1 BEFORE THE

2 BOARD OF MEDICAL EXAMINERS

3 STATE OF OREGON

4 In the matter of,	)	
	)	
5 STUART GORDON WEISBERG, MD	)	STIPULATED ORDER
LICENSE NO. MD 23402	)	

6

7 1.

8 The Board of Medical Examiners (Board) is the state agency responsible for licensing,
9 regulating and disciplining certain health care providers, including psychiatrists, in the state of
10 Oregon. Stuart Gordon Weisberg MD (Licensee) is a licensed physician in the state of Oregon.

11 2.

12 The Board proposed taking disciplinary action pursuant to ORS 677.205 against Licensee
13 for violations of the Medical Practice Act, to wit ORS 677.190(1)(a) unprofessional or
14 dishonorable conduct, as defined in ORS 677.188(4)(a) and ORS 677.190(14), gross negligence
15 or repeated acts of negligence in the practice of medicine; and ORS 677.190(25) prescribing
16 controlled substances without a legitimate medical purpose, without following accepted
17 procedures for record keeping and without giving the notice required under ORS 677.485.

18 3.

19 Licensee is a psychiatrist who has a solo practice in a clinic in Portland, Oregon.
20 Licensee resigned in lieu of being terminated from his four year residency program at Oregon
21 Health Sciences University in Portland, several months prior to completion. Licensee is certified
22 by the federal Food and Drug Administration to prescribe the sublingual tablet forms of
23 buprenorphine (Suboxone and Subutrex, Schedule III), which have been approved to treat opioid
24 dependence. Suboxone is a combination of buprenorphine and naloxone. Naloxone is an opioid
25 antagonist.

26 3.1 Review of Licensee's management of adult patients presenting at his clinic
27 revealed a pattern of practice in which Licensee attempted to convert opioid-dependent patients

who were being treated with methadone to buprenorphine without documenting withdrawal symptoms and without stating an induction protocol in the chart. In some cases, Licensee prescribed buprenorphine for chronic pain, which is an off-label use of the drug. On frequent occasions, Licensee concomitantly prescribed benzodiazepines for patients who were taking buprenorphine, which placed his patients at risk of potentially life threatening drug interaction. Licensee also failed to follow the best practice standards of placing medication lists and keeping duplicate prescriptions in the chart to assist in the management of complex medication regimens for his patients.

The Board's review has identified the following specific concerns in regard to Patients A - G:

a. Patient A, a 28-year-old female, presented at Licensee's clinic in May 14, 2004, with a six year history of methadone use after two years of abusing both heroin and methamphetamine and a conviction for the possession of illegal drugs. Licensee prescribed buprenorphine (Suboxone, 4 mg twice day) with authorized refills. Suboxone in most circumstances should be ordered once daily rather than twice daily, and no refills should be authorized. Licensee failed to determine whether Patient A was pregnant, failed to chart an induction protocol, and failed to document informed consent. Licensee prescribed methylphenidate (Ritalin, Schedule II) to Patient A without establishing the requisite diagnosis of attention deficit hyperactivity disorder (ADHD). Licensee also concomitantly prescribed alprazolam (Xanax, Schedule IV) and methylphenidate to this patient who was a known methamphetamine abuser. Benzodiazepines, such as alprazolam, present the risk of adverse interaction, to include reported deaths, when a patient is taking buprenorphine.

b. Patient B, a 25-year-old female, self-referred to Licensee's clinic sometime in May of 2004, reporting chronic pain associated with an automobile collision that occurred seven years earlier. Patient B was taking methadone administered by a methadone clinic. Licensee evaluated Patient B and prescribed clonazepam (Klonopin,

1 Schedule IV), a benzodiazepine that had been previously prescribed by a former
2 physician, which is inadvisable when a patient is taking methadone. Licensee did not
3 document communication with the methadone clinic to coordinate his prescribing. After
4 a number of months, Licensee caused Patient B to discontinue treatment at the methadone
5 clinic and began prescribing sustained release morphine for chronic pain. Licensee did
6 not identify the source of the pain or obtain the patient's medical records from her
7 previous health care providers. Licensee failed to obtain Patient B's informed consent for
8 his treatments and failed to have her sign a material risk notice for the treatment of her
9 chronic pain. After several months, Licensee also prescribed methylphenidate (Ritalin,
10 Schedule II) for Patient B without establishing the requisite diagnosis of ADHD.
11 c. Patient C, a 46-year-old male, was self-referred to Licensee with a history of
12 abusing hydrocodone and acetaminophen (Vicodin, Schedule III). Licensee determined
13 that Patient C was a good candidate for buprenorphine without verifying opioid
14 dependence, and failed to document opioid withdrawal or an induction protocol in the
15 chart. Licensee prescribed buprenorphine, using an abrupt detoxification schedule, as
16 well as lorazepam (Ativan, Schedule IV), which is a benzodiazepine and which could
17 have provoked a dangerous drug interaction.
18 d. Patient D, a 31- year- old female, was referred to Licensee for treatment with
19 buprenorphine in 2004. Her history included five years of methadone maintenance for
20 opioid dependence. Again, it should be noted that buprenorphine should generally be
21 given once per day due to its long half-life of thirty-nine hours. Licensee prescribed
22 buprenorphine (8 mg twice a day) while Patient D's primary care physician continued to
23 prescribe clonazepam (Klonopin, Schedule IV) a benzodiazepine, and while Patient D
24 continued to receive methadone. Licensee failed to document opioid withdrawal or an
25 induction protocol for this patient. Licensee's chart does not document necessary
26 coordination of care between Licensee and Patient D's primary care physician or the
27 methadone clinic. Licensee subsequently prescribed methylphenidate (Ritalin, Schedule

1 II) for Patient D without establishing the requisite diagnosis and without evaluating the
2 medical efficacy of prescribing multiple controlled substances for a drug dependent
3 patient with a history of drug abuse.
4 e. Patient E, a 28-year-old female, was referred to Licensee in August of 2004 for
5 treatment of her chronic pain. Patient E had suffered injuries from an automobile
6 accident five years prior, and was receiving prescriptions from other providers for
7 hydrocodone & acetaminophen (Vicodin, Schedule III), oxycodone & acetaminophen
8 (Percocet, Schedule II) and carisoprodol (Soma, Schedule IV). Licensee prescribed 8 mg
9 of buprenorphine (Subutrex) to treat her pain, but without an induction protocol or
10 diagnosis of opioid dependence stated in the chart. Patient E initially reported a good
11 response to the buprenorphine, but in September of 2004, reported an allergic reaction.
12 Licensee subsequently prescribed sustained release oxycodone (OxyContin, Schedule II)
13 and sertraline (Zoloft). Licensee failed to coordinate care with Patient E's primary care
14 physician, who wrote a prescription of morphine sustained release (MS Contin, Schedule
15 II) for Patient E also in September of 2004. In December of 2004, Licensee displayed
16 poor judgment in directing that a month's prescription (with two refills, which violates
17 federal standards) of OxyContin be mailed to Patient E's home.
18 f. Patient F, a 19-year-old male with a history of heroin abuse, presented to Licensee
19 in November of 2004. Licensee diagnosed opioid dependence and attention deficit
20 disorder without sufficient basis to establish either diagnosis. Licensee prescribed
21 buprenorphine to detoxify Patient F, but failed to note an induction protocol or
22 withdrawal symptoms. Licensee concomitantly prescribed the benzodiazepine,
23 lorazepam (Ativan, Schedule IV), as well as dextroamphetamine & racemic amphetamine
24 (Adderall, Schedule II) without medical justification.
25 g. Patient G, a 71-year-old female, presented to Licensee with a history that
26 reportedly included fibromyalgia, opiate escalation and odd behavior. Patient G was
27 taking a complex regimen of medications that included sustained release oxycodone

1 (OxyContin, Schedule II), oxycodone & acetaminophen (Percodan, Schedule II),
2 clonazepam (Klonopin, Schedule IV), pramipexole (Mirapex, an anti-Parkinsonian agent)
3 and valsartan/hydrochlorthiazide (Diovan, for hypertension). Licensee attempted to
4 detoxify Patient G by substituting MS Contin for Oxycontin and by adjusting the dosage
5 of her other medications, but he did so without communicating with Patient G's
6 rheumatologist or her primary care physician. Licensee noted that he was treating Patient
7 G's "opioid dependence on a slow, steady taper." Licensee's efforts to detoxify Patient G
8 in an office based setting were inappropriate.

9 4.

10 Licensee and the Board desire to settle this matter by entry of this Stipulated Order.
11 Licensee understands that he has the right to a contested case hearing under the Administrative
12 Procedures Act (chapter 183), Oregon Revised Statutes, and fully and finally waives the right to
13 a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the
14 Board's records. Licensee admits that he engaged in the conduct described in paragraph 3 and
15 that this conduct violated ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined
16 in ORS 677.188(4)(a) and ORS 677.190(14), gross negligence or repeated acts of negligence in
17 the practice of medicine; and ORS 677.190(25) prescribing controlled substances without a
18 legitimate medical purpose, without following accepted procedures for record keeping and
19 without giving the notice required under ORS 677.485. Licensee understands that this Order is a
20 public record and is reportable to the National Practitioner Databank.

21 5.

22 Licensee and the Board desire to settle this matter by the entry of this Stipulated Order,
23 subject to the following terms and conditions of probation:

24 5.1 Licensee is reprimanded.

25 5.2 Licensee will arrange call coverage for his patients. The coverage will be
26 provided by a psychiatrist who does not have a physician/patient relationship with
27 the Licensee.

5.3 Licensee is placed on probation for five years. At the conclusion of Licensee's first year of probation, Licensee may request and the Board will consider a reduction in the term of Licensee's probationary period. The Board shall have the sole discretion to either shorten the probationary period or deny Licensee's request. Licensee will report in person to the Board at each of its regularly scheduled quarterly meetings for a probationer interview unless ordered to do otherwise by the Board's Compliance Officer.

5.4 Within 30 days from the approval of this Order, Licensee shall enroll in the Oregon Medical Association's Physicians Evaluation Education Renewal program (PEER). Licensee must successfully complete this program within 24 months from the approval of this Order. Licensee must also sign all necessary releases to ensure that the Board may freely communicate with PEER, and that quarterly progress reports and the final evaluation report from the education program are provided promptly to the Board.

5.5 Licensee shall obey all federal, state and local laws, and all rules governing the practice of medicine in the state of Oregon.

5.6 Licensee stipulates and agrees that any deviation or violation from terms of this Order shall be grounds for discipline pursuant to ORS 677.190(18).

5.

This Order becomes effective the date it is signed by the Board Chair.

IT IS SO STIPULATED THIS 31st day of May, 2006.

STUART GORDON WEISBERG, MD

IT IS SO STIPULATED THIS 13th day of July, 2006.

BOARD OF MEDICAL EXAMINERS
State of Oregon

DAVID R. GRUBE, MD
BOARD CHAIR

1 BEFORE THE

2 OREGON MEDICAL BOARD

3 STATE OF OREGON

4 In the Matter of)
)
5 STUART GORDON WEISBERG, MD) CORRECTIVE ACTION ORDER
LICENSE NO. MD23402)
6)

7

8 1.

9 The Oregon Medical Board (Board) is the state agency responsible for licensing,
10 regulating and disciplining certain health care providers, including physicians, in the state of
11 Oregon. Stuart Gordon Weisberg, MD (Licensee) is a licensed physician in the state of Oregon.

12 2.

13 Licensee and the Board entered into a Stipulated Order on May 31, 2006, which included
14 terms and conditions of probation. On August 1, 2008, Licensee successfully completed the
15 Physicians Education Renewal Program (PEER), and was in compliance with the terms of the
16 Stipulated Order. The Board opened additional investigations on the Licensee in April of 2007
17 and May of 2008. The Board asked Licensee to undergo an evaluation by the Physician
18 Assessment and Clinical Education Program (PACE) located in San Diego, California and asked
19 that he complete their recommended intensive training program. On April 24, 2009, Licensee
20 successfully completed a 40-hour intensive training program in psychiatry designed for him by
21 the PACE.

22 3.

23 The Board now terminates the Stipulated Order, dated May 31, 2006, and enters into an
24 agreement with Licensee that Licensee will satisfy the following conditions:

25 3.1 Licensee will practice with the benefit of a practice mentor pre-approved by the
26 Board's Medical Director. Licensee will meet with this mentor at least twice a month to
27 conduct chart review and to discuss ongoing patient care issues.

1 3.2 The practice mentor will provide the Board with quarterly written reports.

2 3.3 Licensee's practice location is subject to no-notice compliance visits by a Board

3 designee.

4 3.4 Evidence of violation of the terms of this agreement will be grounds for discipline

5 pursuant to ORS 677.190(18).

6 4.

7 Licensee and the Board understand that by resolving this matter through this Corrective

8 Action Order, Licensee waives his right to a contested case hearing or appeal therefrom. This

9 Order does not constitute Board discipline and is not reportable to the National Practitioner

10 Databank, although it is a public document.

11

12 IT IS SO STIPULATED this 9th day of June, 2009.

13

14 STUART GORDON WEISBERG, MD

15

16

17

18 IT IS SO ORDERED this 9 day of July, 2009.

19

20

OREGON MEDICAL BOARD
21 State of Oregon

22

23

DOUGLAS B. KIRKPATRICK, MD
24 Board Chair

25

26

27

BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

In the Matter of	)	
	)	
STUART GORDON WEISBERG, MD LICENSE NO. MD23402	)	ORDER OF EMERGENCY SUSPENSION
	)	

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the state of Oregon. Stuart Gordon Weisberg, MD, (Licensee), is a licensed physician in the state of Oregon.

2.

Licensee was previously disciplined by the Board and placed on probation consistent with the terms of a Stipulated Order, dated July 13, 2006. The acts and conduct that support this Order for Emergency Suspension are as follows:

2.1 Licensee is currently required to practice medicine consistent with the terms of a Corrective Action Order, approved by the Board on June 9, 2009, which requires Licensee to practice with the benefit of a practice mentor pre-approved by the Board's Medical Director and to meet with this mentor at least twice a month to conduct chart review and to discuss ongoing patient care issues. Licensee informed the Board in a letter dated June 14, 2010, that his practice mentor no longer supported his ideas pertaining to practice and requested "removal from his services." In a letter dated June 22, 2010, Licensee presented the Board with a form purporting to modify his Corrective Action Order that would eliminate the term requiring a practice mentor and offered to meet with a Board member periodically. He also stated that his "practice as a psychiatrist is full." Licensee is no longer meeting with his Board approved practice mentor, in violation of term 3.1 of the Corrective Action Order.

1 2.2 Licensee has recently manifested behavior indicative of grandiosity, compulsivity,
2 and risk taking behavior that calls his ability to practice medicine competently and in conformity
3 to the law into question.
4 2.3 Patient A, a 68-year-old female, presented to Licensee with complaints of
5 melancholic depression. Licensee tried multiple antidepressants without apparent beneficial
6 effect. Licensee subsequently augmented this treatment with various medications, to include a
7 trial of Ketamine (Schedule III). This off label treatment with Ketamine was not medically
8 indicated and exposed Patient A to the unnecessary risk of harm.
9 2.4 Patient B, 54-year-old female, presented to Licensee with complaints associated
10 with a long history of bipolar disorder, chronic pain, with symptoms of hypomania and substance
11 dependence. Licensee signed a marijuana card for Patient B in what he described as an effort to
12 engage in "harm reduction." Recommending medical marijuana for this patient was not
13 medically indicated and exposed Patient B to the unnecessary risk of harm.
14 3.
15 Based on the above information, the Board has determined that from the evidence
16 available to the Board at this time, Licensee's continued practice of medicine would pose an
17 immediate danger to the public and to his patients, and that his medical judgment may be
18 impaired. The Board is also concerned that Licensee practices alone, without frequent
19 professional interaction with colleagues. This behavior causes the Board to conclude that it
20 would be subjecting patients to the risk of harm if he were allowed to continue to practice while
21 this case remains under investigation. Pursuant to ORS 677.205(3), the Board orders that the
22 license of Stuart Gordon Weisberg, MD, to practice medicine, including refilling medications, is
23 suspended on an emergency basis. Licensee is directed to immediately cease the practice of
24 medicine until otherwise ordered by the Board. This Order becomes effective at 6:00 p.m. on
25 June 24, 2010.
26
27

4.

Licensee is entitled to a hearing as provided by the Administrative Procedures Act (chapter 183), Oregon Revised Statutes. Licensee may be represented by legal counsel at a hearing. If Licensee desires a hearing, the Board must receive Licensee's written request for hearing within ninety (90) days from the date the mailing of this Notice to Licensee, pursuant to ORS 183.430(2). Upon receipt of a request for a hearing, the Board will notify Licensee of the time and place of the hearing and will hold a hearing as soon as practical.

IT IS SO ORDERED THIS 24th day of June, 2010.

OREGON MEDICAL BOARD
State of Oregon

SIGNATURE REDACTED

Lisa A. Cornelius, DPM
Board Chair

1 BEFORE THE

2 OREGON MEDICAL BOARD

3 STATE OF OREGON

4 In the Matter of	)	
	)	
5 STUART GORDON WEISBERG, MD	)	DEFAULT FINAL ORDER
LICENSE NO. MD 23402	)	
6	)	

7 1.

8 The Oregon Medical Board (Board) is the state agency responsible for licensing,
9 regulating and disciplining certain health care providers, including physicians, in the state of
10 Oregon. Stuart Gordon Weisberg, MD (Licensee) is a licensed physician in the state of Oregon.

11 2.

12 On June 24, 2010, the Board issued an Order of Emergency Suspension against the medical
13 license of Licensee while the Board continued its investigation into reports of personal behavior and
14 manner of practice that called into serious question his ability to practice medicine safely and
15 competently. On July 9, 2010, Licensee requested a contested case hearing. On November 4, 2010,
16 the Board issued a Complaint and Notice of Proposed Disciplinary Action. This Notice designated
17 the Board's file on this matter as the record for purposes of a default order and granted Licensee an
18 opportunity for a hearing, if requested in writing within 21 days of service of the Notice. This Notice
19 was sent by Certified Mail on November 8, 2010 to Licensee at the address provided by Licensee. In
20 a letter received by the Board on February 7, 2011, Licensee wrote the following: "I wish to
21 withdraw my request for a contested case hearing and proceed to judgment. Thank you." As a result,
22 Licensee has waived his right to request a hearing and now stands in default. The Board elects in this
23 case to designate the record of proceeding to date, which consists of Licensee's file with the Board,
24 as the record for purposes of proving a prima facie case, pursuant to ORS 183.417(4).

25 ///

26 ///

1 3.

2 NOW THEREFORE, after considering the Board's file relating to this matter, the Board

3 enters the following Order.

4 FINDINGS OF FACT

5 In the Complaint and Notice of Proposed Disciplinary Action dated November 4, 2010,

6 the Board informed Licensee that it intended to take disciplinary action against him based upon

7 violations of the Medical Practice Act, as follows: ORS 677.190(1)(a) unprofessional or

8 dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(7) impairment; ORS

9 677.190(13), gross or repeated negligence; and ORS 677.190(17) willfully violate a Board order

10 or regulation. This notice was based upon the following conduct:

11 3.1 Licensee has been in private (solo) practice since June 1, 2004 after resigning

12 from his four year residency at Oregon Health Science University six weeks prior to graduation.

13 Licensee was previously disciplined by the Board and was placed on probation for five years

14 consistent with the terms of a Stipulated Order, dated July 13, 2006, for violations of the Medical

15 Practice Act, to wit ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in

16 ORS 677.188(4)(a) and ORS 677.190(13), gross negligence or repeated acts of negligence in the

17 practice of medicine; and ORS 677.190(24) prescribing controlled substances without a

18 legitimate medical purpose, without following accepted procedures for record keeping and

19 without giving the notice required under ORS 677.485. Consistent the terms of his

20 probation, Licensee completed the Oregon Physicians Education Renewal Program (PEER) on

21 June 17, 2008.

22 3.2 The Board subsequently opened a new investigation, which was resolved with

23 Licensee undergoing an evaluation by the Physician Assessment and Clinical Education Program

24 (PACE). On April 24, 2009, Licensee successfully completed a 40 hour intensive training

25 program in psychiatry that was designed for him by PACE. Licensee entered into a Corrective

26 Action Order (CAO) that was approved by the Board on June 9, 2009, which required Licensee

1 to practice with the benefit of a practice mentor pre-approved by the Board's Medical Director
2 and to meet with this mentor at least twice a month to conduct chart review and to discuss
3 ongoing patient care issues. One year later, in a letter dated June 14, 2010, Licensee informed
4 the Board that his practice mentor no longer supported his ideas pertaining to practice and
5 regarding this practice mentor, Licensee requested "removal from his services." Licensee ceased
6 meeting with his Board approved practice mentor shortly after this. In a subsequent letter dated
7 June 18, 2010, Licensee presented the Board with a form purporting to modify his CAO of 2009
8 that would eliminate the term requiring a practice mentor and, apparently in replacement, offered
9 to meet with a Board member periodically. He also stated that his "practice as a psychiatrist is
10 full." The sum of the information gathered by the Board, to include information that both
11 preceded and followed the Licensee's two letters mentioned above, prompted the Board to issue
12 an Order of Emergency Suspension on June 24, 2010. Licensee's unilateral decision to cease
13 meeting with his Board approved practice mentor violated the terms of the CAO.
14 3.3 Prior to Licensee's unauthorized attempt to void the CAO, Licensee's practice
15 mentor reviewed a case in which Patient A, a 68-year-old female presented to Licensee with
16 complaints of melancholic depression. Licensee tried multiple antidepressants without apparent
17 beneficial effect. Licensee subsequently augmented this treatment with various medications, to
18 include escitalopram (Lexapro), alprazolam (Xanax, Schedule IV) and a trial of Kentamine
19 (Schedule III). Licensee also recommended electroconvulsive therapy. Licensee's off label
20 treatment with Ketamine was not medically indicated and exposed Patient A to the unnecessary
21 risk of harm.
22 3.4 Licensee's practice mentor also reviewed a case involving Patient B, a 54-year-
23 old female that presented to Licensee with complaints associated with a long history of bipolar
24 disorder with rapid cycles and delusions, chronic pain, substance dependence, and some
25 symptoms of bipolar hypomania. Licensee signed a marijuana card for Patient B in what he
26 described as an effort to engage in "harm reduction," which exposed Patient B to the unnecessary

1 risk of harm. Licensee's chart notes fail to state why medical marijuana for this patient was
2 medically indicated.

3 3.5 During the spring, summer and fall of 2010, Licensee engaged in a pattern of
4 erratic behavior that culminated in his hospitalization in October 2010. The Board concludes
5 based on this behavior that Licensee lacks the capacity to practice with reasonable competence
6 and safety.

7 4.

8 CONCLUSIONS OF LAW

9 Licensee's conduct, as described above, breached well recognized standards of practice
10 and ethics of the medical profession. By failing to meet with Licensee's practice mentor and
11 trying to unilaterally modify and terminate his Corrective Action Order, Licensee violated the
12 terms of a Board order. Furthermore, Licensee's manner of practice in regard to Patient A and
13 Patient B constituted repeated acts of negligence and exposed these patients to the unnecessary
14 risk of harm. In addition, Licensee's personal and professional conduct in 2010 demonstrates a
15 pattern of erratic behavior that leads the Board to the conclusion that Licensee lacks the mental
16 and emotional capacity to safely and competently practice medicine. The Board, therefore,
17 concludes that Licensee's conduct as described above violated the following: ORS 677.190(1)(a)
18 unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a); ORS 677.190(7)
19 impairment; ORS 677.190(13), gross or repeated negligence; and ORS 677.190(17) willfully
20 violate a Board order or regulation. Based upon its examination of the record in this case, the
21 Board finds that each alleged violation of the Medical Practice Act is supported by reliable,
22 probative and substantial evidence.

23 ///

24 ///

25 ///

26 ///

5.

ORDER

IT IS HEREBY ORDERED THAT the license of Stuart Gordon Weisberg, MD, to practice medicine is revoked.

DATED this 8th day of April, 2011.

OREGON MEDICAL BOARD
State of Oregon

Signature Redacted

KATHLEEN A. YATES, DO
BOARD CHAIR

Right to Judicial Review

NOTICE: You are entitled to judicial review of this Order. Judicial review may be obtained by filing a petition for review with the Oregon Court of Appeals within 60 days after the final order is served upon you. See ORS 183.482. If this Order was personally delivered to you, the date of service is the day it was mailed, not the day you received it. If you do not file a petition for judicial review within the 60 days time period, you will lose your right to appeal.