COMMONWEALTH of VIRGINIA

Sandra Whitley Ryals
Director

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

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TEL (804) 367- 4400
FAX (804) 527- 4475

January 28, 2010

Richard Hill, M.D.
Comprehensive Psychological Services
860 Greenbrier Circle, Suite 100
Chesapeake, Virginia 23320

CERTIFIED MAIL
7160 3901 9848 0162 7196

RE: **License No.: 0101-058825**

Dear Dr. Hill:

This letter is official notification that an informal conference of the Virginia Board of Medicine ("Board") will be held on **Wednesday, March 10, 2010, at 2:30 p.m., at the office of the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Henrico, Virginia.** The conference will be conducted pursuant to Sections 54.1-2400(10), 2.2-4019 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code").

A Special Conference Committee ("Committee") will inquire into allegations that you may have violated certain laws and regulations governing the practice of medicine in Virginia. Specifically:

1. You may have violated Sections 54.1-2915.A(2) and (14) of the Code, in that you are unfit for the performance of your professional obligations and duties and/or are unable to practice medicine with reasonable skill and safety because of substance abuse and/or illness. Specifically,

a. On or about April 29, 2009, you admitted to an investigator with the Virginia Department of Health Professions ("DHP investigator"), that from approximately 2006 through approximately December 2008, you self-medicated with and abused Roxicet (C-II) and Oxycontin (C-II).

b. Despite the fact that you told the DHP investigator on or about April 29, 2009, that you last abused Roxicet or Oxycontin in February 2009, a urine drug screen sample you provided on or about May 1, 2009, tested positive for oxycodone (C-II) and oxymorphone (C-II) on or about May 15, 2009.

c. On or about May 21, 2009, your attorney reported to the DHP investigator that you entered treatment for substance abuse on that date.

2. You may have violated Sections 54.1-2915.A(1), (8), (12), (13), (16), (17) and (18), 54.1-3303.A and 54.1-3408.A of the Code, and Section 54.1-2915.A(10) of the Code, as defined by Section 18.2-258.1 of the Code, and 18 VAC 85-20-25(A) and (C) and 18 VAC 85-20-29(A)(3), of the Board of Medicine General Regulations, in that, by your own admission, beginning in 2006, you fraudulently obtained Roxicet (C-II) and/or Oxycontin (C-II) by diverting those medications for your own personal and unauthorized use from prescriptions you wrote and authorized for Individual X, a family member. Further, by your own admission, beginning in approximately June 2008 through approximately November 2008, pursuant to an agreement you initiated with Patient A, you fraudulently obtained Roxicet (C-II) and/or Oxycontin (C-II) by writing and authorizing prescriptions for those controlled substances in the name of Patient A, who purchased those medications with money provided by you, and returned them to you for your own personal and unauthorized use. Furthermore, on one occasion when delivering a prescription to Patient A, you left a partial prescription pad at the residence of Patients A and B and failed to retrieve it.

3. You may have violated Sections 54.1-2915.A(12), (16) and (18) of the Code and Board of Medicine General Regulation 18 VAC 85-20-29(A)(3), in that, by your own admission, in November 2008, you paid a total of approximately $10,000.00 to Patients A and B to remain silent about your illegal and unethical conduct regarding prescription writing.

4. You may have violated Sections 54.1-2915.A(1) and (16) of the Code and 54.1-2915.A(10) of the Code, as further defined in Section 18.2-260.1 of the Code, in that in or around November 2008, after Patient B confronted you regarding your excessive prescribing of Adderall (C-II) for Patient A and your fraudulent prescribing activities with Patient A, you fraudulently created after-the-fact medical records for Patients A and B, and subsequently, submitted those records to the Board.

5. You may have violated Sections 54.1-2915.A(3), (12), (13), (16) and (18) of the Code and Board of Medicine General Regulation 18 VAC 85-20-26(C), in that you failed to manage the treatment of Patients A and B within acceptable standards. Specifically:

a. You provided samples of antidepressants and prescribed amphetamines, benzodiazepines, and opioids to Patient A from approximately June 2008 through November 2008 and to Patient B from approximately August 2008 through November 2008; however, you failed to: consistently document many of those prescriptions in the medical records of Patients A and B; require Patients A and B present for an office visit prior to your prescribing controlled substances; perform and/or document adequate evaluations, assessments, diagnoses, or physical findings prior to prescribing. Further, you failed to: document a discussion of the risks/benefits of the

medications prescribed; obtain prior treatment records of Patients A and B; and make appropriate patient referrals to other physicians.

b. From approximately July 2008 through approximately November 2008, you prescribed Adderall (C-II) for Patient A, who exhibited drug seeking behavior or who you knew or should have known was abusing or had become addicted to or dependent upon Adderall, in that Patient A frequently made early requests for Adderall prescriptions and you regularly provided and/or authorized Adderall prescriptions prior to the time Patient A should have run out of it if taken as prescribed. Specifically, Patient A filled prescriptions you wrote and/or authorized for a thirty-day supply of Adderall (C-II) on July 8, 2008, July 21, 2008, August 2, 2008, August 9, 2008, September 6, 2008, September 22, 2008, September 30, 2008, and October 16, 2008.

6. You may have violated Section 54.1-2915.A(3), (12), (13), (16), and (18) and Board of Medicine General Regulation 18 VAC 85-20-26(C), in that you failed to manage Patient C's treatment within acceptable standards. By your own admission, in or around January 2007, you agreed to treat Patient C, a professional colleague, for chronic pain. From approximately January 2007 through approximately April 2009, by your own admission, and as evidenced by Patient C's statements to the DHP investigator and the Prescription Monitoring Program Profile for Patient C, on various and diverse occasions, you prescribed Dilaudid (C-II), Oxycontin (C-II), Adderall (C-II), Xanax (C-IV), Valium (C-IV), Ativan (C-IV), and Xyrem Oral Solution (C-III) ("Xyrem") for Patient C. However, during that period:

a. You failed to obtain and/or document a complete patient history prior to prescribing those controlled substances, including prior psychiatric and substance abuse history, as well as past intervention and treatment for chronic pain conditions. Further, you did not request or obtain treatment records, including prior diagnostic studies and/or tests, directly from Patient C's prior treating physicians and/or you failed to document that you did so.

b. You prescribed controlled substances, including opioids, benzodiazepines, amphetamines, and Xyrem to Patient C without first performing and/or documenting a proper physical examination, evaluation or assessment, and without documenting the presence of one or more recognized medical indications for the use of those controlled substances. Further, you failed to require and/or document having any office visits with Patient C.

c. Prior to prescribing controlled substances to Patient C, you did not discuss and/or document discussing information concerning the risks and benefits of the medications being prescribed, nor did you document your reasons for selecting the types and doses of medications prescribed. Further, you failed to document any of the prescriptions you wrote and/or authorized for Patient C during 2007 and 2009, and

you failed to document many of the prescriptions you wrote and/or authorized for Patient C during 2008, including the date, type, dosage and quantity prescribed.

d. You failed to develop and/or document a comprehensive treatment plan and/or to periodically review and monitor the efficacy of treatment for Patient C. Specifically, you did not employ and/or document pain rating scales or other appropriate measures to determine the effect of prescribed medications on Patient C's daily living, and you failed to order any drug urine/serum screens, conduct pill counts, or take other appropriate measures to determine whether Patient C was taking his medications as prescribed and was otherwise compliant with his medication regimen.

e. You failed to appropriately recommend and/or document recommending or prescribing to Patient C treatment modalities other than the prescription of controlled substances.

f. You failed to make and/or document making an appropriate referral of Patient C to a pain management specialist, despite the fact that by your own admission, you have no formal training in the treatment and management of chronic pain and had only treated three to four patients in the past for chronic pain.

Please see Attachment I for the name of the patients and individual referenced above.

After consideration of all information, the Committee may:

1. Exonerate you;
2. Continue/Place you on probation with such terms it deems appropriate;
3. Reprimand you;
4. Modify a previous Board Order; and
5. Impose a monetary penalty pursuant to Section 54.1-2401 of the Code.

Further, the Committee may refer this matter for a formal administrative proceeding when it has failed to dispose of a case by consent pursuant to Section 2.2-4019 of the Code.

You have the right to information that will be relied upon by the Committee in making a decision. Therefore, I enclose a copy of the documents that will be distributed to the Committee for its consideration when discussing the allegations with you and when deliberating upon your case. These documents are enclosed only with the original notice sent by certified mail, and must be claimed at the post office. These materials have been provided this date to your counsel, John Franklin, III, Esquire.

To facilitate this proceeding, you must submit eight (8) copies of any documents you wish for the Committee to consider to Reneé S. Dixson, Discipline Case Manager, Virginia Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia, 23233, by **February 17, 2010**. Your documents may not be submitted by facsimile or e-mail. Should you or Adjudication Specialist Stacy P. Thompson wish to submit any documents for the Committee's consideration after **February 17, 2010**, such documents shall be considered only upon a ruling by the Chair of the Committee that good cause has been shown for late submission.

You may be represented by an attorney at the informal conference. If you obtain counsel, you should do so as soon as possible, because absent good cause to support a request for a continuance, the informal conference will be held on March 10, 2010. A request to continue this proceeding must state **in detail** the reason for the request and must establish good cause. Such request must be made, in writing, to me at the address listed on this letter and must be received by **February 10, 2010**. Only one such motion will be considered. Absent exigent circumstances, such as personal or family illness, a request for a continuance after **February 10, 2010**, will not be considered.

Relevant sections of the Administrative Process Act, which govern proceedings of this nature, as well as laws relating to the practice of medicine and other healing arts in Virginia cited in this notice can be found on the Internet at **http://leg1.state.va.us.** To access this information, please click on the *Code of Virginia* for statutes and *Virginia Administrative Code* for regulations.

In its deliberations, the Committee may utilize the Sanction Reference Points System, as contained in the Sanction Reference Manual. The manual, which is a guidance document of the Board, may be accessed at **http://www.dhp.virginia.gov/medicine**. You may request a paper copy from the Board office by calling (804) 367-4513.

Please advise the Board, in writing, of your intention to be present. Should you fail to appear at the informal conference, the Board may proceed to a formal administrative hearing in order to impose sanctions.

If you have any questions regarding this notice, please contact Stacy P. Thompson, Adjudication Specialist, at (804) 367-4417.

Sincerely,

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

ST/hill51nic v3.DOC

Enclosures:
Attachment I
Informal Conference Package
Map

cc: Jane E. Piness, M.D., President, Virginia Board of Medicine
Reneé S. Dixson, Discipline Case Manager, Board of Medicine
Stacy P. Thompson, Adjudication Specialist, APD
Lorraine McGehee, Deputy Director, APD
John Franklin, III, Esquire [*w/enclosures*]
Lawrence H. Woodward, Esquire
Anthony J. Sellers, Senior Investigator [123651]

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: RICHARD HILL, M.D.
License No.: 0101-058825

ORDER

In accordance with Sections 54.1-2400(10), 2.2-4019 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code"), an informal conference was held with Richard Hill, M.D., on March 10, 2010, in Henrico, Virginia. Members of the Virginia Board of Medicine ("Board") serving on the Special Conference Committee ("Committee") were: Sandra Anderson Bell, M.D., Chairman; Jennifer S. Lee, M.D., and Deeni Bassam, M.D. Dr. Hill appeared personally and was represented by legal counsel, John Franklin, III, Esquire. Stacy P. Thompson, Adjudication Specialist, was present as a representative for the Administrative Proceedings Division of the Department of Health Professions. The purpose of the informal conference was to inquire into allegations that Dr. Hill may have violated certain laws and regulations governing the practice of medicine in the Commonwealth of Virginia, as set forth in a Notice of Informal Conference dated January 28, 2010.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Now, having properly considered the evidence and statements presented, the Committee makes the following Findings of Fact and Conclusions of Law:

1. Richard Hill, M.D., was issued license number 0101-058825 by the Board to practice medicine and surgery in the Commonwealth of Virginia on December 29, 1998. Said license is currently active and will expire on May 31, 2010, unless renewed or otherwise restricted.

2. Dr. Hill violated Section 54.1-2915.A(2) of the Code, in that he is unfit for the performance of his professional obligations and duties because of substance abuse. Specifically,

a. On or about April 29, 2009, Dr. Hill admitted to an investigator with the Virginia Department of Health Professions ("DHP investigator"), that from approximately 2006 through approximately December 2008, he self-medicated with and abused Roxicet (C-II) and Oxycontin (C-II).

b. Despite the fact that Dr. Hill told the DHP investigator on or about April 29, 2009, that he last abused Roxicet or Oxycontin in February 2009, a urine drug screen sample he provided on or about May 1, 2009, tested positive for oxycodone (C-II) and oxymorphone (C-II) on or about May 15, 2009.

c. On or about May 21, 2009, Dr. Hill's attorney reported to the DHP investigator that Dr. Hill entered treatment for substance abuse on that date.

3. Dr. Hill violated Sections 54.1-2915.A(1), (8), (13), (17) and (18), 54.1-3408.A of the Code, and Section 54.1-2915.A(10) of the Code, as defined by Section 18.2-258.1 of the Code, and 18 VAC 85-20-29(A)(3) of the Board of Medicine General Regulations, in that, by Dr. Hill's own admission, beginning in 2006, he fraudulently obtained Roxicet (C-II) and/or Oxycontin (C-II) by diverting those medications for his personal and unauthorized use from prescriptions he wrote and authorized for Individual X, a family member. Further, by his own admission, beginning in approximately June 2008 through approximately November 2008, pursuant to an agreement Dr. Hill initiated with Patient A, Dr. Hill fraudulently obtained Roxicet (C-II) and/or Oxycontin (C-II) by writing and authorizing prescriptions for

those controlled substances in the name of Patient A, who purchased those medications with money provided by Dr. Hill, and returned them to Dr. Hill for his personal and unauthorized use.

4. Dr. Hill violated Section 54.1-2915.A(16), in that by his own admission, in November 2008, Dr. Hill paid a total of approximately $10,000.00 to Patients A and B to remain silent about his illegal and unethical conduct regarding prescription writing.

5. Dr. Hill violated Sections 54.1-2915.A(3), (12), (13) and (18) of the Code and Board of Medicine General Regulation 18 VAC 85-20-26(C), in that Dr. Hill failed to manage the treatment of Patients A and B within acceptable standards. Specifically:

a. Dr. Hill provided samples of antidepressants and prescribed amphetamines, benzodiazepines, and opioids to Patient A from approximately June 2008 through November 2008 and to Patient B from approximately August 2008 through November 2008; however, he failed to: consistently document many of those prescriptions in the medical records of Patients A and B; require Patients A and B present for an office visit prior to his prescribing controlled substances; perform and/or document adequate evaluations, assessments, diagnoses, or physical findings prior to prescribing. Further, Dr. Hill failed to: document a discussion of the risks/benefits of the medications prescribed; obtain prior treatment records of Patients A and B; and make appropriate patient referrals to other physicians.

b. From approximately July 2008 through approximately November 2008, Dr. Hill prescribed Adderall (C-II) for Patient A, who exhibited drug seeking behavior or who Dr. Hill knew or should have known was abusing or had become addicted to

or dependent upon Adderall, in that Patient A frequently made early requests for Adderall prescriptions and Dr. Hill regularly provided and/or authorized Adderall prescriptions prior to the time Patient A should have run out of it if taken as prescribed. Specifically, Patient A filled prescriptions Dr. Hill wrote and/or authorized for a thirty-day supply of Adderall (C-II) on July 8, 2008, July 21, 2008, August 2, 2008, August 9, 2008, September 6, 2008, September 22, 2008, September 30, 2008, and October 16, 2008.

6. Dr. Hill violated Sections 54.1-2915.A(3), (13), and (18) of the Code and 18 VAC 85-20-26(C) of the Board of Medicine General Regulations, in that Dr. Hill failed to manage Patient C's treatment within acceptable standards. By Dr. Hill's own admission, in or around January 2007, he agreed to treat Patient C, a professional colleague, for chronic pain. From approximately January 2007 through approximately April 2009, by his own admission, and as evidenced by Patient C's statements to the DHP investigator and the Prescription Monitoring Program Profile for Patient C, on various and diverse occasions, Dr. Hill prescribed Dilaudid (C-II), Oxycontin (C-II), Adderall (C-II), Xanax (C-IV), Valium (C-IV), Ativan (C-IV), and Xyrem Oral Solution (C-III) ("Xyrem") for Patient C. However, during that period:

a. Dr. Hill failed to obtain and/or document a complete patient history prior to prescribing those controlled substances, including prior psychiatric and substance abuse history, as well as past intervention and treatment for chronic pain conditions. Further, Dr. Hill did not request or obtain treatment records, including prior diagnostic studies and/or tests, directly from Patient C's prior treating

physicians and/or Dr. Hill failed to document that he did so.

b. Dr. Hill prescribed controlled substances, including opioids, benzodiazepines, amphetamines, and Xyrem to Patient C without first performing and/or documenting a proper physical examination, evaluation or assessment, and without documenting the presence of one or more recognized medical indications for the use of those controlled substances. Further, Dr. Hill failed to require and/or document having any office visits with Patient C.

c. Prior to prescribing controlled substances to Patient C, Dr. Hill did not discuss and/or document discussing information concerning the risks and benefits of the medications being prescribed, nor did he document his reasons for selecting the types and doses of medications prescribed. Further, he failed to document any of the prescriptions he wrote and/or authorized for Patient C during 2007 and 2009, and he failed to document many of the prescriptions he wrote and/or authorized for Patient C during 2008, including the date, type, dosage, and quantity prescribed.

d. Dr. Hill failed to develop and/or document a comprehensive treatment plan and/or to periodically review and monitor the efficacy of treatment for Patient C. Specifically, Dr. Hill did not employ and/or document pain rating scales or other appropriate measures to determine the effect of prescribed medications on Patient C's daily living, and Dr. Hill failed to order any drug urine/serum screens, conduct pill counts, or take other appropriate measures to determine whether Patient C was taking his medications as prescribed and was otherwise compliant with his medication regimen.

e. Dr. Hill failed to appropriately recommend and/or document recommending or prescribing to Patient C treatment modalities other than the prescription of controlled substances.

f. Dr. Hill failed to make and/or document making an appropriate referral of Patient C to a pain management specialist, despite the fact that by his own admission, Dr. Hill has no formal training in the treatment and management of chronic pain and had only treated three to four patients in the past for chronic pain.

7. Dr. Hill stated that he has known Patient C for many years and is very familiar with his many medical issues and disorders. Dr. Hill began treating Patient C when he lost his insurance coverage. Dr. Hill stated he had a pain management contract with Patient C, and did not escalate the doses of medications that were prescribed by Patient C's previous provider. Initially, Dr. Hill kept records on Patient C, but admitted that once in active addiction he stopped keeping records on Patient C. Dr. Hill stated he is no longer treating or prescribing for Patient C.

8. Dr. Hill stated that he began using Roxicet and Oxycontin to self-medicate for pain related to his diabetic neuropathy, and it eventually got out of control and he became addicted.

9. Dr. Hill underwent a comprehensive psychological assessment with a psychologist in January 2009. In a letter dated January 5, 2009, the psychologist reported that Dr. Hill has accepted responsibility for his behavior and actions and would benefit from psychotherapy to address these issues and other significant stressors in his life.

10. In a letter dated January 13, 2009, Dr. Hill's treating physician reported that Dr. Hill suffers from neuropathy in both extremities and is being prescribed certain medications to alleviate the pain and numbness.

11. In a letter dated February 17, 2010, Dr. Hill's treating addiction specialist advised that Dr. Hill was referred to him for monitoring of his recovery efforts and therapy. He reported that he began seeing Dr. Hill in October, 2009, after Dr. Hill had completed approximately fifteen (15) weeks of residential treatment, which began in June 2009. The addiction specialist reported that Dr. Hill is committed to his on-going recovery and sobriety.

12. In a letter dated February 19, 2010, Dr. Hill's peer monitor, who is an addictionologist, reported that he has been monitoring Dr. Hill's recovery program for the past six (6) months. He confirmed that Dr. Hill is attending regular recovery support meetings and is involved in counseling.

13. In a letter dated March 8, 2010 and through statements made to the Committee on March 10, 2010, Dr. Hill's Virginia Health Practitioners' Monitoring Program ("HPMP") case manager reported that Dr. Hill has been a participant in HPMP since May 2009, and he signed a recovery monitoring contract on October 2, 2009, which requires: attendance in aftercare; follow-up with an addictionologist; attendance at twelve-step meetings; and participation in random urine toxicology screening at a frequency of thirty-six (36) times per year. Dr. Hill has been approved for return to practice with a work-site monitor in the practice and a peer monitor, who reports to HPMP monthly. All reports from his monitors indicate no further concerns of impairment and all screens have been negative. Finally, HPMP believes Dr. Hill is safe and competent to continue to practice.

14. Dr. Hill reported a sobriety date of May 21, 2009, and stated that he got into trouble trying to treat himself, and by the time he realized he was in active addiction, he was isolated and couldn't reach out. He stated that he is grateful for his recovery and for the noble people who assisted him to seek help.

ORDER

WHEREFORE, based on the above Findings of Fact and Conclusions of Law, it is hereby ORDERED that Richard Hill, M.D., shall continue to fully comply with the terms of his HPMP contract(s), and any addenda thereto, until he successfully completes the program. In accordance with Dr. Hill's contract(s), the Board will be notified of any noncompliance, dismissal or resignation from HPMP.

It is further ORDERED that Dr. Hill be, and hereby is, issued a REPRIMAND and that his license be subject to the following TERMS AND CONDITIONS:

1. Within twelve (12) months of entry of this Order, Dr. Hill shall submit a certificate or other evidence satisfactory to the Board verifying that he has completed fifteen (15) hours of continuing medical education ("CME") in the subject of medical recordkeeping. Such CME shall be approved in advance of registration by the Executive Director of the Board, and shall be completed through face-to-face, interactive sessions (i.e., no home study, journal or Internet courses). Any CME hours obtained in compliance with this term shall not be used toward compliance with the Board's continuing education requirements for license renewal.

2. Within twelve (12) months of entry of this Order, Dr. Hill shall submit a certificate or other evidence satisfactory to the Board verifying that he has completed twelve (12) hours of continuing medical education ("CME") in the subject of proper prescribing of

controlled substances. Such CME shall be approved in advance of registration by the Executive Director of the Board, and shall be completed through face-to-face, interactive sessions (i.e., no home study, journal or Internet courses). Any CME hours obtained in compliance with this term shall not be used toward compliance with the Board's continuing education requirements for license renewal.

3. The Committee authorizes the Board's Executive Director to close this matter without further proceedings upon receipt of evidence of Dr. Hill's completion of Terms 1 and 2.

Violation of this Order may constitute grounds for suspension or revocation of Dr. Hill's license. In the event that Dr. Hill violates this Order, an administrative proceeding may be convened to determine whether such action is warranted.

Dr. Hill shall maintain a course of conduct in his practice of medicine commensurate with the requirements of Title 54.1, Chapter 29 of the Code and all laws of the Commonwealth.

Pursuant to Sections 2.2-4023 and 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

Pursuant to Section 54.1-2400(10) of the Code, Dr. Hill may, not later than 5:00 p.m., on April 19, 2010, notify William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in writing that he desires a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated.

Therefore, this Order shall become final on April 19, 2010, unless a request for a formal administrative hearing is received as described above.

FOR THE BOARD

for William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

ENTERED: 3/15/2010

COMMONWEALTH of VIRGINIA

Dianne L. Reynolds-Cane, M.D.
Director

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

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TEL (804) 367- 4400
FAX (804) 527- 4475

March 28, 2011

Richard Hill, M.D.
Comprehensive Psychological Services
860 Greenbrier Circle, Suite 100
Chesapeake, Virginia 23320

RE: License No.: 0101-058825

Dear Dr. Hill:

The Virginia Board of Medicine ('Board") has received verification of your compliance with Terms #1 and #2 of the Order entered March 15, 2010.

Therefore, pursuant to the authority granted by Term #3, I have determined that the terms placed on your license should be TERMINATED effective this date. The record of the Board currently reflects that you have a full and unrestricted license in the Commonwealth of Virginia.

Further, please be advised that this closure does not relieve you of your responsibility to continue to fully comply with the terms of your HPMP contract(s) until you have successfully completed the program.

Pursuant to §54.1-2400.2 (F) of the *Code of Virginia,* a signed copy of this letter shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

The Board wishes you well in your future endeavors.

Sincerely,

William L. Harp, M. D.
Executive Director
Virginia Board of Medicine

cc: Renée S. Dixson, Compliance Manager [123651]
Susan Brooks, Office Manager, APD
Nicole Denike, Administrative Assistant
Amy Stewwart, Case Manager, HPMP