IN THE MATTER OF	*	BEFORE THE
ORLANDO R. DAVIS, M.D.	*	MARYLAND STATE BOARD
Respondent	*	OF PHYSICIANS
LICENSE NUMBER: D33967	*	CASE NUMBER: 2011-0811

* * * * * * * * * * * * * *

CONSENT ORDER

On July 31, 2012, the Maryland State Board of Physicians (the "Board") charged Orlando R. Davis, M.D. (the "Respondent") (D.O.B. 03/10/61), license number D33967, with violating the Maryland Medical Practice Act (the "Act") codified at Md. Health Occ. Code Ann. (H.O.) §§ 14-101 *et seq*. (2009 Repl. Vol. and 2011 Supp.).

The pertinent provisions of the Act under which the Board voted charges are H.O. § 14-404:

> (a) *In general*. --Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of the quorum, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in the State;
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review[;].

On October 3, 2012, a Case Resolution Conference ("CRC") with a committee of the Board was held. Based on negotiations between the parties and the members of the CRC, the Board accepts this Consent Order as a resolution of the charges.

FINDINGS OF FACT

The Board makes the following findings of fact:

I. Background

1. At all times relevant hereto, the Respondent was, and is, licensed to practice medicine in Maryland. The Respondent was originally licensed to practice medicine in Maryland on July 22, 1986. On or about August 1, 2010, the Respondent last renewed his license, which will expire on September 30, 2012.

2. Beginning in or about 2002, the Respondent practiced psychiatry at a private, for- profit health center in Baltimore, Maryland.

3. In or about 2008, the Respondent practiced psychiatry for a private, not-for-profit health clinic in Baltimore, Maryland.

4. From approximately, at least, spring 2003 to, at least, fall 2011, the Respondent's private practice of psychiatry is known as "Ridge 103 LLC."

5. Since in or about February 2009, the Respondent has maintained an office for the private practice of psychiatry at 1706 West Lombard Street, Baltimore, Maryland.

6. In or about August 2011, the Respondent also practiced psychiatry at a private not-for-profit community mental health clinic in Baltimore City which provides rehabilitation and support services to people who are disabled or disadvantaged; and, as an independent practitioner at a mental health service facility also in Baltimore City.

7. In October 1990, the Respondent was granted life-time board-certification by the American Board of Psychiatry and Neurology in psychiatry.

II. Complaint and Investigation

8. On or about May 2, 2011, the Board received a complaint from Patient 1 regarding the Respondent's lack of "concern" and "compassion" for his patients.

9. On August 25, 2011, the Respondent was interviewed by Board staff. He acknowledged numerous changes in his office location and how he continued to treat patients during these times of transition. At times, the Respondent traveled with medication to patients' homes and gave them prescriptions.

10. Previously, on August 25, 2010, during the investigation of a prior complaint, the Board issued several subpoenas to various major pharmacies requesting a computer-generated printout of all prescriptions written by the Respondent from June 1, 2008 to on or about August 25, 2010.[1]

11. On October 28, 2011, Board staff selected fifteen (15) patient names at random from the pharmacy printouts and issued a subpoena to the Respondent for any and all medical and billing records for each of the fifteen (15) patients.

12. On October 28, 2011, the Board issued subpoenas to various major pharmacies for a "computer generated printout of all prescriptions written by [the Respondent]" for each of the fifteen (15) patients.

13. On November 16, 2011 the Respondent filed a response to the complaint.

14. On December 16, 2011 the Respondent hand delivered to the Board the medical records, written summaries of care, and signed certification of medical records of fourteen (14) patients.[2]

15. On January 30, 2012, the Board sent the case to Permedion Inc., an independent peer review entity, for a peer review of the fourteen (14) patients. The Board included the complaint from Patient 1, the Respondent's response to the complaint, a transcript of the interview of the Respondent, the Respondent's summary

---

[1] This prior complaint was closed by the Board.

[2] Respondent stated that he did not have any medical records for one of the patients.

of care provided, and medical and billing records as provided by the Respondent.

16. The two (2) Peer Reviewers, both board-certified by the American Board of Psychiatry and Neurology, in psychiatry, concurred that the Respondent failed to meet standards for quality medical care in twelve (12) of the cases and failed to keep adequate medical records in some of the cases.

17. Based on the completed investigatory information and reports, the Board voted to charge the Respondent with violations of §§ 14-404(a)(22) and (40) of the Act.

III. Patient-Specific Findings[3]

Patient 1

18. On or about March 9, 2008, the Respondent began to treat Patient 1, then a 42 year-old female who presented with over 20 years of substance abuse and mental health issues. The Respondent evaluated and diagnosed Patient 1 with major depression and chronic opioid dependency. The Respondent treated Patient 1 with medication, supportive individual and group therapy, and addiction counseling.

19. From March 2008 to March of 2010, the Respondent saw Patient 1 on a monthly basis. After that time, the Respondent conducted home visits and provided home delivery of medications, prescriptions and counseling services. The Respondent made these visits on a monthly basis. The Respondent treated Patient 1 with Seroquel[4] for three years, and Prozac[5] throughout treatment and added

---

[3] In order to maintain confidentiality, the names of the patients are not used in the consent order but are stated in the Confidential Patient Identification List, which was made available to the Respondent.

[4] Seroquel is a "second-generation" antipsychotic drug used in the treatment of schizophrenia and bipolar mania, as well as for unresponsive depression.

[5] Prozac is an antidepressant medication.

Trazodone[6] in 2008. On April 9, 2008, the Respondent documented that the patient was stable. The periodic obtained periodic drug screens.

20. As of November 16, 2011, the date of the Respondent's supplemental response to the Board, the Respondent was continuing to treat Patient 1.

21. The Respondent failed to meet standards of quality medical care in violation of H.O. § 14-404(a)(22) and failed to keep adequate medical records in violation of H.O. § 14-404(a)(40) with respect to his care and treatment of Patient 1 in that he:

a. Failed to request initial laboratory screening, including CBC and thyroid functions;

b. Failed to order initial and periodic laboratory work to monitor lipids and glucose levels in conjunction with prescribing Seroquel; and

c. Failed to maintain adequate medication reviews in early 2011.

Patient 2

22. On or about January 16, 2007, the Respondent began to treat Patient 2, then a 49 year-old female. The Respondent diagnosed chronic opioid dependency and depression. The Respondent treated Patient 2 with medication management and supportive psychotherapy. The Respondent treated Patient 2 with Flouxetine, Doxepine, Trazodone, and Prozac, later adding Seroquel. The Respondent did not document a medical history for Patient 2, who has a history of seizure disorder for which another physician was prescribing medication. The Respondent did not document his collaboration with other doctors in the medication management of Patient 2.

---

[6] Trazodone is an antidepressant medication.

23. The Respondent failed to meet standards of quality medical care in violation of H.O. § 14-404(a)(22) and failed to keep adequate medical records in violation of H.O. § 14-404(a)(40) with respect to his care and treatment of Patient 2 in that he:

a. Failed to request initial laboratory screening, including CBC and thyroid and request periodic urine drug screening for drugs of abuse;

b. Failed to request initial and periodic laboratory work to monitor lipids and glucose levels in conjunction with prescribing Seroquel; and

c. Failed to document collaboration with the physician who was prescribing anti-seizure medication.

Patient 3

27. On or about March 8, 2002, the Respondent began to treat Patient 3, then a 44 year-old male. The Respondent diagnosed Patient 3 with bipolar disorder, chronic pain, and pedophilia. Patient 3 had a history of diabetes. The Respondent used a combination of medication management, prescribing numerous medications, including Lithium[7], and psychotherapy to treat Patient 3. The Respondent did not order renal function, thyroid, or Lithium blood level tests in conjunction with prescribing Lithium. The Respondent did not order laboratory work to check lipids and glucose in conjunction with prescribing Geodon[8] and Zyprexa to Patient 3, a known diabetic.[9] The Respondent did not document justification for prescribing these two antipsychotic medications at the same time.

---

[7] Lithium ion is used as a mood-stabilizing drug in the treatment of bipolar disorder, depression, and mania.

[8] Geodon is a "second generation" antipsychotic medication.

[9] Zyprexa is a "second generation" antipsychotic medication.

28. The Respondent failed to meet standards of quality medical care in violation of H.O. § 14-404(a)(22) and failed to keep adequate medical records in violation of H.O. § 14-404(a)(40) with respect to his care and treatment of Patient 3 in that he:

a. Failed to request, or obtain from Patient 3's primary care physician, initial and periodic laboratory work to monitor glucose and lipids in conjunction with prescribing Geodon and Zyprexa, which can exacerbate Patient 3's diabetes and cause undesirable and dangerous weight gain; and

b. Failed to order laboratory work every 6 months to monitor Lithium levels, and renal and thyroid functions.

Patient 4

29. On or about February 12, 2004, the Respondent began to treat Patient 4, then a 50 year-old female, with a history of bipolar disorder and anxiety, using medication management. The Respondent initially prescribed Paxil. On May 13, 2004, Respondent considered mania but did not make any change in medication. On July 22, 2004, the Respondent diagnosed "major decompensation" and "bipolar relapse" discontinued Paxil and added Zyprexa and Lithium. On July 22, 2004, Patient 4 had a psychiatric hospitalization. The Respondent resumed treatment after Patient 4 was discharged.

30. The Respondent failed to meet standards of quality medical care in violation of H.O. § 14-404(a)(22) and failed to keep adequate medical records in violation of H.O. § 14-404(a)(40) with respect to his care and treatment of Patient 4 in that he:

a. Failed to obtain a full initial psychiatric evaluation including family, social, medical, legal, and medication histories;

b. Failed to place Patient 4 on a mood stabilizer when he noted mania, or failed to document his rationale for not doing so; and

c. Failed to order laboratory work every 6 months to monitor Lithium levels.

Patient 5[10]

Patient 6

31. On or about September 30, 2002, the Respondent began to treat Patient 6, then a 35 year-old male. The Respondent diagnosed Patient 6 with anxiety and bipolar depression. The Respondent met with Patient 6 on a monthly basis from 2002 to 2005; thereafter the visits became less frequent. The Respondent prescribed a variety of medications, including Clonazepam,[11] Zyprexa and Paroxetine.[12] In conjunction with prescribing Zyprexa, the Respondent did not order laboratory work to monitor lipids and glucose.

32. The Respondent failed to meet standards of quality medical care in violation of H.O. § 14-404(a)(22) and failed to keep adequate medical records in violation of H.O. § 14-404(a)(40) with respect to his care and treatment of Patient 6 in that he:

a. Failed to obtain and document a full initial psychiatric evaluation including family, social, medical, legal, and medication histories; and

b. Failed to request initial and periodic laboratory work to monitor lipids and glucose in conjunction with prescribing Zyprexa.

---

[10] There are no findings regarding Patient 5.

[11] Clonazepam is the generic form of Klonopin, a benzodiazepine having anticonvulsant, anti-anxiety, and muscle relaxant properties.

[12] Paroxetine is an antidepressant medication.

Patient 7

33. On or about March 18, 2004, the Respondent began to treat Patient 7, then a 48 year-old female. The Respondent did not document an initial evaluation. The Respondent continued to treat Patient 7 approximately from March 2004 to 2009 for depression, anxiety, and unstable mood. The Respondent used medication management to treat Patient 7 by prescribing a combination of medications including antipsychotic medication, antidepressant medications, and medications for sleep. The Respondent did not obtain laboratory work to check lipids and glucose in conjunction with prescribing Abilify.[13] The Respondent failed to meet standards of quality medical care in violation of H.O. § 14-404(a)(22) and failed to keep adequate medical records in violation of H.O. § 14-404(a)(40) with respect to his care and treatment of Patient 7 in that he:

a. Failed to obtain and document a full initial psychiatric evaluation including a history of present illness, family, social, medical, legal, medication histories; and

b. Failed to order initial and periodic laboratory work to monitor lipid and glucose levels in conjunction with prescribing Abilify.

Patient 8

34. On or about March 11, 2002, the Respondent began to treat Patient 8, then a 27 year-old female for anxiety and depression using medication management. The Respondent saw Patient 8 from approximately 2002 to 2008. The Respondent prescribed various medications for Patient 8. The Respondent also treated Patient 8

[13] Abilify is an antipsychotic, antidepressant medication.

with Clonidine[14] for hypertension. The Respondent did not document any blood pressure recordings. The Respondent did not order laboratory work for Patient 8 to check for medical contributions to her hypertension including testing blood pressure, kidney, and thyroid function.

35. The Respondent failed to meet standards of quality medical care in violation of H.O. § 14-404(a)(22) and failed to keep adequate medical records in violation of H.O. § 14-404(a)(40) with respect to his care and treatment of Patient 8 in that he:

a. Treated Patient 8's blood pressure without monitoring and documenting blood pressure recordings; and

b. Failed to document an explanation for a gap in treatment from August 30, 2007 to July 30, 2008 when treatment resumed.

Patient 9[15]

Patient 10

36. On or about August 11, 2008, the Respondent began to treat Patient 10, then a 51 year-old female, for bipolar disorder and anxiety. The Respondent treated Patient 10 using medication management, prescribing numerous medications for Patient 10 including: Lithium, Alprazolam[16] and Fluoxetine. The Respondent treated Patient 10 until approximately March 2010. The Respondent did not obtain an intake history of Patient 10 or order laboratory work to check for thyroid dysfunction. Respondent did not obtain periodic Lithium blood levels.

---

[14] Clonidine is a medication used to treat high blood pressure.

[15] There are no findings regarding Patient 9.

[16] Alprazolam, the generic form of Xanax, is a benzodiazepine, often used in the treatment of anxiety disorders.

37. The Respondent failed to meet standards of quality medical care in violation of H.O. § 14-404(a)(22) and failed to keep adequate medical records in violation of H.O. § 14-404(a)(40) with respect to his care and treatment of Patient 10 in that he:

a. Failed to obtain an initial psychiatric evaluation including history of present illness and family, social, medical, legal, and medication histories; and

b. Failed to order laboratory work every 6 months to monitor Lithium levels.

Patient 11

39. On or about July 2, 2007, the Respondent began to treat Patient 11, then a 27 year-old female with a history of bipolar disorder and insomnia. In 2007, the Respondent added Prozac to Patient 11's medications, which included Xanax and Ambien. In September of 2007, the Respondent added Lamictal[17] to Patient 11's medications. The Respondent did not record an explanation for a gap in treatment from December 2007 until September 2008.

40. The Respondent failed to keep adequate medical records in violation of H.O. § 14-404(a)(40) with respect to his care and treatment of Patient 11 in that he:

a. Failed to document an explanation for the 9-month gap in treatment between December 2007 and September 2008.

Patient 12

41. On or about July 19, 2007, the Respondent began to treat Patient 12, then a 56 year-old male whom the Respondent diagnosed with anxiety and depression. Patient 12 had a history of chronic benzodiazepine dependence and

[17] Lamictal is an anticonvulsant medication used in the treatment of epilepsy and bipolar disorder.

alcoholism. The Respondent received a "letter of discharge" for Patient 12, which was provided to the Respondent by the prior provider in July 2007. The prior provider discharged Patient 12 based on abuse of Xanax. The Respondent treated Patient 12 approximately from July 2007 to February 2010. The Respondent utilized medication management, prescribing various medications to Patient 12, including Xanax. The Respondent did not attempt to detoxify or refer Patient 12 for substance abuse treatment, including a 12-step program.

42. The Respondent failed to meet standards of quality medical care in violation of H.O. § 14-404(a)(22) and failed to keep adequate medical records in violation of H.O. § 14-404(a)(40) with respect to his care and treatment of Patient 12 in that he:

a. Continued to prescribe Xanax, which Patient 12 was abusing, without an attempt to reduce the dosage;

b. Failed to order drug screening for other drugs of abuse, considering Patient 12's history of abuse;

c. Failed to refer Patient 12 for substance abuse treatment; and

d. Failed to record progress notes from October 2007 to September 2008 and then from September 2008 to August 2009 despite Patient 12 having prescriptions filled during this timeframe.

Patient 13

43. On or about August 30, 2007, the Respondent began to treat Patient 13, then a 39 year-old female, for depression. Patient 13 presented on Prozac to which the Respondent added Elavil.[18] On November 15, 2007, Respondent added Abilify.

---

[18] Elavil is a tricyclic antidepressant medication.

Respondent did not document any progress notes from November 15, 2007 to until June 23, 2008. In June 1, 2009 Respondent added Zoloft.[19] The Respondent did not order laboratory work to monitor lipid and glucose levels in response to prescribing Abilify. The Respondent met with Patient 13 until approximately March 2010.

44. The Respondent failed to meet standards of quality medical care in violation of H.O. § 14-404(a)(22) and failed to keep adequate medical records in violation of H.O. § 14-404(a)(40) with respect to his care and treatment of Patient 13 in that he:

a. Failed to document the risks of adding Elavil to Prozac;

b. Failed to document his rationale for prescribing two SSRI medications (Prozac and Zoloft) concurrently;

c. Failed to monitor and document Patient's progress and response to medication between November 2007 and June 2008 even though he had added new medication in November 2007; and

d. Failed to order initial and periodic laboratory work to monitor lipids and glucose in conjunction with prescribing Abilify.

Patient 14

45. On or about March 24, 2005, the Respondent began to treat Patient 14 then a 58 year-old male with a history of alcohol abuse. The Respondent prescribed Wellbutrin[20] and Klonopin[21] throughout treatment. The Respondent referred Patient 14 for treatment of alcohol abuse. The Respondent did not document the reason Patient 14 terminated treatment in 2008 or the reason Patient 14 resumed treatment

[19] Prozac and Zoloft are both classified as selective serotonin reuptake inhibitors ("SSRIs")

[20] Wellbutrin is a "second generation" antidepressant medication.

[21] Klonopin, the brand name of Clonazapam, is a benzodiazepine having anticonvulsant, anti-anxiety, and muscle relaxant properties.

in June 22, 2009.

46. The Respondent failed to keep adequate medical records in violation of H.O. § 14-404(a)(40) with respect to his care and treatment of Patient 14 in that he:

a. Failed to obtain laboratory work, or consult with primary care physician, to check for complications of alcoholism such as liver function tests and triglycerides; and

b Failed to document the reason for the gap in treatment between the end of 2007 and mid 2009.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that Respondent violated H.O. § 14-404(a)(22) (fails to meet standards of quality care) and § 14-404(a)(40) (inadequate medical records).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 14TH day of NOVEMBER, 2012, by a majority of a quorum of the Board considering this case hereby:

ORDERED, that Respondent is **REPRIMANDED**; and be it further

ORDERED, effective the date of this Consent Order, Respondent is placed on **PROBATION** for a minimum of **two (2) years** and until he fully and satisfactorily complies with the following conditions of probation:

1. Within three (3) months of the date of this Order, Respondent shall enroll in, and within nine (9) months of the date of this Order, Respondent shall successfully complete, a Board-approved course in medical record keeping;

2. Within three (3) months of the date of this Order, Respondent shall enroll in, and within nine (9) months of the date of this Order, Respondent shall successfully complete, a Board-approved course in psychopharmacology;

3. The above courses will not count toward fulfilling the continuing education requirements that Respondent must fulfill in order to renew his license to practice medicine;

4. Within three (3) months of the date of this Consent Order, Respondent shall begin supervision with a Board-approved supervisor who is Board-certified in Psychiatry. Respondent shall obtain prior approval from the Board of the supervisor before entering into the supervisory arrangement. As part of the approval process, Respondent shall provide the Board with the curriculum vitae and any other information requested by the Board regarding the qualifications of the physician who is submitted for approval. The supervisory arrangement shall continue as described for a minimum of one (1) year, subject to the following:

   i. The supervisor shall have no personal, professional relationship with Respondent;

   ii. The supervisor shall notify Board in writing of acceptance of the supervisory role with Respondent;

   iii. Respondent shall agree that the Board will provide the supervisor with a copy of the charging document, this Consent Order, and any other documents from the investigation file that the Board deems relevant, including the Peer Review Reports of (insert), 2012;

   iv. Respondent shall meet in person with the supervisor on a monthly basis who will review a random selection of Respondent's medical charts. The supervisor will assess and provide feedback to Respondent with regard to the quality of his medical care and whether the documentation is adequate and sufficiently legible;

   v. Respondent shall ensure that the supervisor submits written reports to the Board on a quarterly basis regarding his/her assessment of Respondent's compliance with appropriate standards of care and appropriate documentation;

   vi. Respondent shall have sole responsibility for ensuring that the supervisor submits the required quarterly reports to the Board in a timely manner; and

   vii. Respondent may petition the Board for a decrease in the frequency of supervisory meetings after one (1) year of supervision;

5. Within six (6) months after the completion of the courses on medical record keeping and psychopharmacology, Respondent's practice shall be subject to peer review by an appropriate peer review entity, or a chart review by a Board designee, to be determined at the discretion of the Board;

6. An unsatisfactory peer review by an appropriate peer review entity shall be deemed a violation of probation as described below;

7. Respondent shall be responsible for all costs associated with fulfilling the terms and conditions of this Consent Order;

8. Respondent shall practice according to the Maryland Medical Practice Act and in accordance with all applicable laws, statutes, and regulations pertaining to the practice of medicine. Failure to do so shall constitute a violation of this Consent Order;

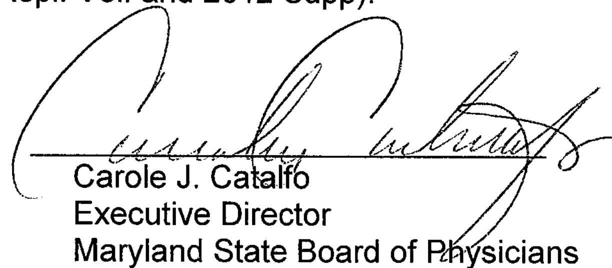
9. There shall be no early termination of probation; and be it further

ORDERED if Respondent violates any term or condition of probation or this Consent Order, the Board, in its discretion, after notice and an opportunity for a show cause hearing before the Board, or opportunity for an evidentiary hearing before an Administrative Law Judge at the Office of Administrative Hearings if there is a genuine dispute as to the underlying material facts, may impose any sanction which the Board may have imposed in this case under §§ 14-404(a) and 14-405.1 of the Medical Practice Act, including a probationary term and conditions of probation, reprimand, suspension, revocation and/or a monetary penalty, said violation of the terms and conditions being proved by a preponderance of the evidence; and be it further

ORDERED that after a minimum of **two (2) years** from the effective date of this Consent Order, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated, through an order of the Board or designated Board committee. The Board,

or designated Board committee, will grant the termination if the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and be it further

ORDERED that the Consent Order is a public document pursuant to Md. State Gov't Code Ann. §§ 10-611 *et seq*. (2009 Repl. Vol. and 2012 Supp).



11-16-12
Date

Carole J. Catalfo
Executive Director
Maryland State Board of Physicians

CONSENT

I, Orlando R. Davis, M.D., License No. D33967, by affixing my signature hereto, acknowledge that:

1. I have consulted with counsel, David J. McManus, Esquire, and knowingly and voluntarily elect to enter into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

2. I am aware that I am entitled to a formal evidentiary hearing, pursuant to Md. Health Occ. Code Ann. § 14-405 (2009 Repl. Vol. & 2011 Cum. Supp.) and Md. State Gov't Code Ann §§ 10-201 *et seq.* (2009 Repl. Vol. & 2012 Cum. Supp.).

3. I acknowledge the validity and enforceability of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I am waiving those procedural and substantive protections.

4. I voluntarily enter into and agree to abide by the terms and conditions set forth herein as a resolution of the Charges against me. I waive any right to contest the Findings of Fact and Conclusions of Law and I waive my right to a full evidentiary hearing, as set forth above, and any right to appeal this

Consent Order or any adverse ruling of the Board that might have followed any such hearing.

5. I sign this Consent Order voluntarily, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

10/24/12
Date

Orlando R. Davis, M.D.
Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF

I HEREBY CERTIFY that on this 24th day of October, 2012 before me, a Notary Public of the State and County aforesaid, personally appeared Orlando R. Davis, M.D, License number D33967, and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

ALICIA LYN MOSKAL RIDDLE
NOTARY PUBLIC STATE OF MARYLAND
My Commission Expires October 5, 2013

Alicia Lyn Moskal Riddle

Notary Public
My commission expires: