

STATE OF ALABAMA            )  
  )  
MONTGOMERY COUNTY        )

**VOLUNTARY RESTRICTION ON CERTIFICATE  
OF QUALIFICATION AND LICENSE TO PRACTICE MEDICINE**

The undersigned, LAURENCE DeRICH McMILLAN, M. D., does hereby voluntarily request and consent that the following restrictions be placed upon his certificate of qualification and license to practice medicine in Alabama:

These restrictions are voluntarily entered upon by me, and I understand and agree that these voluntary restrictions shall continue in full force and effect until they are modified, amended or terminated by the Alabama Board of Medical Examiners (“the Board”) at my written request.

**RESTRICTIONS**

1. I agree to continue and complete a program of twice-weekly out-patient psychotherapy/counseling treatment with Kathy Avsar, PhD., or a Board-approved psychotherapist, and I understand and agree that this treatment will address the concerns and treatment process recommendations stated in the written report from the Vanderbilt Comprehensive Assessment Program (VCAP).

2. I agree that I shall sign consent to release forms authorizing the Board to share information with the psychotherapy/counseling treatment program specified in paragraph 1., and, specifically, to release a copy of the VCAP evaluation report to the treatment program.

3. Pursuant to this Voluntary Restriction, I shall sign consent to release forms authorizing any physician or health care provider or facility at which I undergo treatment or monitoring to provide to the Board photocopies of any and all patient or client reports or documents relating to my treatment and prognosis, including psychiatric, psychological and drug

and alcohol treatment records, and to provide to the Board written and verbal reports and information concerning my treatment. I hereby expressly waive any privilege which may otherwise be afforded the disclosure of such records pursuant to state or Federal law.

4. I agree that I shall maintain my Clinical Dependency/Mental Health Assistance Agreement (“APHP Agreement”) executed January 11, 2019 with the Alabama Physician Health Program (APHP) for a period of time deemed appropriate by the APHP. I agree to abide by the terms and conditions set forth in that APHP Agreement. I understand that it is my responsibility to provide a copy of the APHP Agreement to the Board within 10 (ten) calendar days of any amendments or changes to the APHP Agreement. Failure to notify the Board within the 10 (ten) day period of any changes to the APHP Agreement constitutes a violation of this Voluntary Restriction with the Board.

5. I understand that the terms and conditions of the APHP Agreement may include urine, blood, and/or hair testing and/or polygraph testing at frequencies determined by the APHP, and I hereby agree to submit to urine, blood, and/or hair testing and/or polygraph testing as required by the APHP, at my expense.

6. Subsequent to completion of my intensive, twice-weekly out-patient psychotherapy/counseling treatment as outlined in paragraph 1, and being released from those required intensive therapy sessions by the psychotherapist and the APHP, I agree that I shall establish an ongoing, less-intensive outpatient psychotherapy/counseling process with a Board-approved psychotherapist under the guidance of the APHP, if such therapy is deemed necessary by the APHP.

7. I agree that I shall abstain from using any and all potentially addictive chemicals, whether over-the-counter, scheduled or unscheduled, including, but not limited to alcohol (i.e., ethyl alcohol or ethanol), marijuana, hemp oil, tranquilizers, sedatives, stimulants, narcotics, opioids including ultram (tramadol), nubain, hypnotics, and androgenic steroids, except if prescribed by a physician and only after consultation with the APHP.

8. Prior to my return to medical practice, I will submit a detailed practice plan to the Board outlining my employer, the address of the medical practice, my supervisor's name and a signed statement from the supervisor that he or she has read my APHP Agreement and this Voluntary Restriction, my practice hours not to exceed 30 (thirty) hours per week, and any specialty I will be practicing. I agree to limit my medical practice to ambulatory care only.

9. I also agree to strictly limit my medical practice to patients that are at least 19 (nineteen) years of age. I agree to cooperate fully with the Board in their random patient chart reviews to ensure that I am abiding by the "adults patients only" requirement.

10. I agree to provide to the Board, upon request, blood and/or urine and/or hair samples for the purpose of laboratory testing to determine the presence of alcohol, controlled substances, and/or mood-altering substances, and I understand and acknowledge that I shall be responsible for the expense of said testing. I understand and agree that a refusal by me to provide a blood and/or urine and/or hair sample to the Board upon request shall constitute a violation of this Voluntary Restriction.

11. I understand and agree that, immediately upon signing and returning this document, I shall contact Mr. Jeff Grimsley, Physician Monitoring Director, Alabama Board of Medical Examiners, PO Box 946, Montgomery AL, 36101-0946 (street address: 848 Washington

Avenue, Montgomery AL, 36104), telephone (334) 833-0162, email [jgrimsley@albme.org](mailto:jgrimsley@albme.org), or Ms. Burke Britton McMahon, Physician Monitoring Coordinator, at the same address and telephone number, email [bbmcmahon@albme.org](mailto:bbmcmahon@albme.org), for information concerning the required releases to be signed, and any other matters necessary for fulfilling the requirements of this Voluntary Restriction; and I understand and agree that Mr. Grimsley and his office shall be the Board's agent for monitoring my compliance with these requests.

12. During the period of this Voluntary Restriction, I shall notify the Board of any change of my residence address and any change in my medical practice location or employment and shall provide the reason for such change.

#### PENALTIES FOR VIOLATION

The occurrence of one or more of the following acts or omissions shall constitute a violation of this Voluntary Restriction:

a. Failure or refusal to satisfy any one or more of the requirements and conditions stated in paragraphs 1 through 12.

Any violation of this Voluntary Restriction, if established after notice and hearing as provided by the Alabama Administrative Procedure Act and the Rules and Regulations of the Medical Licensure Commission, shall constitute grounds for the suspension, restriction or revocation of the named physician's license to practice medicine in Alabama or the imposition of any other penalty authorized by Ala. Code §§ 34-24-361 and 34-24-381(2002).

#### DISCLOSURE NOTICE

This Voluntary Restriction constitutes a public record of the Alabama Board of Medical Examiners and will be reported by the Board to the Federal National Practitioner Data Bank (NPDB)

and the Federation of State Medical Boards disciplinary data bank. This voluntary restriction may be released by the Alabama State Board of Medical Examiners to any person or entity requesting information concerning the licensure status in Alabama of the physician named herein.

CERTIFICATION

I certify that I have read the foregoing Voluntary Restriction on my certificate of qualification to practice medicine in Alabama, that I understand the terms and conditions thereof, and that the same are entered into by me, voluntarily, this 06 day of May, 2019.



LAURENCE DeRICH McMILLAN, M. .D

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(Address)

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(Telephone Number)



Witness/Attorney for Dr. McMillan