Final Order No. DOH-10-1923-S -MQA
FILED DATE - 8-24-10
Department of Health
By: [signature]
Deputy Agency Clerk

STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOH CASE NO.: 2006-01633
LICENSE NO.: ME0016595

JOSE L. VIVO, M.D.,

Respondent.
_______________________________/

FINAL ORDER

THIS CAUSE came before the BOARD OF MEDICINE (Board) on August 6, 2010, in Orlando, Florida, for the purpose of considering Respondent's offer to voluntarily relinquish his license to practice medicine in the State of Florida. (Attached hereto as Exhibit A.) Said written offer of relinquishment specifically provides that Respondent agrees never again to apply for licensure as a physician in the State of Florida.

Upon consideration of the written offer of voluntary relinquishment, the charges, and the other documents of record, and being otherwise fully advised in the premises,

IT IS HEREBY ORDERED that Respondent's Voluntary Relinquishment of his license to practice medicine in the State of Florida is hereby ACCEPTED, and shall constitute discipline upon Respondent's license.

This Final Order shall take effect upon being filed with the Clerk of the Department of Health.

DONE AND ORDERED this 20 day of AUGUST, 2010.

BOARD OF MEDICINE

Larry McPherson, Jr., Executive Director
For Onelia Lage, M.D., Chair

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by U.S. Mail to JOSE L. VIVO, M.D., 1420 Brickell Bay Drive, #305, Miami, Florida 33131; and 1330 Coral Way, #408, Miami, Florida 33145; by email to Steven H. Brotman, Esquire, at brotlaws@att.net; and by interoffice delivery to Veronica Donnelly, Department of Health, 4052 Bald Cypress Way, Bin #C-65, Tallahassee, Florida 32399-3253 this 24 day of August, 2010.

Deputy Agency Clerk

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK: Brandi Sharp
DATE 6.16.10

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. CASE NO. 2006-01633

JOSE L. VIVO, M.D.,

RESPONDENT.
_______________________________/

VOLUNTARY RELINQUISHMENT OF LICENSE

Respondent Jose L. Vivo, M.D, license number ME 16595, hereby voluntarily relinquishes Respondent's license to practice medicine in the State of Florida and states as follows:

1. Respondent's purpose in executing this Voluntary Relinquishment is to avoid further administrative action with respect to this cause. Respondent understands that acceptance by the Board of Medicine (hereinafter the Board) of this Voluntary Relinquishment shall be construed as disciplinary action against Respondent's license pursuant to Section 456.072(1)(f), Florida Statutes. As with any disciplinary action, this relinquishment will be reported to the National

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Practitioner's Data Bank as disciplinary action. Licensing authorities in other states may impose discipline in their jurisdiction based on discipline taken in Florida.

2. Respondent agrees to never reapply for licensure as a medical doctor in the State of Florida.

3. Respondent agrees to voluntarily cease practicing medicine immediately upon executing this Voluntary Relinquishment. Respondent further agrees to refrain from the practice of medicine until such time as this Voluntary Relinquishment is presented to the Board and the Board issues a written final order in this matter.

4. In order to expedite consideration and resolution of this action by the Board in a public meeting, Respondent, being fully advised of the consequences of so doing, hereby waives the statutory privilege of confidentiality of Section 456.073(10), Florida Statutes, and waives a determination of probable cause, by the Probable Cause Panel, or the Department when appropriate, pursuant to Section 456.073(4), Florida Statutes, regarding the complaint, the investigative report of the Department of Health, and all other information obtained pursuant to the Department's investigation in

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the above-styled action. By signing this waiver, Respondent understands that the record and complaint become public record and remain public record and that information is immediately accessible to the public. Section 456.073(10), Florida Statutes.

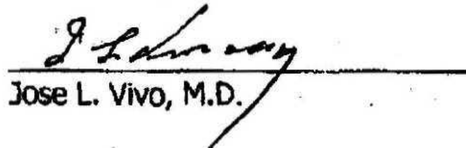
5. Upon the Board's acceptance of this Voluntary Relinquishment, Respondent agrees to waive all rights to seek judicial review of, or to otherwise challenge or contest the validity of, this Voluntary Relinquishment and of the Final Order of the Board incorporating this Voluntary Relinquishment.

6. Petitioner and Respondent hereby agree that upon the Board's acceptance of this Voluntary Relinquishment, each party shall bear its own attorney's fees and costs related to the prosecution or defense of this matter.

7. Respondent authorizes the Board to review and examine all investigative file materials concerning Respondent in connection with the Board's consideration of this Voluntary Relinquishment. Respondent agrees that consideration of this Voluntary Relinquishment and other related materials by the Board shall not prejudice or preclude the Board, or any of its members, from further

participation, consideration, or resolution of these proceedings if the terms of this Voluntary Relinquishment are not accepted by the Board.

DATED this 14TH day of June, 2010.

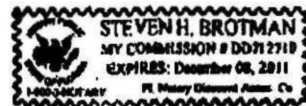


Jose L. Vivo, M.D.

STATE OF FLORIDA
COUNTY OF:
Before me, personally appeared Jose L. Vivo, M.D. who is personally known to me and who, under oath, acknowledges that his signature appears above. Sworn to and subscribed before me this 14th day of June, 2010.

NOTARY PUBLIC

My Commission Expires:



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STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO. 2006-01633**

JOSE L. VIVO, M.D.,

RESPONDENT.

______________________________/

ADMINISTRATIVE COMPLAINT

COMES NOW, Petitioner, Department of Health, by and through its undersigned counsel, and files this Administrative Complaint before the Board of Medicine against Respondent, Jose L. Vivo, M.D., and in support thereof alleges:

1. Petitioner is the state department charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 458, Florida Statutes.

2. At all times material to this Complaint, Respondent was a licensed medical doctor within the state of Florida, having been issued license number ME 16595.

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3. Respondent's address of record is 1330 Coral Way, #408, Miami, Florida 33145.

4. Respondent is a board certified psychiatrist.

5. At all times relevant to this proceeding, Respondent practiced medicine at 1330 Coral Way, #408, Miami, Florida 33145.

MEDICATIONS RELATED TO THIS COMPLAINT

6. Alprazolam (brand name Xanax), lorazepam, estazolam, and temazepam (brand name Restoril) are all benzodiazepine derivates and are prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes, alprazolam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States, and abuse of the substance may lead to limited physical or psychological dependence relative to the substances in Schedule III.

7. Ambien and Ambien CR are legend drugs as defined by Section 465.003(8), Florida Statutes, and contain zolpidem tartrate, a Schedule IV controlled substance listed in Chapter 893, Florida Statutes. The abuse of Ambien and Ambien CR can lead to physical

and psychological dependence. Ambien and Ambien CR are indicated for the short-term treatment of insomnia and should generally be limited to seven to ten days of use. The drugs should not be prescribed in quantities exceeding a one-month supply.

8. Benztropine mesylate (brand name Cogentin) is used to treat symptoms of Parkinson's disease or involuntary movements due to the side effects of certain psychiatric drugs (antipsychotic such as chlorpromazine/haloperidol).

9. Bupropion HCL (brand name Wellbutrin) is a legend drug as defined in Section 465.003(8), Florida Statutes. Bupropion is used to treat depression.

10. Diphenhydramine (brand name Benadryl) can be used to help a patient relax and asleep. Diphenhydramine is also used alone or with other medications to treat shaking (tremor) and muscle stiffness caused by Parkinson's disease. It may also be used to treat side effects of certain psychiatric drugs such as involuntary movements and muscle stiffness.

11. Effexor is a legend drug as defined in Section 465.003(8), Florida Statutes. Effexor is prescribed for depression and/or anxiety.

12. Clonazepam (brand name Klonopin) is prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes, clonazepam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States, and abuse of clonazepam may lead to limited physical or psychological dependence relative to the substances in Schedule III.

13. Paxil is a legend drug as defined in Section 465.003(8), Florida Statutes. Paxil is prescribed for depression and/or anxiety.

14. Zoloft is a legend drug as defined in Section 465.003(8), Florida Statutes. Zoloft is used to treat depression, obsessive compulsive disorder, and/or anxiety.

15. Zyprexa (generic olanzipine) is a legend drug as defined in Section 465.003(8), Florida Statutes. Zyprexa is used to treat schizophrenia and bipolar disorder. The use of the drug for extended periods should periodically be re-evaluated to determine the long-term usefulness of the drug for an individual patient. There may be an increased risk of increased blood sugar levels and diabetes with this medication. Therefore, patients should be tested during

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treatment for elevated blood sugar. Additionally, persons with risk factors for diabetes, including obesity or a family history of diabetes, should have their fasting levels of blood sugar tested before starting treatment.

FACTS RELATED TO PATIENT EA

16. Between December 14, 1998, and January 13, 2005, Patient EA presented to Respondent for psychotherapy and medication management.

17. Respondent documented a diagnostic impression of Patient EA as "Major Depression, Psychotic 296.34, Panic disorder, rule out bipolar, 296.34." The treatment recommendation documented by Respondent included reassessing medications. The medical records contain no information regarding the medication Patient EA was currently taking or any side effects or benefits of medications.

18. Respondent's initial examination of Patient EA does not contain an adequate medical history of the patient, the history of the patient's illness, or the previous treatments and medications and whether they were effective in treating Patient EA's illness. The

history does not contain adequate information relating to substance abuse history, past medical history and past psychiatric history.

19. Subsequently, Respondent diagnosed Patient EA with bipolar disorder but did not document any history to support the diagnosis.

20. Respondent did not conduct or document an adequate mental status examination, psychiatric evaluation, or explanation as to how Respondent reached a diagnosis for Patient EA.

21. Periodically, Respondent documented his recommendations for the patient as referral to her "private physician for future medical workup, medical work every four to six months." Further treatment recommendations included reassessing medications, although no medications were listed.

22. During 2003 and 2004, Respondent regularly prescribed Zyprexa, Lorazepam and Cogentin to Patient EA.

23. During the seven years (7) years that Respondent treated Patient EA, Respondent failed to document the effectiveness of the medication he prescribed, side effects or plans for adjustment. Respondent failed to follow a standard organized diagnostic system.

24. Respondent's medical records for Patient EA contain no orders for clinical chemistry tests or clinical chemistry test results.

25. A reasonably prudent physician in a similar circumstance would have monitored the patient's weight and either ordered regular clinical chemistry reports and labs on Patient EA or referred her to her primary care physician for the reports and labs and then followed up to document the test results given the known side effects of the medications Respondent was prescribing.

26. A reasonably prudent physician in a similar circumstance would have followed a standard organized diagnostic and treatment plan in diagnosing Patient EA, would have used a full range of medications available to him that would have better treated patients' symptoms and documented the reasons for the adjustments to address Patient EA's chronic long term condition.

FACTS RELATED TO PATIENT RA

27. Between October of 1998, and June of 2004, Patient RA presented to Respondent regularly for psychotherapy and medication management. Respondent diagnosed Patient RA as having schizoaffective disorder.

28. During 2003 and 2004, Respondent monthly prescribed Zyprexa, Zoloft, Xanax, Klonopin and Cogentin to Patient RA.

29. During the six years (6) years that Respondent treated Patient RA, Respondent failed to document the effectiveness of the medication he prescribed, side effects or plans for adjustment. Respondent's medical records for Patient RA document that depressive and psychotic symptoms persist in the form of depressed mood, hallucinations and delusions. Respondent does not significantly adjust medication or his treatment plan for Patient RA to adequately address RA's chronic symptoms.

30. Respondent's records for Patient RA do not contain an adequate medical history of the patient, the history of the patient's illness, or the previous treatments and medications and whether they were effective in treating Patient RA's illness. The history does not contain adequate information relating to substance abuse history, past medical history and past psychiatric history.

31. Respondent's medical records for Patient RA contain no orders for clinical chemistry tests or clinical chemistry test results.

32. A reasonably prudent physician in a similar circumstance would have monitored the patient's weight and either ordered regular clinical chemistry reports and labs on Patient RA or referred her to her primary care physician for the reports and labs and then followed up to document the test results given the known side effects of the medications Respondent was prescribing.

33. A reasonably prudent physician in a similar circumstance would have adjusted medication and treatment plan, would have used a full range of medications available to him that would have better treated patients' symptoms and documented the reasons for the adjustments to address Patient RA's chronic condition.

34. A reasonably prudent physician in a similar circumstance would have followed a standard organized diagnostic system in treating Patient RA.

FACTS RELATED TO PATIENT MA

35. Between on or about December 14, 1998 and June 7, 2004, Patient MA presented to Respondent monthly for psychotherapy and medication management. Respondent diagnosed MA with schizoaffective disorder.

36. During 2003 and 2004, Respondent monthly prescribed Zyprexa, temazepam, alprazolam, and benztropine mesylate. In January of 2004, Respondent added diphenhydramine (Benadryl) to Patient MA's prescribed medication.

37. During the previously described six years (6) years that Respondent treated Patient MA, Respondent failed to document the effectiveness of the medication he prescribed, side effects or plans for adjustment. Respondent's medical records document that depressive and psychotic symptoms persist in the form of depressed mood, anxiety with delusions at times. Respondent does not adjust medication or his treatment plan to adequately address Patient MA's chronic symptoms.

38. Respondent's records for Patient MA do not contain an adequate medical history of the patient, the history of the patient's illness, or the previous treatments and medications and whether they were effective in treating Patient MA's illness. The records do not contain adequate information relating to past medical history and past psychiatric history.

39. Respondent's medical records for Patient MA contain no orders for clinical chemistry tests or clinical chemistry test results.

40. A reasonably prudent physician in a similar circumstance would have monitored the patient's weight and either ordered regular clinical chemistry reports and labs on Patient MA or referred her to her primary care physician for the reports and labs and then followed up to document the test results given the known side effects of the medications Respondent was prescribing.

41. A reasonably prudent physician in a similar circumstance would have adjusted medication and treatment plan, would have used a full range of medications available to him that would have better treated patients' symptoms and documented the reasons for the adjustments to address Patient MA's chronic condition.

42. A reasonably prudent physician in a similar circumstance would have followed a standard organized diagnostic system in treating Patient MA.

FACTS RELATED TO PATIENT LR

43. Between September 20, 1991, and December 8, 2004, Patient LR presented to Respondent regularly for psychotherapy and

medication management. Respondent diagnosed LR with schizoaffective disorder.

44. During 2003 and 2004, Respondent monthly prescribed Zyprexa, alprazolam, and Ambien to Patient LR. In August of 2003, Respondent added a prescription for temazepam to Patient LR's medication, deleted the prescription in November of 2003 and added a prescription for benztropine mesylate. In March of 2004, Respondent added a prescription for estazolam to Patient LR's medications. Respondent's medical records contain no explanation for the deletion or addition of these prescriptions.

45. During the previously described thirteen years (13 years) that Respondent treated Patient LR, Respondent failed to document the effectiveness of the medication he prescribed, side effects or plans for adjustment. Respondent's medical records for Patient LR document that depressive and psychotic symptoms persist in the form of depressed mood, poor judgment and anxiety. Respondent does not significantly adjust medication or his treatment plan to address Patient LR's chronic symptoms.

46. Respondent's records for Patient LR do not contain an adequate medical history of the patient, the history of the patient's illness, or the previous treatments and medications and whether they were effective in treating Patient LR's illness.

47. Respondent's medical records for Patient LR contain no orders for clinical chemistry tests or clinical chemistry test results.

48. A reasonably prudent physician in a similar circumstance would have monitored the patient's weight and either ordered regular clinical chemistry reports and labs on Patient LR or referred her to her primary care physician for the reports and labs and then followed up to document the test results given the known side effects of the medications Respondent was prescribing.

49. A reasonably prudent physician in a similar circumstance would have adjusted medication and the treatment plan, would have used a full range of medications available to him that would have better treated patients' symptoms and documented the reasons for the adjustments to address Patient LR's chronic condition.

50. A reasonably prudent physician in a similar circumstance would have followed the standard of an organized diagnostic system in treating Patient LR.

FACTS RELATED TO PATIENT FR

51. Between June of 1995 and June of 2004, Patient FR presented to Respondent regularly for psychotherapy and medication management. Respondent diagnosed Patient FR with schizoaffective disorder.

52. During 2003 and 2004, Respondent routinely prescribed benztropine, alprazolam, Ambien, Effexor, Paxil, temazepam and Zyprexa for Patient FR. In September of 2003, Respondent eliminated a previous prescription for Effexor and added a prescription for Paxil to Patient FR's medication. In January of 2004, Respondent eliminated the prescription for Paxil and added a prescription for Effexor and temazepam. In March of 2004, Respondent eliminates the prescription for Effexor and added a prescription for Zoloft.

53. During the previously described nine (9) years that Respondent treated Patient FR, Respondent failed to document the

effectiveness of the medication he prescribed, any side effects or plans for adjustment. Respondent's medical records for Patient FR document that depressive and psychotic symptoms persist in the form of depressed mood, poor judgment, anxiety and tactile hallucinations. Respondent does not significantly adjust medication or his treatment plan to address Patient FR's chronic symptoms.

54. Respondent's records for Patient FR do not contain an adequate medical history, a history of the patient's illness, or the previous treatments and medications and whether they were effective in treating Patient FR's illness.

55. Respondent's medical records for Patient FR contain no orders for clinical chemistry tests or clinical chemistry test results.

56. A reasonably prudent physician in a similar circumstance would have monitored the patient's weight and either ordered regular clinical chemistry reports and labs on Patient FR or referred her to her primary care physician for the reports and labs and then followed up to document the test results given the known side effects of the medications Respondent was prescribing.

57. A reasonably prudent physician in a similar circumstance would have followed the standard of an organized diagnostic system in treating Patient FR.

58. A reasonably prudent physician in a similar circumstance would have adjusted medication, would have used a full range of medications available to him that would have better treated patients' symptoms and documented the reasons for the adjustments to address Patient FR's chronic condition.

FACTS RELATED TO PATIENT MV

59. Between May of 1994 and November of 2004, Patient MV presented to Respondent regularly for psychotherapy and medication management. Initially, Respondent diagnosed Patient MV with schizoaffective disorder, appears to have changed his diagnosis to dysthymia and then back to schizoaffective disorder. Respondent's medical records for Patient MV contain no justification or explanation as to the changes in diagnosis.

60. During the above described period of time that Respondent treated Patient MV, Patient MV reported auditory

hallucinations, moodiness, paranoid delusions, low energy, anxiety, short-term memory lapses, and somatic delusions.

61. Throughout Respondent's treatment of Patient MV he added and deleted medications without any explanation as why the changes were made. In addition, the records were not clear as to whether previously prescribed medications were discontinued.

62. During the previously described ten (10) years that Respondent treated Patient MV, Respondent failed to document the effectiveness of the medication he prescribed, any side effects or plans for adjustment. Respondent prescribed benztropine, Klonopin, Restoril and Zyprexa for Patient MV but never documented the effectiveness of the medication. Respondent's medical records for Patient MV document that depressive and psychotic symptoms persisted in the form of depressed mood, poor judgment, anxiety, hallucinations and delusions.

63. Respondent's medical records document that depressive and psychotic symptoms persist in the form of depressed mood, poor judgment, anxiety, hallucinations and delusions. Respondent did not significantly adjust medication or his treatment plan to address

Patient MV's chronic symptoms. The records do not document whether the patient is better or worse from visit to visit.

64. Respondent failed to develop a treatment plan that contained a specific plan for therapy; instead his plan year after year was "Therapy helping patient deal with sadness, obsessions, anxiety and Depression."

65. Respondent's records for Patient MV do not contain an adequate medical history of the patient, the history of the patient's illness, or the previous treatments and medications and whether they were effective in treating Patient MV's illness.

66. Respondent's medical records for Patient MV contain no orders for clinical chemistry tests or clinical chemistry test results.

67. A reasonably prudent physician in a similar circumstance would have monitored the patient's weight and either ordered regular clinical chemistry reports and labs on Patient MV or referred her to her primary care physician for the reports and labs and then followed up to document the test results given the known side effects of the medications Respondent was prescribing.

68. A reasonably prudent physician in a similar circumstance would have adjusted medication, used a full range of medications available to him that would have better treated patients' symptoms and documented the reasons for the adjustments to appropriately address Patient MV's chronic condition.

69. A reasonably prudent physician in a similar circumstance would have followed a standard organized diagnostic system in diagnosing and treating Patient MV.

COUNT ONE

70. Petitioner realleges and incorporates paragraphs one (1) through sixty-nine (69) as if fully set forth herein.

71. Section 458.331(1)(t), Florida Statutes (1991) through (2004), subjects a licensee to discipline for gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

72. Respondent engaged in gross and repeated malpractice and failed to practice medicine with that level of care, skill, and

treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances in Respondent's treatment of Patients EA, RA, MA, LR, FR, and MV in one or more of the following ways:

a. By failing to obtain and document an initial history, including medical history, psychiatric history, current medications, substance abuse history, and social and family history;

b. By failing to prepare an adequate written treatment plan that addressed changes in medications and included a broader scope to the treatment of Patients EA, RA, MA, LR, FR, and MV;

c. By failing to follow the standard of an organized diagnostic system in diagnosing and treating the above-listed patients;

d. By failing to use the full range of medications available to him that would have better treated patients' symptoms;

e. By failing to adequately monitor patients prescribed medication with known side-effects and risks when prescribed over an extended period of time.

73. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes (1991) through (2004), by failing to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

COUNT TWO

74. Petitioner realleges and incorporates paragraphs one (1) through sixty-nin4 (69) and paragraph seventy-two (72) as if fully set forth herein.

75. Section 458.331(1)(m), Florida Statutes (1991) through (2004), provides that failing to keep legible, as defined by department rule in consultation with the board, medical records that justify the course of treatment of the patient including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of

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consultations and hospitalizations constitutes grounds for disciplinary action by the Board of Medicine.

76. Respondent failed to maintain legible medical records that justify the course of treatment of the following Patients EA, RA, MA, LR, FR, and MV in one or more of the following ways:

a. By failing to document an adequate initial medical history, psychiatric history, current medications, substance abuse history and social history and family history;

b. By failing to document patients' responses to medication or to document patient progress or lack thereof;

c. By failing to create legible medical records that justified Respondent's prescribing practices, including the changing of medication, for all of the above-described patients, as well as justification for not using more appropriate medications for the patients symptoms; and

d. By failing to contain sufficient information to support a diagnosis for the above described patients.

77. Based on the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes (1991) through (2004), by failing to

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keep legible, as defined by department rule in consultation with the board, medical records that justify the course of treatment of the patient including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

WHEREFORE, the Petitioner respectfully requests that the Board of Medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, corrective action, refund of fees billed or

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collected, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 19th day of February, 2010

Ana M. Viamonte Ros, M.D., M.P.H.
State Surgeon General

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK: Angela Baxter
DATE 2/22/2010

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