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

IN THE MATTER OF NANCY E. SANDERSON, M.D.	MODIFICATION ORDER
	BPMC No. #05-221

Upon the proposed Application for a Modification Order of **NANCY E. SANDERSON, M.D.**, (Respondent) which is made a part of this Modification Order, it is agreed and

ORDERED, that the attached Application and its terms are adopted and it is further

ORDERED, that this Modification Order shall be effective upon issuance by the Board, either by mailing, by first class mail, a copy of the Modification Order by first class mail to Respondent at the address in the attached Application or by certified mail to Respondent's attorney or upon transmission via facsimile to Respondent or Respondent's attorney, whichever is earliest.

SO ORDERED.

DATED: 4-1-2008

Redacted Signature
KENDRICK A. SEARS, M.D.
Chairman
State Board for Professional Medical Conduct

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

IN THE MATTER OF NANCY E. SANDERSON, M.D.	APPLICATION FOR MODIFICATION ORDER

NANCY E. SANDERSON, M.D., (Respondent) being duly sworn deposes and says:

That on or about August 13, 1996, I was licensed to practice as a physician in the State of New York, having been issued License No. 204084 by the New York State Education Department.

My current address is : Redacted Address and I will advise the Director of the Office of Professional Medical Conduct of any changes of my address thirty (30) days, thereof.

I am currently subject to Consent Order BPMC No. 05-221, (hereinafter "Original Order"), annexed hereto, made a part, hereof, and marked as Exhibit 1, that was issued on October 13, 2005.

I apply, hereby, to the State Board for Professional Medical Conduct for a Modification Order (hereinafter "Modification Order"), modifying the Original Order, as follows: to delete the language in the Original Order that states:

> " That Respondent shall maintain current registration of licensure with the New York State Education Department Division of Professional Licensing Services (except during periods of actual suspension), and shall pay all registration fees.
> This condition shall take effect thirty (30) days after the Consent Order's effective date and will continue so long as Respondent remains licensed in New York State; and"

Substituting the following language in the Original Order that states:

"Respondent shall notify the New York State Education Department, Division of Professional Licensing and change Respondent's status to inactive. Respondent agrees to provide the Director of OPMC notice within thirty (30) days of Respondent's intent to change the status from inactive to active and to resume clinical practice and further agrees to complete any recommended continuing medical education as determined by the Director of OPMC prior to changing the status from inactive to active and engaging in the active practice of medicine. Respondent shall provide the Director of OPMC with proof of active registration prior to resuming clinical practice."

All remaining Terms and Conditions will continue as written in the Original Order.

The Modification Order to be issued will not constitute a new disciplinary action against me, but will substitute the proposed language for the above described language in the Original Order.

I make this Application of my own free will and accord and not under duress, compulsion or restraint, and seek the anticipated benefit of the requested Modification. In consideration of the value to me of the acceptance of the Board of this Application, I knowingly waive the right to contest the Original Order or the Modification Order for which I apply, either administratively or judicially, and ask that the Board grant this Application.

I understand and agree that the attorney for the Bureau of Professional Medical Conduct, the Director of the Office of Professional Medical Conduct, and the Chair of the State Board for Professional Medical Conduct each retain complete discretion either to enter into the proposed Agreement and Modification 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.

AFFIRMED:

DATED: 3/10/08

Redacted Signature
NANCY E. SANDERSON, M.D.
Respondent

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

DATE: 27 March 2008

Redacted Signature
ROBERT BOGAN
Associate Counsel
Bureau of Professional Medical Conduct

DATE: 3/31/08

Redacted Signature
KEITH W. SERVIS
Director
Office of Professional Medical Conduct

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

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

Dennis P. Whalen
Executive Deputy Commissioner
NYS Department of Health

Dennis J. Graziano, Director
Office of Professional Medical Conduct

Kendrick A. Sears, M.D.
Chairman

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

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

Public

October 14, 2005

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Nancy E. Sanderson, M.D.
Redacted Address

Re: License No. 204084

Dear Dr. Sanderson:

Enclosed is a copy of Order #BPMC 05-221 of the New York State Board for Professional Medical Conduct. This order and any penalty provided therein goes into effect October 21, 2005.

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,

Redacted Signature

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

Enclosure
cc: Mark Dunn, Esq.
Martin, Ganotis, Brown, Mould & Currie, P.C.
5790 Widewaters Parkway
DeWitt, NY 13214

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

IN THE MATTER OF NANCY E. SANDERSON, M.D.	CONSENT ORDER BPMC No. #05-221

Upon the application of (Respondent) NANCY E. SANDERSON, 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 SO ORDERED, and it is further

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

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

Whichever is first.

SO ORDERED.

DATED: 10-13-2005

Redacted Signature
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 NANCY E. SANDERSON, M.D.	CONSENT AGREEMENT AND ORDER

NANCY E. SANDERSON, M.D., representing that all of the following statements are true, deposes and says:

That on or about August 13, 1996, I was licensed to practice as a physician in the State of New York, and issued License No. 204084 by the New York State Education Department.

My current address is Redacted Address, 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 three specifications of professional misconduct.

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

I plead guilty to the factual allegations of paragraphs C. and C.1, E. and E.1 and E. and E.2 of the first specification, in full satisfaction of the charges against me, and agree to the following penalty:

> Pursuant to PHL §230-a (1) a censure and reprimand.
>
> Pursuant to §230-a (9) of the Public Health Law, I shall be placed on probation for a period of three years, 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 not engage in emergency or urgent care medicine without the approval of the Director of OPMC after she obtains a clinical competency assessment performed by a program for such assessment as directed by the Director of OPMC. This condition will remain in effect even after the period of probation is satisfied. Respondent shall cause a written report of such assessment to be provided directly to the Director of OPMC. Respondent shall not resume the practice of any emergency or urgent care medicine until she is granted the written approval by the Director of OPMC, who may impose any conditions he deems necessary.

Respondent shall be responsible for all expenses related to the clinical competency assessment and shall provide to the Director of OPMC proof of full payment of all costs that may be charged. This condition shall not be satisfied in the absence of actual receipt, by the Director, of such documentation. If deficiencies are identified in the report of the competency assessment, at the direction of the Board and within 60 days following the completion of the clinical competency assessment (CCA) the Respondent shall identify a Preceptor, preferably a physician who is board certified in the same specialty, to be approved in writing, by the Director of OPMC.

The Respondent shall cause the Preceptor to:

a. Develop and submit to the Director of OPMC for written approval a remediation plan, which addresses any deficiencies /retraining recommendations identified in the CCA. Additionally, this proposal shall establish a time frame for completion of the remediation program of not less than three months and no longer than twelve months.

b. Submit progress reports at periods identified by OPMC certifying whether the Respondent is fully participating in the personalized continuing medical education program and is making satisfactory progress towards the completion of the approved remediation plan.

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

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

That Respondent shall maintain current registration of licensure with the New York State Education Department Division of Professional Licensing Services (except during periods of actual suspension), and shall pay all registration fees. This condition shall take effect thirty (30) days after the Consent Order's effective date and will continue so long as Respondent remains licensed 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 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 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 Order shall constitute misconduct as defined by New York State Education 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 Public 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 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.

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 ask that the Board adopt this Consent Agreement.

DATED 8/16/05

Redacted Signature
NANCY E. SANDERSON, M.D.
RESPONDENT

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

DATE: 9/15/05

Redacted Signature
MARK L. DUNN, ESQ.
Attorney for Respondent

DATE: 9-26-05

Redacted Signature
LEE A. DAVIS
Assistant Counsel
Bureau of Professional Medical Conduct

DATE: 10/12/2005

Redacted Signature
DENNIS J. GRAZIANO
Director
Office of Professional Medical Conduct

EXHIBIT "A"

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

IN THE MATTER OF NANCY E. SANDERSON, M.D.	STATEMENT OF CHARGES

NANCY E. SANDERSON, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 13, 1996, by the issuance of license number 204084 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine through November 30, 2005, with a practice address of Carthage Area Hospital, 1001 West Street, Carthage, New York 13610.

FACTUAL ALLEGATIONS

A. Respondent provided medical care and treatment to Patient A (patients are identified in Appendix A, attached hereto), a female patient 50 years old when treated with history of hypertension and smoking, on or about February 8, 9 and 11, 1999 in the emergency department at Carthage Area Hospital, Carthage, New York for complaints of left leg pain, blurred vision, headache, and left elbow pain and left-sided weakness associated with a fall. Respondent's care and treatment of Patient A deviated from accepted standards of medical care in the following respects:

1. Respondent failed to perform and/or record an appropriate history of Patient A on February 8, 1999 admission;

2. Respondent failed to perform and/or record an appropriate physical examination of Patient A on February 8, 1999;

3. Respondent failed to perform and/or record an appropriate neurologic examination of Patient A on February 8, 1999;

4. Respondent failed to perform and/or record an appropriate cardiovascular of examination of Patient A on February 8, 1999;

5. Respondent failed to take appropriate medical action in response to Patient A's complaints of headache and blurred vision of the right eye during her visit of February 8, 1999, and/or record what was done in response to said complaints;

6. Respondent failed to detect and/or record the change in Patient A's neurologic presentation from February 8, 1999 to February 9, 1999; and

7. Respondent failed to perform and/or record an appropriate history of Patient A on February 9, 1999 admission;

8. Respondent failed to perform and/or record an appropriate physical examination of Patient A on February 9, 1999;

9. Respondent failed to perform and/or record an appropriate neurologic examination of Patient A on February 9, 1999;

10. Respondent failed to perform and/or record an appropriate cardiovascular of examination of Patient A on February 9, 1999;

11. Respondent failed to consider a possible central nervous system problem during her treatment of Patient A on February 8 and 9, 1999 and or record the central nervous system problem;

12. Respondent inappropriately dictated the medical chart entry of Patient A for her care of February 8, 1999 three days after she provided care to the patient; and

13. Respondent inappropriately dictated the medical chart entry of Patient A for her care of February 9, 1999 two days after she provided care to the patient.

B. Respondent provided medical care and treatment to Patient B, a male patient 26 years old when treated on or about August 11, 2001 in the emergency department at Carthage Area Hospital, Carthage, New York who presented following an ATV rollover accident and sustained left scapular and clavicular fractures, possible T-6 or T-7 vertebrae fractures and possible sternal fracture/dislocation. Respondent's care and treatment of Patient B deviated from accepted standards of medical care in the following respects:

1. Respondent failed to perform and/or record an appropriate history of Patient B;

2. Respondent failed to perform and/or record an appropriate physical examination of Patient B;

2. Respondent inappropriately failed to admit Patient B to the hospital on August 11, 2001 for monitoring of complications from potentially serious trauma in light of the documented fractures; and

3. Respondent inappropriately dictated the medical chart entry of Patient B one day after she provided care to the patient.

C. Respondent provided medical care and treatment to Patient C, a female patient 44 years old when treated on or about January 10, 2000 in the emergency department at Carthage Area Hospital, Carthage, New York with complaints of back and leg pain. Respondent's care and treatment of Patient C deviated from accepted standards of medical care in the following respects:

1. Respondent failed to perform and/or record an appropriate history of Patient C;

2. Respondent failed to perform a musculoskeletal examination of Patient C;

3. Respondent failed to perform a neurological examination of Patient C;

4. Respondent failed to address and/or record addressing the chief complaints expressed by Patient C; and

5. Respondent inappropriately dictated the medical chart entry of Patient C three days after she provided care to the patient.

D. Respondent provided medical care and treatment to Patient D, a male patient 41 years old when treated on or about January 10, 2000 in the emergency department at Carthage Area Hospital, Carthage, New York with a lacerated left finger. Respondent's care and treatment of Patient D deviated from accepted standards of medical care in the following respects:

1. Respondent failed to perform a neurovascular examination; and
2. Respondent failed to determine and/or record whether Patient D required a tetanus shot .

E. Respondent provided medical care and treatment to Patient E, a female patient 37 years old when treated on or about December 4, 2002 in the emergency department at Carthage Area Hospital, Carthage, New York with complaint of left lower quadrant pain. Respondent's care and treatment of Patient E deviated from accepted standards of medical care in the following respects:

1. Respondent failed to perform and/or record an appropriate history of Patient E;
2. Respondent inappropriately failed to perform a rectal examination;
3. Respondent inappropriately failed to perform a pelvic examination;
4. Respondent inappropriately failed to order a microscopic examination of Patient E's urine;
5. Respondent failed to address the elevated white blood cell count of Patient E; and
6. Respondent inappropriately dictated the medical chart entry of Patient E one day after she provided care to the patient.

F. Respondent provided medical care and treatment to Patient F, a female patient 5 months old when treated on or about November 2, 2001 in the emergency department at Carthage Area Hospital, Carthage, New York after falling on her head. Respondent's care and treatment of Patient F deviated from accepted standards of medical care in the following respects:

1. Respondent failed to obtain and/or record an appropriate history of Patient F;
2. Respondent failed to order a "babygram" and skull series radiographs;
3. Respondent failed to perform a neurological examination of Patient F;
4. Respondent inappropriately provided Tylenol to Patient F while the patient was in the emergency department;
5. Respondent failed to observe Patient F for an adequate period;
6. Respondent inappropriately failed to admit Patient F for an overnight observation; and
7. Respondent inappropriately dictated the medical chart entry of Patient F six days after she provided care to the patient.

G. Respondent provided medical care and treatment to Patient G, a female patient 30 years old when treated on or about July 2, 2002 in the emergency department at Carthage Area Hospital, Carthage, New York who presented with vomiting, abdominal pain and vaginal bleeding. Respondent's care and treatment of Patient G deviated from accepted standards of medical care in the following respects:

1. Respondent failed to perform and/or record an appropriate physical examination;
2. Respondent inappropriately diagnosed Patient G with "functional bleeding"; and
3. Respondent inappropriately dictated the medical chart entry of Patient G three days after she provided care to the patient.

H. Respondent provided medical care and treatment to Patient H, a female patient 45 years old when treated on or about September 24, 2002 in the emergency department at Carthage Area Hospital, Carthage, New York who presented with fever and chills. Respondent's care and treatment of Patient H deviated from accepted standards of medical care in the following respects:

1. Respondent failed to perform and/or record an appropriate physical examination;
2. Respondent failed to perform a neurological examination;
3. Respondent failed to address and/or record the abnormal blood analysis listed in the "Final Diagnosis";
3. Respondent's diagnosis of pneumonia was too vague;
4. Respondent failed to admit Patient H given her symptoms and abnormal blood analysis in the absence of a primary care physician to contact; and
5. Respondent failed to prescribe an antibiotic to act against a community-acquired pneumonia.

I. Respondent provided medical care and treatment to Patient I, a male patient 31 years old when treated on or about February 6, 2001 in the emergency department at Carthage Area Hospital, Carthage, New York with facial trauma and lacerations above and below the right eye following a physical altercation. Respondent's care and treatment of Patient I deviated from accepted standards of medical care in the following respects:

1. Respondent failed to perform and/or record an appropriate physical examination of Patient I;
2. Respondent failed to perform and/or record a visual acuity examination of Patient I;
3. Respondent failed to perform and/or record an orbit examination of Patient I;

4. Respondent failed to perform a flouroscein dye study examination of Patient I.

J. Respondent provided medical care and treatment to Patient J, a female patient 19 years old when treated on or about February 9, 2001 in the emergency department at Carthage Area Hospital, Carthage, New York who presented with low back and neck pain following a motor vehicle accident. Respondent's care and treatment of Patient J deviated from accepted standards of medical care in the following respects:

1. Respondent failed to obtain and/or record an appropriate history of Patient J;
2. Respondent failed to perform and/or record an appropriate physical examination of Patient J;
3. Respondent failed to perform and/or record an appropriate neurological examination of Patient J;
4. Respondent failed to perform and/or record a cardiovascular examination of Patient J;
5. Respondent failed to obtain and/or record hemoglobin and hematocrit levels of Patient J;
6. Respondent inappropriately discharged Patient J without adequate provisions for monitoring Patient J; and
7. Respondent failed to obtain and/or record a urine analysis of Patient J.

K. Respondent provided medical care and treatment to Patient K, a female patient 40 years old when treated on or about April 4, 2001 in the emergency department at Carthage Area Hospital, Carthage, New York who presented with diffuse abdominal pain. Respondent's care and treatment of Patient K deviated from accepted standards of medical care in the following respects:

1. Respondent failed elicit and/or record history from Patient E regarding menstruation and pregnancies;

2. Respondent failed to perform a rectal examination; and

3. Respondent failed to perform a pelvic examination.

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 two or more of the following:

1. The facts in paragraphs A. and A.1, A. and A.2, A. and A.3, A. and A.4, B. and B.1, C. and C.1, C. and C.2, D. and D.1, D. and D.2, E. and E.1, E. and E.2, E. and E.3, E. and E.4, E. and E.5, F. And F.1, F. and F.2, F. and F.3, G. and G.1, G. and G.2, H. and H.1, H. and H.2, H. and H.3, I. and I.1, I. and I.2, J. and J.1, J. and J.2, J. and L.3, K. and K.1, K. and K.2, and K. and K.3.

SECOND THROUGH THIRD 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:

2. The facts in Paragraph A. and A.1;and
3. The facts in Paragraph A. and A.4.

DATED: ~~July~~ Sept. 27, 2005
Albany, New York

Redacted Signature
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 New York State Education Law §6530 or §6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to New York State Public Health Law §230(19).

2. Respondent shall maintain current registration of licensure with the New York State Education Department Division of Professional Licensing Services (except during periods of actual suspension), 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 such 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, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty (30) days of each action.

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 section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law section 32].

6. The probation period shall toll when Respondent is not engaged in active medical practice in New York State for a period of thirty (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 thirty (30) day period. Respondent shall then notify the Director again at least fourteen (14) days before returning to active practice. Upon Respondent's return to active practice in New York State, the probation period will resume and Respondent shall fulfill any unfulfilled probation terms.

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 and/or hospital charts; 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.

PRACTICE MONITOR

9. Within thirty days of the effective date of the order, 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.

    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.

10. Respondent shall comply with this Order and all its terms, and shall bear all associated compliance costs. Upon my successful completion of 24 months of probation, I may petition the Director for an early termination of probation and the Director shall exercise reasonable discretion in deciding whether to grant my petition. Upon receiving evidence of noncompliance with, or 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.