STATE OF NEW YORK
DEPARTMENT OF HEALTH
433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

February 10, 2009

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Constancio Preciaro Tiglao, Jr., M.D.
11 Ralph Place
Staten Island, New York 10304

Mark Furman, Esq.
Hoffman, Polland & Furman, PLLC
220 East 42nd Street – Suite 435
New York, New York 10017

Claudia Morales Bloch, Esq.
NYS Department of Health
Office of Professional Medical Conduct
145 Huguenot Street
New Rochelle, New York 10801

RE: In the Matter of Constancio Preciaro Tiglao, Jr., M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 09-18) 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), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "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,

Redacted Signature

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

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

COPY

IN THE MATTER

OF

CONSTANCIO PRECIARO TIGLAO JR., MD

DETERMINATION

AND

ORDER

BPMC #09-18

A Notice of Hearing, and Amended Statement of Charges both dated April 16, 2008 were served upon the Respondent **CONSTANCIO PRECIARO TIGLAO JR., M.D.** Chairperson **DONALD H. TEPLITZ D.O., PROSPERE REMY M.D.,** and **GARRY J. SCHWALL RPA-C.** duly designated members of the State Board of Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. Administrative Law Judge **KIMBERLY A. O'BRIEN ESQ**. served as the Administrative Officer.

The Department of Health appeared by THOMAS CONWAY ESQ., General Counsel, by **CLAUDIA MORALES BLOCH**, of Counsel. The Respondent CONSTANCIO PRECIARO TIGLAO JR, M.D. appeared in person and by Counsel **MARK L. FURMAN ESQ.**

Evidence was received and argument heard, and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Notice of Hearing & Amended Statement of Charges	April 3, 2008 & April 16, 2008
Respondent's Answer	April 29, 2008
Hearing Dates	May 6, 2008, June 17, 2008, July 15, 2008, August 5, 2008 and October 22, 2008
Witnesses for Petitioner	Richard Pinsker M.D.
Witnesses for Respondent	Arthur Frank M.D., Constancio Preciaro Tiglao Jr. M.D., Patient F, Patient E, Patient D
Final Hearing Transcript Received	November 1, 2008
Parties Briefs	December 5, 2008
Deliberations Date	December 17, 2008

STATEMENT OF THE CASE

The State Board of Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York pursuant to Section 230 et seq. of the Public Health Law of New York. This case was brought by the New York State Department of Health, Office of Professional Medical Conduct (hereinafter "Petitioner" or "Department") pursuant to Section 230 of the Public Health Law. Costancio Preciaro Tiglao Jr. M.D. (hereinafter "Respondent") is charged with ten specifications of misconduct. The Respondent is charged with: negligence on more than one occasion, incompetence on more than one occasion, gross negligence, gross incompetence, and failing to maintain patient records as set forth in Section 6530 of the Education Law of the State of New York (hereinafter Education Law). The Respondent denies the First through the Sixth Specifications set forth in the Amended Statement of Charges. The Respondent alleges that "his treatment of each of the patients, each of whom were known to the Respondent

and were long-standing patients thereof" was "appropriate" (Ex. A). The Respondent requests that all factual allegations regarding Patients A-F and ten specifications of misconduct set forth in the Notice of Hearing and Amended Statement of Charges, attached hereto and made part of this Decision and Order, and marked as Appendix 1, be dismissed in their entirety.

FINDING OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all findings and conclusions set forth below are the unanimous determinations of the Hearing Committee. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript page numbers ("Tr."). These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding.

Having heard argument and considered the documentary evidence presented, the Hearing Committee hereby makes the following finding of fact:

1. On or about February 1, 1967, Constancio Preciaro Tiglao M.D., the Respondent, was authorized to practice medicine in New York State by the issuance of license number 098352 (Ex. 2). The Respondent treated Patients A-F at the practice he maintains at 11 Ralph Place, Staten Island New York, and he specializes in the area of weight loss treatment and weight management ("specialty") and customarily provides each specialty patient with information about weight loss, a diet plan, and prescribes weight loss medications including Phendimetrazine and Phentermine (Tr. 731-768; Ex. 3,4, 5,6,7,8, F).

2. Adipex, Phendimetrazine and Phentermine are sympathomimetic drugs which are prescribed for short periods of time to aid weight loss, and their use is contraindicated for patients with high

blood pressure, heart disease, diabetes, and/or psychiatric problems (Tr. 17, 30-32, 36-37, 206-210).

3. Vicodin is an opiate analgesic drug which can be habit forming, and is prescribed for pain relief (Tr. 226-229).

4. A reasonably prudent physician treating any patient shall: maintain a medical record that accurately reflects the care and treatment of a Patient, obtain a medical history, perform physicals, order basic laboratory studies, rule out underlying disorders, diagnose conditions, make a treatment plan, and justify prescribing (Tr. 21-22, 25, 27-28, 43-45, 207-210, 502-503, 523-525).

Patient A

5. During the Respondent's treatment of Patient A from on or about to June 11, 1996 through November 11, 2005 he failed to: maintain a medical record that accurately reflects the care and treatment of Patient A, obtain a medical history, perform physicals, order laboratory studies, rule out underlying disorders, diagnose conditions, establish a treatment plan, and provide justification for prescribing Phendimetrazine, Fioricet, Tenuate, and Hycodan for Patient A (Ex. 3; Tr. 777-883).

Patient B

6. The Respondent treated Patient B from on or about April 10, 2000 through on or about August 29, 2006, during that time he failed to: maintain a medical record that accurately reflects the care and treatment of Patient B, obtain a medical history, physicals, EKG's, laboratory studies/ bloodwork, rule out underlying disorders, diagnose conditions, establish a treatment plan, and provide justification for prescribing Phendimetrazine, Vicodin, Hycodan, Soma Compound, Adipex and Imitrex for Patient B (Ex. 4, 10&11; Tr. 895-1029).

Patient C

7. The Respondent treated Patient C from on or about April 20, 2005 through on or about August 4, 2006 and during this time he failed to: maintain a medical record that accurately reflects the care and treatment of Patient C, obtain a medical history, perform physical examinations, order laboratory studies/ bloodwork, rule out underlying disorders, diagnose conditions, establish a treatment plan, and provide justification for prescribing Phendimetrazine, Vicodin, Xanax, Hycodan and Diovan for Patient C (Ex 5, 12; Tr. 735-737, 1030-1064).

Patient D

8. The Respondent treated Patient D from on or about December 2, 1996 through on or about September 19, 2006. During this time the Respondent failed to: maintain a medical record that accurately reflects the care and treatment of Patient D, obtain a medical history, perform physical examinations, obtain laboratory studies/ blood work, rule out underlying disorders, diagnose conditions, establish a treatment plan, and provide justification for prescribing Vicodin, Xanax, and Hycodan for Patient D without justification (Ex. 6,13,14,15; Tr. 1065-1086).

Patient E

9. The Respondent treated Patient E on or about four occasions June 10, 2003; September 29, 2004; March 9, 2005; and August 19, 2005. During this time the Respondent failed to: maintain a medical record that accurately reflects the care and treatment of Patient E, obtain a medical history, perform physical examinations, establish a treatment plan, and provide justification for prescribing Vicodin for Patient E (Ex. 7, 15; 1087-1105).

Patient F

10. The Respondent treated Patient F from on or about January 18, 1998 through on or about September 12, 2006 (Ex. 8). During this time the Respondent failed to: maintain a medical record

that accurately reflects the care and treatment of Patient F, obtain a medical history, perform physical examinations, establish a treatment plan, and provide justification for prescribing Vicodin for Patient F (Ex. 8, 16; Tr. 1106-1155).

CONCLUSIONS

The Hearing Committee ("Hearing Committee" or "Committee") sustained the Factual Allegations set forth in Paragraph A1, A2, A3 (a), (b), (c), A4, A5, A6, A7, A8; B1, B2, B3 (a), (b), (e), (f), (g), (h) B5, B6, B7, B8, B9; C1, C2, C3 (a) –(d), C4, C5, C6 C7; D1, D2, D3 (a)-(d), D4, D5, D6, D7; E1, E2, E3, E4 E5; and F1, F2, F 3(a), (b), (d), F7, F8, and the First, Third and Fifth through Tenth Specifications of misconduct as set forth in the Amended Statement of Charges (Ex.1 See Tr. 1066 - Allegation D (3)(a) withdrawn). The Hearing Committee found based on a preponderance of the evidence that the Respondent's conduct constitutes negligence on more than one occasion, gross negligence, and failure to maintain a record for a patient which accurately reflects the care and treatment of the patient pursuant to Education Law Section 6530(3), (4), and (32) respectively (Ex. 1).

The Hearing Committee's conclusions were unanimous and based mainly on the Respondent's own testimony and the documentary evidence introduced at the hearing. The Respondent testified that for almost twenty years he has been treating patients interested in weight loss and weight management, and he increased this specialty practice in the year 2000. (Tr.735, 800-801). Throughout the hearing, the Respondent confidently defended the treatment he provided to Patients A-F testifying that they are all long-term patients that he knows well. The Respondent testified about his ability to assess a patient's condition by looking at and talking with a patient, and confirmed that he does not regularly perform EKGs or order diagnostic laboratory testing because of his abilities as a clinician, and he added that many of his

patient's do not have insurance and he tries to minimize patient costs (Tr. 735-736, 765-767, 803-808, 818-821, 1041, 1048-1050, 1086-1087). The Respondent testified that he wrote prescriptions with multiple refills for pain medications as a convenience to his patients, and he was aware that some of these prescriptions were for medications for conditions that were being treated by another physician (Tr. 903-906). The Respondent was not overly concerned about writing prescriptions for multiple refills and/or prescriptions for medications that may be prescribed by another treating physician, because he believed that a pharmacy would not fill multiple prescriptions for the same medication. The Respondent acknowledged that there are some deficiencies in his record keeping practices, explaining that he learned these skills nearly forty years ago (Ex. A; Tr. 771-774).

The Respondent's own self-described practice reveals that he often prescribed weight loss medications and a diet plan for his patients without a full review of systems, and /or ordering preliminary or follow up diagnostic testing to: rule out underlying causes for obesity, identify preexisting or emerging conditions and/or co morbidities that would require treatment and/or contraindicate use of the prescribed medications or diet plan (Tr. 763- 770). Further, the Respondent wrote prescriptions for pain medications with multiple refills, without justification or monitoring, and in some instances prescribed these medications when he knew a patient was being treated by another physician for the condition (Ex. 4, 6, 7, 10 & 11; Tr. 936-965, 974). Finally, the Respondent repeatedly failed to obtain and /or document in the patient medical records: history, physical, symptoms, diagnosis, and prescribing rationale or dosage. The Respondent's failure to note and/ or obtain patient histories, perform physicals, order initial and follow up diagnostic testing, diagnose patient conditions, develop treatment plans, and justify his prescribing fall well below acceptable standards of medical practice. The Hearing Committee found that Respondent's care and treatment of

Patients A-F constitutes repeated and "significant deviations from acceptable standards of medical care and present the risk of potentially grave consequences to the patient," and he is guilty of negligence on more than one occasion, gross negligence, and failure to maintain medical records that accurately reflect the care and treatment of a patient (See Ex. ALJ 1A, Definitions of Professional Misconduct-Greenberg Memorandum," Education Law Section 6530 (3),6530(4) & 6530 (32)).

The Hearing Committee did not sustain the Factual Allegations in Paragraph A3 (d), (e); B3(c) & (d), B4; F3(c), F4, F5, F6, and the Second and Fourth Specifications set forth in the Amended Statement of Charges that specifically relate to incompetence on more than one occasion and gross incompetence pursuant to Education Law Sections 6530(5)&(6) (Ex.1). In order to sustain the allegations of incompetence and /or gross incompetence the Hearing Committee would be required to find that the Respondent lacks the requisite skill or knowledge necessary to practice the profession (See Ex. ALJ 1A, Education Law Section 6530(5) & 6530(6)). The Hearing Committee concluded that in limited instances during Respondent's treatment of Patient A, Patient B & Patient F, he did provide an adequate diagnosis, treatment, and/ or justification for prescribing medications in the medical record. Based on the foregoing, the Hearing Committee concludes that there is insufficient credible evidence that the Respondent was incapable of meeting accepted professional medical standards, and thus could not sustain the allegations of incompetence and/or gross incompetence.

DETERMINATION AS TO PENALTY

The Respondent expressed no remorse. While the Respondent conceded that he could put more detail in the record and if requested by the Hearing Committee he would get more training regarding record keeping, he showed no genuine interest in receiving training and /or improving or altering his practice and has not acknowledged the potentially grave consequences of his

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

IN THE MATTER

OF

CONSTANCIO PRECIARO TIGLAO, Jr., M.D.

AMENDED STATEMENT OF CHARGES

CONSTANCIO PRECIARO TIGLAO, M.D., the Respondent, was authorized to practice medicine in New York State on or about February 1, 1967, by the issuance of license number 098352 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent, at his office, located at 11 Ralph Place, Staten Island, N.Y. 10304 ("his office"), undertook the care and treatment of Patient A (the identity of all patients is set forth in the annexed Appendix) from on or about June 11, 1996 through on or about November 11, 2005. Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, and/or history of current complaints from Patient A;
2. Failed to perform and/or note a complete and appropriate physical examination of Patient A;
3. Inappropriately and without accepted medical indication and/or justification prescribed and/or maintained Patient A on various medications, to wit:
   a. Phendimetrazine
   b. Fioricet
   c. Tenuate
   d. Cipro

e. Hycodan

4. Failed to obtain and/or note appropriate and medically indicated laboratory studies on Patient A;
5. Failed to properly diagnosis and/or note a diagnosis for Patient A's condition(s) and/or rule out underlying disorders;
6. Subsequent to Patient A's release from a psychiatric hospital and on or about March 8, 2005, failed to obtain and/or note an adequate and complete medical history of the patient's hospitalization, diagnosis and/or medications;
7. Failed to determine and/or note a treatment plan for Patient A;
8. Failed to maintain a medical record for Patient A in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

B. Respondent, at his office, undertook the care and treatment of Patient B from on or about April 10, 2000 through on or about August 29, 2006. Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, and/or history of current complaints from Patient B;
2. Failed to perform and/or note a complete and appropriate physical examination of Patient B;
3. Inappropriately and without accepted medical indication and/or justification prescribed and/or maintained Patient B on various medications, to wit:
   a. Phendimetrazine
   b. Vicodin
   c. Hycodan
   d. Avelox

(sic)

e. Proventyl (sic)

f. Soma Compound

g. Adipex

h. Imitrex

4. Continued to prescribe, Vicodin and/or Hycodan, controlled substances, without accepted medical indication and/or justification, while Respondent knew or should have known that Patient B was addicted to said controlled substances;

5. Failed to properly diagnosis and/or note a diagnosis for Patient B's condition(s) and/or rule out underlying disorders;

6. Failed to determine and/or note a treatment plan for Patient B;

7. Failed to obtain and/or note any laboratory blood work and/or maintain a record of any laboratory data for Patient B;

8. Failed, any time during the years of treatment, to perform and/or note an EKG on Patient B;

9. Failed to maintain a medical record for Patient B in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

C. Respondent, at his office, undertook the care and treatment of Patient C from on or about April 20, 2005 through on or about August 4, 2006. Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, and/or history of current complaints from Patient C;

2. Failed to perform and/or note a complete and appropriate physical examination of Patient C;

3. Inappropriately and without accepted medical indication and/or justification prescribed and/or maintained Patient C on various

medications, to wit:

a. Phendimetrazine

b. Vicodin

c. Xanax

d. Diovan

4. Failed to properly diagnosis and/or note a diagnosis for Patient C's condition(s) and/or rule out underlying disorders;

5. Failed to determine and/or note a treatment plan for Patient C;

6. Failed to obtain and/or note any laboratory blood work and/or maintain a record of any laboratory data for Patient C;

7. Failed to maintain a medical record for Patient C in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

D. Respondent, at his office, undertook the care and treatment of Patient D from on or about December 2,1996 through on or about September 19, 2006. Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, and/or history of current complaints from Patient D;

2. Failed to perform and/or note a complete and appropriate physical examination of Patient D;

3. Inappropriately and without accepted medical indication and/or justification prescribed and/or maintained Patient D on various medications, to wit:

~~a. Phendimetrazine~~ withdrawn 10/22/08 KAO

b. Vicodin

c. Xanax

d. Hycodan

4. Failed to properly diagnosis and/or note a diagnosis for Patient D's condition(s) and/or rule out underlying disorders;

5. Failed to determine and/or note a treatment plan for Patient D;

6. Failed to obtain and/or note any laboratory blood work and/or maintain a record of any laboratory data for Patient D;

7. Failed to maintain a medical record for Patient D in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

E. Respondent undertook the care and treatment of Patient E at his office on or about three (3) occasions, June 10, 2003; September 29, 2004 and March 9, 2005. On or about August 19, 2005, Respondent:

1. Without seeing Patient E, inappropriately and without accepted medical indication and/or justification prescribed and/or maintained Patient E on Vicodin.

2. Failed to note in his medical record, on or about August 19, 2005, that he prescribed Vicodin for Patient E and/or note any medical indication and/or justification for having prescribed Vicodin;

3. Failed to obtain and/or note a an adequate and complete medical history, and/or history of current complaints from Patient E;

4. Failed to perform and/or note a complete and appropriate physical examination of Patient E;

5. Failed to maintain a medical record for Patient E in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

F. Respondent, at his office, undertook the care and treatment of Patient F from

on or about January 18, 1998 through on or about September 12, 2006. Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, and/or history of current complaints from Patient F;
2. Failed to perform and/or note a complete and appropriate physical examination of Patient F;
3. Inappropriately and without accepted medical indication and/or justification prescribed and/or maintained Patient F on various medications, to wit:
   a. Phendimetrazine
   b. Phentermine
   c. Vicodin
4. At all times, failed to note in his medical record that he prescribed Vicodin for Patient F and/or note any medical indication and/or justification for having prescribed Vicodin;
5. Failed to properly diagnosis and/or note a diagnosis for Patient F's condition(s) and/or rule out underlying disorders;
6. Failed to determine and/or note a treatment plan for Patient F;
7. Failed to obtain and/or note any laboratory blood work and/or maintain a record of any laboratory data for Patient F during the first 8 years of treatment;
8. Failed to maintain a medical record for Patient F in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

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 of paragraphs A, A.1, A.2, A.3a - A.3e, A.4 - A.8, B, B.1, B.2, B.3a - B.3h, B.4 - B.9, C., C.1, C.2, C.3a - C.3d, C.4 - C.7, D, D.1, D.2, D.3a - D.3d, D.4 - D.7, E, E.1 - E.5, F, F.1, F.2, F.3a - F.3c, F.4 - F.8.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

2. The facts of paragraphs A, A.1, A.2, A.3a - A.3e, A.4 - A.8, B, B.1, B.2, B.3a - B.3h, B.4 - B.9, C., C.1, C.2, C.3a - C.3d, C.4 - C.7, D, D.1, D.2, D.3a - D.3d, D.4 - D.7, E, E.1 - E.5, F, F.1, F.2, F.3a - F.3c, F.4 - F.8.

THIRD SPECIFICATION

GROSS NEGLIGENCE

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

3. The facts of paragraphs A, A.1, A.2, A.3a - A.3e, A.4 - A.8, B, B.1, B.2, B.3a - B.3h, B.4 - B.9, C., C.1, C.2, C.3a - C.3d, C.4 -

C.7, D, D.1, D.2, D.3a - D.3d, D.4 - D.7, E, E.1 - E.5, F, F.1, F.2, F.3a - F.3c, F.4 - F.8.

FOURTH 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:

4. The facts of paragraphs A, A.1, A.2, A.3a - A.3e, A.4 - A.8, B, B.1, B.2, B.3a - B.3h, B.4 - B.9, C., C.1, C.2, C.3a - C.3d, C.4 - C.7, D, D.1, D.2, D.3a - D.3d, D.4 - D.7, E, E.1 - E.5, F, F.1, F.2, F.3a - F.3c, F.4 - F.8.

FIFTH THROUGH TENTH 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:

5. The facts of paragraphs A.1, A.2, A.4 - A.8,
6. The facts of paragraphs B.1, B.2, B.5 - B.9,
7. The facts of paragraphs C.1, C.2, C.4 - C.7,
8. The facts of paragraphs D.1, D.2, D.4 - D.7,
9. The facts of paragraphs E, E.2 - E.5,
10. The facts of paragraphs F.1, F.2, F.4 - F.8.

DATE: April 16, 2008
New York, New York

Redacted Signature

ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical Conduct

clinical, diagnostic, prescribing, and record keeping practices. After due and careful consideration of the penalties available pursuant to Public Health Law Section 230-a, the Hearing Committee has determined that in order to protect the public the Respondent's medical license shall be ***REVOKED***.

ORDER

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

1. The Hearing Committee sustained the Factual Allegations set forth in Paragraph A1, A2, A3 (a), (b), (c), A4, A5, A6, A7, A8; B1, B2, B3 (a), (b), (e), (f), (g), (h) B5, B6, B7, B8, B9; C1, C2, C3 (a) –(d), C4, C5, C6 C7; D1, D2, D3 (a)-(d), D4, D5, D6, D7; E1, E2, E3, E4 E5; and F1, F2, F 3(a), (b), (d), F7, F8, and the First, Third and Fifth through Tenth Specifications of misconduct as set forth in the Amended Statement of Charges (Ex. 1) are **SUSTAINED;**

2. The Factual Allegations in Paragraph A3 (d), (e); B3(c) & (d), B4; F3(c), F4, F5, F6, and the Second and Fourth Specifications set forth in the Amended Statement of Charges (Ex. 1) are **NOT SUSTAINED;**

3. The Respondent's license to practice medicine in New York State is hereby **REVOKED;**

4. This **ORDER** shall be effective upon service on the Respondent pursuant to Public Health Law Section 230(10)(h).

DATED: 2/9/09, New York
,2009

Redacted Signature

BY: _____
DONALD H. TEPLITZ D.O., Chairperson
PROSPERE REMY M.D.
GARRY SCHWALL RPA-C

To: Constancio Preciaro Tiglao, Jr. M.D.
11 Ralph Place
Staten Island, NY 10304

Mark Furman, Esq.
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220 East 42nd Street Suite 435
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Claudia Morales Bloch, Esq.
NYSDOH -Bureau of Professional Medical Conduct
145 Huguenot Street
New Rochelle, NY 10801

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

IN THE MATTER

OF

CONSTANCIO PRECIARO TIGLAO, JR., M.D.

NOTICE

OF

HEARING

TO: CONSTANCIO PRECIARO TIGLAO, JR., M.D.
c/o Mark L. Furman, Esq.
Hoffman Polland & Furman PLLC
220 E. 42nd Street, Suite 435
New York, N.Y. 10017

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §23 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 May 6, 2008, at 10:00 a.m., at the Offices of the New York State Department of Health, 9 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. TYRONE BUTLER, 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 (McKinney Supp. 2008) 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
April 3 ,2008

Redacted Signature

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Claudia Morales Bloch
Associate Counsel
Bureau of Professional
Medical Conduct
145 Huguenot Street, 6th Fl.
New Rochelle, N.Y. 10801
914-654-7047