HEARING CONDUCTED BY THE
TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS
SOAH DOCKET NO. 503-17-5952.MD
TEXAS MEDICAL LICENSE NO. K-2288

IN THE MATTER OF THE	BEFORE THE
COMPLAINT AGAINST	
RAJINDER S. SHIWACH, M.D.	TEXAS MEDICAL BOARD

COMPLAINT

TO THE HONORABLE TEXAS MEDICAL BOARD AND ADMINISTRATIVE LAW JUDGE TO BE ASSIGNED:

The Staff of the Texas Medical Board (the Board) files this Complaint against Rajinder S. Shiwach, M.D. (Respondent), for alleged violations of the Medical Practice Act (the Act), Title 3, Subtitle B, Texas Occupations Code, and would show the following:

I. SUMMARY OF FACTUAL ALLEGATIONS

The Board alleges that Respondent failed to meet the standard of care for nine patients in his psychiatric practice, including non-therapeutically prescribing medications, including controlled substances; failure to demonstrate a medical rationale for the patients' care; failure to adequately monitor patients' care; failure to meet the Board's Guidelines for the treatment of chronic pain; and failure to maintain an adequate medical record of his patient care.

II. LEGAL AUTHORITY AND JURISDICTION

1. Respondent is a Texas physician and holds Texas Medical License No. K-2288, which was originally issued by the Board on March 1, 1997. Respondent's license was in full force and effect at all times material and relevant to this Complaint.

2. Respondent received notice of one or more Informal Settlement Conferences (ISC). The Board complied with all procedural rules, including but not limited to, Board Rules 182 and 187, as applicable.

3. No agreement to settle this matter has been reached by the parties.

4. All jurisdictional requirements have been satisfied.

5. The filing of this Complaint and the relief requested are necessary to protect the health and public interest of the citizens of the State of Texas, as provided in Section 151.003 of the Act.

III. APPLICABLE STATUTES AND STATUTORY VIOLATIONS

The following Statutes, Rules, and Agency Policy are applicable to the procedures for conduct of the hearing this matter:

A. General Statutes and Rules:

1. Section 164.007(a) of the Act requires that the Board adopt procedures governing formal disposition of a contested case before the State Office of Administrative Hearings.

2. 22 TEX. ADMIN. CODE, CH.187 sets forth the procedures adopted by the Board under the requirement of Section 164.007(a) of the Act.

3. 22 TEX. ADMIN. CODE, CH. 190 sets forth aggravating factors that warrant more severe or restrictive action by the Board.

4. 1 TEX. ADMIN. CODE, CH. 155 sets forth the rules of procedure adopted by SOAH for contested case proceeding.

5. 1 TEX. ADMIN. CODE, CH. 155.507, requires the issuance of a Proposal for Decision (PFD) containing Findings of Fact and Conclusions of Law.

6. Section 164.007(a) of the Act, Board Rules 187 et seq. and Board Rule 190 et seq., provide the Board with the sole and exclusive authority to determine the charges on the merits, to impose sanctions for violation of the Act or a Board rule, and to issue a Final Order.

B. Specific Violations Cited:

Respondent has violated one or more of the following provisions of the Act:

1. Section 164.051(a)(1) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's commission of an act prohibited under Section 164.052 of the Act.

2. Section 164.051(a)(3) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's violation of a rule adopted under this Act; specifically, Board Rules 165.1(a), failure to maintain an adequate medical record; 170.3, failure to adhere to those established guidelines and requirements for the treatment of chronic pain; and 193.4 and 193.5, *et. seq.*, regarding supervision and delegation to competent practitioners.

3. Section 164.051(a)(6) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's failure to practice medicine in an acceptable professional manner consistent with public health and welfare, as further defined by Board Rules 190.8(1)(A), failure to treat a patient according to the generally accepted standard of care; 190.8(1)(B), negligence in performing medical services; 190.8(1)(C), failure to use proper diligence in one's professional practice; 190.8(1)(D), failure to safeguard against potential complications; 190.8(1)(G), failure to disclose reasonably foreseeable side effects or a procedure or treatment; 190.8(1)(H), failure to disclose reasonable alternative treatments to a proposed procedure or treatment; and 190.8(1)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, procedures, or autopsies as required under Chapter 49 of the Code of Criminal Procedure.

4. Section 164.052(a)(5) of the Act authorizes the Board to take disciplinary action against Respondent based upon Respondent's unprofessional or dishonorable conduct that is likely to deceive or defraud the public or injure the public, as provided by §164.053, or injure the public, as defined by Board Rules: 190.8(2)(J) providing medically unnecessary services to a patient or submitting a billing statement to a patient or a third party payer that the licensee knew or should have known was improper; and 190.8(2)(R) commission of the following violations of federal and state laws whether or not there is a complaint, indictment, or conviction: any felony, and any criminal violation of the Medical Practice Act or other statutes regulating or pertaining to the practice of medicine, to wit: Texas Health and Safety Code §481.129(c), related to prescribing controlled substances without a valid medical purpose.

5. Section 164.053(a)(1) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's commission of an act that violates any state or federal law if the act is connected with the physician's practice of medicine, including but not limited to: Texas Health and Safety Code §481.129(c).

6. Section 164.053(a)(3) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's writing prescriptions for or dispensing to a person who is known to be an abuser of narcotic drugs, controlled substances, or dangerous drugs or to a person who the physician should have known was an abuser of the narcotic drugs, controlled substances, or dangerous drugs.

7. Section 164.053(a)(5) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent prescribing or administering a drug or treatment that is nontherapeutic in nature or nontherapeutic in the manner the drug or treatment is administered or prescribed.

8. Section 164.053(a)(6) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent prescribing, administering, or dispensing in a manner inconsistent with public health and welfare, dangerous drugs as defined by Chapter 483, Texas Health and Safety Code; or controlled substances scheduled in Chapter 481 Texas Health and Safety Code; or controlled substances scheduled in the Comprehensive Drug Abuse Prevention and Control Act of 1970, (21 U.S.C. § 801 *et seq.*).

9. Section 164.053(a)(8) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent failure to supervise adequately the activities of those acting under his supervision.

IV. ALLEGATIONS

Based on information and belief, Board Staff alleges:

A. GENERAL ALLEGATIONS

1. Respondent is a psychiatrist practicing psychiatry as a solo practitioner in DeSoto, Texas.
2. Respondent is authorized to treat patients with Suboxone®, or buprenorphine/naloxone, which is prescribed in the treatment of opioid dependence under Drug Enforcement Agency (DEA) number XS 5229629.[1]
3. In his treatment of Patients 1-9, Respondent or his delegates have exhibited a pattern of practice that fails to meet the standard of care in that Respondent or his delegates have:

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[1] https://www.fda.gov/downloads/drugs/drugsafety/postmarketdrugsafetyinformationforpatientsandproviders/ucm191533.pdf

a. Failed to adequately document his medical rationale for initiation of new medications;
b. Failed to adequately document his medical rationale for the use of multiple medications;
c. Failed to adequately document his medical rationale for using stimulants in patient(s) with Bipolar Disorder or in patients without documentation of diagnoses approved for usage of stimulants;
d. Failed to adequately document his monitoring of significant side effects of medications with diagnostic tests such as therapeutic levels, CBC, liver functions, lipid profiles, etc.;
e. Failed to adequately document the general physical effects of medications on patients such as vital signs or discussions about weight gain, blood pressure effects, or coordination with other medical diagnoses or interactions with other medications;
f. Failed to adequately document attempts to obtain information from prior treating physicians;
g. Failed to adequately document communication with or coordination with any other treating physicians;

B. SPECIFIC PATIENTS

Patient 1

1. On or about January 20, 2010 through January 15, 2016, Respondent or his delegates treated Patient 1 for depression, insomnia, anxiety and bipolar disorder. Patient 1 had a history of persistent substance abuse, lower back pain, hypothyroidism, asthma and angina.

2. Respondent or his delegates prescribed Adderall, Lithium (LiCo3 ER 300 mg), Risperidone and other medications to Patient 1.

3. During the period of time that Respondent treated Patient 1, Respondent failed to adequately: perform an assessment of the patient, including vital signs (e.g. height, weight, heart rate, and blood pressure) and a risk assessment for substance abuse; document or justify through his medical rationale the initiation of new medications such as stimulants; failed to adequately document his monitoring of significant side effects of medications through diagnostic testing;

and failed to document discussion of consent and risks and benefits of the treatments he prescribed, in violation of the standard of care.

Patient 2

4. On or about March 7, 2010 through December 15, 2015, Respondent or his delegates treated Patient 2 for depression. Patient 2 had a history of depression, apathy, decreased sleep and low back pain.

5. On the initial visit on March 7, 2010, Respondent documented, "low back pain – has difficulty [bending]" and in the treatment plan, documented what appears to be "Allow med for depression/anxiety/chronic pain" but failed to document what medications and their dosages.

6. On November 16, 2010, Respondent documented that he prescribed Fluoxetine 40 mg, Klonopin .5 mg, Norco 10/325, and Seroquel 1000 mg to Patient 2.

7. On November 16, 2010, Respondent prescribed Seroquel for Patient 2. However, during the period of time that Respondent treated the patient with Seroquel, Respondent failed to order any diagnostic or laboratory studies to monitor the patient's response to the medication.

8. During the period of time that Respondent treated Patient 2, Respondent failed to meet the Board's Guidelines for the treatment of chronic pain.

9. Further, Respondent non-therapeutically prescribed pain medications (Norco) to the patient; failed to adequately document his monitoring of significant side effects of medications through diagnostic testing; and failed to document discussion of consent and risks and benefits of the treatments he prescribed, in violation of the standard of care.

Patient 3

10. On or about September 18, 2012 through January 4, 2016, Respondent or his delegates treated Patient 3 for Bipolar Disorder and Learning Disorder Not Otherwise Specified (NOS).

11. On or about September 18, 2012, Respondent's delegate prescribed Seroquel 25 mg and Vistaril for mood and anxiety.

12. Under Respondent's care, Patient 3 submitted to multiple Urine Drug Screen which were positive for illicit substances; however, neither Respondent nor his delegates

adequately documented a discussion or action taken regarding the positive drug screens or a risk assessment for abuse and diversion.

13. On October 18, 2012, Respondent or his delegates increased the dose of Seroquel and prescribed Neurontin for anxiety without adequately documenting the medical rationale for this change.

14. On January 17, 2013 the patient requested and Respondent prescribed Vyvanse. Neither Respondent nor his delegates documented the medical rationale for or diagnosis supporting the prescription of Vyvanse.

15. During the period of time that Respondent treated Patient 3, Respondent or his delegates failed to adequately perform an assessment of the patient, including vital signs and a risk assessment for substance abuse; failed to adequately monitor or address the patient's demonstrated risk of substance abuse; non-therapeutically prescribed Vyvanse to the patient; failed to adequately document his monitoring of significant side effects of medications through diagnostic testing; and failed to document discussion of consent and risks and benefits of the treatments he prescribed, in violation of the standard of care.

Patient 4

16. On or about October 11, 2011 through January 8, 2016, Respondent or his delegates treated Patient 4 for Bipolar Disorder, lower back pain, and opioid dependence.

17. During his care of Patient 4, Respondent or his delegates prescribed Seroquel, Clonidine, Elavil, Ambien, Phenergan, and Suboxone. However, Respondent failed to order any diagnostic testing, including valproate levels or toxic levels regarding Elavil, a CBC or a liver/chemistry panel.

18. Under Respondent's care, Patient 4 submitted to multiple Urine Drug Screens which were positive for illicit substances such as marijuana, THC and opiates. These results were not adequately addressed by Respondent or his delegates.

19. During the period of time that Respondent treated Patient 4, Respondent or his delegates failed to adequately perform an assessment of the patient, including vital signs and physical response to medications; and failed to adequately monitor through diagnostic tests or otherwise, in violation of the standard of care.

Patient 5

20. On or about January 22, 2014 through December 7, 2015, Respondent or his delegates treated Patient 5 for bipolar disorder and depression. The patient had a history of schizophrenia.

21. During the Patient's course of treatment, Respondent or his delegates prescribed Cogentin, Depakote, Prozac, Zyprexa, Adderall and Xanax.

22. Under Respondent's care, Patient 5 admitted to using illicit substances such as marijuana and cocaine and regularly ran out of medications early or reported noncompliance with Respondent's treatment plan.

23. On January 7, 2015, Respondent or his delegate prescribed Adderall 10 mg to Patient 5 based on a vague history of forgetfulness and reports about what the patient's mother told him about prior treatment. Respondent or his delegates failed to document a formal diagnosis of Attention Deficit Hyperactivity Disorder (ADHD).

24. On May 4, 2015, Patient 5 reported that he was using cocaine and had racing thoughts; however, neither Respondent nor his delegates addressed the cocaine use in the treatment plan, nor changed the patient's medications.

25. On October 23, 2015, Respondent's delegate documented that Patient 5 reported having anxiety but showed no signs of anxiety and demonstrated normal attention span. The patient reported he had been off Adderall and Xanax for four months, but Respondent's delegate prescribed two weeks worth of Xanax and Adderall based on the patient's subjective report, in violation of the standard of care.

26. Respondent or his delegates failed to obtain baseline vital signs, and failed to order any diagnostic testing to adequately monitor the patient on a periodic basis, which is required by the standard of care.

27. Further, Respondent's documentation of his medical rational for initiation of medications and treatments was inadequate.

Patient 6

28. On or about April 28, 2015 through November 11, 2015, Respondent or his delegates treated Patient 6 for Bipolar Disorder, moderate Mental Retardation (MR), and ADHD.

29. During the Patient's course of treatment, Respondent or his delegates prescribed Lithium, Tenex, Zoloft, Haldol, Cogentin, Depakote and Vyvanse.

30. However, Respondent or his delegates filed to obtain baseline vital signs, and failed to order any diagnostic testing (e.g. fasting plasma glucose level or hemoglobin A1c, lipid screening, and complete blood count) to adequately monitor the patient on a periodic basis, which is required by the standard of care when treating ADHD and prescribing lithium and second generation antipsychotics.

Patient 7

31. On or about June 20, 2012 through October 7, 2015, Respondent or his delegates treated Patient 7 for opioid dependence and chronic pain.

32. During the initial visit, the patient reported taking up to 17 Norco 10/325mg pills per day prescribed by Dr. Siddiqui.

33. During the Patient's course of treatment, Respondent or his delegates prescribed Suboxone, Soma, Depakote, Valium, Lexapro and Ambien.

34. On January 23, 2013, Respondent or his delegates documented a medication summary sheet showing that the patient was prescribed Fioricet (a barbiturate) as well as Abilify 15 mg per day. However, the progress note for that visit does not document the prescription or indication for either of these medications, and there is no further mention of Abilify throughout the rest of the medical record.

35. On July 26, 2013, Respondent or his delegates prescribed Soma to Patient 7 without documenting a medical rationale or clear indication for the medication. The patient continued taking Soma throughout Respondent's care, a long-term use which was not supported by a clear medical rationale in the records.

36. On March 17, 2015, Respondent or his delegates prescribed Patient 7 Depakote 250 mg. However, Respondent and his delegates failed to document a medical rationale or indication for the prescription of Depakote.

37. Further, Respondent or his delegates filed to obtain baseline vital signs, and failed to order any diagnostic testing to adequately monitor the patient on a periodic basis, which is required by the standard of care.

38. During the period of time that Respondent treated Patient 7, Respondent failed to meet the Board's Guidelines for the treatment of chronic pain.

Patient 8

39. On or about June 19, 2012 through November 5, 2014, Respondent or his delegates treated Patient 8 for opioid dependence and Major Depressive Disorder.

40. Respondent and his delegates failed to adequately assess the patient, or obtain a detailed history of the patient's past history of pain, opioid dependence or past psychiatric history. The patient reports running out of Suboxone on the first visit, but the patient's past treatment for and use of opioids is sparse and contains no documentation of extrapyramidal symptoms. Further, Respondent or his delegates document that all medications were renewed, but did not document what those medication were.

41. During the Patient's course of treatment, Respondent or his delegates prescribed Suboxone, Trazodone, Valium, Tegretol, Effexor, Depakote, Gabapentin, Paxil, Risperdal, and Seroquel.

42. However, Respondent or his delegates failed to document a medical indication for the use of Depakote, Tegretol, Gabapentin or any antipsychotic since the patient is only diagnosed with Major Depressive Disorder (MDD).

43. Respondent or his delegates failed to obtain baseline vital signs, and failed to order any diagnostic testing to adequately monitor the patient on a periodic basis, which is required by the standard of care.

44. Further, Respondent's documentation is extremely disorganized and consists of a mixture of handwritten notes and print outs from an electronic medical record (EMR). The EMR prints out medications written in the future. For instance, for the visit on November 30, 2012, the progress note states that the patient is on Suboxone, Valium, and Trazodone while the Tegretol and Effexor are to be discontinued. There is then a list of medications from 2014 and beyond appearing in a note from 2012, making it impossible to follow the patient's medication course.

Patient 9

45. On or about June 17, 2011 through August 13, 2015, Respondent or his delegates treated Patient 8 for opioid dependence and Major Depression. Patient 9 had a history of chronic back pain and surgical pain.

46. During the Patient's course of treatment, Respondent or his delegates prescribed Suboxone, Prozac, Valium, Ambien and Wellbutrin.

47. On September 27, 2013, Patient 9 reported a pregnancy, but Respondent and his delegates continued the patient on her regiment of medications throughout her pregnancy with no monitoring of vital signs.

48. Further, Respondent or his delegates filed to obtain baseline vital signs, and failed to order any diagnostic testing to adequately monitor the patient on a periodic basis, which is required by the standard of care.

C. ALLEGED VIOLATIONS

1. Respondent's treatment of Patients 1 – 9 violated the Act and/or Board Rules, specifically:

Section 164.051(a)(1) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's commission of an act prohibited under Section 164.052 of the Act.

Section 164.051(a)(3) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's violation of a rule adopted under this Act, specifically Board Rule 170.3.

Section 164.051(a)(6) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent' failure to practice medicine in an acceptable professional manner consistent with public health and welfare as defined by Board Rules: 190.8(1)(A), failure to treat a patient according to the generally accepted standard of care; 190.8(1)(B), negligence in performing medical services; 190.8(1)(C), failure to use proper diligence in one's professional practice; 190.8(1)(D), failure to safeguard against potential complications; 190.8(1)(G), failure to disclose reasonably foreseeable side effects of a procedure or treatment; 190.8(1)(H), failure to disclose reasonable alternative treatments to a proposed procedure or treatment; and 190.8(1)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.

Section 164.052(a)(5) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent' unprofessional or dishonorable conduct that is likely

to deceive or defraud the public, as provided by Section 164.053, or injure the public, and further defined by Board Rules, including but not limited to the following: 190.8(2)(J) providing medically unnecessary services to a patient or submitting a billing statement to a patient or a third party payer that the licensee knew or should have known was improper; and 190.8(2)(R) commission of the following violations of federal and state laws whether or not there is a complaint, indictment, or conviction: any felony, and any criminal violation of the Medical Practice Act or other statutes regulating or pertaining to the practice of medicine, to wit: Texas Health and Safety Code §481.129(c), related to prescribing controlled substances without a valid medical purpose.

Section 164.053(a)(1) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's commission of an act that violates any state or federal law if the act is connected with the physician's practice of medicine, including but not limited to: Texas Health and Safety Code §481.129(c).

Section 164.053(a)(3) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's writing prescriptions for or dispensing to a person who is known to be an abuser of narcotic drugs, controlled substances, or dangerous drugs or to a person who the physician should have known was an abuser of the narcotic drugs, controlled substances, or dangerous drugs.

Section 164.053(a)(5) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's prescribing or administering a drug or treatment that is non-therapeutic in nature or non-therapeutic the manner the drug or treatment is administered or prescribed.

Section 164.053(a)(6) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's prescribing, administering, or dispensing in a manner inconsistent with public health and welfare dangerous drugs as defined by TEX. HEALTH AND SAFETY CODE ch.483; or controlled substances scheduled in TEX. HEALTH AND SAFETY CODE ch.481, or the Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. §801 et seq.).

2. Respondent or his delegates failed to maintain adequate medical records for Patients 1 - 9, including meaningful documentation of the following:

a. The reason for the encounter and relevant history, physical examination findings, and diagnostic test results;

b. An assessment, clinical impression, or specific diagnosis;

c. Past and present diagnoses, including prior treatment records from other providers;

d. Rationale for and results of diagnostic and other ancillary services;

e. The patient's progress, including response to treatment, change in diagnosis, and patient's non-compliance;

f. Relevant risk factors for medications and treatments prescribed;

g. A written plan for care including the following information: specific treatment objectives and benchmarks; any referrals and consultations; patient/family education; and, specific instructions for follow up; and

h. A summary or documentation memorializing communications transmitted or received by the physician about which a medical decision is made regarding the patient.

Respondent's conduct constitutes a violation of the Act and Board rules, specifically:

> Section 164.051(a)(3) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's violation of a rule adopted under this Act, specifically Board Rules 165.1(a), regarding adequate maintenance of medical records and 170.3(a), regarding the Board's pain management guidelines, including documentation requirements.

3. Respondent failed to provide adequate supervision of his delegates. Respondent's lack of supervision is reflected in the prior subsections related to the standard of care violations for Patients 1-9. Board Staff incorporates those violations of the standard of care into the failure to provide adequate supervision. Respondent's conduct constitutes a violation of the Act and Board rules, specifically:

> Section 164.051(a)(3) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's violation of a rule adopted under this Act; specifically, Board Rules 193.4 and 193.5, *et. seq.*, regarding supervision and delegation to competent practitioners.
>
> Section 164.053(a)(8) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's failure to supervise adequately the activities of those acting under Respondent's supervision.

V. AGGRAVATING AND MITIGATING FACTORS

Board Rule 190.14 provides that the Board may impose more restrictive sanctions when there are multiple violations of the Act. Board Rule 190.15 provides that the Board may consider aggravating factors that warrant more severe or restrictive disciplinary action. This case includes

the following aggravating factors: (3) one or more violations that involve more than one patient;. . . (5) increased potential for harm to the public;. . . (7) intentional, premeditated, knowing, or grossly negligent act constituting a violation; and . . . (11)other relevant circumstances increasing the seriousness of the misconduct.

Board staff is aware of no mitigating factors that apply and demands that Respondent submit proof to substantiate any alleged mitigating factors.

VI. NOTICE TO RESPONDENT

IF YOU DO NOT FILE A WRITTEN ANSWER TO THIS COMPLAINT WITH THE STATE OFFICE OF ADMINISTRATIVE HEARINGS WITHIN 20 DAYS AFTER THE DATE OF RECEIPT, A DEFAULT ORDER MAY BE ENTERED AGAINST YOU, WHICH MAY INCLUDE THE DENIAL OF LICENSURE OR ANY OR ALL OF THE REQUESTED SANCTIONS, INCLUDING THE REVOCATION OF YOUR LICENSE. A COPY OF ANY ANSWER YOU FILE WITH THE STATE OFFICE OF ADMINISTRATIVE HEARINGS SHALL ALSO BE PROVIDED TO THE HEARINGS COORDINATOR OF THE TEXAS MEDICAL BOARD.

VII. PRAYER

Board Staff requests that an administrative law judge employed by the State Office of Administrative Hearings conduct a contested case hearing on the merits of the Complaint, and issue a Proposal for Decision containing Findings of Fact and Conclusions of Law necessary to support a determination that Respondent violated the Act as set forth in this Complaint.

Respectfully submitted,

TEXAS MEDICAL BOARD

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Litigation Manager

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By: Susan Rodriguez by permission for

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THE STATE OF TEXAS §
§
COUNTY OF TRAVIS §

SUBSCRIBED AND SWORN to before me by the said Nikki Karr, J.D., on August 31, 2017.

Notary Public, State of Texas

CHRISTINE R. RODRIGUEZ
Notary Public-State of Texas
Notary ID #13075322-8
Commission Exp. JULY 26, 2020
Notary without Bond

Filed with the Texas Medical Board on Aug 31st, 2017.

Scott M Freshour

Scott Freshour, J.D.
Interim Executive Director
Texas Medical Board

CERTIFICATE OF SERVICE

I certify that on the 31st day of August, 2017, a true and correct copy of the foregoing document has been served as follows:

Via Email to docketing@soah.texas.gov
Docket Clerk
State Office of Administrative Hearings
William P. Clements Bldg.
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Austin, TX 78701-1649

Via Facsimile to (512) 473-8525
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