Statement of Charges Pending
(See Attached)

A Statement of Charges is the document that contains the Department of Public Health's allegations against a practitioner that result from a formal investigation of the practitioner. Unless a summary suspension has been granted or the practitioner is currently subject to the terms of a previous disciplinary action or other agreement (which would also be posted on this site), the practitioner is eligible to continue to practice without restriction while a Statement of Charges is pending. The Board or Commission, or the Department of Public Health for professions where there is no Board or Commission, will determine what discipline, if any, is appropriate.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

In re: Douglas Zelisko, MD Petition Number: 2026-245

AMENDED
STATEMENT OF CHARGES

Pursuant to Connecticut General Statutes Chapter 54 and §§19a-10 and 19a-14, the Department of Public Health ("Department") brings the following charges against Douglas Zelisko, MD:

1. Douglas Zelisko ("Respondent") is and at all times referenced in this Statement of Charges, the holder of Connecticut physician and surgeon license number 065291.

2. From approximately October 11, 2023 through December 2, 2024, Respondent prescribed and/or dispensed approximately three (3) ketamine prescriptions and six (6) testosterone prescriptions in patient #1's name however, patient #1 never received, nor was aware of, the prescriptions. Respondent submitted the prescriptions to a compounding pharmacy and had them delivered to Respondent's residence for his personal use.

3. In approximately February 2025, Respondent hired his romantic partner ("Individual #1") as a practice administrator, life coach, counselor and/or administrative assistant to work at his psychiatric practice and meet with his patients. Individual #1 has never been licensed by the Department.

4. From approximately November 26, 2024 through July 8, 2025, Respondent provided care and treatment for Individual #1, his romantic partner, which included issuing prescriptions for dextroamphetamine-amphetamine, alprazolam, clonazepam, lorazepam, testosterone cypionate injection, methocarbamol, bupropion hydrochloride SR, quetiapine, lamotrigine, lurasidone, epinephrine auto-injector, ciprofloxacin, banophen, antibiotics and/or inhalers. Respondent failed to maintain appropriate medical records for Individual #1.

5. From approximately January 20, 2025 through September 15, 2025, Respondent provided care and treatment for patient #2 who had a history of multiple inpatient hospital stays for behavioral health issues, including psychosis. During this time, Respondent:

    a. violated professional boundaries by socializing with patient #2 at bars and/or restaurants, permitted patient #2 to stay overnight at his residence, and/or consumed alcohol and/or illicit substances with patient #2;
    b. recommended that patient #2 retain Individual #1 as a "life coach" and/or "certified addiction specialist" and misrepresented Individual #1's credentials and/or facilitated such engagement;
    c. arranged for Individual #1 to hold and/or administer patient #2's medications including controlled substances;
    d. arranged for Individual #1 to conduct therapy sessions with patient #2 and/or with patient #2's parents; and/or
    e. shared patient #2's confidential patient information with Individual #1 without patient #2's consent.

6. From approximately July 18, 2025 through July 25, 2025, patient #2 was inpatient at the Institute of Living; from approximately May 12, 2025 through June 16, 2025, patient #2 was inpatient at Silver Hills Hospital; and from approximately September 17, 2025 through October 20, 2025, patient #2 was inpatient at Yale New Haven Hospital. A physician from Silver Hills Hospital telephoned patient #2's parent and stated that Individual #1 was visiting patient #2 and brought a vape pen to Silver Hills Hospital campus and that patient #2 and Individual #1 were smoking on campus and/or using illicit drugs. Due to the drug use, the physician told patient #2's parent that Respondent and Individual #1 should not be working with patient #2 and that she believed Respondent and Individual #1 were "grooming" patient #2.

7. From approximately March 2025 through September 2025, Respondent billed patient #2 for medical appointments which never occurred. In fact, some of the appointments Respondent billed occurred while patient #2 was inpatient at a hospital.

8. From approximately May 2024 through September 2025, patient #3, a psychiatrically complex and fragile individual, came under Respondent's care. Respondent violated the standard of care in one or more of the following ways, including, but not limited to, when he:

    a. inappropriately prescribed ketamine RDT 150 mg to be used 6 times per day and shipped from a compounding pharmacy directly to patient #3's residence for self-administration;
    b. prescribed ketamine without clinical justification and/or dispensed ketamine in an unsafe and/or inappropriate manner;
    c. failed to monitor the patient's blood pressure during the ketamine administration;
    d. failed to attend one or more scheduled appointments and/or return patient #3's phone calls;
    e. failed to timely provide medication refills;
    f. violated professional boundaries by permitting Individual #1 to share Respondent's personal details and health information with patient #3, took possession and/or permitted Individual #1 to take possession of patient #3's laptop; engaged in a relationship with patient #3's parents, including sharing confidential information; and/or visited the patient at his residence;
    g. recommended and/or facilitated patient #3 to retain Individual #1 as a life coach;
    h. billed for treatment sessions which did not occur; and/or
    i. shared patient #3's confidential patient information with Individual #1 without patient #3's consent.

9. On or about September 16, 2025, after multiple unsuccessful attempts to contact Respondent for care and treatment, patient #3 requested an urgent consultation with another psychiatrist ("MD #1"). Patient #3 reported being abandoned by Respondent and provided MD #1 with a medical release. MD #1 repeatedly requested patient #3's medical records from Respondent however, Respondent failed to provide patient #3's medical records.

10. From approximately April 2024 through August 2025, Respondent provided care and treatment for patient #4 which included medication management. On multiple occasions in August 2025, patient #4 requested a medication refill. Respondent failed to timely provide a prescription refill for her medication and/or appropriately respond to her repeated requests for the medication refill.

11. In August 2025, Respondent billed patient #4 for a medical appointment which never occurred.

12. From approximately August 30, 2024 through July 16, 2025, Respondent provided care and treatment for patient #5. Patient #5 requested that Respondent fill out disability paperwork to which Respondent agreed. Despite patient #5's repeated requests, Respondent failed to fill out the disability paperwork. Respondent also failed to return patient #5's multiple phone calls.

13. In approximately August 2025, patient #5 came under the care of another psychiatrist ("MD #2"). MD #2 contacted Respondent to discuss patient #5's treatment. Despite repeated attempts from MD #2, Respondent failed to contact MD #2.

14. On various occasions in 2025, Respondent provided care and treatment for patient #6 which included medication management for bipolar disorder. Respondent violated the standard of care in one or more of the following ways, including, but not limited to, when he:
    a. abandoned patient #6 resulting in missed medication refills and a major depressive episode with mixed features as a consequence of his bipolar disorder;
    b. inappropriately prescribed desvenlafaxine and lisdexamfetamine;
    c. failed to attend one or more scheduled appointments and/or return patient #6's phone calls; and/or
    d. failed to timely provide medication refills.

15. Respondent practiced psychiatry and shared office space with another psychiatrist ("MD #3") and each maintained separate practices. In approximately February 2025, Respondent and/or Individual #1 accessed MD #3's office space and/or her website without MD #3's authorization.

16. In approximately April and/or May, 2025, Respondent and/or Individual #1 accessed MD #3's Quest Diagnostic's account without MD #3's authorization. Respondent and/or Individual #1 changed the account name and contact information from MD #3 to Individual #1 and arranged to have MD #3's facsimile communications, which contained confidential patient information, sent to Respondent and/or Individual #1. Respondent and/or Individual #1 ordered supplies from Quest including specialty needles utilizing MD #3's Quest Diagnostic's account without MD #3's authorization.

17. In approximately April and/or May 2025, Respondent's and MD #3's medical office landlord told MD #3 that he witnessed "strange behaviors" from Respondent and/or Individual #1 including changing door locks, meeting men late at night, and possible illicit drug use and illegal activity in the shared office space.

18. On various occasions in 2023, 2024 and/or 2025, Respondent received and/or stored controlled substances at his residence and failed to maintain receipts, inventory, and/or destruction records in violation Connecticut General Statutes §21a-254(c).

19. From June 30, 2022, through June 30, 2025, Respondent authored approximately 1260 controlled substance prescriptions written in quantities greater than a seventy-two-hour supply for approximately 152 patients. Respondent failed to access the Connecticut Prescription Monitoring and Reporting System prior to issuing said controlled substance prescriptions for approximately 132 patients in violation Connecticut General Statutes §21a-254(j)(9).

20. The Department provided Respondent with executed medical releases and requested several patient medical records as part of its investigation. Respondent failed to provide the Department with the requested patient medical records despite repeated requests. The Department thereafter issued a subpoena to obtain the patient medical records, and the subpoena was similarly ignored. To date, Respondent failed to cooperate with the Department's investigation and/or provide the requested medical records.

21. The above-described facts constitute grounds for disciplinary action pursuant to Connecticut General Statutes §20-13c including but not limited to §§20-13c(4) and/or 20-13c(5).

The Connecticut Medical Examining Board, as authorized in Connecticut General Statutes §§19a-17 and 20-13c, revoke or order other disciplinary action against Respondent's physician and surgeon license as deemed appropriate and consistent with law.

Dated September 4, 2026.



Lorraine Cullen MS, RRT-ACCS, Branch Chief,
Regulatory Affairs Branch