Public

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

November 10, 2009

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Patrick A. Barrett, D.O.
Sunrise Family Medical
4568 Sunrise Highway
Oakdale, NY 11769

RE: License No. 208138

Dear Dr. Barrett:

Enclosed is a copy of Order BPMC #09-201 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect November 17, 2009.

If the penalty imposed by the Order is a fine, please write the check payable to the New York State Department of Health. Noting the BPMC Order number on your remittance will assist in proper crediting. Payments should be directed to the following address:

Bureau of Accounts Management
New York State Department of Health
Corning Tower, Room 1717
Empire State Plaza
Albany, New York 12237

Sincerely,

Redacted Signature

Katherine A. Hawkins, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

cc: Amy T. Kulb, Esq.
Jacobson,Goldberg & Kulb, LLP
585 Seward Avenue, Suite 720
Garden City, NY 11530

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

IN THE MATTER

OF

PATRICK BARRETT, D.O.

CONSENT
ORDER

BPMC No. #09-201

Upon the application of (Respondent) PATRICK BARRETT, D.O. 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: 11-9-2009

Redacted Signature

KENDRICK A. SEARS, M.D.
Chair
State Board for Professional Medical Conduct

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

IN THE MATTER

OF

PATRICK BARRETT, D.O.

CONSENT AGREEMENT AND ORDER

PATRICK BARRETT, D.O., represents that all of the following statements are true:

That on or about September 2, 1997, I was licensed to practice as a physician in the State of New York, and issued License No. 208138 by the New York State Education Department.

My current address is Sunrise Family Medical, 4568 Sunrise Highway, Oakdale, New York 11769, 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 Three Specifications of professional misconduct.

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

I admit the First Specification (negligence on more than one occasion) to the extent of Factual Allegations 1, 2, and 3, relating solely to Patients A, C, and E, in full satisfaction of the charges against me, and agree to the following penalty:

> I shall receive a Censure and Reprimand, and I shall comply with the Terms of Probation for a period of three years, as set forth set forth in Exhibit "B", attached hereto. I also agree to pay a fine of $10,000 (Ten Thousand Dollars). The fine is payable in full within 30 days of the effective date of this Order.

Payments must be submitted to:

Bureau of Accounts Management
New York State Department of Health
Empire State Plaza
Corning Tower, Room 1717
Albany, New York 12237

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

That Respondent shall remain in continuous compliance with all requirements of N.Y. Educ Law § 6502 including but not limited to the requirements that a licensee shall register and continue to be registered with the New York State Education Department (except during periods of actual suspension) and that a licensee shall pay all registration fees. Respondent shall not exercise the option provided in N.Y. Educ. Law § 6502(4) to avoid registration and payment of fees. This condition shall take effect 120 days after the Consent Order's effective date and will continue so long as Respondent remains a licensee in New York State; and

That Respondent shall cooperate fully with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this 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.

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 Consent 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 Consent Order are authorized by N.Y. Pub. Health Law §§ 230 and 230-a, and that the Board and OPMC 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 I ask that the Board adopt this Consent Agreement.

I understand and agree that the attorney for the Department, the Director of OPMC and the Chair of the Board each retain complete discretion either to enter into the proposed agreement and Consent Order, based upon my application, or to decline to do so. I further understand and agree that no prior or separate written or oral communication can limit that discretion.

DATE 10/26/09

Redacted Signature

PATRICK BARRETT, D.O.
RESPONDENT

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

DATE: 10/20/09

Redacted Signature

AMY T. KULB, ESQ.
Attorney for Respondent

DATE: 10/29/09

Redacted Signature

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

DATE: 11/9/09

Redacted Signature

KEITH W. SERVIS
Director
Office of Professional Medical Conduct

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

IN THE MATTER

OF

PATRICK A. BARRETT, D.O.

STATEMENT

OF

CHARGES

PATRICK A. BARRETT, D.O., the Respondent, was authorized to practice medicine in New York State on or about September 2, 1997, by the issuance of license number 208138 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A [patients are identified in the attached appendix], a male 24 years old when treatment began, at various times from approximately July 2002 through November 2007 at his office at 4568 Sunrise Highway, Oakdale, New York, 11769 (the "Office"). Patient A presented at 6 feet 2 inches in height, weighing 265 pounds. Patient A was at the time taking testosterone from an unidentified source, was on a "bodybuilder's diet", and was employed as a "trainer", with an active "5 day a week" exercise program. He had complaints of back pain and a biceps tear. Respondent's care and treatment of Patient A was contrary to accepted standards of medical practice, in that:

1. Respondent failed to adequately evaluate the patient prior to diagnosing and treating the patient, including diagnosing him for "hypogonadism", and/or failed to adequately document an adequate evaluation.

2. Respondent ordered, prescribed, and or injected the patient with testosterone without adequate medical indications and/or failed to adequately document an adequate medical indication.

3. Respondent failed to adequately manage the provision of testosterone therapy for the patient, in that the Respondent continued to order, prescribe, and/or inject the patient with

testosterone despite markedly elevated serum levels of total testosterone and/or signs of testosterone toxicity, including elevated hematocrit, elevated triglycerides, or lowered HDL levels, and without initially evaluating and/or ongoing monitoring of the patient's prostate, and/or failed to adequately document such conditions or therapies.

4. Respondent ordered repeated laboratory testing of the patient's blood for FSH and LH levels, as well as Prolactin, which were not medically indicated, and/or without documenting such medical indication.

5. Respondent ordered, prescribed, and or provided Femara for the patient, without adequate medical indication, and/or failed to adequately document adequate medical indication.

B. Respondent provided medical care to Patient B, a male 40 years old when treatment began, at various times from approximately March 2003 through February 2008 at Respondent's Office. Patient B presented at 5 feet 11 inches in height, weighing 245 pounds. Patient B was at that time taking two anabolic steroids from an unidentified source, and had an active "7 day a week" exercise program. He had an initial complaint of pain in a quadriceps. By December, 2004, Respondent diagnosed the patient with "malaise/fatigue", and "low testosterone", among others. Respondent's care and treatment of Patient B was contrary to accepted standards of medical practice, in that:

1. Respondent failed to adequately evaluate the patient prior to diagnosing and treating the patient for "low testosterone", and/or failed to adequately document an adequate evaluation.

2. Respondent ordered, prescribed, and or injected the patient with testosterone without adequate medical indications, and /or without adequately documenting such medical indication.

3. Respondent failed to adequately manage the provision of testosterone therapy for the patient, in that the Respondent continued to order, prescribe, and/or inject the patient with

testosterone despite markedly elevated serum levels of total testosterone and/or signs of testosterone toxicity, including elevated hematocrit, elevated triglycerides, or lowered HDL levels, and without initially evaluating and/or ongoing monitoring of the patient's prostate, and/or failed to adequately document such conditions or therapies.

4. Respondent ordered repeated laboratory testing of the patient's blood for FSH and LH levels, as well as Prolactin, which were not medically indicated, and/or without documenting such medical indication.

C. Respondent provided medical care to Patient C, a male 38 years old when treatment began, at various times from approximately July 2006 through February 2008 at Respondent's Office. Patient C presented at 6 feet in height, weighing 250 pounds. Patient C was at that time taking testosterone from an unidentified source, and was engaging in "weight training 6 times a week". He had a complaint of "malaise/fatigue". Respondent's care and treatment of Patient C was contrary to accepted standards of medical practice, in that:

1. Respondent failed to adequately evaluate the patient prior to diagnosing and treating the patient, including diagnosing him for "hypogonadism", and/or failed to adequately document an adequate evaluation.

2. Respondent ordered, prescribed, and or injected the patient with testosterone without adequate medical indications and/or failed to adequately document an adequate medical indication.

3. Respondent failed to adequately manage the provision of testosterone therapy for the patient, in that the Respondent continued to order, prescribe, and/or inject the patient with testosterone despite signs of testosterone toxicity, including elevated hematocrit, elevated triglycerides, or increased HDL levels, and without initially evaluating and/or ongoing monitoring of the patient's prostate, and/or failed to adequately document such conditions or therapies.

4. Respondent ordered repeated laboratory testing of the patient's blood for FSH and LH levels, as well as Prolactin, which were not medically indicated, and/or without documenting such medical indication.

D. Respondent provided medical care to Patient D, a male 41 years old when treatment began, at various times from approximately September 2006 through May 2007 at Respondent's Office. Patient D presented at 5 feet nine inches in height, weighing 212 pounds. Patient D was on an elevated protein diet, and had an active exercise program of "4-6 times per week" that included "weight lifting". He had complaints of "fatigue" and "anxiety". Respondent's care and treatment of Patient D was contrary to accepted standards of medical practice, in that:

1. Respondent failed to adequately evaluate the patient prior to diagnosing and treating the patient for "hypogonadism", and/or failed to adequately document an adequate evaluation.

2. Respondent ordered, prescribed, and or injected the patient with testosterone without adequate medical indications and/or failed to adequately document an adequate medical indication.

3. Respondent failed to adequately manage the provision of testosterone therapy for the patient, in that the Respondent continued to order, prescribe, and/or inject the patient with testosterone despite markedly elevated serum levels of total testosterone and/or signs of testosterone toxicity, including elevated hematocrit, elevated triglycerides, or lowered HDL levels, and without initially evaluating and/or ongoing monitoring of the patient's prostate, and/or failed to adequately document such conditions or therapies.

4. Respondent ordered repeated laboratory testing of the patient's blood for FSH and LH levels, as well as Prolactin, which were not medically indicated, and/or without documenting such medical indication.

E. Respondent provided medical care to Patient E, a male 44 years old when treatment began, at various times from approximately April 2006 through November 2008 at Respondent's Office. Patient E presented at 5 feet 8 inches in height, weighing 225 pounds. Patient E had an active "5 times a week weights and cardio" exercise program. He had complaints of "anxiety and depression", among others. Respondent's care and treatment of Patient E was contrary to accepted standards of medical practice, in that:

1. Respondent failed to adequately evaluate the patient prior to diagnosing and treating the patient, and/or failed to adequately document an adequate evaluation.

2. Respondent ordered, prescribed, and or injected the patient with testosterone without adequate medical indications and/or failed to adequately document an adequate medical indication.

3. Respondent failed to adequately manage the provision of testosterone therapy for the patient, in that the Respondent continued to order, prescribe, and/or inject the patient with testosterone despite markedly elevated serum levels of total testosterone and/or signs of testosterone toxicity, including elevated hematocrit, elevated triglycerides, or lowered HDL levels, and without initially evaluating and/or ongoing monitoring of the patient's prostate, and/or failed to adequately document such conditions or therapies.

4. Respondent ordered repeated laboratory testing of the patient's blood for FSH and LH levels, as well as Prolactin, which were not medically indicated, and/or without documenting such medical indication.

F. Respondent provided medical care to Patient F, a male 35 years old when treatment began, at various times from approximately June 2003 through February 2008 at Respondent's Office. Patient F presented at 6 feet one inch in height, weighing 235 pounds. Patient F was at that time taking ephedrine from an unidentified source, and he had complaints of a productive cough and nasal congestion. Respondent's care and treatment of Patient F was contrary to accepted standards of medical practice, in that:

1. Respondent failed to adequately evaluate the patient prior to diagnosing and treating the patient, including diagnosing him for "hypogonadism", and/or failed to adequately document an adequate evaluation.

2. Respondent ordered, prescribed, and or injected the patient with testosterone without adequate medical indications and/or failed to adequately document an adequate medical indication.

3. Respondent failed to adequately manage the provision of testosterone therapy for the patient, in that the Respondent

continued to order, prescribe, and/or inject the patient with testosterone despite markedly elevated serum levels of total testosterone and/or signs of testosterone toxicity, including benign prostatic hypertrophy, and without initially evaluating and/or ongoing monitoring of the patient's prostate, and/or failed to adequately document such conditions or therapies.

4. Respondent ordered repeated laboratory testing of the patient's blood for FSH and LH levels, as well as Prolactin, which were not medically indicated, and/or without documenting such medical indication.

5. Respondent ordered, prescribed, and or provided Femara for the patient, without adequate medical indication, and/or failed to adequately document adequate medical indication.

G. Respondent provided medical care to Patient G, a male 27 years old when treatment began, at various times from approximately March 2005 through March 2007 at Respondent's Office. Patient G presented at 5 feet 11 inches in height, weighing 215 pounds. Patient G had a "4 day a week" exercise program, with complaints of "low testosterone". Respondent's care and treatment of Patient G was contrary to accepted standards of medical practice, in that:

1. Respondent failed to adequately evaluate the patient prior to diagnosing and treating the patient for "hypogonadism", and/or failed to adequately document an adequate evaluation.

2. Respondent ordered, prescribed, and or injected the patient with testosterone without adequate medical indications and/or failed to adequately document an adequate medical indication.

3. Respondent failed to adequately manage the provision of testosterone therapy for the patient, in that the Respondent continued to order, prescribe, and/or inject the patient with testosterone despite markedly elevated serum levels of total testosterone and/or signs of testosterone toxicity, including elevated hematocrit, elevated triglycerides, or lowered HDL levels, and without initially evaluating and/or ongoing monitoring of the patient's prostate, and/or failed to adequately document such conditions or therapies.

4. Respondent ordered repeated laboratory testing of the patient's blood for FSH and LH levels, as well as Prolactin, which were not medically indicated, and/or without documenting such medical indication.

H. Respondent provided medical care to Patient H, a male 35 years old when treatment began, at various times from approximately April 2005 through February 2008 at Respondent's Office. Patient H presented at 5 feet 10 inches in height, weighing 225 pounds. Patient H had an active "cardio and weights" exercise program, with complaints of joint pain and bone pain, among others. Respondent's care and treatment of Patient H was contrary to accepted standards of medical practice, in that:

1. Respondent failed to adequately evaluate the patient prior to diagnosing and treating the patient for "hypogonadism", and/or failed to adequately document an adequate evaluation.

2. Respondent ordered, prescribed, and or injected the patient with testosterone without adequate medical indications and/or failed to adequately document an adequate medical indication.

3. Respondent failed to adequately manage the provision of testosterone therapy for the patient, in that the Respondent continued to order, prescribe, and/or inject the patient with testosterone despite markedly elevated serum levels of total testosterone and/or signs of testosterone toxicity, including elevated hematocrit, elevated triglycerides, or lowered HDL levels, and without initially evaluating and/or ongoing monitoring of the patient's prostate, and/or failed to adequately document such conditions or therapies.

4. Respondent ordered, prescribed, and or provided Femara for the patient, without adequate medical indication, and/or failed to adequately document adequate medical indication.

5. Respondent ordered, prescribed, and or provided Phentermine for the patient, without adequate medical indication, and/or failed to adequately document adequate medical indication.

6. Respondent ordered repeated laboratory testing of the patient's blood for FSH and LH levels, as well as Prolactin, which were not medically indicated, and/or without documenting such medical indication.

I. Respondent provided medical care to Patient I, a male 34 years old when treatment began, at various times from approximately February 2004 through August 2007 at Respondent's Office. Patient I presented at 6 feet 5 inches in height, weighing 233 pounds. Patient I was employed as a "trainer", with an active "weight lifting" exercise program. He had complaints of cough and congestion. Respondent's care and treatment of Patient I was contrary to accepted standards of medical practice, in that:

1. Respondent failed to adequately evaluate the patient prior to diagnosing and treating the patient, including diagnoses for "malaise/fatigue", ADHD", etc, and/or failed to adequately document an adequate evaluation.

2. Respondent on more than one occasion started medications for Patient I such as Adderal and Xanax at intermediate or high doses without consideration of appropriate starting dose and titration, and/or without using a medication with less risk of adverse effects or addiction potential, and/or failed to adequately document such consideration.

3. Respondent failed to adequately order or recommend treatment modalities to complement pharmacologic therapies and/or failed to adequately document such orders or recommendations.

4. Respondent failed to periodically monitor the prescribed pharmacologic treatments for efficacy or potential adverse effects, and/or failed to adequately document such monitoring.

5. Respondent used potentially hazardous medication combinations, such as Xanax with Prozac, Oxycontin with Xanax and Ambien, and Valium with Xanax, Prozac, Lunesta,

and Ambien, without adequate medical indication, and/or without document such adequate medical indication.

6. Respondent ordered, prescribed, and or provided Femara for the patient, without adequate medical indication, and/or failed to document adequate medical indication.

7. Respondent prescribed opioid medication to initially treat uncomplicated musculoskeletal pain secondary to trauma without adequate medical indication, and/or failed to document adequate medical indication.

8. Respondent ordered or prescribed benzodiazepine sedative/hypnotics such as Ambien and a non-benzodiazepine sedative/hypnotics such as Lunesta for inappropriately long periods of time without evidence of appropriate evaluation of the cause of the insomnia being treated, or attempts to treat the sleeping problem through some non-pharmacologic approach, and/or without adequately documenting such an evaluation.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, B and B.1, B and B.2, B and B.3, B and B.4, C and C.1, C and C.2, C and C.3, C and C.4, D and D.1, D and D.2, D and D.3, D and D.4, E and E.1, E and E.2, E and E.3, E and E.4, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, G and G.1, G and G.2, G and G.3, G and G.4, 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, and/or I and I.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 in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, B and B.1, B and B.2, B and B.3, B and B.4, C and C.1, C and C.2, C and C.3, C and C.4, D and D.1, D and D.2, D and D.3, D and D.4, E and E.1, E and E.2, E and E.3, E and E.4, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, G and G.1, G and G.2, G and G.3, G and G.4, 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, and/or I and I.8.

THIRD 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:

3. The facts in Paragraphs A and A.1, A and A.2, A and A.4, A and A.5, B and B.1, B and B.2, B and B.4, C and C.1, C and C.2, C and C.4, D and D.1, D and D.2, D and D.4, E and E.1, E and E.2, E and E.4, F and F.1, F and F.2, F and F.4, F and F.5, G and G.1, G and G.2, G and G.4, H and H.1, H and H.2, 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, and/or I and I.8.

DATE: October 29, 2009
Albany, New York

Redacted Signature

Peter D. Van Buren
Deputy Counsel
Bureau of Professional Medical Conduct

EXHIBIT "B"

Terms of Probation

1. Respondent's conduct shall conform to moral and professional standards of conduct and governing law. Any act of professional misconduct by Respondent as defined by N.Y. Educ. Law §§ 6530 or 6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to N.Y. Pub. Health Law § 230(19).

2. Respondent shall maintain active registration of Respondent's license (except during periods of actual suspension) with the New York State Education Department Division of Professional Licensing Services, and shall pay all registration fees.

3. Respondent shall provide the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299 with the following information, in writing, and ensure that this information is kept current: a full description of Respondent's employment and practice; all professional and residential addresses and telephone numbers within and outside New York State; and all investigations, arrests, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility. Respondent shall notify OPMC, in writing, within 30 days of any additions to or changes in the required information.

4. Respondent shall cooperate fully with, and respond in a timely manner to, OPMC requests to provide written periodic verification of Respondent's compliance with the terms of this Consent Order. Upon the Director of OPMC's request, Respondent shall meet in person with the Director's designee.

5. Respondent's failure to pay any monetary penalty by the prescribed date shall subject Respondent to all provisions of law relating to debt collection by New York State, including but not limited to: the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law § 171(27); State Finance Law § 18; CPLR § 5001; Executive Law § 32].

6. The probation period shall toll when Respondent is not engaged in active medical practice in New York State for a period of 30 consecutive days or more. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in, or intends to leave, active medical practice in New York State for a consecutive 30 day period. Respondent shall then notify the Director again at least 14 days before returning to active practice. Upon Respondent's return to active practice in New York State, the probation period shall resume and Respondent shall fulfill any unfulfilled probation terms and such additional requirements as the Director may impose as reasonably relate to the matters set forth in Exhibit "A" or as are necessary to protect the public health.

7. The Director of OPMC may review Respondent's professional performance. This review may include but shall not be limited to: a review of office records, patient records, hospital charts, and/or electronic records; and interviews with or periodic visits with Respondent and staff at practice locations or OPMC offices.

8. Respondent shall adhere to federal and state guidelines and professional standards of care with respect to infection control practices. Respondent shall ensure education, training and oversight of all office personnel involved in medical care, with respect to these practices.

9. Respondent shall maintain complete and legible medical records that accurately reflect the evaluation and treatment of patients and contain all information required by State rules and regulations concerning controlled substances.

PRACTICE MONITOR

10. Within thirty days of the Consent Order's effective date, Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. Any medical practice in violation of this term shall constitute the unauthorized practice of medicine.

    a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no fewer than 20) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

    b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

    c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

    d. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

11. Respondent shall enroll in and complete a continuing education program in the area of proper prescribing of anabolic steroids for a minimum of 20 credit hours. This continuing education program is subject to the Director of OPMC's prior written approval and shall be completed within the first 90 days of the probation period.

12. Respondent shall comply with this Consent Order and all its terms, and shall bear all associated compliance costs. Upon receiving evidence of

noncompliance with, or a violation of, these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding, and/or any other such proceeding authorized by law, against Respondent.