NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

June 2, 2016

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Tiffany P. Aiello, M.D.
[redacted]

Re: License No. 235222

Dear Dr. Aiello:

Enclosed is a copy of the New York State Board for Professional Medical Conduct (BPMC) Order No. 16-183. This order and any penalty provided therein goes into effect June 9, 2016.

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: c/o Physician Monitoring Unit, NYS DOH - OPMC, Riverview Center, Suite 355, 150 Broadway, Albany, NY 12204-2719.

If your license is framed, please remove it from the frame and only send the parchment paper on which your name is printed. Our office is unable to store framed licenses.

If the document(s) are lost, misplaced or destroyed, you are required to submit to this office an affidavit to that effect. Please complete and sign the affidavit before a notary public and return it to the Office of Professional Medical Conduct.

Please direct any questions to: NYS DOH - OPMC, Riverview Center, Suite 355, 150 Broadway, Albany, NY 12204-2719, telephone # (518)402-0855.

Sincerely,

[redacted]

Henry Spector, M.D.
Acting Executive Secretary
Board for Professional Medical Conduct

cc: Heather Neu, Esq.
Evans & Fox, LLP
95 Allens Creek Road, Suite 300
Rochester, New York 14618

Enclosure

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

BPMC No. 16-183

IN THE MATTER
OF
TIFFANY P. AIELLO, M.D.

SURRENDER
ORDER

Upon the application of (Respondent) TIFFANY P. AIELLO, M.D. to surrender his or her license as a physician in the State of New York, which is made a part of this Surrender Order, it is

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

ORDERED, that Respondent's name be stricken from the roster of physicians in the State of New York; it is further

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

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

Whichever is first.

SO ORDERED.

DATE: 5/28/2016

[redacted]

ARTHUR S. HENGERER, 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 TIFFANY P. AIELLO, M.D.	SURRENDER OF LICENSE AND ORDER

TIFFANY P. AIELLO, M.D., represents that all of the following statements are true:

That on or about February 14, 2005, I was licensed to practice as a physician in the State of New York, and issued License No. 235222 by the New York State Education Department.

My current address is [redacted]

I understand that the New York State Board for Professional Medical Conduct (Board) has charged me with one or more specifications of professional misconduct, as set forth in a Statement of Charges, marked as Exhibit "A", which is attached to and part of this Surrender of License.

I am applying to the State Board for Professional Medical Conduct for permission to surrender my license as a physician in the State of New York on the grounds that I do not contest the Second Specification of misconduct in the Statement of Charges as it relates to factual allegations A and A.1, A and A.2, E and E.1, E and E.2, G and G.1 and G and G.2, in full satisfaction of the charges against me.

I ask the Board to accept my Surrender of License, and I agree to be bound by all of the terms set forth in attached Exhibit "B".

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

I agree that, if the Board accepts my Surrender of License, the Chair of the Board shall issue a Surrender Order in accordance with its terms. I agree that this Order shall take effect upon its issuance by the Board, either by mailing of a copy of the Surrender Order by first class mail to me at the address in this Surrender of License, or to my attorney by certified mail, or upon facsimile transmission to me or my attorney, whichever is first. The Surrender 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(s). OPMC shall report this action to the National Practitioner Data Bank, the Federation of State Medical Boards, and any other entities that the Director of OPMC shall deem appropriate.

I ask the Board to accept this Surrender of License, which I submit of my own free will and not under duress, compulsion or restraint. In consideration of the value to me of the Board's acceptance of this Surrender of License, 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 Surrender Order for which I apply, whether administratively or judicially, and I agree to be bound by the Surrender Order.

I understand and agree that the attorney for the Department, the Director of the Office of Professional Medical Conduct and the Chair of the State Board for Professional Medical Conduct each retain complete discretion either to enter into the proposed agreement and 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 3/28/14

[redacted]

TIFFANY P. AIELLO, M.D.
RESPONDENT

The undersigned agree to Respondent's attached Surrender of License and Order and to its proposed penalty, terms and conditions.

DATE: 5.23.16

[redacted]
HEATHER NEU, ESQ.
Attorney for Respondent

DATE: 5/23/16

[redacted]
NATHANIAL WHITE
Associate Counsel
Bureau of Professional Medical Conduct

DATE: 5/23/16

[redacted]
KEITH W. SERVIS
Director
Office of Professional Medical Conduct

EXHIBIT A

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

IN THE MATTER

OF

TIFFANY P. AIELLO, M.D.

STATEMENT

OF

CHARGES

TIFFANY P. AIELLO, M.D., the Respondent, was authorized to practice medicine in New York State on or about February 14, 2005, by the issuance of license number 236222 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (each patient is identified in the attached Appendix A), a forty-four year old female patient, at Respondent's office at 3853 Caledonia-Avon Road in Caledonia, NY (hereafter "Respondent's office") at various times from on or about July 16, 2008 to, at least, on or about January 22, 2014. Respondent's care of Patient A deviated from accepted standards of care as follows:

1. Respondent failed to adequately evaluate and/or document Patient A's need for Suboxone therapy.

2. Respondent failed to adequately manage and/or document Patient A's Suboxone therapy.

3. Respondent prescribed medications to Patient A contrary to accepted standards of medical care, as follows:

    a. Respondent prescribed Patient A narcotic pain medication without adequate medical indication and/or without documenting an adequate medical indication; and/or

b. Respondent maintained Patient A on short-acting narcotic pain medication to treat the patient's complaints of chronic pain; and/or

c. Respondent prescribed Patient A dangerous levels and/or combinations of controlled substances without adequate medical indication and/or without documenting an adequate medical indication; and/or

d. Respondent provided early refills for Patient A's prescriptions for controlled substances without adequate medical indication and/or without documenting an adequate medical indication; and/or

e. Respondent failed to adequately address, and/or adequately document addressing, Patient A's drug screens that indicated evidence of substance abuse and/or addiction; and/or

f. Respondent failed to obtain and/or document adequate liver and renal function tests despite prescribing Patient A medications requiring such tests.

4. Respondent failed to refer Patient A to appropriate specialist(s) for Patient A's complaints of pain and/or Respondent failed to document having made adequate referrals.

5. Respondent failed to maintain a medical record that accurately reflected the evaluation and/or treatment of Patient A.

B. Respondent provided medical care to Patient B, a fifty year old female patient, at Respondent's office at various times from on or about November 30, 2006 to on or about October 8, 2012. Respondent's care of Patient B deviated from accepted standards of care as follows:

1. Respondent, on or about August 1, 2012, misappropriated approximately $9,000.00 that belonged to Patient B.

2. Respondent prescribed medications to Patient B contrary to accepted standards of medical care, as follows:

a. Respondent prescribed phentermine to Patient B despite diagnosing the patient with an "eating disorder" in July 2009; and/or

b. Respondent prescribed phentermine to Patient B for extended periods.

3. Respondent failed to maintain a record that accurately reflected the evaluation and/or treatment of Patient B.

C. Respondent provided medical care to Patient C, a forty-five year old male patient, at Respondent's office at various times from on or about December 7, 2011 to, at least, on or about May 29, 2012. Respondent's care of Patient C deviated from accepted standards of care as follows:

1. Respondent, at various times during Patient C's treatment, engaged in an inappropriate personal relationship with Patient C, that included:

a. Respondent engaged in a sexual relationship with Patient C; and/or

b. Respondent allowed Patient C to sleep at her residence; and/or

c. Respondent maintained regular communication with Patient C regarding their personal relationship; and/or

d. Respondent gave money to Patient C and/or made purchases on behalf of Patient C; and/or

e. Respondent vacationed in Florida with Patient C.

2. Respondent failed to perform an adequate initial evaluation of Patient C and/or Respondent failed to adequately document the initial evaluation.

3. Respondent prescribed medications to Patient C contrary to accepted standards of medical care, as follows:

a. Respondent maintained Patient C on short-acting narcotic pain medication to treat Patient C's complaints of chronic pain; and/or

b. Respondent prescribed Patient C three different benzodiazepines without adequate medical indication and/or without documenting an adequate medical indication; and/or

c. Respondent, on or about December 10, 2011, prescribed Patient C stimulant medication without adequate medical indication and/or without documenting an adequate medical indication; and/or

d. Respondent prescribed Patient C stimulant medication concurrent with benzodiazepines without adequate medical indication and/or without documenting an adequate medical indication; and/or

e. Respondent provided early refills for Patient C's prescriptions for controlled substances without adequate medical indication and/or without documenting an adequate medical indication; and/or

f. Respondent repeatedly prescribed Patient C controlled substances despite indication of substance abuse and/or addiction; and/or

g. Respondent prescribed Patient C controlled substances without routine office visits and/or without documenting that such office visits occurred.

4. Respondent failed to timely refer Patient C to appropriate specialist(s) for Patient C's complaints of pain and/or Respondent failed to document having made adequate referrals.

5. Respondent failed to maintain a record that accurately reflected the evaluation and/or treatment of Patient C.

D. Respondent provided medical care to Patient D, a thirty-two year old female patient, at Respondent's office at various times from on or about November 22, 2010 to, at least, on or about March 20, 2013. Respondent's care of Patient D deviated from accepted standards of care as follows:

1. Respondent failed to obtain and/or document an adequate history for Patient D.

2. Respondent failed to adequately evaluate and/or document Patient D's need for Suboxone therapy.

3. Respondent prescribed medications to Patient D contrary to accepted standards of medical care, as follows:

    a. Respondent failed to adequately manage and/or document Patient D's Suboxone therapy, including, but not limited to, an occasion on or about January 12, 2011 where Respondent increased Patient D's Suboxone dose to allow Patient D to "pay her husband back" for Suboxone Patient D had taken from him; and/or

    b. Respondent prescribed Patient D dangerous combinations of Suboxone and benzodiazepines without adequate medical indication and/or without documenting an adequate medical indication; and/or

    c. Respondent prescribed excessive quantities of Xanax to Patient D; and/or

    d. Respondent, on or about June 17, 2011, increased Patient D's Xanax dose without adequate medical indication and/or without documenting an adequate medical indication.

4. Respondent failed to adequately address, and/or adequately document addressing, Patient D's drug screens that indicated evidence of substance abuse and/or addiction.

5. Respondent failed to maintain a record that accurately reflected the evaluation and/or treatment of Patient D.

E. Respondent provided medical care to Patient E, a thirty-nine year old female patient, at Respondent's office at various times from on or about June 22, 2009 to, at least, on or about April 29, 2013. Respondent's care of Patient E deviated from accepted standards of care as follows:

1. Respondent failed to obtain and/or document an adequate history of opiate dependence and addiction for Patient E.

2. Respondent failed to obtain and/or document an adequate initial medical history for Patient E.

3. Respondent failed to obtain and/or document an adequate physical exam of Patient E.

4. Respondent failed to adequately manage and/or document the management of Patient E's Suboxone therapy.

5. Respondent prescribed medications to Patient E contrary to accepted standards of medical care, as follows:

   a. Respondent prescribed Patient E excessive amounts of narcotic pain medication; and/or

   b. Respondent prescribed Patient E controlled substances without routine office visits and/or without documenting that such office visits occurred; and/or

   c. Respondent prescribed Patient E dangerous combinations of controlled substances; and/or

   d. Respondent prescribed excessive amounts of Adderall to Patient E without adequate medical indication and/or without documenting an adequate medical indication; and/or

   e. Respondent prescribed Patient E controlled substances without adequately managing the patient's care and/or without adequately documenting the management of the patient's care; and/or

   f. Respondent failed to obtain and/or document adequate liver and renal function tests despite prescribing Patient E medications requiring such tests.

6. Respondent failed to maintain a record that accurately reflected the evaluation and/or treatment of Patient E.

F. Respondent provided medical care to Patient F, a forty-seven year old male patient, at Respondent's office at various times from on or about December 4, 2008 to on or about September 25, 2010. Respondent's care of Patient F deviated from accepted standards of care as follows:

1. Respondent, at various times during Patient F's treatment, engaged in an inappropriate personal relationship with Patient F.

2. Respondent prescribed medications to Patient F contrary to accepted standards of medical care, as follows:

    a. Respondent, at the initial examination of Patient F on or about December 4, 2008, prescribed Patient F narcotic pain medication without adequate medical indication and/or without documenting an adequate medical indication; and/or

    b. Respondent repeatedly prescribed Patient F narcotic pain medication without adequate medical indication and/or without documenting such indication; and/or

    c. Respondent maintained Patient F on short-acting narcotic pain medication to treat Patient F's complaints of chronic pain; and/or

    d. Respondent failed to perform adequate drug screening of Patient F despite prescribing Patient F medications requiring such tests.

3. Respondent failed to adequately manage and/or document her management of Patient F's hypertension.

4. Respondent failed to maintain a record that accurately reflected the evaluation and/or treatment of Patient F.

G. Respondent provided medical care to Patient G, a thirty-seven year old male patient, at Respondent's office at various times from on or about July 2, 2008 to, at least, on or about April 19, 2013. Respondent's care of Patient G deviated from accepted standards of care as follows:

1. Respondent failed to adequately evaluate and/or document Patient G's need for Suboxone therapy.

2. Respondent failed to adequately manage and/or document Patient G's Suboxone therapy.

3. Respondent prescribed medications to Patient G contrary to accepted standards of medical care, as follows:

a. Respondent prescribed Patient G dangerous combinations of Suboxone and other controlled substances; and/or

b. Respondent prescribed Patient G Subutex for opiate dependency treatment; and/or

c. Respondent diagnosed and treated Patient G for Attention-Deficit / Hyperactivity Disorder (ADHD) without adequate medical indication and/or without documenting an adequate medical indication; and/or

d. Respondent prescribed Patient G excessive doses of amphetamine salts and/or Adderall without adequate medical indication and/or without documenting an adequate medical indication; and/or

e. Respondent prescribed Patient G Xanax without adequate medical indication and/or without documenting an adequate medical indication; and/or

f. Respondent prescribed Patient G Vyvanse without adequate medical indication and/or without documenting an adequate medical indication; and/or

g. Respondent prescribed Patient G Nuvigil without adequate medical indication and/or without documenting an adequate medical indication; and/or

h. Respondent failed to obtain and/or document adequate liver and renal function tests despite prescribing Patient G medications requiring such tests.

4. Respondent failed to maintain a medical record that accurately reflected the evaluation and/or treatment of Patient G.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

1. B and B.1.

SECOND SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

2. A and A.1, A and A.2, A and A.3a, A and A.3b, A and A.3c, A and A.3d, A and A.3e, A and A.3f, A and A.4, B and B.1, B and B.2a, B and B.2b, C and C.1a, C and C.1b, C and C.1c, C and C.1d, C and C.1e, C and C.2, C and C.3a, C and C.3b, C and C.3c, C and C.3d, C and C.3e, C and C.3f, C and C.3g, C and C.4, D and D.1, D and D.2, D and D.3a, D and D.3b, D and D.3c, D and D.3d, D and D.4, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5a, E and E.5b, E and E.5c, E and E.5d, E and E.5e, E and E.5f, F and F.1, F and F.2a, F and F.2b, F and F.2c, F and F.2d, F and F.3, G and G.1, G and G.2, G and G.3a, G and G.3b, G and G.3c, G and G.3d, G and G.3e, G and G.3f, G and G.3g and/or G and G.3h.

THIRD THROUGH NINTH SPECIFICATIONS

GROSS NEGLIGENCE

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

3. A and A.1, A and A.2, A and A.3a, A and A.3b, A and A.3c, A and A.3d and/or A and A.3e.

4. B and B.2a and/or B and B.2b.

5. C and C.1a, C and C.1b, C and C.1c, C and C.1d, C and C.1e, C and C.3a, C and C.3b, C and C.3c, C and C.3d, C and C.3e, C and C.3f and/or C and C.3g.

6. D and D.1, D and D.2, D and D.3a, D and D.3b, D and D.3c and/or D and D.3d.

7. E and E.1, E and E.4, E and E.5a, E and E.5b, E and E.5c, E and E.5d and/or E and E.5e.

8. F and F.1, F and F.2a, F and F.2b and/or F and F.2b.

9. G and G.1, G and G.2, G and G.3a, G and G.3b, G and G.3c, G and G.3d, G and G.3e, G and G.3f and/or G and G.3g.

TENTH 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:

10. A and A.1, A and A.2, A and A.3a, A and A.3b, A and A.3c, A and A.3d, A and A.3e, A and A.3f, A and A.4, B and B.2a, B and B.2b, C and C.2, C and C.3a, C and C.3b, C and C.3c, C and C.3d, C and C.3e, C and C.3f, C and C.3g, C and C.4, D and D.1, D and D.2, D and D.3a, D and D.3b, D and D.3c, D and D.3d, D and D.4, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5a, E and E.5b, E and E.5c, E and E.5d, E and E.5e, E and E.5f, F and F.2a, F and F.2b, F and F.2c, F and F.2d, F and F.3, G and G.1, G and G.2, G and G.3a, G and G.3b, G and G.3c, G and G.3d, G and G.3e, G and G.3f, G and G.3g and/or G and G.3h.

ELEVENTH THROUGH SEVENTEENTH 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 facts of the following:

11. A and A.1, A and A.2, A and A.3a, A and A.3b, A and A.3c, A and A.3d and/or A and A.3e.

12. B and B.2a and/or B and B.2b.

13. C and C.3a, C and C.3b, C and C.3c, C and C.3d, C and C.3e, C and C.3f and/or C and C.3g.

14. D and D.1, D and D.2, D and D.3a, D and D.3b, D and D.3c and/or D and D.3d.

15. E and E.1, E and E.4, E and E.5a, E and E.5b, E and E.5c, E and E.5d and/or E and E.5e.

16. F and F.2a, F and F.2b and/or F and F.2c.

17. G and G.1, G and G.2, G and G.3a, G and G.3b, G and G.3c, G and G.3d, G and G.3e, G and G.3f and/or G and G.3g.

EIGHTEENTH THROUGH TWENTIETH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

18. B and B.1.

19. C and C.1a, C and C.1b, C and C.1c, C and C.1d and/or C and C.1e.

20. F and F.1.

TWENTY-FIRST 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 evaluation and treatment of the patient, as alleged in the facts of:

21. A and A.1, A and A.2, A and A.3a, A and A.3c, A and A.3d, A and A.3e, A and A.3f, A and A.4, A and A.5, B and B.3, C and C.2, C and C.3b, C and C.3c, C and C.3d, C and C.3e, C and C.3g, C and C.4, C and C.5, D and D.1, D and D.2, D and D.3a, D and D.3b, D and D.3d, D and D.4, D and D.5, E and E.1, E and E.2, E and E.3, E and E.4, E

and E.6b, E and E.6d, E and E.6e, E and E.6f, E and E.6, F and F.2a, F and F.2b, F and F.3, F and F.4, G and G.1, G and G.2, G and G.3c, G and G.3d, G and G.3e, G and G.3f, G and G.3g, G and G.3h and/or G and G.4.

DATE: April 14, 2016
Albany, New York

[redacted]

MICHAEL A. HISER
Deputy Counsel
Bureau of Professional Medical Conduct

EXHIBIT "B"

Requirements for Closing a Medical Practice Following a Revocation, Surrender, Limitation or Suspension of a Medical License

1. Licensee shall immediately cease and desist from engaging in the practice of medicine in New York State, or under Licensee's New York license, in accordance with the terms of the Order. In addition, Licensee shall refrain from providing an opinion as to professional practice or its application and from representing that Licensee is eligible to practice medicine.

2. Within 5 days of the Order's effective date, Licensee shall deliver Licensee's original license to practice medicine in New York State and current biennial registration to the Office of Professional Medical Conduct (OPMC) at Riverview Center, 150 Broadway, Suite 355, Albany, New York 12204-2719.

3. Within 15 days of the Order's effective date, Licensee shall notify all patients of the cessation or limitation of Licensee's medical practice, and shall refer all patients to another licensed practicing physician for continued care, as appropriate. Licensee shall notify, in writing, each health care plan with which the Licensee contracts or is employed, and each hospital where Licensee has privileges, that Licensee has ceased medical practice. Within 45 days of the Order's effective date, Licensee shall provide OPMC with written documentation that all patients and hospitals have been notified of the cessation of Licensee's medical practice.

4. Licensee shall make arrangements for the transfer and maintenance of all patient medical records. Within 30 days of the Order's effective date, Licensee shall notify OPMC of these arrangements; including the name, address, and telephone number of an appropriate and acceptable contact person who shall have access to these records. Original records shall be retained for at least 6 years after the last date of service rendered to a patient or, in the case of a minor, for at least 6 years after the last date of service or 3 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 include provisions to ensure that the information in the record is kept confidential and is available only to authorized persons. When a patient or a patient's 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 forwarded at a reasonable cost to the patient (not to exceed 75 cents per page.) Radiographic, sonographic and similar materials shall be provided at cost. A qualified person shall not be denied access to patient information solely because of an inability to pay.

5. In the event that Licensee holds a Drug Enforcement Administration (DEA) certificate for New York State, Licensee shall, within 15 days of the Order's effective date, advise the DEA, in writing, of the licensure action and shall surrender Licensee's DEA controlled substance privileges for New York State to the DEA. Licensee shall promptly surrender any unused DEA #222 U.S. Official Order Forms Schedules 1 and 2 for New York State to the DEA. All submissions to the DEA shall

be addressed to Diversion Program Manager, New York Field Division, U.S. Drug Enforcement Administration, 99 Tenth Avenue, New York, NY 10011.

6. Within 15 days of the Order's effective date, Licensee shall return any unused New York State official prescription forms to the Bureau of Narcotic Enforcement of the New York State Department of Health. If no other licensee is providing services at Licensee's practice location, Licensee shall properly dispose of all medications.

7. Within 15 days of the Order's effective date, Licensee shall remove from the public domain any representation that Licensee is eligible to practice medicine, including all related signs, advertisements, professional listings (whether in telephone directories, internet or otherwise), professional stationery or billings. Licensee shall not share, occupy, or use office space in which another licensee provides health care services.

8. Licensee shall not charge, receive or share any fee or distribution of dividends for professional services rendered by Licensee or others while Licensee is barred from engaging in the practice of medicine. Licensee may be compensated for the reasonable value of services lawfully rendered, and disbursements incurred on a patient's behalf, prior to the Order's effective date.

9. If Licensee is a shareholder in any professional service corporation organized to engage in the practice of medicine, Licensee shall divest all financial interest in the professional services corporation, in accordance with New York Business Corporation Law. Such divestiture shall occur within 90 days. If Licensee is the sole shareholder in a professional services corporation, the corporation must be dissolved or sold within 90 days of the Order's effective date.

10. Failure to comply with the above directives may result in a civil penalty or criminal penalties as may be authorized by governing law. Under N.Y. Educ. Law § 6512, it is a Class E Felony, punishable by imprisonment for up to 4 years, to practice the profession of medicine when a professional license has been suspended, revoked or annulled. Such punishment is in addition to the penalties for professional misconduct set forth in N.Y. Pub. Health Law § 230-a, which include fines of up to $10,000 for each specification of charges of which the Licensee is found guilty, and may include revocation of a suspended license.