STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H. , Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

Public

January 18, 2006

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Moshe Ostad, M.D.
62-59 108th Street
Forest Hills, New York 11375

Wendy A. Stimpfl, Esq.
Rivkin Radler LLP
926 EAB Plaza
Uniondale, New York 11556-0926

Courtney Berry, Esq.
NYS Department of Health
Bureau of Professional
Medical Conduct
90 Church Street – 4th Floor
New York, New York 10007

RE: In the Matter of Moshe Ostad, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 06-008) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:djh

Enclosure

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

COPY

IN THE MATTER

OF

MOSHE OSTAD, M.D.

DETERMINATION

AND

ORDER

BPMC NO. 06-008

LINDA D. LEWIS, M.D., Chairperson, **PAUL F. TWIST, D.O.** and **LAURENCE BRAUNSTEIN, D.P.M.** duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **CHRISTINE C. TRASKOS, ESQ.**, served as Administrative Officer for the Hearing Committee. The Department of Health appeared by **DONALD P. BERENS, Jr.**, General Counsel, **COURTNEY BERRY, ESQ.**, Associate Counsel, of Counsel. The Respondent appeared by **T. LAWRENCE TABAK , ESQ.** and **RIVKIN RADLER, LLP., WENDY A. STIMPFL, ESQ.**, of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee submits this Determination and Order.

STATEMENT OF CHARGES

The accompanying Statement of Charges alleged seven (7) specifications of professional misconduct, including allegations of gross incompetence, negligence, incompetence, making a false report, failure to maintain accurate medical records, fraudulent practice and violating Public Health Law § 2805-k(c) The charges are more specifically set forth in the Statement of Charges dated May 31, 2005, a copy of which is attached hereto as Appendix I and made a part of this Determination and Order. Respondent filed an Answer dated June 15, 2005 and denied all allegations.

SUMMARY OF PROCEEDINGS

Notice of Hearing Date:	May 31, 2005
Pre-Hearing Conference	June 22, 2005
Hearing Dates:	June 29, 2005
	November 7, 2005
Deliberation Date:	December 14, 2005

WITNESSES

For the Petitioner:	Richard Bonforte, M.D. Gilda Cucci, M.D.
For the Respondent:	Moshe Ostad, M.D.

FINDINGS OF FACT

1. Moshe Ostad, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 1, 1972, by the issuance of license number 113669 by the New York State Education Department.

2. Respondent, in his office located in Forest Hills, N.Y., treated Patient A approximately 29 times, from on or about December 1, 1997 until on or about December 9, 2002. (Pet. Ex. 3 and 3A; Resp. Ex. A).

3. Respondent was Patient A's primary care physician. Respondent treated Patient A for both well-child and acute visits. (Pet. Ex.3; 3A; T. pp. 33-34; 239-240).

4. Respondent made numerous diagnoses of bilateral otitis media, and bronchitis with respect to Patient A. (Pet. Ex. 3; 3A; T. pp. 34-36).

5. Respondent often diagnosed Patient A without a history or physical findings to support the diagnosis. He then prescribed antibiotics to the patient. Respondent claimed that his medical judgment justified his actions. (Pet. Ex. 3 and 3A; T. pp. 39-42;44;62; 69; 243-244; 245-247; 250-254).

6. Respondent inappropriately prescribed antibiotics and other medication to Patient A. (T. pp. 61-62; 67-72).

7. Respondent diagnosed Patient A with pharyngitis and prescribed antibiotics without first taking a throat culture. (Pet. Ex. 3 and 3A; T. pp. 45-46; 247-250). The minimum standard of care dictates that a physician take a throat culture prior to prescribing antibiotics for pharyngitis. (Pet. Ex. 3 and 3A; T. pp. 68-70).

8. Respondent maintained that his medical judgment allowed him to prescribe antibiotics without taking a throat culture and he provided alternate justifications for not taking throat cultures (T. p. 248-254).

9. On numerous occasions, Respondent diagnosed viral syndrome and then prescribed antibiotics to Patient A, which was inappropriate. (Pet. Ex. 3 and 3A).

10. Respondent failed to adequately document Patient A's clinical condition. The information provided is inadequate; there is a lack of histories and the diagnoses and treatments were not consistent with the history and physical of the patient. (Pet. Ex. 3 and 3A; T. pp. 42-44). Respondent admitted during his testimony that he did not document everything with respect to Patient A. (T. pp. 243; 246). Respondent's medical record for Patient A did not meet minimally accepted medical standards. (T. pp. 42-44).

11. Respondent, in his office located in Forest Hills, N.Y., treated Patient B approximately 70 times, from on or about October 18, 1993, until on or about June 12, 2002. (Ex. 4 and 4A; Resp. Ex. A).

12. Respondent was Patient B's primary care physician. Respondent treated Patient B for both well-child and acute visits. (Pet. Ex.4; 4A; T. pp.73; 257).

13. Respondent made numerous diagnoses of bilateral otitis media, viral syndrome and bronchitis with respect to Patient B. (Pet. Ex. 4; 4A; T. pp.75-76).

14. Respondent often diagnosed Patient B without a history or physical findings to support the diagnosis. He then prescribed antibiotics to the patient. Respondent claimed that his medical judgment justified his actions. This is a deviation from the minimum standard of care. (Pet. Ex. 4 and 4A; T. pp. 77;79-80; 82-84; 89-91;273-279;).

15. Respondent inappropriately prescribed antibiotics and other medication to Patient B. (Pet. Ex. 4 and 4A; T. pp.79-81; 83-84).

16. Respondent diagnosed Patient B with pharyngitis and prescribed antibiotics without first taking a throat culture. (Pet. Ex. 4 and 4A; T. pp.85-89; 279-80). The minimum standard of care dictates that a physician take a throat culture prior to prescribing antibiotics for pharyngitis. (Pet. Ex. 4 and 4A; T. pp. 86-90).

17. Respondent maintained that his medical judgment dictated that he prescribe antibiotics without taking a throat culture and provided alternate justifications for not taking throat cultures (T. p. 280).

18. Respondent prescribed antibiotics for Patient B 11 times when he had documented a normal exam. (Pet. Ex. 4 and 4A).

19. Respondent's medical record for Patient B did not meet minimally accepted medical standards, in that Respondent failed to adequately document Patient B's clinical condition. The information provided is inadequate; there is a lack of histories and the diagnoses and treatments were not consistent with the history and physical of the patient. (Pet. Ex. 4 and 4A; T. pp. 89-90;97; 98-99)., Respondent admitted that he did not document everything with respect to Patient B. (T. pp. 172; 270-71; 276-279).

20. Respondent, in his office located in Forest Hills N.Y., treated Patient C approximately 45 times, from on or about January 16,1995, until on or about September 18, 2002. (Pet. Ex. 5 and 5A; Resp. Ex. A).

21. Respondent was Patient C's primary care physician. Respondent treated Patient C for both well-child and acute visits. (Pet. Ex.5 and 5A; T. pp.105; 281).

22. Respondent made numerous diagnoses of otitis media, viral syndrome pharyngitis, and bronchitis with respect to Patient C. (Pet. Ex. 5 and 5A; T. p.106).

23. Respondent diagnosed Patient C without a history or physical findings to support the diagnosis. He then prescribed antibiotics to the patient. Respondent claimed that his medical judgment justified his actions. This is a deviation from the minimum standard of care. (Pet. Ex. 5 and 5A; T. pp.114-116; 295-302).

24. Respondent diagnosed Patient C with pharyngitis and prescribed antibiotics without first taking a throat culture. (Pet. Ex.5 and 5A; T. pp.107-115; 288; 292-293; 295; 300-302). The minimum standard of care dictates that a physician take a throat culture prior to prescribing antibiotics for pharyngitis. (Pet. Ex. 5 and 5A; T. pp. 108; 110-113;115).

25. Respondent maintained that his medical judgment dictated that he prescribe antibiotics without taking a throat culture and provided alternate justifications for not taking throat cultures (T. pp. 288-294).

26. Respondent often prescribed erythromycin to Patient C. If the patient has strep throat then, Erythromycin is not the drug of choice, due in part to its side effects. The recommended antibiotic is penicillin, unless the patient is allergic. (T. pp. 90; 109)

27. There is no documentation in the records that Patient C had a penicillin allergy. (Pet. Ex. 5 and 5A) .

28. Respondent's medical record for Patient C did not meet minimally accepted medical standards, in that Respondent failed to adequately document Patient C's clinical condition. The information provided is inadequate; there is a lack of histories and the diagnoses and treatments were not consistent with the history and physical of the patient. (Pet. Ex. 5 and 5A; T. pp. 120-123; 295-297).

29. Respondent, in his office located in Forest Hills, N.Y., treated Patient D approximately 40 times, from on or about April 1998, until on or about May 2003. (Pet. Ex. 6 and 6A; Resp. Ex. A).

30. Respondent was Patient D's primary care physician. Respondent treated Patient D for both well-child and acute visits. (Pet. Ex.6 and 6A; T. pp.127; 303).

31. Respondent made numerous diagnoses of bilateral otitis media, viral syndrome, pharyngitis, asthma, broncho spasm and bronchitis with respect to Patient D. (Pet. Ex. 6 and 6A; T. pp. 127-128).

32. Respondent diagnosed Patient D without history or physical findings to support the diagnosis. He then prescribed antibiotics to the patient. Respondent claimed that his medical judgment justified his actions. This is a deviation from the minimum standard of care. (Pet. Ex. 6 and 6A; T.129-130; 132-133; 321-325).

33. Respondent inappropriately prescribed antibiotics on several occasions to Patient D. (T. pp. 90; 109;126-127;130-131; 312).

34. Respondent's medical record for Patient D did not meet minimally accepted medical standards, in that Respondent failed to adequately document Patient D's clinical

condition. The information provided is inadequate; there is a lack of histories and the diagnoses and treatments were not consistent with the history and physical of the patient (Pet. Ex. 6 and 6A; T. pp. 132-134;). Respondent admitted that he did not document everything with respect to Patient D. (T. p. 336).

35. On August 18, 2004, Respondent was interviewed by Dr. Gilda Cucci, a Medical Coordinator from the Office of Professional Medical Conduct (O.P.M.C.). The interview was with respect to Patients A, B, C, and D. (T. p. 156.).

36. During his O.P.M.C. interview, Respondent maintained that he can diagnose in the absence of findings, based on his many years of clinical practice. (T. pp. 168-169, 293-294).

37. Respondent stated during the interview with Dr. Cucci that he prescribed Erythromycin because it is a cheap drug that saves Medicaid money. (T. pp.170-171).

38. Respondent admitted that he prescribes antibiotics for viral syndromes because parents demanded it. Respondent further stated that they just "want to get the medicine and go. " (T. 295) Otherwise, they would go elsewhere. (T. pp.169-170;253-4).

39. Respondent maintained that he did not need to perform throat cultures because "all red throats are strep throats." (T. pp. 171, 248-249).

40. Respondent admitted that his medical records were incomplete; he asserted to Dr. Cucci that "it is easy to criticize what is on the paper, but what is on the paper is not everything I do." (T. p. 172, 277-278).

41. On or about October 12, 2001, a disciplinary hearing was commenced against Respondent before the New York State Board for Professional Medical Conduct. The testimony concluded on November 27, 2001. (Resp. Ex. A.).

42. On or about November 16, 2001, Respondent completed an application for reappointment to the medical staff at North Shore University Hospital at Forest Hills. (Pet. Ex. 7; Resp. Ex. A).

43. Respondent answered "No" in response to the question: "Are there presently or have there ever been any professional medical or dental misconduct proceeding in this state or any other state concerning your professional practice?". (Pet. Ex. 7; Resp. Ex. A).

44. This answer was false and deceptive. (Resp. Ex. A).

CONCLUSIONS OF LAW

Respondent is charged with seven (7) specifications alleging professional misconduct within the meaning of Education Law § 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but do not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested

definitions for gross negligence, negligence, gross incompetence, incompetence and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Gross incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine.

Fraudulent practice is the intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine. The Hearing Committee must find that (1) a false representation was made by the licensee, whether by words, conduct or concealment of that which should have been disclosed, (2) the licensee knew the representation was false, and (3) the licensee intended to mislead through the false representation. The licensee's knowledge and intent may properly be inferred from facts found by the Hearing Committee, but the Committee must specifically state the inferences it is drawing regarding knowledge and intent.

Using the above-referenced definition as a framework for its deliberations, the Hearing Committee concluded, by a preponderance of the evidence, that all seven (7) specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset of deliberations, the Hearing Committee made a determination as to the credibility of various witnesses presented by the parties. Richard Bonforte, M.D., testified for the Department. Dr. Bonforte is a board certified pediatrician who is presently the senior vice president for medical affairs at Jersey City Medical Center and the vice-president and chairman of the Department of Pediatrics. Dr. Bonforte is also a full professor of pediatrics at Mt. Sinai School of Medicine. (Pet. Ex.8 ; T. 18-20) The Hearing Committee found Dr.Bonforte to be an experienced physician and credible witness, who testified in a straightforward, methodical manner. Gilda Cucci, M.D. also testified for the Department. Dr. Cucci is board certified in pediatrics and is employed by the Department of Health as a pediatric medical coordinator and supervisor of an investigative unit. (T. 151) The Hearing Committee found Dr Cucci to be a credible witness who held up under cross-examination.

Respondent took the stand on his own behalf. The Hearing Committee found that Respondent was in total denial and had no concept of what was wrong with the care he provided. The Hearing Committee totally rejects Respondent's rationale that he used his best judgment to prescribe antibiotics to poor immigrant families who do not have telephones. He alleged that they might not come back to his office and if it is at night, "they want to get the medicine and go." (T. 248, 295) The Hearing Committee found Respondent's overall testimony as not credible.

GROSS INCOMPETENCE

Factual Allegations A, B, C and D and their subparagraphs : SUSTAINED

For all four patients, the Hearing Committee finds that Respondent demonstrated a complete lack of skill in looking in the tympanic membrane or auscultation of the chest. They note that he recorded "chest clear" in the patients' chart but then prescribed medication as if they were sick. By his own admission he stated that he prescribed these drugs not out of medical necessity, but because the parents wanted them.

NEGLIGENCE ON MORE THAN ONE OCCASION

Factual Allegations : A, B, C. and D and their subparagraphs : SUSTAINED

The Hearing Committee sustains all charges of negligence against Respondent because they concur with Dr. Bonforte that Respondent's care of these patients was below the standard of care and that he prescribed antibiotics without medical justification.

INCOMPETENCE ON MORE THAN ONE OCCASION

Factual Allegations: A, B, C, and D and their subparagraphs : SUSTAINED

The Hearing Committee sustains incompetence because Respondent believes that he has the requisite skill but he robotically treats these patients in the same fashion, even when their exams were normal.

FAILURE TO MAINTAIN RECORDS

Factual Allegations: A, B, C, and D and their subparagraphs : SUSTAINED

The Hearing Committee finds that Respondent's records were inadequate and note that he repeatedly acknowledged that his records were poor and that it did not matter because he relied upon his clinical judgment . (T. 302)

FALSE REPORT

Factual Allegations : E and its subparagraphs: SUSTAINED

The Hearing Committee sustains this charge because they find that Respondent lied on his application for reappointment to the medical staff at North Shore University Hospital because he knew on that date that he was under investigation and in the midst of a professional medical conduct disciplinary hearing.

FRAUDULENT PRACTICE

Factual Allegations E and its subparagraphs : SUSTAINED

The Hearing Committee finds that Respondent intentionally concealed the fact that he had been investigated by and was involved in a disciplinary hearing with the Board of Professional Medical Conduct at the time of his hospital re-appointment application.

VIOLATION OF PHL § 2805k(c)

Factual Allegations E and E.1: SUSTAINED

The Hearing Committee finds that Respondent violated the above statute because he failed to provide North Shore University Hospital any information regarding the pending professional medical misconduct proceeding on his re-appointment application.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above determined by a unanimous vote that Respondent's license to practice medicine in New York State should be revoked. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, the imposition of monetary penalties and dismissal in the interests of justice.

The Hearing Committee voted for revocation because they found a clear pattern where on innumerable occasions Respondent failed to perform a complete physical, failed to document any disease, yet he prescribed antibiotics anyway. They believe that he was "overly seeing" patients with known chronic problems. Respondent exhibited no contrition for his actions. He lacked insight and does not perceive that the treatment he provided was wrong. Respondent sadly believes that he is providing good service to the poor immigrant community. The Hearing Committee believes that physicians should not practice poor medicine just because they are treating the poor. The Hearing Committee concludes that Respondent is providing a disservice to the community and that his license should be revoked. Under the totality of the circumstances, the Hearing Committee concludes that this penalty is commensurate with the level and nature of Respondent's professional misconduct.

ORDER

Based upon the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The First through Seventh of the Specifications of Professional Misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit #1)

   are **SUSTAINED**; and

2. Respondent's license to practice medicine in New York State be and hereby is **REVOKED**; and

3. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: New York, New York

January 16, 2006

LINDA D. LEWIS, M.D.

(Chairperson)

PAUL F. TWIST, D.O.

LAURENCE BRAUNSTEIN, D.P.M.

TO: Courtney Berry Esq.
Associate Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
90 Church Street- 4th Floor
New York, NY 10007

Wendy A. Stimpfl, Esq.
Rivkin Radler LLP
926 EAB Plaza
Uniondale, NY 11556-0926

Moshe Ostad, M.D.
62-59 108th Street
Forest Hills, New York 11375

APPENDIX I

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

IN THE MATTER

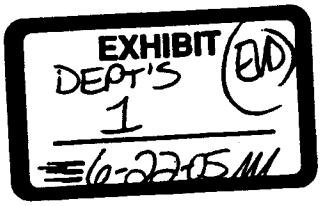
OF

Moshe Ostad, M.D.

NOTICE

OF

HEARING



TO: Moshe Ostad, M.D.
62-59 108th Street
Forest Hills, NY 11375

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on June 29, 2005, at 10:00 a.m., at the Offices of the New York State Department of Health, 90 Church Street, 4th Floor, New York, N.Y. 10007, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. SEAN D. O'BRIEN, DIRECTOR, BUREAU OF

ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A

DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
May 31 ,2005

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Courtney Berry
Associate Counsel
Bureau of Professional Medical Conduct
90 Church Street, 4th Floor
New York, N.Y. 10007
(212) 417-4450

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

IN THE MATTER
OF
Moshe Ostad, M.D.

STATEMENT
OF
CHARGES

Moshe Ostad, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 1, 1972, by the issuance of license number 113669 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent, in his office located in Forest Hills, N.Y., treated Patient A approximately 29 times, from on or about December 1, 1997, until on or about December 9, 2002.

1. Respondent failed to appropriately evaluate, diagnose and treat Patient A.
2. Respondent inappropriately prescribed medication for Patient A.
3. Respondent failed to adequately document Patient A's clinical condition.

B. Respondent, in his office located in Forest Hills, N.Y., treated Patient B approximately 70 times, from on or about October 18, 1993, until on or about June 12, 2002.

1. Respondent failed to appropriately evaluate, diagnose and treat Patient B.
2. Respondent inappropriately prescribed medication for Patient B.
3. Respondent failed to adequately document Patient B's clinical condition.

C. Respondent, in his office located in Forest Hills, N.Y., treated Patient C approximately 45 times, from on or about January 16,1995, until on or about

September 18, 2002.

1. Respondent failed to appropriately evaluate, diagnose and treat Patient C.
2. Respondent inappropriately prescribed medication for Patient C.
3. Respondent failed to adequately document Patient C's clinical condition.

D. Respondent, in his office located in Forest Hills, N.Y., treated Patient D approximately 40 times, from on or about April 3, 1998, until on or about May 27, 2003.

1. Respondent failed to appropriately evaluate, diagnose and treat Patient D.
2. Respondent inappropriately prescribed medication for Patient D.
3. Respondent failed to adequately document Patient D's clinical condition.

E. On or about October 12, 2001, a disciplinary hearing was commenced against Respondent before the New York State Board for Professional Medical Conduct.. The testimony concluded on November 27, 2001. On or about November 16, 2001, Respondent completed an application for reappointment to the medical staff at North Shore University Hospital at Forest Hills.

1. Respondent answered "No" in response to the question: "Are there presently or have there ever been any professional medical or dental misconduct proceeding in this state or any other state concerning your professional practice?".
2. Respondent did so knowingly and with intent to deceive.

SPECIFICATION OF CHARGES

FIRST 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:

1. Paragraphs A, B, C, and D and their subparagraphs.

SECOND 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:

2. Paragraphs A, B, C, and D and their subparagraphs.

THIRD 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:

3. Paragraphs A, B, C and D and their subparagraphs.

FOURTH 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:

4. Paragraphs A, B, C and D and their subparagraphs.

FIFTH SPECIFICATION

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21) by wilfully 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:

5. Paragraph E and its subparagraphs.

SIXTH SPECIFICATION

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:

6. Paragraph E and its subparagraphs.

SEVENTH SPECIFICATION

VIOLATION OF PUBLIC HEALTH LAW §2805(k)

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(14) by violating Public Health Law §2805-k(c), as alleged in the facts of:

7. Paragraph E and E1.

1.

DATED: May 31, 2005
New York, New York

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

AFFIDAVIT OF ATTEMPTED SERVICE OF
NOTICE OF HEARING:
STATEMENT OF CHARGES

NEW YORK STATE DEPT. OF HEALTH

PLAINTIFF

IN RE: MOSHE OSTAD M.D.

-against-

DEFENDANT

STATE OF NEW YORK)
COUNTY OF NEW YORK) SS:

ROBERT RAMSEY being duly sworn, deposes and says that deponent is not a party to this action, is over the age of 18 years and resides in the State of New York.

That on the 9th day of June 2005, deponent attempted to serve the within NOTICE OFHEAR ING: STATEMENT OF CHARGES in the above entitled action upon MOSHE OSTAD M.D. the defendant at at 62-59 108th Street, FOrest Hills, New YOrk

On Calling There:

On June 1, 2005 at about 10:30 am
On June 7, 2005, at 5:15 PM
On June 9, 2005, at about 12:45 PM

On the dates and times above stated, deponent attempted to serve the NOtice of Hearing and Statement of Charge supon MOSHE OSTAD,MD., at 62-59 108th Street, Forest Hills, New YOrk, but on all attempts to serve the said MOSHE OSTAD M.D. he was not in.

Sworn to before me this 10th day of June 2005

SANDRA FARR
Notary Public, State o
No. 01FA478
Qualified in Nas
Commission Expire

ROBERT RAMSEY 871 312

SANDRA FARRON
Notary Public, State of New York
No. 01FA4784241
Qualified in Nassau County
Commission Expires Sept 30, 2005