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

Public

August 10, 2006

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Syed A. Farooq, M.D.
28 Halston Parkway
East Amherst, NY 14051

Re: License No. 129137

Dear Dr. Farooq:

Enclosed is a copy of Order #BPMC 06-186 of the New York State Board for Professional Medical Conduct. This order and any penalty provided therein goes into effect August 17, 2006.

If the penalty imposed by this Order is a surrender, revocation or suspension, you are required to deliver your license and registration within five (5) days of receipt of this Order to the Board for Professional Medical Conduct, New York State Department of Health, 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: Richard A. Dollinger, Esq.
Underberg & Kessler
300 Bausch & Lomb Place
Rochester, NY 14604

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

IN THE MATTER

OF

SYED A. FAROOQ, M.D.

CONSENT

ORDER

BPMC No. #06-186

Upon the application of Syed A. Farooq, M.D. in the attached Consent Agreement and Order, which is made a part of this Consent Order, it is

ORDERED, that the Consent Agreement, and its terms, are adopted and it is further

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

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

SO ORDERED.

DATE: 8-8-06

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

SYED A. FAROOQ, M.D.

CONSENT AGREEMENT AND ORDER

Syed A. Farooq, M.D., representing that all of the following statements are true, deposes and says:

That on or about October 29, 1976, I was licensed to practice as a physician in the State of New York, and issued License No. 129137 by the New York State Education Department.

My current address is 28 Halston Parkway, East Amherst, New York 14051, and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

I understand that the New York State Board for Professional Medical Conduct (Board) has charged me with twenty-three specifications of professional misconduct. Five days of hearing have been conducted before a Hearing Committee of the State Board for Professional Medical Conduct.

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

I plead no contest to the thirteenth specification, in full satisfaction of the charges against me, and agree to the following penalty:

> My license to practice medicine shall be limited, pursuant to §230-a of the Public Health Law, to preclude patient contact and any practice of medicine, clinical or otherwise. I shall be precluded from diagnosing, treating, operating, or prescribing for any human disease, pain, injury, deformity, or physical condition. The limitation of my license as imposed herein shall preclude any assertion of

exemption from the requirements of licensure, certification or otherwise of any other profession licensed, regulated, or certified by the Board of Regents, Department of Education, Department of Health or Department of State.

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

- That Respondent shall, within thirty days of the issuance of the Consent Order, notify the New York State Education Department, Division of Professional Licensing Services, that Respondent's license status is "inactive," and shall provide proof of such notification to the Director of OPMC within thirty days thereafter; and
- That Respondent shall return any and all official New York State prescriptions to the Bureau of Narcotic Enforcement, and shall surrender Respondent's Controlled Substance Registration Certificate to the United States Department of Justice, Drug Enforcement Administration, within 15 days of the effective date of this Order. Further, within thirty days of returning said prescriptions and surrendering said registration, Respondent shall provide documentary proof of such transaction(s) to the Director of OPMC; and

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

That Respondent shall cooperate fully with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Consent Order and in its investigations of matters concerning Respondent. Respondent shall respond in a timely manner to all OPMC requests for written periodic verification of Respondent's

compliance with this Consent Order. Respondent shall meet with a person designated by the Director of OPMC, as directed. Respondent shall respond promptly and provide all documents and information within Respondent's control, as directed. This condition shall take effect upon the Board's issuance of the Consent Order and will continue so long as Respondent remains licensed in New York State; and

Respondent shall comply with all conditions set forth in attached Exhibit "B" ("Guidelines for Closing a Medical Practice") which is attached.

I stipulate that my failure to comply with any conditions of this Consent Order shall constitute misconduct as defined by N.Y. Educ. Law § 6530(29).

I agree that, if I am charged with professional misconduct in future, this Consent Agreement and Order **shall** be admitted into evidence in that proceeding.

I ask the Board to adopt this Consent Agreement.

I understand that if the Board does not adopt this Consent Agreement, none of its terms shall bind me or constitute an admission of any of the acts of alleged misconduct; this Consent Agreement shall not be used against me in any way and shall be kept in strict confidence; and the Board's denial shall be without prejudice to the pending disciplinary proceeding and the Board's final determination pursuant to N.Y. Pub. Health Law.

I agree that, if the Board adopts this Consent Agreement, the Chair of the Board shall issue a Consent Order in accordance with its terms. I agree that this Consent Order shall take effect upon its issuance by the Board, either by mailing of a copy of the Consent Order by first class mail to me at the address in this Consent Agreement, or to my attorney by certified mail, OR upon facsimile transmission to me or my attorney, whichever is first. The Order, this agreement,

and all attached Exhibits shall be public documents, with only patient identities, if any, redacted. As public documents, they may be posted on the Department's website.

I stipulate that the proposed sanction and Order are authorized by N.Y. Pub. Health Law §§ 230 and 230-a, and that the Board for Professional Medical Conduct and the Office of Professional Medical Conduct have the requisite powers to carry out all included terms. I ask the Board to adopt this Consent Agreement of my own free will and not under duress, compulsion or restraint. In consideration of the value to me of the Board's adoption of this Consent Agreement, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive my right to contest the Consent Order for which I apply, whether administratively or judicially, I agree to be bound by the Consent Order, and ask that the Board adopt this Consent Agreement.

I am aware and agree that regardless of prior communication, the attorney for the Department, the Director of the Office of Professional Medical Conduct, and the Chairperson of the State Board for Professional Medical Conduct each reserve full discretion to enter into the agreement which I propose and this application which I submit, or to decline to do so.

DATE 7/18/06

SYED A. FAROOQ, M.D.
RESPONDENT

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

DATE: 7/18/06

RICHARD A. DOLLINGER, ESQ.
Underberg & Kessler
Attorneys for Respondent

DATE: 7/19/06

TIMOTHY J. MAHAR
Associate Counsel
Bureau of Professional Medical Conduct

DATE: 27 July 2006

DENNIS J. GRAZIANO
Director
Office of Professional Medical Conduct

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

EXHIBIT A

IN THE MATTER

OF

SYED A. FAROOQ, M.D.

STATEMENT

OF

CHARGES

Syed Farooq, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 29, 1976, by the issuance of license number 129137 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A at his office during the period from November 16, 1998 through October 29, 2003 for hypertension and heart disease, among other conditions. Respondent's care of Patient A deviated from accepted standards of medical care as follows:

1. Respondent failed to appropriately and/or adequately manage Patient A's treatment for hypertension.
2. Respondent failed at various times to adequately evaluate Patient A for the development of bradycardia.
3. Respondent failed to adequately evaluate Patient A for complications of hypertension and/or symptoms of heart disease.
4. Respondent failed at various times to obtain an adequate history from Patient A.
5. Respondent failed to adequately evaluate Patient A's heart function prior to prescribing digoxin.
6. Respondent failed to adequately monitor Patient A's digoxin and/or potassium levels.

7. Respondent failed to maintain an adequate and/or accurate medical record for Patient A.

B. Respondent provided medical care to Patient B in his office during the period from March 25, 2002 through September 17, 2003 for respiratory infections and rheumatoid arthritis, among other conditions. Respondent's care of Patient B deviated from accepted standards of medical care as follows:

1. Respondent failed to obtain an adequate medical history from Patient B.
2. Respondent failed at various times to perform an adequate physical examination on Patient B.
3. Respondent failed to order appropriate and/or timely diagnostic testing for Patient B and/or, in the alternative, failed to order a timely referral to a medical specialist.
4. Respondent failed to appropriately manage Patient B's treatment and/or in the alternative, Respondent failed to timely order a referral of Patient B to a medical specialist.
5. Respondent failed to appropriately diagnose Patient B's rheumatoid arthritis.
6. Respondent failed to maintain an adequate and/or accurate medical record for Patient B.

C. Respondent provided medical care to Patient C at his office during the period from June 3, 2002 through May 12, 2003 for heart disease and hyper-lipidemia, among other conditions. Respondent's care of Patient C deviated from accepted standards of medical care as follows:

1. Respondent at various times failed to obtain an adequate medical history from Patient C.
2. Respondent failed to perform an adequate physical examination of Patient C.
3. Respondent failed to adequately evaluate Patient C for rheumatoid arthritis.
4. Respondent failed to adequately treat Patient C for rheumatoid arthritis and/or to refer Patient C for a consultation with a rheumatologist.
5. Respondent failed to adequately and/or timely evaluate Patient C's lipid levels.
6. Respondent failed to adequately and/or timely evaluate Patient C's renal function and/or electrolyte levels.
7. Respondent failed to recommend lifestyle changes to Patient C and/or to document any such recommendations.
8. Respondent failed to maintain an adequate and/or accurate medical record for Patient C.

D. Respondent provided medical care to Patient D from July 8, 1998 through August 25, 2003 at his office for hypertension and heart disease, among other conditions. Respondent's care of Patient D deviated from accepted standards of medical care as follows:

1. Respondent failed on various occasions to adequately evaluate Patient D for hypertension and/or it's complications
2. Respondent failed to adequately evaluate and/or treat Patient D's arteriosclerotic heart disease.

3. Respondent failed to adequately evaluate Patient D's erectile dysfunction by history and/or by physical examination and/or by indicated diagnostic testing.
4. Respondent failed to maintain an adequate and/or accurate medical record for Patient D.

E. Respondent provided medical care to Patient E at his office from June 14, 1999 through June 16, 2003 for neck and back pain, and for depression, among other conditions. Respondent's care of Patient E deviated from accepted standards of care as follows:

1. Respondent failed at various times to obtain an adequate medical history from Patient E for depression and/or anxiety and/or insomnia.
2. Respondent failed at various times to perform an adequate physical examination on Patient E.
3. Respondent failed to order indicated diagnostic testing for Patient E.
4. Respondent failed to adequately manage and/or evaluate Patient E's treatment for depression and/or anxiety and/or insomnia.
5. Respondent failed to obtain from Patient E an adequate medical history for complaints of arm and leg weakness and/or neck and back pain.
6. Respondent failed to perform an adequate physical examination for Patient E's arm and leg weakness, and/or neck and back pain.
7. Respondent failed to order indicated diagnostic tests for Patient E's arm and leg weakness and/or neck and back pain and/or failed to refer Patient E to a medical specialist.
8. Respondent failed to appropriately manage Patient E's treatment for neck and back pain and/or leg and arm weakness.

9. Respondent failed to obtain from Patient E an adequate history of abdominal symptoms.
10. Respondent failed to perform an adequate physical examination of Patient E for abdominal symptoms
11. Respondent failed to order indicated diagnostic tests for Patient E's abdominal symptoms.
12. Respondent failed to appropriately treat Patient E's gastroesophageal reflux disease.
13. Respondent failed to obtain from Patient E an adequate medical history of chest pain.
14. Respondent failed to perform an adequate physical examination on Patient E for complaints of chest pain and/or palpitations.
15. Respondent failed to order indicated diagnostic testing for Patient E.
16. Respondent failed to maintain an adequate and/or accurate medical record for Patient E.

F. Respondent provided medical care to Patient F at his office from October 28, 1998 through October 29, 2003 for hypertension, hyperlipedemia, joint and back pain and urinary obstructive symptoms, among other conditions. Respondent's care of Patient F deviated from accepted standards of medical care as follows:

1. Respondent failed to obtain from Patient F an adequate medical history of his joint and back pain:
2. Respondent failed to perform an adequate physical examination of Patient F's joint and back pain.
3. Respondent failed to order indicated diagnostic testing for Patient F.

4. Respondent failed to adequately manage Patient F's treatment for joint and back pain.
5. Respondent failed to obtain from Patient F an adequate medical history of urinary obstructive symptoms.
6. Respondent failed to perform an adequate and/or a timely physical examination of Patient F's urinary obstructive symptoms.
7. Respondent failed to maintain an adequate and/or accurate medical record for Patient F.

G. Respondent provided medical care to Patient G at his office from February 27, 2002 through October 29, 2003 for heart disease; rheumatoid arthritis and gastroesophageal reflux disease, among other conditions. Respondent's care of Patient G deviated from accepted standards of care as follows:

1. Respondent failed to order indicated diagnostic testing in the evaluation of Patient G's hypertension and/or it's complications.
2. Respondent failed to obtain an adequate medical history from Patient G relating to her complaints of chest pain and/or dyspnea or exertion.
3. Respondent failed to order indicated diagnostic testing in circumstances in which Patient G was suspected to have arteriosclerotic heart disease.
4. Respondent made a diagnosis of arteriosclerotic heart disease in Patient G without adequate medical indication and/or without adequate supporting findings.

5. Respondent failed to obtain an adequate medical history from Patient G concerning his joint and neck pain, and/or arm numbness or weakness.
6. Respondent failed to perform an adequate physical examination of Patient G for joint and neck pain and/or arm numbness or weakness.
7. Respondent failed to properly diagnose rheumatoid arthritis in Patient G and/or failed to provide the appropriate treatment for rheumatoid arthritis.
8. Respondent failed to maintain for Patient G an adequate and/or accurate medical record.

H. Respondent provided medical care to Patient H at his office from February 9, 1999 through February 18, 2003, for viral and bacterial infections. Respondent's care of Patient H deviated from accepted standards of medical care as follows:

1. Respondent prescribed antibiotics and/or anti-viral and/or anti-motility medications to Patient H at various times without adequate medical indications.
2. Respondent failed to adequately evaluate Patient H on February 6, 1999 when Patient H telephoned Respondent's office with complaints of fever, chills, nausea, vomiting and diarrhea, among other things.
3. Respondent prescribed for Patient H an anti-viral medication and at the same time prescribed an antibiotic medication contrary to accepted standards of medical care.
4. Respondent failed to obtain an adequate medical history from Patient H as to respiratory symptoms.

5. Respondent failed to adequately evaluate Patient H's respiratory condition.
6. Respondent failed to obtain an adequate medical history from Patient H for gastro-intestinal symptoms.
7. Respondent failed to maintain an adequate and/or accurate medical record for Patient H.

I. Respondent provided medical care to Patient I at his office from April 26, 1999 through November 17, 2003 for allergies and upper respiratory infections. Respondent's care of Patient I deviated from accepted standards of medical care as follows:

1. Respondent failed to obtain an adequate medical history from Patient I relating to her allergy symptoms.
2. Respondent failed to adequately evaluate and/or treat Patient I's allergies and/or failed to refer her to a medical specialist.
3. Respondent failed to adequately evaluate Patient I by history and/or physical examination to diagnose a bacterial infection.
4. Respondent failed to order indicated diagnostic testing of Patient I in the evaluation of chest pain.
5. Respondent failed to properly prescribe Atenolol to Patient I.
6. Respondent failed to order indicated diagnostic testing of Patient I for heart palpitations.
7. Respondent diagnosed vitamin B-12 deficiency in Patient I and/or ordered vitamin B-12 without adequate medical indications.
8. Respondent failed to adequately evaluate Patient I by medical history and/or physical examination.

9. Respondent prescribed thyroid extract to Patient I without conducting an adequate evaluation by medical history and/or physical examination and/or diagnostic testing of thyroid function.

10. Respondent failed to maintain an adequate and/or accurate medical record for Patient I.

SPECIFICATION OF CHARGES

FIRST THROUGH SIXTH 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 following:

1. The facts set forth in the following paragraph: A and A.3.
2. The facts set forth in the following paragraph: A and A.4.
3. The facts set forth in the following paragraph: A and A.5.
4. The facts set forth in the following paragraph: C and C.1.
5. The facts set forth in the following paragraph: D and D.2.
6. The facts set forth in the following paragraph: F and F.6.

SEVENTH THROUGH TWELFTH 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 following:

7. The facts set forth in the following paragraph: A and A.3.
8. The facts set forth in the following paragraph: A and A.4.
9. The facts set forth in the following paragraph: A and A.5.
10. The facts set forth in the following paragraph: C and C.1.
11. The facts set forth in the following paragraph: D and D.2.
12. The facts set forth in the following paragraph: F and F.6.

THIRTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law § 6530(3) by reason of his having practiced medicine with negligence on more than one occasion, in that Petitioner charges:

13. The facts set forth in two or more of the following paragraphs: A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, D and D.1, D and D.2, D and D.3, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, E and E.10, E and E.11, E and E.12, E and E.13, E and E.14, E and E.15, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, G and G.7, H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, H and H.6, I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6, I and I.7, I and I.8 and/or I and I.9.

FOURTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law § 6530(5) by reason of his having practiced medicine with incompetence on more than one occasion, in that Petitioner charges:

14. The facts set forth in two or more of the following paragraphs: A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, D and D.1, D and D.2, D and D.3, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, E and E.10, E and E.11, E and E.12, E and E.13, E and E.14, E and E.15, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, G and G.7, H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, H and H.6, I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6, I and I.7, I and I.8, and/or I and I.9.

FIFTEENTH THROUGH TWENTY-THIRD SPECIFICATIONS

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, in that Petitioner charges:

15. The facts set forth in the following paragraphs: A and A.7.
16. The facts set forth in the following paragraphs: B and B.6.
17. The facts set forth in the following paragraphs: C and C.8.
18. The facts set forth in the following paragraphs: D and D.4.
19. The facts set forth in the following paragraphs: E and E.16.
20. The facts set forth in the following paragraphs: F and F.7.
21. The facts set forth in the following paragraphs: G and G.8.
22. The facts set forth in the following paragraphs: H and H.7.
23. The facts set forth in the following paragraphs: I and I.10.

DATE: March 1, 2006
Albany, New York

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct

EXHIBIT "B"

GUIDELINES FOR CLOSING A MEDICAL PRACTICE

1. Respondent shall immediately cease the practice of medicine in compliance with the terms of the Consent 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 15 days of the Consent 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. Respondent shall arrange for the transfer and maintenance of all patient medical records. Within thirty days of the Consent 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 years after the last date of service, and, for minors, at least six years after the last date of service or three 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 75 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.

4. Within 15 days of the Consent 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.

5. Within 15 days of the Consent Order's effective date, Respondent shall return any unused New York State official prescription forms to the Bureau of Narcotic Enforcement 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 Respondent's practice location, Respondent shall dispose of all medications.

6. Within 15 days of the Consent 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.

7. 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 Consent Order's effective date.

8. 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 months or more pursuant to this Consent Order, Respondent shall, within ninety 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 days of the Consent Order's effective date.

9. 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 years, under § 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 § 230-a of the Public Health Law.