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**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| In the Matter of the First Amended Accusation Against:<br><br>**NICOLE POLIQUIN, M.D.**<br>**3151 Airway Ave., Suite T-2**<br>**Costa Mesa, CA 92626-4607**<br><br>**Physician's and Surgeon's Certificate No. A 30419,**<br><br>Respondent. | Case No. 800-2018-042938<br><br>**FIRST AMENDED ACCUSATION** |

## PARTIES

1. William Prasifka (Complainant) brings this First Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about August 30, 1976, the Board issued Physician's and Surgeon's Certificate No. A 30419 to Nicole Poliquin, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2022, unless renewed.

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## JURISDICTION

3. This First Amended Accusation, which supersedes the Accusation filed on March 23, 2021, is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states, in pertinent part:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
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> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
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> ...

5. Section 2234 of the Code, states, in pertinent part:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but

not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

...

6. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

**COST RECOVERY**

7. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licentiate that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g)(1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

**FIRST CAUSE FOR DISCIPLINE**

**(Gross Negligence)**

8. Respondent has subjected her Physician's and Surgeon's Certificate No. A 30419 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that she was grossly negligent in her care and treatment of Patient A,[1] as more particularly alleged hereinafter:

9. On or about December 3, 2013,[2] Patient A, a then sixty-five-year-old male patient, was referred to Respondent by his endocrinologist for severe depression. Patient A's medical issues included obesity, urinary incontinence, neuropathy in his feet, low testosterone, and type II diabetes. Patient A had a lengthy history of depression spanning back to childhood that included suicidal ideation and two prior suicide attempts. Patient A attempted suicide in 2005 with an overdose of Tylenol PM and alcohol, and subsequently received inpatient psychiatric treatment at the McDonald Center followed by two years of outpatient psychiatric treatment. Patient A had a history of alcohol and phentermine[3] abuse. Patient A's liver function test, completed in or around

[1] To protect the privacy of the patient involved, the patient's name has not been included in this pleading. Respondent is aware of the identity of the patient referred to herein.

[2] Conduct occurring more than seven years before the filing of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action. (Bus. & Prof. Code, § 2230.5.)

[3] Phentermine is an amphetamine-like stimulant medication used to suppress appetite. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022.

2005, revealed poor results and he was told he may need a liver transplant. Patient A had maintained his sobriety since 2005 and was active in Alcoholics Anonymous. At the time of the referral, Patient A's medications included, but were not limited to, metformin,[4] Actos,[5] levothyroxine,[6] Lipitor,[7] losartan,[8] Axiron,[9] and Lexapro[10] 10 mg.

10. On or about December 3, 2013, Patient A presented to Respondent for psychiatric treatment with complaints of depression and anger issues. At this initial visit, Respondent documented in the patient's chart a history of present illness, medication and psychiatric history, and a mental status examination. Respondent noted Patient A had previously taken Prozac[11] and Dexamyl,[12] but no further details were obtained about his use of these medications, or his prior abuse of phentermine. At the conclusion of the visit, Respondent diagnosed Patient A with major depression, recurrent, severe, nonpsychotic, and alcohol abuse, unspecified, in later remission.

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[4] Metformin is an anti-diabetic medication used to treat Type II diabetes. It is a dangerous drug pursuant to Business and Professions Code section 4022.

[5] Actos (brand name for Pioglitazone) is an anti-diabetic medication used to treat Type II diabetes. It is a dangerous drug pursuant to Business and Professions Code section 4022.

[6] Levothyroxine is a hormone medication used to treat hypothyroidism. It is a dangerous drug pursuant to Business and Professions Code section 4022.

[7] Lipitor (brand name for atorvastatin) is a statin medication used to treat high cholesterol and triglyceride levels. It is a dangerous drug pursuant to Business and Professions Code section 4022.

[8] Losartan is an antihypertensive medication used to treat high blood pressure. It is a dangerous drug pursuant to Business and Professions Code section 4022.

[9] Axiron is a testosterone medication used to treat the symptoms of testosterone deficiency. It is a dangerous drug pursuant to Business and Professions Code section 4022.

[10] Lexapro (brand name for escitalopram) is a selective serotonin reuptake inhibitor (SSRI) antidepressant medication used to treat anxiety and major depressive disorder. It is a dangerous drug pursuant to Business and Professions Code section 4022.

[11] Prozac (brand name for fluoxetine) is an SSRI antidepressant medication used to treat anxiety and major depressive disorder. It is a dangerous drug pursuant to Business and Professions Code section 4022.

[12] Dexamyl was a brand name combination drug composed of sodium amobarbital and dextroamphetamine sulfate within the same pill. It was widely abused, and is no longer manufactured.

Respondent maintained Patient A on his prior prescription of Lexapro 10 mg and added a prescription of Abilify[13] 2 mg. Prior to her initial visit with Patient A, or anytime thereafter, Respondent did not order and/or document receipt and review of any prior treatment records, did not order thyroid function tests and/or document receipt and review of Patient A's prior thyroid function tests, did not order baseline labs and/or document receipt and review of Patient A's prior liver function test results, and did not confer and document a discussion with Patient A's internist or endocrinologist regarding the current nature and extent of his chronic liver failure.

11. On or about April 4, 2014, Patient A presented to Respondent for a follow-up visit. At this visit, Respondent noted an increase in Patient A's anxiety and discussed a recent event where he had lost his temper at work. At the conclusion of this visit, Respondent increased Patient A's Lexapro dose to 20 mg, and prescribed gabapentin[14] 300 mg. The chart notes for this visit, or any visit thereafter, do not include a documented discussion with the patient regarding the risks and benefits of gabapentin or an increased dose of Lexapro.

12. Between on or about April 4, 2014, and on or about August 2, 2019, Respondent maintained Patient A on regular prescriptions of gabapentin 300 mg.

13. Between on or about April 4, 2014, and on or about May 15, 2016, Respondent maintained Patient A on regular prescriptions of Lexapro 20 mg.

14. On or about April 25, 2014, Patient A presented to Respondent for a follow-up visit. At this visit, Patient A expressed a desire for more energy. Respondent discussed Nuvigil[15] and Dexedrine[16] with Patient A, noting he had previously taken this medication and "had no tendency

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[13] Abilify (brand name for aripiprazole) is an antipsychotic mediation used to treat schizophrenia, bipolar disorder, depression, and Tourette syndrome. It is a dangerous drug pursuant to Business and Professions Code section 4022.

[14] Gabapentin is an anticonvulsant and nerve pain medication. It is a dangerous drug pursuant to Business and Professions Code section 4022.

[15] Nuvigil (brand name for armodafinil) is a controlled substance stimulant medication used to treat sleepiness from narcolepsy, sleep apnea, or night shift work.

[16] Dexedrine (brand name for dextroamphetamine) is a stimulant medication used to treat attention-deficit hyperactivity disorder (ADHD) and narcolepsy. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. This medication contains a "black

to abuse it." The patient's chart does not include when, why, and for how long Patient A had previously taken these medications, what his response was to the medications, or why they were discontinued. The chart notes also do not include a detailed discussion with the patient regarding his prior abuse of phentermine. At the conclusion of this visit, Respondent prescribed Patient A one (1) tab of Dexedrine 5mg twice per day for the treatment of depression. The chart notes for this visit do not include a documented discussion with the patient regarding the risks and benefits of Dexedrine, or any coordination of care with the patient's internist or endocrinologist prior to prescribing Dexedrine.

15. On or about May 21, 2014, Patient A presented to Respondent for a follow-up visit. At this visit, Respondent noted the patient had more energy on Dexedrine, and his motivation and concentration were "ok." At the conclusion of this visit, Respondent increased the patient's Dexedrine dose to one (1) 10 mg tab twice per day. The chart notes for this date do not include the reason for the dose increase or the symptoms being targeted with this increase in medication.

16. On or about June 9, 2014, Patient A presented to Respondent for a follow-up visit. At this visit, Respondent noted the patient's energy was stable, his motivation and concentration were "ok," and he was not feeling depressed. At the conclusion of this visit, Respondent increased the patient's Dexedrine dose to two (2) 10 mg tabs twice per day. The chart notes for this date do not include the reason for the dose increase or the symptoms being targeted with this increase in medication.

17. On or about June 30, 2014, Respondent prescribed Patient A 30 tabs of Lexapro 20 mg with six (6) refills. Between on or about June 30, 2014, and on or about October 4, 2019, Respondent maintained Patient A on regular prescriptions of Lexapro 20 mg.

18. On or about July 21, 2014, Patient A presented to Respondent for a follow-up visit. At this visit, Respondent noted the patient's energy and mood were improved, and that he was feeling "200% better." Patient A informed Respondent that the two (2) tabs of Dexedrine had helped him a lot, but admitted that he sometimes takes three (3) tabs. At the conclusion of this

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box warning" that it is contraindicated in patients with moderate to severe hypertension, advanced arteriosclerosis, or symptomatic cardiac disease.

visit, Respondent increased the patient's Dexedrine dose to two (2) 10 mg tabs three (3) times per day. The chart notes for this date do not include a documented discussion with the patient regarding taking medications as prescribed, the reason for the dose increase, the symptoms being targeted with this increase in medication, or the lack of any adverse side-effects from the medication.

19. On or about October 28, 2014, Patient A presented to Respondent for a follow-up visit. At this visit, Respondent noted the patient's energy was stable, his motivation and concentration were "ok," he was not feeling depressed, and he had lost approximately 68 pounds in six months. Patient A admitted to taking more Dexedrine than prescribed and running out of his medication early. Respondent discussed addiction and misuse with the patient, and documented that he "contracted for staying on track." At the conclusion of this visit, Respondent maintained the patient on two (2) tabs of Dexedrine 10 mg tabs (3) three times per day.

20. On or about January 12, 2015, Patient A presented to Respondent for a follow-up visit. At this visit, Respondent documented an ADHD diagnosis for the first time. The chart notes for this visit do not identify specific DSM-V[17] criteria to support that diagnosis at that time.

21. On or about March 6, 2015, Patient A presented to Respondent for a follow-up visit. At this visit, Patient A admitted taking more Dexedrine than prescribed. Respondent reminded Patient A that this medication can be addicting, but authorized him to take up to seven (7) tabs per day. The chart notes for this visit, or any visit thereafter, do not include Respondent's reasoning for increasing Patient A's dose of Dexedrine beyond the recommended daily dose.

22. On or about November 20, 2015, Patient A presented to Respondent for a follow-up visit. At this visit, Patient A admitted taking more Dexedrine than prescribed due to his lack of energy in the afternoon. At the conclusion of this visit, Respondent increased the patient's Dexedrine dose to two (2) 15 mg tabs three (3) times per day.

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[17] The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) is the 2013 update to the Diagnostic and Statistical Manual of Mental Disorders, the taxonomic and diagnostic tool published by the American Psychiatric Association. In the United States, the DSM serves as the principal authority for psychiatric diagnoses.

23. On or about December 11, 2015, Respondent prescribed Patient A trazodone[18] 150 mg three (3) times per day. The chart notes do not identify a clinical visit on that date, or the reason for this prescription. Between on or about December 11, 2015, and on or about March 2, 2020, Respondent maintained Patient A on regular prescriptions of trazodone 150 mg. The patient's progress notes throughout that time do not include any reference to this medication.

24. On or about December 17, 2015, Patient A presented to Respondent for a follow-up visit. At this visit, Patient A admitted taking too much medication. Respondent discussed the expected and potential side effects of the medication, and adjusted Respondent's prescription of Dexedrine to three (3) 10 mg tabs three (3) times per day.

25. On or about January 14, 2016, Respondent prescribed Patient A 270 tabs of Dexedrine 10 mg, but the chart notes do not identify a clinical visit or any other interaction with the patient on that date.

26. On or about May 16, 2016, Respondent increased Patient A's Lexapro prescription to two (2) 20 mg tabs per day. The chart notes do not identify a clinical visit on that date, the reason for the increase in this prescription, or a documented discussion with the patient regarding the risks and benefits of this dose of Lexapro. Respondent maintained Patient A on that dose until on or about May 15, 2020.

27. On or about October 28, 2016, Patient A presented to Respondent for a follow-up visit. At this visit, Patient A admitted overusing his Dexedrine. At the conclusion of this visit, Respondent refilled Patient A's prescription, but gave him a "fair warning" that she will not refill his next prescription until November 28, 2016.

28. On or about November 23, 2016, Respondent prescribed Patient A 270 tabs of Dexedrine 10 mg. The chart notes do not identify a clinical visit or any other interaction with the patient on that date.

29. On or about December 28, 2016, Patient A presented to Respondent for a follow-up visit. At this visit, Patient A informed Respondent that he had called the office two days earlier

[18] Trazodone is an antidepressant and sedative medication used to treat depression. It is a dangerous drug pursuant to Business and Professions Code section 4022.

asking for an early refill of his medications. At the conclusion of this visit, Respondent maintained Respondent on his prescription of three (3) tabs of Dexedrine 10 mg three (3) times per day.

30. On or about January 13, 2017, Respondent received a letter from OptumRX informing her that Patient A's prescription of Lexapro exceeded the manufacturer's maximum of 20 mg per day. A copy of his prescription profile for that month was attached. Respondent initialed the receipt and review of this letter on or about January 19, 2017, but made no change to the prescription at that time.

31. On or about January 31, 2017, Respondent received a letter from OptumRX informing her that Patient A's prescription of Lexapro exceeded the manufacturer's maximum of 10 mg per day in geriatric patients. Respondent initialed the receipt and review of this letter on or about February 13, 2017, and included a note stating, "ok will decrease," but made no change to the prescription at that time.

32. On or about February 16, 2017, Respondent prescribed Patient A 252 tabs of Dexedrine 10 mg. The chart notes do not identify a clinical visit or any other interaction with the patient on that date.

33. On or about March 10, 2017, Respondent prescribed Patient A 60 tabs of Dexedrine 10 mg. The chart notes do not identify a clinical visit or any other interaction with the patient on that date.

34. On or about March 21, 2017, Patient A presented to Respondent for a follow-up visit. At this visit, Patient A admitted he has addictive tendencies, and informed Respondent that he ran out of his medications one week early. The chart notes for this visit make no reference to Patient A's Lexapro prescription in any way. At the conclusion of this visit, Respondent maintained Respondent on his prescription of three (3) tabs of Dexedrine 10 mg three (3) times per day.

35. Between on or about March 22, 2017, and on or about May 15, 2020, Respondent wrote monthly prescriptions to Patient A for three (3) tabs of Dexedrine 10 mg three (3) times per day. Respondent only documented six (6) clinical encounters with the patient throughout that time period, including progress notes on or about October 9, 2017, March 5, 2018, March 4,

2019, June 19, 2019, and May 15, 2020, and a patient intake form on or about December 16, 2019.

36. On or about April 19, 2017, Respondent prescribed Patient A 252 tabs of Dexedrine 10 mg. The chart notes do not identify a clinical visit with the patient on that date, but contains a handwritten note from the patient thanking Respondent for allowing him to pick up his prescription that day, and stating he will not ask for an early refill.

37. On or about July 12, 2017, Respondent prescribed Patient A two (2) tabs of Lexapro 20 mg per day, with six (6) refills.

38. On or about August 27, 2017, Respondent received a letter from OptumRX informing her that Patient A's prescription of Lexapro exceeded the manufacturer's maximum of 20 mg per day. A copy of his prescription profile for that month was attached. Respondent initialed the receipt and review of this letter on or about August 29, 2017, and included a note stating that the patient is supposed to take only one (1) 20 mg tab per day according to her records, but made no change to the prescription at that time.

39. On or about October 9, 2017, Patient A presented to Respondent for a follow-up visit. At this visit, Respondent noted the patient was doing well. The chart notes for this visit make no reference to his Lexapro prescription in any way. At the conclusion of the visit, Respondent made no changes to Patient A's medication regimen.

40. On or about February 15, 2018, Respondent prescribed Patient A two (2) tabs of Lexapro 20 mg per day, with six (6) refills.

41. On or about September 3, 2020, Respondent was interviewed by an investigator for the Board. During this interview, Respondent indicated that she believed the maximum recommended daily dose of Lexapro was 40 mg, and the maximum recommended daily dose of Dexedrine was 60 mg.

42. Respondent committed gross negligence in her care and treatment of Patient A, which included, but was not limited to, the following:

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(A) Prescribing a daily dose of 40 mg Lexapro to Patient A between in and around May 2016, and in and around May 2020, and failing to appropriately manage the dosing error once brought to her attention; and

(B) Providing Patient A with monthly prescriptions for medications, including dextroamphetamine, between in or around March 2017 and in or around May 2020, while only documenting five (5) progress notes and one (1) patient intake form during that time period.

**SECOND CAUSE FOR DISCIPLINE**

**(Repeated Negligent Acts)**

43. Respondent has further subjected her Physician's and Surgeon's Certificate No. A 30419 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in her care and treatment of Patient A, as more particularly alleged hereinafter:

(A) Paragraphs 8 through 42(B), above, are hereby incorporated by reference and realleged as if fully set forth herein.

(B) Failing to order thyroid function tests and/or obtain and document review of Patient A's prior thyroid function tests at any time while treating Patient A for depression;

(C) Prescribing psychotropic medications to a patient with a history of liver failure without ever ordering baseline labs to assess liver function, and/or obtaining and documenting review of lab work previously performed, and/or conferring and documenting a discussion with Patient A's internist or endocrinologist regarding the current nature and extent of his possible chronic liver failure;

(D) Prescribing daily trazodone 150 mg tabs to Patient A between in and around September 2017 and in and around May 2020, without ever documenting the inclusion of this medication in the patient's treatment plan, progress notes, or medication sheets;

(E) Failing to obtain and document informed consent from Patient A when prescribing gabapentin for anxiety and insomnia;

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(F) Failing to obtain a detailed and thorough prescription substance abuse history from Patient A before prescribing Dexedrine;

(G) Failing to obtain and document informed consent from Patient A when prescribing Dexedrine;

(H) Failing to document any coordination of care with Patient A's internist or endocrinologist prior to prescribing Dexedrine;

(I) Failing to clearly document her rationale for increasing Patient A's dose of Dexedrine on or about May 21, 2014, and again on or about June 9, 2014;

(J) Failing to document her reasoning for increasing Patient A's dose of Dexedrine beyond the recommended daily dose;

(K) Failing to set firm limits and continuously providing refills of Dexedrine to Patient A despite his substance abuse history and his repeated overuse of this medication;

(L) Diagnosing Patient A with ADHD without appropriately documenting DSM-V criteria to support this diagnosis in the patient's chart; and

(M) Failing to document a patient encounter and prescription to Patient A for Dexedrine on or about January 14, 2016.

**THIRD CAUSE FOR DISCIPLINE**

**(Failure to Maintain Adequate and Accurate Records)**

44. Respondent has further subjected her Physician's and Surgeon's Certificate No. A 30419 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding her care and treatment of Patient A, as more particularly alleged in paragraphs 8 through 43(M), above, which are hereby incorporated by reference and realleged as if fully set forth herein.

**FOURTH CAUSE FOR DISCIPLINE**

**(Incompetence)**

45. Respondent has further subjected her Physician's and Surgeon's Certificate No. A 30419 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that Respondent has demonstrated incompetence in her care and

treatment of Patient A, as more particularly alleged in paragraphs 8 through 44, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

**DISCIPLINARY CONSIDERATIONS**

46. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about June 15, 2011, the Board issued a Decision and Order that became effective on or about July 15, 2011, in an action entitled, *In the Matter of the Accusation Against Nicole Poliquin-Williams, M.D.*, Medical Board of California Case No. 06-2007-187121. In that matter, and as a result of Respondent's negligent care and treatment of two patients, Respondent's Physician's and Surgeon's Certificate No. A 30419 was publicly reprimanded. That Decision is now final and is incorporated by reference as if fully set forth herein.

**PRAYER**

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 30419, issued to Respondent, Nicole Poliquin, M.D.;

2. Revoking, suspending or denying approval of Respondent, Nicole Poliquin, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent, Nicole Poliquin, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: JAN 11 2022

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
*Complainant*

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