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

IN THE MATTER

OF

ANTHONY NAPPI, M.D.

SURRENDER ORDER

BPMC No. #08-83

Upon the application of (Respondent) ANTHONY NAPPI, M.D. to Surrender his 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 Application or by certified mail to Respondent's attorney, OR
- upon facsimile transmission to Respondent or Respondent's attorney,

whichever is first.

SO ORDERED.

Redacted Signature

DATE: 5-30-2008

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
ANTHONY NAPPI, M.D.

SURRENDER
of
LICENSE

ANTHONY NAPPI, M.D., representing that all of the following statements are true, deposes and says:

That on or about April 9, 1973, I was licensed to practice as a physician in the State of New York and issued License No. 115906 by the New York State Education Department.

My current address is 1402 Genesee Street, Suite 202, Utica, New York, 13502, 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 has charged me with forty six specifications of professional misconduct.

A copy of the Statement of Charges, marked as Exhibit "A", 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 admit the Forty-Fifth Specification [breach of patient confidentiality] and the Forty-Sixth Specification [failure to maintain accurate records], and I do not contest the Fifteenth through Twentieth Specifications [fraud in the practice of medicine], and the Forty-Third Specification [negligence

on more than one occasion], all 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.

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.

Redacted Signature

DATE 5-23-08

ANTHONY NAPPI, M.D.
RESPONDENT

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

DATE: 3/23/08

Redacted Signature

JOHN A. LONGERETTA, ESQ.
Attorney for Respondent

DATE: 3/23/08

Redacted Signature

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

DATE: 3/30/08

Redacted Signature

KEITH W. SERVIS
Director
Office of Professional Medical Conduct

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

EXHIBIT A

IN THE MATTER

OF

ANTHONY NAPPI, M.D.

STATEMENT

OF

CHARGES

ANTHONY NAPPI, M.D., the Respondent, was authorized to practice medicine in New York State on or about April 9, 1973, by the issuance of license number 115906 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 31 year old female patient, at various times from on or about August 24, 2007, to September 24, 2007, at Respondent's Office at 1402 Genesee Street, Suite 202, Utica, New York, 13502 [hereafter, "Respondent's Office"]. Respondent's care of Patient A failed to accord with accepted standards of practice in that:

1. Respondent, before beginning suboxone therapy with Patient A, failed to perform and/or document the performance of a comprehensive assessment of the patient including psychiatric and medical history, or substance abuse history, to determine that the patient met reasonable medical criteria for treatment with suboxone.

2. Respondent, before beginning suboxone therapy with Patient A, failed to create and/or document the creation of a treatment plan for the patient.

3. Respondent, before beginning suboxone therapy with Patient A, failed to perform a physical examination of Patient A, including obtaining indicated laboratory tests, or to ensure that the patient obtained such a physical examination and laboratory tests from another physician.

4. Respondent, once the patient was being treated with suboxone, failed to obtain indicated laboratory studies on an ongoing basis, including urine toxicology tests.

5. Respondent, at various times during the patient's office visits, engaged in the following inappropriate conduct:

(A) Respondent told the patient that he liked "pussy", or words to that effect, in the context that the patient understood to be a sexual reference.

(B) Respondent told Patient A that, if she had trouble coming up with money to pay his office visit fee, that they could "work something out", or words to that effect. Patient A interpreted this to mean sexual favors, since Respondent kept mentioning how much he "liked pussy", and he winked at her and licked his lips when he made this proposal.

(C) Respondent, during the first visit with Patient A, bragged about his connections to organized crime, mentioned sexual matters, laughed and joked and displayed excitement, followed by sadness and crying.

(D) Respondent breached patient confidentiality by putting other patients on a speaker phone when they called in and allowing Patient A and her husband to hear the calling patients discuss their medical histories.

(E) Respondent was observed and heard by Patient A telling other patient(s) "don't come here unless you have my fucking money", or words to that effect.

(F) Respondent was observed and heard by Patient A commenting on his hatred of religious or ethnic groups.

6. Respondent required Patient A, a patient whose care with Respondent was to be reimbursed by Medicaid, to pay him an additional amount of between $100 to $150 for each office visit with Respondent on or about the following dates: August 24, 2007, and September 24, 2007, in violation of New York law, as specifically set out in 18 NYCRR 515.2(b)(8) and/or 515.2(b)(9).

B. Respondent provided medical care to Patient B, a 29 year old female patient, on at various times from on or about August 2006 to September 2006 at Respondent's Office. Respondent's care of Patient B failed to accord with accepted standards of practice in that:

1. Respondent, before beginning suboxone therapy with Patient B, failed to perform and/or document the performance of a comprehensive assessment of the patient including psychiatric and medical history, or substance abuse history, to determine that the patient met reasonable

medical criteria for treatment with suboxone.

2. Respondent, before beginning suboxone therapy with Patient B, failed to create and/or document the creation of a treatment plan for the patient.

3. Respondent, before beginning suboxone therapy with Patient B, failed to perform a physical examination of Patient B, including obtaining indicated laboratory tests, or to ensure that the patient obtained such a physical examination and laboratory tests from another physician.

4. Respondent, once the patient was being treated with suboxone, failed to obtain indicated laboratory studies on an ongoing basis, including urine toxicology tests.

5. Respondent documented that he discharged Patient B from care due to her missing 3 appointments, contrary to the Respondent's medical record.

6. Respondent, at various times during the patient's office visits, engaged in the following inappropriate conduct:

   (A) Respondent, after being told by the patient that she had only $50 to pay him in addition to the Medicaid fee, told her she could "suck him or play around with his penis", or words to that effect.

   (B) Respondent, after the patient refused to engage in the conduct described in paragraph (A), above, then cursed at the patient, calling her "a fucking drug addict, a fucking junkie", and told her to "get out of [his] fucking office", or words to that effect.

7. Respondent required Patient B, a patient whose care with Respondent was to be reimbursed by Medicaid, to pay him additional amounts of between $50 to $150 for each office visit with Respondent in August and September 2006, in violation of New York law, as specifically set out in 18 NYCRR 515.2(b)(8) and/or 515.2(b)(9).

C. Respondent provided medical care to Patient C, a 25 year old female patient, at various times from on or about October 19, 2007, to February 8, 2008, at Respondent's office. Respondent's care of Patient C failed to accord with accepted standards of practice in that:

1. Respondent, before beginning suboxone therapy with Patient C, failed to perform and/or document the performance of a comprehensive assessment of the patient including psychiatric and medical history, or substance abuse history, to determine that the patient met reasonable medical criteria for treatment with suboxone.

2. Respondent, before beginning suboxone therapy with Patient C, failed to create and/or document the creation of a treatment plan for the patient.

3. Respondent, before beginning suboxone therapy with Patient C, failed to perform a physical examination of Patient C, including obtaining indicated laboratory tests, or to ensure that the patient obtained such a physical examination and laboratory tests from another physician.

4. Respondent, once the patient was being treated with suboxone, failed to obtain indicated laboratory studies on an ongoing basis, including urine toxicology tests.

5. Respondent started or stopped the prescription of various anti-depressant medications to Patient C without adequate medical indication, and/or without documenting such indication.

6. Respondent, at various times during the patient's office visits, engaged in the following inappropriate conduct:

   (A) Respondent took the patient's hand with his own and moved the patient's hand to the area of the Respondent's genitals.

   (B) Respondent told the patient that he had a bad back, and indicated to her that she could come in every week and give him massages.

   (C) Respondent requested that the patient manipulate his penis in exchange for a reduction in the office fee charged by Respondent.

   (D) Respondent breached patient confidentiality by seeing Patient C along with other patients in groups, and/or by putting other patients on a speaker phone when they called in and allowing the patient to hear the calling patients discuss their medical histories, without adequate consent or medical indication.

   (E) Respondent allowed and/or requested Patient C to obtain her own medical records from file cabinets where she had access to other patient's medical information.

   (F) Respondent told patients in the presence of Patient C, "bring my fucking money," or "get the fuck out of here if you don't have my money", or words to that effect.

   (G) Respondent was observed by Patient C commenting on his hatred of religious or ethnic groups.

   (H) Respondent, in the presence of Patient C and another patient and that patient's father, disclosed personal information about Patient C to the other patient and his father.

7. Respondent required Patient C, a patient whose care with Respondent was to be reimbursed by Medicaid, to pay him an additional amount of between $100 to $150 for each office visit with Respondent on or about the following dates: October 19, 2007, December 10, 2007,

January 11, 2008, January 25, 2008, and February 8, 2008, in violation of New York law, as specifically set out in 18 NYCRR 515.2(b)(8) and/or 515.2(b)(9).

D. Respondent provided medical care to Patient D, a 32 year old female patient, at various times from on or about September 2005 to February 2006, at Respondent's office. Respondent's care of Patient D failed to accord with accepted standards of practice in that:

1. Respondent, before beginning suboxone therapy with Patient D, failed to perform and/or document the performance of a comprehensive assessment of the patient including psychiatric and medical history, or substance abuse history, to determine that the patient met reasonable medical criteria for treatment with suboxone.

2. Respondent, before beginning suboxone therapy with Patient D, failed to create and/or document the creation of a treatment plan for the patient.

3. Respondent, before beginning suboxone therapy with Patient D, failed to perform a physical examination of Patient D, including obtaining indicated laboratory tests, or to ensure that the patient obtained such a physical examination and laboratory tests from another physician.

4. Respondent, once the patient was being treated with suboxone, failed to obtain indicated laboratory studies on an ongoing basis, including urine toxicology tests.

5. Respondent, at various times during the patient's office visits, engaged in the following inappropriate conduct:

   (A) Respondent made comments of a personal sexual nature to the patient, such as mentioning his inability to get an erection.

   (B) Respondent breached patient confidentiality by seeing Patient D along with other patients in groups, and/or by putting other patients on a speaker phone when they called in and allowing the patient to hear the calling patients discuss their medical histories, without adequate consent and/or medical indication.

   (C) Respondent allowed and/or requested Patient D to obtain her own medical records from file cabinets where she had access to other patient's medical information.

6. Respondent required Patient D, a patient whose care with Respondent was being reimbursed by Medicaid, to pay him an additional amount of

between $150 in cash for her initial office visit, and an additional $100 in cash for each office visit thereafter, in violation of New York law, as specifically set out in 18 NYCRR 515.2(b)(8).

E. Respondent provided medical care to Patient E, a 29 year old female patient, at various times from on or about March 2006 to August 2006 at Respondent's office. Respondent's care of Patient E failed to accord with accepted standards of practice in that:

1. Respondent failed to maintain a medical record of his care and treatment of Patient E.

2. Respondent, at various times during the patient's office visits, engaged in the following inappropriate conduct:

   (A) Respondent, at the patient's initial visit, and under the guise of performing a physical exam, fondled her breasts on two occasions, and also crept his hand toward her crotch and thigh.

   (B) Respondent breached patient confidentiality by seeing Patient E along with other patients in groups, and/or by putting other patients on a speaker phone when they called in and allowing the patient to hear the calling patients discuss their medical histories, without proper consent and/or adequate medical indication.

   (C) Respondent allowed and/or requested Patient E to obtain her own medical records from file cabinets where she had access to other patient's medical information.

3. Respondent required Patient E, a patient whose care with Respondent was being reimbursed by Medicaid, to pay him an additional amount of between $100 to $150 for several office visits with Respondent in violation of New York law, as specifically set out in 18 NYCRR 515.2(b)(8).

F. Respondent provided medical care to Patient F, a 37 year old female patient, at various times from on or about October 6, 2006, to August 11, 2007, at Respondent's Office. Respondent's care of Patient F failed to accord with accepted standards of practice in that:

1. Respondent, before beginning suboxone therapy with Patient F, failed to perform and/or document the performance of a comprehensive assessment of the patient including psychiatric and medical history, or substance abuse history, to determine that the patient met reasonable medical criteria for treatment with suboxone.

2. Respondent, before beginning suboxone therapy with Patient F, failed to create and/or document the creation of a treatment plan for the patient.

3. Respondent, before beginning suboxone therapy with Patient F, failed to perform a physical examination of Patient F, including obtaining indicated laboratory tests, or to ensure that the patient obtained such a physical examination and laboratory tests from another physician.

4. Respondent, once the patient was being treated with suboxone, failed to obtain indicated laboratory studies on an ongoing basis, including urine toxicology tests.

5. Respondent increased and decreased suboxone doses without assessing the rationales for such increases or decreases, and/or without documenting the rationales.

6. Respondent, at various times during the patient's office visits, engaged in the following inappropriate conduct:

   (A) Respondent placed his hands on Patient F's breast to "demonstrate" the way that he had touched another person's breasts.

   (B) Respondent breached patient confidentiality by seeing Patient F along with other patients in groups, and/or by putting other patients on a speaker phone when they called in and allowing the patient to hear the calling patients discuss their medical histories, without adequate consent or medical indication.

   (C) Respondent allowed and/or requested Patient F to obtain her own medical records from file cabinets where she had access to other patient's medical information, and also to obtain other patient's records at his request.

   (D) Respondent on several occasions told Patient F, "all you are is a fucking junkie", and "no fucking money, no fucking pills", or words to that effect.

7. Respondent required Patient F, a patient whose care with Respondent was to be reimbursed by Medicaid, to pay him an additional amount of between $100 to $150 for several office visits with Respondent, in violation of New York law, as specifically set out in 18 NYCRR 515.2(b)(8).

G. Respondent provided medical care to Patient G, a 29 year old female patient, at various times from on or about January 2006 to January 2007, at Respondent's office. Respondent's care of Patient G failed to accord with accepted standards of practice in that:

1. Respondent, before beginning suboxone therapy with Patient G, failed to perform and/or document the performance of a comprehensive assessment of the patient including psychiatric and medical history, or substance abuse history, to determine that the patient met reasonable medical criteria for treatment with suboxone.

2. Respondent, before beginning suboxone therapy with Patient G, failed to create and/or document the creation of a treatment plan for the patient.

3. Respondent, before beginning suboxone therapy with Patient G, failed to perform a physical examination of Patient G, including obtaining indicated laboratory tests, or to ensure that the patient obtained such a physical examination and laboratory tests from another physician.

4. Respondent, once the patient was being treated with suboxone, failed to obtain indicated laboratory studies on an ongoing basis, including urine toxicology tests.

5. Respondent increased and decreased suboxone doses without assessing the rationales for such increases or decreases, and/or without documenting the rationales.

6. Respondent prepared two notes of his care of Patient G for a visit of December 18, 2006, which are directly contradictory in terms of future plans for the patient's care in that one indicates a next visit for the patient in "1/07", and the other indicates "Pat. discharged. Last Rx."

H. Respondent provided medical care to Patient H, a 37 year old female patient, at various times from on or about September 2004 to February 2008 at Respondent's Office. Respondent's care of Patient H failed to accord with accepted standards of practice in that:

1. Respondent, before beginning suboxone therapy with Patient H, failed to perform and/or document the performance of a comprehensive assessment of the patient including psychiatric and medical history, or substance abuse history, to determine that the patient met reasonable medical criteria for treatment with suboxone.

2. Respondent, before beginning suboxone therapy with Patient H, failed to create and/or document the creation of a treatment plan for the patient.

3. Respondent, before beginning suboxone therapy with Patient H, failed to perform a physical examination of Patient H, including obtaining indicated laboratory tests, or to ensure that the patient obtained such a physical examination and laboratory tests from another physician.

4. Respondent, once the patient was being treated with suboxone, failed to obtain indicated laboratory studies on an ongoing basis, including urine toxicology tests.

5. Respondent started or stopped the prescription of various anti-depressant medications to Patient H without adequate medical indication, and/or without documenting such indication.

6. Respondent increased and decreased suboxone doses without assessing the rationales for such increases or decreases, and/or without documenting the rationales.

I. Respondent provided medical care to Patient I, a 26 year old female patient, at various times from on or about February 2007 and November 2007 at Respondent's office. Respondent's care of Patient I failed to accord with accepted standards of practice in that:

1. Respondent, before beginning suboxone therapy with Patient I, failed to perform and/or document the performance of a comprehensive assessment of the patient including psychiatric and medical history, or substance abuse history, to determine that the patient met reasonable medical criteria for treatment with suboxone.

2. Respondent, before beginning suboxone therapy with Patient I, failed to create and/or document the creation of a treatment plan for the patient.

3. Respondent, before beginning suboxone therapy with Patient I, failed to perform a physical examination of Patient I, including obtaining indicated laboratory tests, or to ensure that the patient obtained such a physical examination and laboratory tests from another physician.

4. Respondent, once the patient was being treated with suboxone, failed to obtain indicated laboratory studies on an ongoing basis, including urine toxicology tests.

5. Respondent failed to assess the patient and/or document an adequate assessment of the patient prior to diagnosing her with "bipolar disorder", and beginning treatment for same.

J. Respondent provided medical care to Patient J, a 38 year old female patient, at various times from on or about April 2006 to February 2008, at Respondent's office. Respondent's care of Patient J failed to accord with accepted standards of practice in that:

1. Respondent, before beginning suboxone therapy with Patient J, failed to perform and/or document the performance of a comprehensive assessment of the patient including psychiatric and medical history, or substance abuse history, to determine that the patient met reasonable medical criteria for treatment with suboxone.

2. Respondent, before beginning suboxone therapy with Patient J, failed to create and/or document the creation of a treatment plan for the patient.

3. Respondent, before beginning suboxone therapy with Patient J, failed to perform a physical examination of Patient J, including obtaining indicated laboratory tests, or to ensure that the patient obtained such a physical examination and laboratory tests from another physician.

4. Respondent, once the patient was being treated with suboxone, failed to obtain indicated laboratory studies on an ongoing basis, including urine toxicology tests.

5. Respondent increased and decreased suboxone doses without assessing the rationales for such increases or decreases, and/or without documenting the rationales.

6. Respondent documented that the patient's status on 8/3/07 and 9/14/07 was of "maintaining abstinence from all illegal and controlled substances since our last session", despite the fact that the patient was in-patient at the St. Lawrence Addiction Treatment Center as of August 7, 2007.

7. Respondent's note of his care of Patient J for a visit of February 4, 2008 repeatedly mentions that the patient is male. Patient J is female.

8. Respondent, at various times during the patient's office visits, engaged in the following inappropriate conduct:

(A) Respondent repeatedly used profane language and racial slurs, and told the patient that all his patients were "fucking junkies", or words to that effect.

(B) Respondent often made sexual comments to or in the presence of Patient J, such as, "do you think this girl would give me a blowjob", or words to that effect.

(C) Respondent allowed and/or requested Patient J to obtain her own medical records from file cabinets where she had access to other patient's medical information, and also to obtain to copy or file other patient's medial records.

K. Respondent provided medical care to Patient K, a 27 year old female patient, on at various times from on or about November 26, 2007, to February 11, 2008 at Respondent's Office. Respondent's care of Patient K failed to accord with accepted standards of practice in that:

1. Respondent, before beginning suboxone therapy with Patient K, failed to perform and/or document the performance of a comprehensive assessment of the patient including psychiatric and medical history, or substance abuse history, to determine that the patient met reasonable medical criteria for treatment with suboxone.

2. Respondent, before beginning suboxone therapy with Patient K, failed to create and/or document the creation of a treatment plan for the patient.

3. Respondent, before beginning suboxone therapy with Patient K, failed to perform a physical examination of Patient K, including obtaining indicated laboratory tests, or to ensure that the patient obtained such a physical examination and laboratory tests from another physician.

4. Respondent, once the patient was being treated with suboxone, failed to obtain indicated laboratory studies on an ongoing basis, including urine toxicology tests.

5. Respondent's documented note for the patient's visit of Dec. 19, 2007, inconsistently notes that the patient has a normal mental status exam, and also that she shows "bi-polar" symptoms for which medication, including Seroquel, is given.

SPECIFICATION OF CHARGES

FIRST TO SEVENTH 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 following:

1. The facts in Paragraphs A and A.5(A), A and A.5(B), A and A.5(C), A and A.5(E), A and A.5(F), and/or A and A.6.
2. The facts in Paragraphs B and B.6(A), B and B.6(B), and/or B and B.7.
3. The facts in Paragraphs C and C.6(A), C and C.6(B), C and C.6(C), C and C.6(F), C and C.6(G), C and C.6(H) and/or C and C.7.
4. The facts in Paragraphs D and D.5(A) and/or D and D.6.
5. The facts in Paragraphs E and E.2(A) and/or E and E.3.
6. The facts in Paragraphs F and F.6(A), F and F.6(D) and/or F and F.7.
7. The facts in Paragraphs J and J.8(A), and/or J and J.8(B).

EIGHTH TO FOURTEENTH SPECIFICATIONS

WILFUL PHYSICAL AND VERBAL ABUSE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(31) by wilfully harassing, abusing, or intimidating a patient either physically or verbally, as alleged in the following:

8. The facts in Paragraphs A and A.5(A), A and A.5(B), A and A.5(C), A and A.5(E), and/or A and A.5(F).
9. The facts in Paragraphs B and B.6(A) and/or B and B.6(B).
10. The facts in Paragraphs C and C.6(A), C and C.6(B), C and C.6(C), C and C.6(F), C and C.6(G), and/or C and C.6(H).

11. The facts in Paragraphs D and D.5A.

12. The facts in Paragraphs E and E.2(A).

13. The facts in Paragraphs F and F.6(A) and/or F and F.6(D).

14. The facts in Paragraphs J and J.8(A) and/or J and J.8(B).

FIFTEENTH TO TWENTIETH SPECIFICATIONS

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 following:

15. The facts in Paragraphs A and A.6.

16. The facts in Paragraphs B and B.7.

17. The facts in Paragraphs C and C.7.

18. The facts in Paragraphs D and D.6.

19. The facts in Paragraphs E and E.3.

20. The facts in Paragraphs F and F.7.

TWENTY-FIRST TO THIRTY-FIRST SPECIFICATIONS

GROSS NEGLIGENCE

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

21. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, and/or A and A.5(D).

22. The facts in Paragraphs B and B.1, B and B.2, B and B.3, B and B.4, and/or B and B.5.

23. The facts in Paragraphs C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6(D), C and C.6(E), and/or C and C.6(H).

24. The facts in Paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.5(B), and/or D and D.5(C) .

25. The facts in Paragraphs E and E.1, E and E.2(B) and/or E and E.2(C).

26. The facts in Paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6(B), and/or F and F.6(C).

27. The facts in Paragraphs G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, and/or G and G.6.

28. The facts in Paragraphs H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, and/or H and H.6.

29. The facts in Paragraphs I and I.1, I and I.2, I and I.3, I and I.4, and/or I and I.5.

30. The facts in Paragraphs J and J.1, J and J.2, J and J.3, J and J.4, J and J.5, J and J.6, and/or J and J.8(C).

31. The facts in Paragraphs K and K.1, K and K.2, K and K.3, K and K.4, and/or K and K.5.

THIRTY-SECOND TO FORTY-SECOND SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the following:

32. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, and/or A and A.5(D).

33. The facts in Paragraphs B and B.1, B and B.2, B and B.3, B and B.4, and/or B and B.5.

34. The facts in Paragraphs C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6(D), C and C.6(E), and/or C and C.6(H).

35. The facts in Paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.5(B), and/or D and D.5(C) .

36. The facts in Paragraphs E and E.1, E and E.2(B) and/or E and E.2(C).

37. The facts in Paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6(B), and/or F and F.6(C).

38. The facts in Paragraphs G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, and/or G and G.6.

39. The facts in Paragraphs H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, and/or H and H.6.

40. The facts in Paragraphs I and I.1, I and I.2, I and I.3, I and I.4, and/or I and I.5.

41. The facts in Paragraphs J and J.1, J and J.2, J and J.3, J and J.4, J and J.5, J and J.6, and/or J and J.8(C).

42. The facts in Paragraphs K and K.1, K and K.2, K and K.3, K and K.4, and/or K and K.5.

FORTY-THIRD 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 two or more of the following:

43. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.5(D), B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6(D), C and C.6(E), C and C.6(H), D and D.1, D and D.2, D and D.3, D and D.4, D and D.5(B) and D and D.5(C), E and E.1, E and E.2(B), E and E.2(C), F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6(B), F and F.6(C), G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, 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, J and J.1, J and J.2, J and J.3, J and J.4, J and J.5, J and J.6, J and J.7, J and J.8(C), K and K.1, K and K.2, K and K.3, K and K.4, and/or K and K.5.

FORTY-FOURTH 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 two or more of the following:

44. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.5(D), B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6(D), C and C.6(E), C and C.6(H), D and D.1, D and D.2, D and D.3, D and D.4, D and D.5(B) and D and D.5(C), E and E.1, E and E.2(B), E and E.2(C), F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6(B), F and F.6(C), G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, 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, J and J.1, J and J.2, J and J.3, J and J.4, J and J.5, J and J.6, J and J.7, J and J.8(C), K and K.1, K and K.2, K and K.3, K and K.4, and/or K and K.5.

FORTY-FIFTH SPECIFICATION

CONFIDENTIALITY

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(23) by revealing of personally identifiable facts, data, or information obtained in a professional capacity without the prior consent of the patient, as alleged in the following:

45. The facts in Paragraphs A and A.5(D), C and C.6(D), C and C.6(E), C and C.6(H), D and D.5(B), D and D.5(C), E and E.2(B), E and E.2(C), F and F.6(B), and/or F and F.6(C).

FORTY-SIXTH 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 following:

46. The facts in Paragraphs A and A.1, A and A.2, B and B.1, B and B.2, B and B.5, C and C.1, C and C.2, C and C.5, D and D.1, D and D.2, E and E.1, F and F.1, F and F.2, F and F.5, G and G.1, G and G.2, G and G.5, G and G.6, H and H.1, H and H.2, H and H.5, H and H.6, I and I.1, I and I.2, I and I.5, J and J.1, J and J.2, J and J.5, J and J.6, J and J.7, K and K.1, K and K.2, and/or K and K.5.

DATE: May 6, 2008
Albany, New York

Redacted Signature

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

EXHIBIT "B"

GUIDELINES FOR CLOSING A MEDICAL PRACTICE FOLLOWING MEDICAL LICENSE REVOCATION, SURRENDER OR SUSPENSION OF SIX MONTHS OR MORE

1. Respondent shall immediately cease the practice of medicine in compliance with the terms of the Surrender Order. Respondent shall not represent that Respondent is eligible to practice medicine and shall refrain from providing an opinion as to professional practice or its application.

2. Within 15 days of the Surrender Order's effective date, Respondent shall notify all patients that Respondent has ceased the practice of medicine, and shall refer all patients to another licensed practicing physician for continued care, as appropriate.

3. Within 30 days of the Surrender Order's effective date, Respondent shall deliver Respondent's original license to practice medicine in New York State and current biennial registration to the Office of Professional Medical Conduct (OPMC) at 433 River Street Suite 303, Troy, NY 12180-2299.

4. Respondent shall arrange for the transfer and maintenance of all patient medical records. Within 30 days of the Surrender Order's effective date, Respondent shall notify OPMC of these arrangements, including the name, address, and telephone number of an appropriate contact person, acceptable to the Director of OPMC, who shall have access to these records. Original records shall be retained for patients for at least 6 years after the last date of service, and, for minors, 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 ensure that all patient information is kept confidential and is available only to authorized persons. When a patient or authorized representative requests a copy of the patient's medical record, or requests that the original medical record be sent to another health care provider, a copy of the record shall be provided promptly or sent to the patient at reasonable cost (not to exceed 75 cents per page). Radiographic, sonographic and like materials shall be provided at cost. A qualified person shall not be denied access to patient information solely because of inability to pay.

5. Within 15 days of the Surrender Order's effective date, if Respondent holds a Drug Enforcement Agency (DEA) certificate, Respondent shall advise the DEA in writing of the licensure action and shall surrender Respondent's DEA controlled substance certificate, privileges, and any unused DEA #222 U.S. Official Order Forms Schedules 1 and 2, to the DEA.

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

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

8. Respondent shall not charge, receive or share any fee or distribution of dividends for professional services rendered (by Respondent or others) while barred from practicing medicine. Respondent may receive compensation for the reasonable value of services lawfully rendered, and disbursements incurred on a patient's behalf, before the Surrender Order's effective date.

9. If Respondent is a shareholder in any professional service corporation organized to engage in the practice of medicine and Respondent's license is revoked, surrendered or suspended for 6 months or more pursuant to this Surrender Order, Respondent shall, within 90 days of the Surrender Order's effective date, divest all financial interest in the professional services corporation in accordance with New York Business Corporation Law. If Respondent is the sole shareholder in a professional services corporation, the corporation must be dissolved or sold within 90 days of the Surrender Order's effective date.

10. Failure to comply with the above directives may result in civil or criminal penalties. Practicing medicine when a medical license has been suspended, revoked or annulled is a Class E Felony, punishable by imprisonment for up to 4 years, under N.Y. Educ. Law § 6512. Professional misconduct may result in penalties including revocation of the suspended license and/or fines of up to $10,000 for each specification of misconduct, under N.Y. Pub. Health Law § 230-a.