State Medical Board of Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

June 14, 2023

Case number: 23-CRF-0109

Vincent Anthony Paolone, M.D.
8166 Market Street, Unit B
Boardman, OH 44512

Dear Doctor Paolone:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke or suspend your license or certificate, or refuse to grant or register or issue the license or certificate for which you have a pending application in accordance with Section 9.79 of the Ohio Revised Code, or refuse to renew or reinstate your license or certificate to practice medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

(1) During the time period of in or around 2007 to in or around September 2021, you provided care and treatment in the routine course of your practice to eight patients as identified in the attached Patient Key. (Patient Key is confidential and to be withheld from public disclosure). From on or about January 1, 2016, to at least in or around September 2021, you inappropriately treated and/or failed to appropriately treat and/or failed to appropriately document your treatment of these patients, which included:

- Inappropriately prescribing, and failing to appropriately monitor the patients' medications;
- A failure to provide appropriate care, and failing to appropriately manage the patients' conditions; and
- Inadequate and/or incomplete documentation.

(2) Examples of such conduct and care to the eight patients include, but are not limited to, the following:

(a) You treated Patient 1 from in or around November 2017 to at least in or around July 2020. During the initial evaluation, you diagnosed the patient with generalized anxiety disorder and prescribed alprazolam, a benzodiazepine. Patent 1 remained on alprazolam 0.5 mg twice daily until a family member passed away in March 2019, when the patient indicated that she had been taking the medication three times daily, and you then increased the dose to three times a day. You

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subsequently switched the patient to different benzodiazepines in response to complaints of increased anxiety, "brain zaps," headaches and jitters. In or around June 2020, you doubled the dose of lorazepam, another benzodiazepine, to 1 mg four times daily after you indicated that Patient 1 was not getting total coverage, even though Patient 1 previously had indicated that she was afraid to take a whole lorazepam. By in or around July 2020, you were prescribing an additional benzodiazepine, Klonopin, 1 mg three times daily. In your messages to Patient 1, you encouraged her to continue to take the benzodiazepine, even though she was anxious about taking the medication; you told the patient that she should stop second guessing you; and you informed the patient that while you were on vacation, she should take as much Klonopin as she needed to stay calm. In or around August 2020, Patient 1 informed you that she had been in treatment detoxing from Klonopin and she was ceasing treatment with you.

Your documentation of mental status exams was inadequate and incomplete. You failed to document or appropriately consider and/or assess the risks of long-term prescribing of benzodiazepines to Patient 1, and her reactions to the medications, both from a cognitive and addiction standpoint. You failed to appropriately manage the patient's medication, and it was inappropriate to encourage the patient to take as much Klonopin as she needed. You also failed to appropriately conduct or document conducting pill counts or urine screens, despite the long-term prescribing of a benzodiazepine, increasing the dosage, and indications that the patient was becoming addicted to the medication.

(b) You treated Patient 2 from in or around May 2014 to at least in or around July 2021. The diagnoses listed in the records included Mood Disorder, NOS; ADHD, inattentive type; insomnia; anxiety disorder, unspecified; and posttraumatic stress disorder. You prescribed a number of medications to Patient 2, including Ritalin, Adderall, alprazolam, diazepam, zolpidem, aripiprazole, venlafaxine, and trazadone. You also recommended medical marijuana, starting in or around November 2020, when you first documented a diagnosis of PTSD, and only after the patient indicated an interest in using marijuana At the time of the patient's office visit in or around July 2021, the final office visit in the records produced, you were prescribing the same doses of benzodiazepines that you had prescribed before recommending medical marijuana. The addition of marijuana to the combination of alprazolam, diazepam, and zolpidem increased the risk of respiratory depression.

Although you took the patient's vital signs on a couple of occasions, you failed to perform, or document performing, appropriate physical exams. In addition, the documentation of mental status exams was inadequate and incomplete. You also failed to appropriately conduct any urine drug screens or pill counts, despite the fact that the patient would sometimes increase the doses of medications on his own or would run out early. While the patient signed some consent forms in 2021, you failed to directly address, or document addressing, the risk of prescribing two benzodiazepines (alprazolam and diazepam) at the same time along with zolpidem and medical marijuana. You also failed to appropriately consider or document considering that your prescribing of a combination of benzodiazepines and stimulants may have been counteracting each other, causing or contributing to the patient's complaints of insomnia and anxiety. While the patient had ongoing complaints of insomnia, you failed to appropriately consider or document

considering that stimulants can precipitate hypomanic or manic symptoms in patients who have underlying bipolar spectrum illness. In addition, some of your interactions and portal messages with the patient were overly accommodating, such as encouraging the patient to make a case for posttraumatic stress disorder to justify a recommendation for medical marijuana.

(c) Your treated Patient 3 from in or around February 2017 to at least in or around September 2021. The diagnoses listed in the chart included anxiety disorder, fibromyalgia and osteoarthritis. During the initial visit in February 2017, Patient 3 indicated that since moving to Ohio, that she was looking for someone to prescribe medications that she previously had found helpful for pain and anxiety; that she had been on alprazolam 1 mg twice daily for thirty years; and that she could not find a psychiatrist in Ohio to prescribe the medication to her. You documented in Patient 3's chart that she drove 1 hour and 45 minutes from her home to your office. You then started the patient on alprazolam 1 mg twice daily. In or around April 2017, you also assumed management of the patient's fibromyalgia because her primary care physician [PCP] would no longer manage it. You prescribed gabapentin 300 mg twice daily, oxycodone 10 mg four times daily, and alprazolam 1 mg twice daily. In addition, Patient 3 was being prescribed Fioricet by her PCP, and you also recommended medical marijuana. As of the patient's office visit with you in September 2021, the final office visit in the records produced, you had increased the dose of alprazolam to 1 mg three times daily, and you had added Norco (10/325 mg up to twice daily) for breakthrough pain while also prescribing oxycodone four times daily, and you continued to recommend medical marijuana, which the patient was using nightly.

Throughout the course of your treatment, you failed to perform or document performing physical exams, and your mental status exams were inadequate and incomplete. In addition, you failed to take appropriate measures to reduce the risk that the patient was misusing her medications, such as pill counts and urine drug screens, despite indications that Patient 3 was misusing her medication, including that she specifically requested alprazolam during the first office visit because she could not find another psychiatrist to prescribe the medication, that she reported a number of falls, that she lived some distance from your office, and that her PCP was unwilling to treat fibromyalgia. You failed to document an appropriate rationale for your long-term prescribing of two opioids along with a benzodiazepine and for increasing the doses. Despite your long-term prescribing of two opioids, you further failed to appropriately refer the patient to a pain management specialist.

(d) You treated Patient 4 from in or around July 2016 to at least in or around September 2021. The diagnoses listed in the patient chart included ADHD, depression and chronic low back pain. During the initial office visit in or around July 2017, Patient 4 indicated that her PCP had been prescribing hydrocodone, but he would not prescribe both hydrocodone and Adderall. You diagnosed the patient with ADHD, depression and chronic low back pain, and prescribed Adderall 30 mg twice daily and trazodone for insomnia. At an office visit on or about August 11, 2016, the patient told you she had run out of her hydrocodone early and she was frustrated that her PCP had stopped prescribing the medication for her. You prescribed Norco 10/325, 1-2 tablets as needed for pain every 4 hours up to a maximum of 6 tablets per day; Norco contains hydrocodone. In or around

December 2016, you increased the dose of Norco of up to 8 tablets per day. You also prescribed lorazepam, after the patient indicated that it had helped her anxiety in the past. A pill count in August 2017 indicated that the patient was taking 10-11 Norco tablets per day, while the prescription provided for a maximum of 8 per day, which you indicated was your comfort level. While you subsequently decreased the Norco dose to 6 tablets per day, you increased the Lorazepam dose in or around July 2020 from 1 mg twice daily as needed to 1 mg twice daily.

Throughout your treatment of Patient 4, your documentation of physical exams was absent, and your documentation of mental status exams was incomplete. Despite the patient taking more medication than authorized along with your long-term prescribing of an opioid, a benzodiazepine and a stimulant, you failed to appropriately obtain urine drugs screens. In addition, you failed to appropriately conduct pill counts on a regular basis, despite evidence that the patient had failed a pill count. You also failed to document an appropriate rationale for your long-term prescribing of an opiate. Although the patient signed a number of consent forms, you failed to directly address, or document directly addressing, the risk of respiratory depression for the combination of medications you were prescribing. You also failed to document directly addressing with the patient the risk that prescribing a benzodiazepine and a stimulant concurrently can exacerbate anxiety.

(e) You treated Patient 5 from in or around August 2010 to at least in or around July 2021. The diagnoses listed in the chart included pain disorder, depression, obstructive sleep disorder and ADHD. Your treatment initially consisted of prescribing alprazolam, and you then added Ritalin. In June 2016, you increased the dose of alprazolam to 1 mg bid while maintaining the patient on clonazepam 1 mg three times daily. In or around August 2019, you added aripiprazole for augmentation of the patient's antidepressant. In or around September 2019, you increased Patient 5's Modafinil to 200 mg bid and continued Ritalin 20 mg bid for ADHD, although you did not document the ADHD diagnosis until in or around December 2019. Throughout your course of treatment, you did not document any pill counts or urine screens, although the patient had previously reported taking more clonazepam than prescribed and also had reported that his Ritalin prescription had been stolen from his car.

Since on or about January 1, 2016, your documentation of mental status exams was inadequate and incomplete. You also failed to conduct, or document conducting, urine drug screens or pill counts, despite signs of misuse or abuse, which included using more medication than prescribed, a claimed theft of medication, and asking for early refills. You failed to document a rationale for prescribing Ritalin for a number of years, before formally documenting an ADHD diagnosis in or around 2019. While there were consent forms in the records, you failed to directly address, or document directly addressing, the risks of prescribing two benzodiazepines at the same time on a long-term basis and with increasing the doses, from both an addiction and respiratory distress standpoint. In addition, you failed to document an appropriate rationale for concurrently prescribing of two psychostimulant medications (Modafinil and Ritalin), which raised the risk of increasing the patient's anxiety.

(f) You treated Patient 6 from in or around July 2007 to at least in or around September 2021, for diagnoses that included unspecified mood disorder, ADHD, PTSD, chronic pain, and osteoarthritis. During the entire course of your treatment of Patient 6, you prescribed an opioid medication for chronic pain, and from in or around 2007 to in or around mid-2019, you also prescribed a benzodiazepine, and you failed to prescribe Naloxone. In or around July 2020, you also recommended medical marijuana. At the time of the patient's office visit in or around September 2021, the final office visit documented in the records produced, the patient was using medical marijuana, oxycodone 20 mg three times a day, Adderall 30 mg twice daily, and Cymbalta 60 mg every day.

Since on or about January 1, 2016, you failed to perform, or document performing, physical exams, and your mental status exams were inadequate and incomplete. You also failed to take appropriate measures to reduce the risk of patient medication abuse, such as pill counts and urine drug screens, despite signs of misuse or abuse, which included taking extra medication, illegal drug use, and concerns expressed by another physician about the use of opioids for chronic pain. You further failed to directly address, or document directly addressing, the risk of prescribing a benzodiazepine for anxiety while also prescribing a stimulant that can exacerbate anxiety. While Patient 6 signed a number of consent forms, you also failed to directly address or document directly addressing with the patient the risk of respiratory depression when prescribing opioids and benzodiazepines on a long-term basis.

(g) You treated Patient 7 from in or around August 2018 to at least in or around July 2021, for diagnoses that included Bipolar II Disorder, Obsessive Compulsive Disorder, ADHD, Panic Disorder, and PTSD. You initially continued the patient on the medication regimen that he indicated had been helpful in the past, which included lamotrigine, vilazodone, Zenzedi, dextroamphetamine and clonazepam. After Patient 7 reported that he had taken extra clonazepam, in or around September 2018, you increased the dose of that medication from three to four times daily (0.5 mg). Further, in 2020, after the patient took more clonazepam that prescribed and ran out, you authorized refills of clonazepam, and you also increased the dose. After Patient 7 requested to start medical marijuana in or around July 2020, to qualify the patient for medical marijuana, you made a diagnosis of PTSD in or around August 2020. Although the patient reported that he was taking less clonazepam, you increased the prescription so that the patient could take double the dose that he reported taking.

Throughout the course of your treatment, you failed to perform, or document performing, physical exams, and your mental status exams were inadequate and incomplete. You failed to appropriately address, or document addressing, the rationale for prescribing two stimulants, especially given the risk for mood instability. You also failed to address, or document addressing, that a benzodiazepine can precipitate hypomania or manic symptoms in a patient with bipolar disorder. Additionally, you failed to take appropriate measures to reduce the risk that the patient was misusing his medications, such as pill counts and urine drug screens, despite the patient's history of alcohol abuse and his admission of taking more clonazepam than prescribed. Further, you simultaneously prescribed two stimulants and failed to document the reason.

(h) You treated Patient 8 from in or around September 2018 to at least in or around June 2021, and your diagnoses included panic disorder, without agoraphobia, and Attention Deficit and Hyperactivity Disorder, combined type. From in or around September 2018 to in or around December 2018, you prescribed alprazolam, increasing the dosage from 1 mg up to four times daily as needed to 1 mg up to 6 times daily. You inappropriately prescribed a benzodiazepine without first trying other alternatives to treat the patient's anxiety, such as psychotherapy or non-controlled medications. In or around July 2019, Patient 8 reported that he did not feel his current dose of alprazolam was sufficient; you added clonazepam. When Patient 8 subsequently indicated clonazepam was not helpful, you discontinued clonazepam and increased the dose of alprazolam to 2 mg 4 times daily. In or around October 2019, you added ADHD as a diagnosis, and prescribed Adderall. During an office visit in or around October 2019 , Patient 8 mentioned that his estranged wife had presented a condition for shared parenting, which specified that he had to enroll in a rehabilitation program for his alprazolam use, and you discouraged Patient 8 from pursuing that treatment. In or around December 2019, Patient 7 admitted to taking more alprazolam than prescribed and running out early, and you added a prescription for diazepam 10 mg twice daily for breakthrough anxiety. Further, in or around mid-2020, after the patient reported that three diazepam worked better, you increased the dose of diazepam to 10 mg three times daily, and also continued the prescriptions for alprazolam 2mg 4 times daily, dextroamphetamine-amphetamine 30 mg twice daily, and methylphenidate 30 mg daily. In or around December 2020, Patient 8 reported that his wife was making false accusations that he was using heroin, and you failed to take or document taking appropriate action. You also failed to conduct any urine drugs screens or pill counts, despite multiple indications that the patient was misusing or abusing illegal drugs and/or his medications.

Throughout the course of your treatment, you failed to perform, or document performing, physical exams. In addition, the documentation of mental status exams was inadequate and incomplete. You also failed to appropriately assess the patient, including consideration that the patient may have been exhibiting signs of mania. In addition, you sent portal messages to the patient that were inappropriate. Further, your prescribing of benzodiazepines to the patient, in combination with other medications and/or on a long-term basis and/or in consideration of the on-going indications of misuse and/or addiction, was inappropriate. You also failed to counsel or document counseling Patient 8 of the risk of respiratory depression posed by the combination of prescriptions. In or around June 2021, Patient 8 reported that he had been psychiatrically hospitalized for suicidal comments after his house caught fire. The diagnoses listed in the hospital records were cocaine abuse and bipolar II disorder, and the patient's urine drug screen at the hospital was positive for cocaine but negative for prescribed benzodiazepines and stimulants. During a follow-up visit on or about June 9, 2021, you advised the patient to throw away the Depakote that he had been prescribed at the hospital. In or around July 2021, you terminated your care of Patient 8.

Your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2)(a) through 2((h) above, individually and/or collectively, constitute "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific

methods in the selection of drugs or other modalities for treatment of disease," as that clause is used in Section 4731.22(B)(2), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2)(a) through 2(h) above, individually and/or collectively, constitute a "departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions that occurred on or after December 31, 2015, until August 30, 2017, as alleged in paragraphs (1) and (2)(b) through (2)(f) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: General Provisions, Rule 4731-11-02, Ohio Administrative Code, as in effect at that time. Pursuant to Rule 4731-11-02(E), Ohio Administrative Code, as in effect at that time, a violation of Rule 4731-11-02, Ohio Administrative Code, also constitutes a violation of Section 4731.22(B)(2), Ohio Revised Code, and Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions that occurred on or after August 31, 2017, until December 22, 2018, as alleged in paragraphs (1) and (2)(a) through (2)(h) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: General Provisions, Rule 4731-11-02, Ohio Administrative Code, as in effect at that time. Pursuant to Rule 4731-11-02(E), Ohio Administrative Code, as in effect at that time, a violation of Rule 4731-11-02, Ohio Administrative Code, also constitutes a violation of Section 4731.22(B)(2), Ohio Revised Code, and Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2)(a) through (2)(h) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: General Provisions, Rule 4731-11-02, Ohio Administrative Code, as currently in effect. Pursuant to Rule 4731-11-02(E), Ohio Administrative Code, as currently in effect, a violation of Rule 4731-11-02, Ohio Administrative Code, also constitutes a violation of Section 4731.22(B)(2), Ohio Revised Code, and Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2)(b), (2)(d), (2)(e), (2)(f), (2)(g) and (2)(h) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Utilization of schedule II controlled substance stimulants, Rule 4731-11-03, Ohio Administrative Code, as in effect from December 31, 2015 until February 27, 2023. Pursuant to Rule 4731-11-03(C), Ohio Administrative Code, as in effect at that time, a violation of Rule 4731-11-03, Ohio Administrative Code, also constitutes a violation of Section 4731.22(B)(2), Ohio Revised Code, Section 4731.22(B)(3), Ohio Revised Code, and Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions that occurred on or after November 30, 2008, until August 30, 2017, as alleged in paragraphs (1), (2)(c), (2)(d) and (2)(f) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Utilizing Prescription Drugs for the Treatment of Intractable Pain, Rule 4731-21-02, Ohio Administrative Code, as in effect at that time. Pursuant to Rule 4731-21-05, Ohio Administrative Code, as in effect at that time, a violation of Rule 4731-21-02, Ohio Administrative Code, also constitutes a violation of Section 4731.22(B)(2), Ohio Revised Code, Section 4731.22(B)(3), Ohio Revised Code, and Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions that occurred on or after August 31, 2017, until December 22, 2018, as alleged in paragraphs (1), (2)(c), (2)(d) and (2)(f) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Utilizing Prescription Drugs for the Treatment of Chronic Pain, Rule 4731-21-02, Ohio Administrative Code, as in effect at that time. Pursuant to Rule 4731-21-05, Ohio Administrative Code, as in effect at that time, a violation of Rule 4731-21-02, Ohio Administrative Code, also constitutes a violation of Section 4731.22(B)(2), Ohio Revised Code, Section 4731.22(B)(3), Ohio Revised Code, and Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions that occurred on or after December 23, 2018, until October 30, 2020, as alleged in paragraphs (1), (2)(c), (2)(d) and (2)(f) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Prescribing for Subacute and Chronic Pain, Rule 4731-11-14, Ohio Administrative Code, as in effect at that time.

Further, your acts, conduct, and/or omissions that occurred on or after October 31, 2020, as alleged in paragraphs (1) through (2)(c), (d), and (f) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Prescribing for Subacute and Chronic Pain, Rule 4731-11-14, Ohio Administrative Code, as currently in effect.

Furthermore, for any violations that occurred on or after September 29, 2015, the Board may impose a civil penalty in an amount that shall not exceed twenty thousand dollars, pursuant to Section 4731.225, Ohio Revised Code. The civil penalty may be in addition to any other action the Board may take under section 4731.22, Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to

practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke or suspend your license or certificate, or refuse to grant or register or issue the license or certificate for which you have a pending application in accordance with Section 9.79 of the Ohio Revised Code, or refuse to renew or reinstate your license or certificate to practice medicine and surgery, or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant or issue a license or certificate to practice to an applicant, revokes an individual's license or certificate to practice, refuses to renew an individual's license or certificate to practice, or refuses to reinstate an individual's license or certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a license or certificate to practice and the board shall not accept an application for reinstatement of the license or certificate or for issuance of a new license or certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,

Kim G. Rothermel MD

Kim G. Rothermel, M.D.
Secretary

KGR/MRB/lv
Enclosures

CERTIFIED MAIL # 94148149031529680250 69
RETURN RECEIPT REQUESTED

cc: Levi J. Tkach, Esq.
Graff & McGovern, LPA
604 E. Rich Street
Columbus, OH 43215

CERTIFIED MAIL # 94148149031529680250 83
RETURN RECEIPT REQUESTED

IN THE MATTER OF
Vincent Anthony Paolone, M.D.
23-CRF-0109

June 14, 2023, NOTICE OF OPPORTUNITY FOR HEARING - PATIENT KEY

SEALED TO PROTECT PATIENT CONFIDENTIALITY AND MAINTAINED IN CASE RECORD FILE.