing pain during the second abdominal examination performed by Respondent, failed to appropriately evaluate or treat the patient following that examination.
4. Respondent diagnosed the patient as having "constipation" without adequate medical indication.
5. Respondent failed to order or obtain a re-check of the patient's temperature prior to discharge of the patient, despite the patient having a moderately elevated temperature at the time of admission.

E. Respondent provided medical care to Patient E, a 23 year old female, at the Emergency Room of Mercy Hospital of Buffalo, 565 Abbott Road, Buffalo, New York 14220 [Mercy Hospital], on or about March 10, 2000. Patient E was admitted to the emergency department with a chief complaint of vaginal bleeding. Respondent's care of Patient E failed to meet minimum standards of medical care in that:

1. Respondent, despite noting in his differential diagnosis that the patient had possible "STD/PID [Sexually Transmitted Disease/Pelvic Inflammatory Disease]", failed to order appropriate diagnostic tests or lab cultures to rule in or rule out the diagnosis.
2. Respondent's differential diagnoses for the patient included possible "incarcerated uterus" and "placenta previa/ abruptio", neither of which were indicated given the history and duration of the patient's pregnancy.
3. Respondent failed to re-check the patient's vital signs prior to

discharge, and/or order that the patient's vital signs should be re-checked prior to discharge, despite medical indications.

F. Respondent provided medical care to Patient F, a 31 year old female, at the Emergency Room of Mercy Hospital of Buffalo, on or about October 10, 1998, and December 19, 1998. Patient F was admitted to the emergency department on October 10, 1998 with a chief complaint of a change in mental status of two days' duration. She was admitted to the emergency department on December 19, 1998 with a chief complaint of right sided numbness and weakness, inability to use her right hand, slurred speech, and expressive dysphasia. On each occasion, Respondent's care of Patient F failed to meet minimum standards of medical care in that:

1. Respondent, on October 10, 1998, noted in his differential diagnosis that the patient had possible "meningitis", yet failed to order appropriate diagnostic tests or lab cultures to rule in or rule out the diagnosis, such as a lumbar puncture.
2. Respondent, on October 10, 1998, discharged the patient with instructions for her to go to the Erie County Psychiatric Center without adequately assessing her for suicidal ideation, hallucinations, or capacity to make competent medical decisions, and/or documenting that he had performed such an assessment.
3. Respondent, on December 19, 1998, failed to adequately evaluate and treat the patient in light of her presenting symptoms, including a failure to obtain a CT scan of the brain and contemporaneous neuropsychiatric consultation.

G. Respondent submitted an "Application for Medical/Dental Staff Appointment" to Genesee Mercy Healthcare, Batavia, New York, 14020 ["Genesee Mercy Application"], on or about October 9, 1998.

1. Respondent, as part of his Genesee Mercy Application, dated and signed by the Respondent on or about "10/9/98", submitted a "Medical Evaluation Form" that purported to reflect a physical examination of Respondent. The signature that was placed on the form purported to be that of "examining physician" "Ramin Samadi", certifying that "I have performed a medical examination on [Respondent]", and making other representations relating to the Respondent being "free from any health impairment which is of potential risk to patients . . ." Respondent knew or should have known that the document was not in fact signed by Dr. Samadi.

2. Respondent, as part of his Genesee Mercy Application, dated and signed by the Respondent on or about "10/9/98", submitted a "Medical Evaluation Form" that purported to reflect a physical examination of himself performed by a "Dr. Samadi", and that purported to be signed by "examining physician" "Ramin Samadi", certifying that "I have performed a medical examination on [Respondent]" and making other representations relating to the Respondent being "free from any health impairment which is of potential risk to patients . . ." In fact, Respondent himself signed the form in the name of Dr. Samadi without the express or implied consent of Dr. Samadi, and knowing that Dr. Samadi had not performed the physical exam described.

H. Respondent submitted an "Application for Appointment to the Medical Staff" to the Lakeside Memorial Hospital, 156 West Avenue, Brockport, New York 14420 ["Lakeside Hospital Application"], on or about April 21, 2000.

1. Respondent, as part of his application for privileges at the Lakeside Memorial Hospital, on or about April 20, 2000 submitted a "Statement of Health" form that purported to reflect a health assessment of the Respondent. The signature that was placed on the examination form purported to be that of physician "Christian Defazio, M.D." In fact, the signature on the form was not by Dr. Defazio. Respondent knew or should have known that the document was not signed by Dr. Defazio.

2. Respondent, as part of his application for privileges at the Lakeside Memorial Hospital, on or about April 20, 2000 submitted a "Statement of Health" form that purported to reflect a health assessment of the Respondent. The signature that was placed on the examination form purported to be that of physician "Christian Defazio, M.D.", when in fact Respondent himself signed the form in the name of Dr. Defazio without the express or implied consent of Dr. Defazio, and knowing that Dr. Defazio had not performed the physical exam described.

I. Respondent submitted an "Application for Appointment to Medical/Dental Staff" to Niagara Falls Memorial Medical Center, 621 10th Street, Niagara Falls, New York, 14302, ["Niagara Falls Application"], on or about May 4, 2000.

1. Respondent, as part of his Niagara Falls Application, dated and signed by the Respondent on or about "5/4/2000", submitted a "Medical Evaluation Form" that purported to be signed by "examining practitioner" "E. Coggins", certifying that "I have performed a medical examination on [Respondent]", and also that Respondent was "free from any health impairment which is of potential risk to patients . . .". Respondent knew or should have known that the document was not in fact signed by Dr. Coggins, who is also Respondent's wife.

2. Respondent, as part of his Niagara Falls Application dated and signed by the Respondent on or about "5/4/02", submitted a "Medical Evaluation Form" that purported to be signed by "examining practitioner" "E. Coggins", certifying that "I have performed a medical examination on [Respondent"] and also that Respondent was "free from any health impairment which is of potential risk to patients . . .". In fact, the signature on the form was not by Dr. Coggins, but was instead entered by the Respondent in his own handwriting.

J. Respondent submitted an "Application for Appointment to the Medical Staff and/or Clinical Privileges" to the Lockport Memorial Hospital, 521 East Avenue, Lockport, New York 14094 ["Lockport Hospital Application"], on or about August 9, 2000.

1. Respondent, as part of his application for privileges at the Lockport Memorial Hospital, on or about August 9, 2000 submitted a "Medical Staff History [&] Physical" examination form that purported to reflect a health assessment of the Respondent, and a determination that Respondent was "free from any health impairment which is of potential risk to patients . . ." The signature that was placed on the history and physical examination form purported to be that of physician "Judine Davis, M.D." In fact, the signature on the form was not by Dr. Davis. Respondent knew or should have known that the document was not signed by Dr. Davis.

2. Respondent, as part of his application for privileges at the Lockport Memorial Hospital, on or about August 9, 2000 submitted a "Medical

Staff History [&] Physical" examination form that purported to reflect a health assessment of the Respondent, and a determination that Respondent was "free from any health impairment which is of potential risk to patients . . .". The signature that was placed on the history and physical examination form purported to be that of physician "Judine Davis, M.D." In fact, the signature on the form was not by Dr. Davis, but was instead entered by the Respondent in his own handwriting.

K. Respondent submitted an "Application for Appointment to the Medical Staff" to the Ira Davenport Memorial Hospital ["Ira Davenport Application"], 7571 State Route 54, Bath, New York, on or about February 9, 2002.

1. Respondent, on his Ira Davenport Application, dated and signed by the Respondent on or about "2/9/02", falsely answered "no" to the following question, numbered "1":

   Has your employment, medical staff membership status or clinical privileges in any other hospital or health care institution ever been limited, suspended, diminished, revoked, not renewed or subject to probationary conditions?

   In fact, Respondent's employment with Western Niagara Physician, P.C., an emergency department physician service provider, was terminated by letter dated on or about January 23, 2001, for cause related to Respondent's care of a patient at the Mount St. Mary's Hospital, Lewiston, New York, in January, 2001, and Respondent knew such facts.

2. Respondent, on his Ira Davenport Application, dated and signed by the Respondent on or about "2/9/02", was requested to "List each practice, hospital and health care facility with which you have been associated for the past 10 years; include staff appointments and assistantships". Respondent gave as his response, "See CV".

   In fact, Respondent intentionally omitted from his CV his employment affiliation with Western Niagara Physician, P.C., from which Respondent was terminated by letter dated on or about January 23, 2001 for cause related to Respondent's care of a patient at the Mount St. Mary's Hospital, Lewiston, New York, in January, 2001. Respondent's CV also intentionally omitted mention of his staff affiliations at Mount St. Mary's Hospital, Lewiston, New York, and Niagara Falls Memorial Hospital, Niagara Falls, New York.

3. Respondent, as part of his ongoing privileges at the Ira Davenport Hospital, on or about January 20, 2003, submitted a "Verification of Yearly Health Assessment for Practitioners", that purported to confirm a health reassessment of the Respondent. The signature that was

placed on the health verification form, purported to be that of physician "E. Coggins, M.D." In fact, the signature on the form was not by Dr. Coggins. Respondent knew or should have known that the document was not signed by Dr. Coggins, who is also Respondent's wife.

4. Respondent, as part of his ongoing privileges at the Ira Davenport Hospital, on or about January 20, 2003, submitted a "Verification of Yearly Health Assessment for Practitioners", that purported to confirm a health reassessment of the Respondent. The signature that was placed on the health verification form purported to be that of physician "E. Coggins, M.D." In fact, the signature on the form was not by Dr. Coggins, but was instead entered by the Respondent in his own handwriting.

L. Respondent submitted an "Application for Reappointment to the Medical Staff and/or Clinical Privileges" to Medina Memorial Health Care System, 200 Ohio Street, Medina, New York 14103 ["Medina Memorial Application"], on or about February 2, 2002.

1. Respondent, in his Medina Memorial Application, dated and signed by the Respondent on or about "2/20/02", falsely answered "no" to the following question, numbered "8":

During the past two years, has your medical staff membership, medical staff status, or any other type of affiliation at any healthcare entity been suspended, diminished, not renewed, revoked or subjected to probationary conditions, ...?

In fact, Respondent's employment with Western Niagara Physician, P.C., was terminated by letter dated on or about January 23, 2001, for cause related to Respondent's care of a patient at the Mount St. Mary's Hospital in January, 2001, and Respondent knew such facts.

M. Respondent submitted a "Medical Staff Application" to the Nicholas H. Noyes Memorial Hospital, 111 Clara Barton Street, Dansville, New York ["Nicholas Noyes Application"], on or about March 16, 2002.

1. Respondent, on his Nicholas Noyes Application, dated and signed by the Respondent on or about "3/16/02", falsely answered "no" to the following question, numbered "15 [fifth question listed]":

Have you ever voluntarily or involuntarily withdrawn or resigned association, employment, or privileges at any health care facility or practice?

In fact, Respondent's employment with Western Niagara Physician, P.C., an emergency department physician service provider, was terminated by letter dated on or about January 23, 2001, for cause related to Respondent's care of a patient at the Mount St. Mary's Hospital, Lewiston, New York, in January, 2001, and Respondent knew such facts.

2. Respondent, on his Nicholas Noyes Application, dated and signed by the Respondent on or about "3/16/02", was requested to "List, in chronological order, all present and previous hospital affiliations, medical staff memberships, and group/employment associations. . ." In his response, Respondent intentionally failed to list the following:

   (A) Employment association with Western Niagara Physician, P.C., an emergency department physician service provider from which Respondent was terminated by letter dated on or about January 23, 2001 for cause related to Respondent's care of a patient at the Mount St. Mary's Hospital, Lewiston, New York, in January, 2001.

   (B) Hospital affiliation with Mount St. Mary's Hospital, Lewiston, New York.

   (C) Hospital affiliation with Niagara Falls Memorial Hospital, Niagara Falls, New York.

   (D) Hospital affiliation with Lockport Memorial Hospital, Lockport, New York.

   (E) Hospital affiliation with Lakeshore Health Care Center, Irving, New York.

   (F) Employment affiliation with Barnes Primary Care Group.

N. Respondent submitted an "Application for Appointment to the Medical Staff/ Dental Staff" to the Jones Memorial Hospital, 191 N. Main Street, Wellsville, New York 14895, ["Jones Hospital Application"], on or about May 1, 2002.

   1. Respondent, in his Jones Hospital Application,

dated and signed by the Respondent on or about "5/1/02", was requested to "List all healthcare facilities you have been affiliated with since medical school graduation including any facility at which you held temporary privileges as a locum tenens and your reason for disassociation . . ". Respondent answered by referring to his curriculum vitae. Respondent in his curriculum vitae intentionally failed to list the following:

(A) Hospital affiliation with Mount St. Mary's Hospital, Lewiston, New York.

(B) Hospital affiliation with Niagara Falls Memorial Hospital, Niagara Falls, New York.

©) Hospital affiliation with Lockport Memorial Hospital, Lockport, New York.

(D) Hospital affiliation with Lakeshore Health Care Center, Irving, New York.

O. Respondent submitted an "Application for Medical/Dental Staff Membership" to the Catholic Health System, Mercy Hospital of Buffalo, 565 Abbott Road, Buffalo, New York 14220 ["Mercy Hospital Application"], on or about May 17, 2002.

1. Respondent, as part of his Mercy Hospital Application on page "3", was requested to "list chronologically all healthcare affiliations since completion of [his] postgraduate education." Respondent listed several hospitals and attached his curriculum vitae. Respondent in his curriculum vitae intentionally failed to list the following:

(A) Hospital affiliation with Mount St. Mary's Hospital, Lewiston, New York.

(B) Hospital affiliation with Niagara Falls Memorial Hospital, Niagara Falls, New York.

©) Hospital affiliation with Lockport Memorial Hospital, Lockport, New York.

(D) Hospital affiliation with Lakeshore Health Care Center, Irving, New York.

P. Respondent submitted an "Application for Medical/Dental Staff Reappointment" to Kaleida Health [DeGraff Memorial Hospital], 100 High Street, Buffalo, New York 14203 ["Kaleida-DeGraff Application"], on or about August 10, 2002.

1. Respondent, as part of his Kaleida DeGraff Application dated and signed by the Respondent on or about "8/10/02", submitted a "Medical Evaluation Form for Reappointment" that purported to be signed by "examining practitioner" "E. Coggins", certifying that "I have performed a medical examination on [Respondent",] and also that Respondent was "free from any health impairment which is of potential risk to patients . . ." Respondent knew or should have known that the document was not in fact signed by Dr. Coggins, who is also Respondent's wife.

2. Respondent, as part of his Kaleida DeGraff Application dated and signed by the Respondent on or about "8/10/02", submitted a "Medical Evaluation Form for Reappointment" that purported to be signed by "examining practitioner" "E. Coggins", certifying that "I have performed a medical examination on [Respondent",] and also that Respondent was "free from any health impairment which is of potential risk to patients . . ." In fact, the signature on the form was not by Dr. Coggins, but was instead entered by the Respondent in his own handwriting.

Q. Respondent submitted an "Application for Appointment to the Medical Staff" to the Sheehan Memorial Hospital, 425 Michigan Avenue, Buffalo, New York, 14203, ["Sheehan Hospital Application"], on or about September 12 or 13, 2002.

1. Respondent, as part of his application for privileges at the Sheehan Memorial Hospital, on or about September 12, 2002 submitted a "History & Physical Examination Form" that purported, "by my signature below", to reflect a health assessment of the Respondent. The signature that was placed on the history and physical examination form purported to be that of physician "E. Coggins, M.D." In fact, the signature on the form was not by Dr. Coggins. Respondent knew or should have known that the document was not signed by Dr. Coggins, who is also Respondent's wife.

2. Respondent, as part of his application for privileges at the Sheehan Memorial Hospital, on or about September 12, 2002 submitted a "History & Physical Examination Form" that purported, "by my signature below", to reflect a health assessment of the Respondent. The signature that was placed on the history and physical examination form purported to be that of physician "E. Coggins, M.D." In fact, the signature on the form was not by Dr. Coggins, but was instead entered by the Respondent in his own handwriting.

SPECIFICATION OF CHARGES

FIRST AND SECOND SPECIFICATIONS

GROSS NEGLIGENCE

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

1. The facts in paragraphs A and A.1, A and A.2, and/or A and A.4.
2. The facts in paragraphs B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, and/or B and B.9.

THIRD 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:

3. The facts in paragraphs A and A.1, A and A.2, A and A.4, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, C and C.1, 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, F and F.1, F and F.2, and/or F and F.3.

FOURTH AND FIFTH SPECIFICATIONS

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:

4. The facts in paragraphs A and A.1, A and A.2, and/or A and A.4.

5. The facts in paragraphs B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, and/or B and B.9.

SIXTH 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:

6. The facts in paragraphs A and A.1, A and A.2, A and A.4, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, C and C.1, 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, F and F.1, F and F.2, and/or F and F.3.

SEVENTH THROUGH EIGHTEENTH 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:

7. The facts in paragraphs A and A.3.

8. The facts in paragraphs G and G.1, and/or G and G.2.

9. The facts in paragraphs H and H.1, and/or H and H.2.

10. The facts in paragraphs I and I.1, and/or I and I.2.

11. The facts in paragraphs J and J.1, and/or J and J.2.

12. The facts in paragraphs K and K.1, K and K.2, K and K.3 and/or K and

K.4.

13. The facts in paragraphs L and L.1.
14. The facts in paragraphs M and M.1, and/or M and M.2(A)-(F).
15. The facts in paragraphs N and N.1(A)-(D).
16. The facts in paragraphs O and O.1(A)-(D).
17. The facts in paragraphs P and P.1, and/or P and P.2.
18. The facts in paragraphs Q and Q.1, and/or Q and Q.2.

NINETEENTH THROUGH THIRTIETH SPECIFICATIONS
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:

19. The facts in paragraphs A and A.3.
20. The facts in paragraphs G and G.1, and/or G and G.2.
21. The facts in paragraphs H and H.1, and/or H and H.2.
22. The facts in paragraphs I and I.1, and/or I and I.2.
23. The facts in paragraphs J and J.1, and/or J and J.2.
24. The facts in paragraphs K and K.1, K and K.2, K and K.3 and/or K and K.4.
25. The facts in paragraphs L and L.1.
26. The facts in paragraphs M and M.1, and/or M and M.2(A)-(F).
27. The facts in paragraphs N and N.1(A)-(D).
28. The facts in paragraphs O and O.1(A)-(D).
29. The facts in paragraphs P and P.1, and/or P and P.2.

30. The facts in paragraphs Q and Q.1, and/or Q and Q.2.

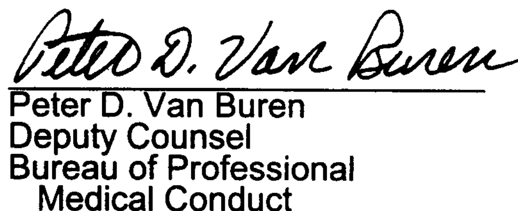
THIRTY-FIRST SPECIFICATION

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:

31. The facts in paragraphs A and A.3, A and A.4, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, D and D.1, and/or F and F.2.

DATED: May 13, 2004
Albany, New York



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Medical Conduct