

BEFORE THE VIRGINIA BOARD OF MEDICINE

IN RE: GERANAMEO VLADIMIR BULLOCK, M.D.
License Number: 0101-253513
Case Numbers: 254910, 249129, 250276

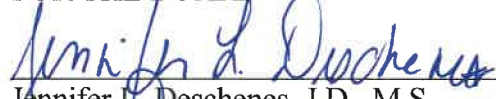
ORDER OF SUMMARY SUSPENSION

Pursuant to Virginia Code § 54.1-2408.1(A), a quorum of the Board of Medicine ("Board") met by telephone conference call on September 15, 2026, after a good faith effort to convene a regular meeting of the Board had failed. The purpose of the meeting was to receive and act upon information indicating that Geranameo Vladimir Bullock, M.D., violated certain laws and/or regulations relating to the practice of medicine in the Commonwealth of Virginia, as more fully set forth in the "Notice of Formal Administrative Hearing and Statement of Allegations," which is attached hereto and incorporated by reference herein.

WHEREUPON, pursuant to its authority under Virginia Code § 54.1-2408.1(A), the Board concludes that a substantial danger to public health or safety warrants this action and ORDERS that the license of Geranameo Vladimir Bullock, M.D., to practice medicine in the Commonwealth of Virginia is SUSPENDED. It is further ORDERED that a hearing be convened within a reasonable time of the date of entry of this Order to receive and act upon evidence in this matter.

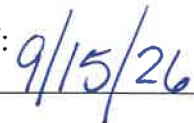
Pursuant to Virginia Code § 54.1-2400.2, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public inspection or copying on request.

FOR THE BOARD



Jennifer L. Deschenes, J.D., M.S.
Deputy Executive Director
Virginia Board of Medicine

ENTERED AND MAILED ON: _____



STATEMENT OF ALLEGATIONS

The Board alleges that:

1. Dr. Bullock violated Virginia Code §§ 54.1-2915(A)(1), (3), (4), (13), (17) and (18), 54.1-3303(B), and 54.1-3408(A) in that Dr. Bullock prescribed controlled substances (C-II to C-IV) to Patients A-H and J, contrary to the standard of care, and absent a bona fide practitioner-patient relationship, as evidenced by records from the Prescription Monitoring Program (“PMP”), medical records, and statements made by Dr. Bullock.

a. Records indicate that between approximately October 2020 and June 2026, Dr. Bullock, as the owner of Stepping Stone Behavioral Health (“Stepping Stone”), provided Patients A-H and J with “psychotherapy with evaluation and management.” Stepping Stone advertises on its website that “virtual and in-person appointments” are conducted at 308 George Washington N Suite 2, Chesapeake, Virginia. According to Dr. Bullock, he has a total of 10 employees, four of whom are “providers,” and his practice has 700 patients on file. Dr. Bullock personally treats 18-20 patients a day.

b. On September 23, 2025, Dr. Bullock was interviewed by the first of three (3) Investigators with the Department of Health Professions (“DHP Investigator 1”). The interview (“September interview”) was conducted at the Chesapeake location referenced above. DHP Investigator 1 noted that the location was devoid of any medical equipment with which to perform diagnostic testing.

c. According to Dr. Bullock, the psychiatric treatment he provided, including the prescribing of various controlled substances, is done exclusively via telemedicine. In their records, Dr. Bullock documented that each visit with Patients A-H and J lasted 30 minutes.¹ On August 27, 2026,

¹ The records provided to the DHP Investigators by Dr. Bullock show that, on average, Dr. Bullock billed each patient, or their insurers, for 25 appointments. Put another way, on average, Dr. Bullock billed for approximately 112.5 hours of psychotherapy with evaluation and management.

Patient J was interviewed by DHP Investigator 1. According to Patient J, his telephone appointments with Dr. Bullock lasted “between five and ten minutes.” Dr. Bullock would ask perfunctory questions and then refill his prescriptions. Patient J confirmed he never met Dr. Bullock, all of his appointments were conducted by telephone, he never saw Dr. Bullock in-person or by video, he was never sent for blood or urine testing, and no vital signs were ever taken. According to Patient J, after each appointment, his credit card was charged for the co-pay, and his health insurer was also billed.

d. Dr. Bullock told DHP Investigator 1 that during “most” appointments, he would have the patient’s “PMP record pulled up while he is conducting the appointment and monitors them regularly.” On the contrary, records from the PMP regarding Patients A-H show that Dr. Bullock rarely, and in some cases never, queried the PMP. Despite prescribing copious numbers of controlled substances to Patients A-H, Dr. Bullock failed to periodically check the PMP to determine whether these patients were being dispensed additional controlled substances, naloxone and/or medical cannabis products by other providers.² For example:

i. On June 24, 2026, Dr. Bullock wrote in Patient C’s medical record that he checked the PMP. Records from the PMP show that statement is false. Dr. Bullock did not query the PMP regarding Patient C on that date.

ii. On June 22, 2026, Dr. Bullock wrote in Patient D’s medical record that he checked the PMP. Records from the PMP show that statement is false. Dr. Bullock did not query the PMP regarding Patient D on that date.

iii. On August 24, 2026, Dr. Bullock was interviewed by a second investigator (“DHP Investigator 2”). During the interview (“August interview”), Dr. Bullock stated that he did not check

² Records show that Dr. Bullock checked the PMP more times after he was first contacted by the three DHP Investigators (September 2025) than he did prior to that date.

Patient E's PMP because "she was on the up and up." This statement is misleading. Records from the PMP show Dr. Bullock queried Patient E's PMP on September 22, 2025 and August 1, 2026.

e. On June 8, 2026, Dr. Bullock was interviewed ("June interview") by DHP Investigator 2. During the June interview, Dr. Bullock stated that he did not check Patient H's PMP, a statement that conflicts with what he told DHP Investigator 1 in September of 2025 ("the September interview"). In a written statement, dated May 15, 2026, Dr. Bullock blamed his failure to check the PMP on his staff and wrote "In the past, I relied on staff to check PMP's on my behalf during the pandemic and during the transition to telemedicine . . . I realize that staff could not be relied upon as they had not always consistently check (sic) the PMP's."

f. In his written statement, Dr. Bullock stated that Patient H "was seen in person for many years until the Covid pandemic. She was seen in person at the office for over two years prior to the pandemic. After and during the pandemic we have been practicing telemedicine."

i. However, records provided by Dr. Bullock do not clearly indicate when Dr. Bullock began treating Patient H. Records produced by Dr. Bullock appear to document treatment for Patient H starting on June 22, 2022, which conflicts with his written statement. Moreover, the PMP shows that Dr. Bullock provided Patient H with prescriptions for temazepam and alprazolam as far back as October 2020.

ii. Records indicate that Dr. Bullock, or someone on his behalf, only queried Patient H's "PMP" twice; once on December 17, 2024, and a second time on September 30, 2025, the day Dr. Bullock terminated Patient H's care.

iii. On December 17, 2024, Dr. Bullock, or whichever staff member queried the PMP that day, would have learned that between June 25, 2023 and December 17, 2024, Patient H had been receiving multiple prescriptions from multiple providers which were being filled at multiple pharmacies.

These included overlapping prescriptions for benzodiazepines and narcotics.³ Patient H's PMP report showed an above average overdose score of 400 yet records indicate that after learning Patient H was likely engaging in drug seeking behavior, Dr. Bullock did not alter Patient H's treatment plan, did not raise any concerns he may have with Patient H, nor did he coordinate care with any of the other providers listed on her PMP. Dr. Bullock stated to DHP Investigator 2 that he "never knew [Patient H] had a substance abuse problem" and that "looking back with [Patient H] he would have checked her PMP and questioned her on the prescribing from other providers . . . would have done urine drug screens and pill counts . . . would not have given refills on the Xanax and had video visits."

g. During the August interview, Dr. Bullock stated that he "understands the importance of checking for other providers prescribing pain medication" while also stating that he "did not historically check the PMP program before the involvement of the other Board investigator last year," a statement that conflicts with the statement he made blaming his staff for failing to check the PMP. During this interview, Dr. Bullock offered yet a fifth falsehood regarding the PMP and stated that in the past he personally checked the PMP "only if he was suspicious of the patient's behaviors," and "now" he keeps the PMP on his computer.

h. Notably, Dr. Bullock told DHP Investigator 1 that he "does not need standard medical equipment" and admitted that he "does not conduct physical exams." Moreover, Dr. Bullock stated that he "sometimes requests labs but he cannot make [patients] if they decide not to get them done." Records also reflect that Dr. Bullock did not refer any of his patients for an in-person examination.

³ In total, between June 25, 2023 and June 24, 2025, Patient H received approximately 77 prescriptions from approximately 25 providers at six (6) different pharmacies.

i. By his own admission, in lieu of providing in-person medical care, Dr. Bullock conducted visits for Patients A-H and J via audio-only telephone calls. Even though these telemedicine appointments did not include a visual component, as part of his mental status examination, Dr. Bullock routinely, and falsely, documented his observations of these patients' appearance. Dr. Bullock consistently documented that "Physically [Patients A-H and J] appeared their stated age, with good eye contact and well groomed" when he knew he had no basis to include such a representation in their medical records. Dr. Bullock prescribed controlled substances to patients for years without ever seeing them in-person, without ever physically examining them, or, at a minimum, personally observing them using any number of widely available video-conferencing platforms.

j. Dr. Bullock rendered medical advice and/or care to patients without fully verifying and authenticating the patient's location or the identity of the patient. More specifically:

i. Between May 2022 and June 2025, Dr. Bullock treated Patient G via telemedicine for various psychiatric conditions including, but not limited to, attention deficit hyperactivity disorder, post-traumatic stress disorder, and panic disorder with agoraphobia, agoraphobic avoidance in partial remission and panic attacks in partial remission. However, it is undisputed that Patient G was incarcerated in a Women's Correctional Center ("Correctional Center") from May 4, 2024 to June 30, 2025.

ii. During Patient G's incarceration, Dr. Bullock allegedly provided her with medical care on approximately 10 occasions and wrote her approximately 25 prescriptions. Records indicate that during the entire period of her incarceration, Dr. Bullock falsely documented in her medical record that Patient G "appeared [her] stated age, with good eye contact and well groomed." Moreover, according to Patient J, an acquaintance of Patient G, that during the time she was incarcerated, she would contact Patient J by phone whenever she had a scheduled appointment with Dr. Bullock. Patient J would then connect a three-way call between himself, Patient G and Dr. Bullock. Once Dr. Bullock was on the call, Patient J

would set the phone aside. Patient J observed that, similarly to his own telephone appointments with Dr. Bullock, the call between Patient G and Dr. Bullock would disconnect within five to ten minutes.⁴

iii. Dr. Bullock admitted to DHP Investigator 1 that, between June 2024 and June 2025, he “validated [Patient G’s] identity by the sound of her voice and her personality, as [appointments] were all conducted by telephone.”

iv. While Patient G was incarcerated, Department of Corrections (“DOC”) staff intercepted prescription medication⁵ and methamphetamine which were intended for Patient G. A DOC investigation, conducted by Individual 1, identified Dr. Bullock as the sole provider of the intercepted medication. On June 2, 2025, during a recorded call from the Correctional Center, Patient G referred to Dr. Bullock as her “plug.”⁶

v. Patient G was found deceased on September 16, 2025. Autopsy records indicate the cause of death was “acute combined fentanyl, amphetamine, alprazolam, cocaine, and ethanol toxicity.” Records indicate that Patient G filled a prescription for alprazolam, written by Dr. Bullock, on August 23, 2025.

vi. Individual 1 also visited Stepping Stone’s Chesapeake location and found the office to be vacant with mail piled up in front of the door. Individual 1 contacted a telephone number posted on the door and was instructed by Dr. Bullock to go to his private residence, also located in Chesapeake, Virginia.

⁴ If true for all nine (9) patients identified by DHP Investigators, Dr. Bullock would have only provided approximately 18.75 hours of actual treatment. Approximately one-sixth of the time he billed for (112.5).

⁵ While incarcerated, Patient G’s prescriptions were filled and picked up at Glendale Pharmacy in Newport News, by Patient J and/or Individual 2.

⁶ A common term in drug culture for a person who sells drugs illegally. <https://www.addictioncenter.com/drugs/drug-alcohol-slang/>

k. Records indicate that between February and July 2022, Dr. Bullock treated Patient F for post-traumatic stress disorder, insomnia, generalized anxiety disorder, and severe recurrent major depression without psychotic features. Records show Dr. Bullock prescribed Patient F various controlled substances including the benzodiazepines, alprazolam and lorazepam. Records from the PMP show that on April 30, 2022, Dr. Bullock prescribed Patient F, “off label” ketamine 500mg 5ml vial and midazolam HCL 50mg 10ml vial. However, Patient F’s medical records are devoid of any information regarding these controlled substances, including how or where they were administered, the potential impact the co-prescribed benzodiazepines may have on their efficacy, or the fact that they were even prescribed at all.

l. Dr. Bullock further admitted that he never performed pill counts and never ordered nor reviewed urine drug screens; a practice he was advised to follow in December 2021.

2. Dr. Bullock violated Virginia Code §§ 54.1-2915(A)(3), (4), (12), (13), (16), (17) and (18), 54.1-2522.1(B),⁷ 54.1-3303(B), and 54.1-3408(A), and 18 VAC 85-20-26(C) of the Regulations Governing the Practice of Medicine (“Board’s Regulations”), and the Regulations Governing Prescribing of Opioids and Buprenorphine (“Prescribing Regulations”), in that between October 2020 and August 2025, contrary to the standard of care, and absent a bona fide practitioner-patient relationship, Dr. Bullock prescribed opioids (C-II and C-IV) to Patients A-E for the treatment of chronic and/or acute pain.

a. Prior to, and/or at the initiation of a new course of treatment that included the prescribing of opioids (*i.e.*, tramadol, oxycodone, hydrocodone) to Patients A-D, Dr. Bullock did not query the PMP, not one time. Moreover, Dr. Bullock failed to counsel these patients on, among other things, the risks of addiction and overdose, in violation of 18 VAC 85-21-22(A) of the Prescribing Regulations.

⁷ Effective until July 1, 2027.

b. Prior to initiating management of chronic pain with a controlled substance containing an opioid for Patients A-D, Dr. Bullock failed to properly evaluate these patients (*e.g.*, admittedly failed to perform and document a physical examination, and/or failed to document the nature and intensity of pain), in violation of 18 VAC 85-21-60(A) and 18 VAC 85-21-120 of the Prescribing Regulations, and in violation of 18 VAC 85-20-26(C) of the Board's Regulations.

c. After initiating treatment of chronic pain with a controlled substance containing an opioid for Patients A-D, Dr. Bullock did not check the PMP every three (3) months in violation of 18 VAC 85-21-100(D) of the Prescribing Regulations.

d. On March 9, 2023, Dr. Bullock provided a prescription to Patient A for #240 tramadol 50 mg (30-day supply) with a morphine milligram equivalent ("MME") of 80.0. On June 16, 2023, Dr. Bullock provided a subsequent prescription to Patient A for #180 tramadol 50 mg (20-day supply) with a MME of 90.0. Following the initiation of treatment of chronic pain with an opioid for Patient A, Dr. Bullock failed to consider, nor document, the reasons to exceed 50/MME/day, in violation of 18 VAC 85-21-70(B)(1) of the Prescribing Regulations, and in violation of 18 VAC 85-20-26(C) of the Board's Regulations.

e. The medical records for Patients A-D are devoid of treatment plans, informed consent and written treatment agreements, in violation of 18 VAC 85-21-80, 18 VAC 85-21-90 and 18 VAC 85-21-120 of the Prescribing Regulations, and in violation of 18 VAC 85-20-26(C) of the Board's Regulations.

f. Medical records show that, among other things, Dr. Bullock failed to properly review the chronic pain treatment he was providing to Patients A-D, failed to support the continued benefit to Patients A-D from such prescribing, and/or failed to order and review urine drug screens, in violation

of 18 VAC 85-21-100 and 18 VAC 85-21-120 of the Prescribing Regulations, and in violation of 18 VAC 85-20-26(C) of the Board's Regulations.

g. Prior to initiating management of acute pain with a controlled substance containing an opioid for Patient E, Dr. Bullock failed to query the PMP, failed to properly evaluate Patient E (*e.g.*, admittedly failed to perform and document a physical examination, failed to document a description of the pain and/or a presumptive diagnosis for the origin of the pain), in violation of 18 VAC 85-21-30(B) and 18 VAC 85-21-50 of the Prescribing Regulations.

h. On July 24, 2026, Dr. Bullock provided DHP Investigator 2 written summaries ("treatment summaries") of the treatment he provided to Patients A-E. In them, Dr. Bullock attempted to create the impression that he was only providing "medication management and counseling" for various psychiatric conditions while minimizing and/or concealing his opioid prescribing activity. For example, Dr. Bullock wrote:

i. Patient A "sees other specialist (sic) regarding comorbid medical issues, some of which relates to pain" Dr. Bullock does not explain why, if that statement were true, he began prescribing Patient A tramadol on October 9, 2020, nor does it explain why not one other prescriber appears on Patient A's PMP between January 1, 2021 and July 23, 2026. Dr. Bullock provided a list of Patient A's current and past medications; tramadol was not among them.

ii. Patient B "carried multiple comorbid medical conditions . . . severe spinal issues associated with chronic and severe pain . . . for which she sees specialist." Dr. Bullock does not explain why, if that statement were true, he began prescribing Patient B hydrocodone on October 13, 2021. Especially since Patient B was simultaneously being provided a separate prescription for oxycodone from another provider. Dr. Bullock provided a list of Patient B's current and past medications; hydrocodone was not among them.

iii. Patient C “was and is followed by her . . . [unidentified] pain specialist” Dr. Bullock does not explain why, if that statement were true, he began prescribing Patient C tramadol on August 15, 2023. Especially since Patient C was simultaneously being provided a separate prescription for tramadol from another provider. Dr. Bullock provided a list of Patient C’s current and past medications; tramadol was not among them. During his August interview, Dr. Bullock confessed that he was not aware that Patient C was “getting pain medication from other providers.”

iv. Patient D “carries a history of . . . comorbid medical issues noteworthy chronic back pain.” Dr. Bullock does not explain why he began prescribing Patient D tramadol on May 1, 2025. Dr. Bullock provided a list of Patient D’s current medications only. Tramadol was not included as a “past” medication even though he last prescribed it only one (1) year ago.

i. Despite objective evidence to the contrary, during the August interview, Dr. Bullock stated that he “is not into treating pain management . . . will only prescribe pain medication in desperate situations,” and that he “prescribed pain medication only for severe pain.” Moreover, Dr. Bullock falsely stated that the “main medication” he prescribed for pain is gabapentin and that “I don’t do opioids.” Records show that Dr. Bullock did not prescribe a single prescription for gabapentin to Patients A, B or D. Records show that Dr. Bullock did prescribe gabapentin to Patients C and E, however, he also prescribed them tramadol and hydrocodone, both of which are opioids.

3. Dr. Bullock violated Virginia Code § 54.1-2915(A)(3), (4), (12), (13), (16) and (18), and the Prescribing Regulations, in that between September 2021 and March 2024, Dr. Bullock co-prescribed an opioid (*i.e.*, oxycodone, hydrocodone) with a benzodiazepine (*i.e.*, alprazolam, temazepam) to Patients B and E, which is contrary to the standard of care and placed Patients B and E at a higher risk of fatal overdose. Specifically:

a. Between September 2021 and August 2022, Dr. Bullock co-prescribed an opioid and a benzodiazepine to Patient B as follows:

Month	Date Filled	Quantity/Drug	Days Supply
September 2021	09/17/21	#90 alprazolam 2mg	30
October 2021	10/13/21	#15 hydrocodone (C-II) 10mg	5
November 2021	11/08/21	#90 alprazolam 2mg	30
	11/18/21	#15 hydrocodone 10mg	5
December 2021	12/13/21	#90 alprazolam 2mg	30
	12/17/21	#30 hydrocodone 10mg	10
February 2022	02/05/22	#90 alprazolam 2mg	30
	02/22/22	#30 hydrocodone 10mg	10
	02/27/22	#90 alprazolam 2mg	30
April 2022	04/05/22	#90 alprazolam 2mg	30
	04/27/22 ⁸	#30 oxycodone (C-II) 10mg	30
June 2022	06/04/22	#90 alprazolam 2mg	30
	06/09/22 ⁹	#30 oxycodone 10mg	30
July 2022	07/02/22	#120 alprazolam 2mg	30
	07/08/22	#30 oxycodone 10mg	30
	07/31/22	#120 alprazolam 2mg	30
August 2022	08/06/22	#30 oxycodone 10mg	30
	08/29/22	#120 alprazolam 2mg	30

b. Following the initiation of treatment of Patient B's chronic pain with an opioid, Dr. Bullock failed to prescribe an FDA-approved opioid reversal agent even though a concomitant benzodiazepine (*i.e.*, alprazolam), prescribed by him, was present, in violation of 18 VAC 85-21-70(B)(3) of the Prescribing Regulations.

⁸ Additionally, had Dr. Bullock checked Patient B's PMP, he would have been aware that, the day before (April 26, 2022), Patient B had obtained a prescription for hydrocodone from another provider.

⁹ Had Dr. Bullock checked Patient B's PMP, he would have been aware that, on the same day, Patient B had obtained a prescription for hydrocodone from yet a third provider.

c. There is an undated “Addendum” to the treatment note, dated August 3, 2022, which claims Patient B was in “severe pain related to back as well as kidney stones. [Patient B] was granted a refill of [oxycodone] this visit and last visit.” According to the records, the “last” visit would have been July 21, 2022, only 13 days prior. Further, a review of the so-called last visit, as well as the previous visit on July 14, 2022, shows that Patient B makes no mention of being in any pain, never mind “severe” pain. Suspiciously, the April 29, 2022 visit, was edited on July 26, 2026 by an LCSW at Stepping Stone, which read “[Patient B] has an appointment with urology on 05/31/22 and at that time pain medications will not be prescribed by this physician.” Yet, Patient B was prescribed oxycodone by Dr. Bullock in June, July and August of 2022.

d. During February and March 2024, Dr. Bullock co-prescribed an opioid and a benzodiazepine to Patient E as follows:

Month	Date Filled	Quantity/Drug	Days Supply
February 2024	02/21/24	#30 temazepam 22.5mg	30
March 2024	03/13/24	#14 hydrocodone 10mg	7

e. Following the initiation of treatment of Patient E’s acute pain, Dr. Bullock failed to prescribe an FDA-approved opioid reversal agent even though a concomitant benzodiazepine (*i.e.*, temazepam), prescribed by him, was present, in violation of 18 VAC 85-21-40(B)(3) of the Prescribing Regulations. Moreover, neither treatment record, February 20, 2024 nor March 12, 2024, documents that Dr. Bullock prescribed Patient E temazepam or hydrocodone in violation of 18 VAC 85-20-26(C) of the Board’s Regulations.

f. Dr. Bullock failed to document in Patient B’s and Patient E’s medical records the extenuating circumstances for prescribing oxycodone or hydrocodone along with alprazolam or temazepam and failed to document a tapering plan to achieve the lowest possible effective doses in

violation of 18 VAC 85-21-40(C) and 18 VAC 85-21-70(D) of the Prescribing Regulations, and in violation of 18 VAC 85-20-26(C) of the Board's Regulations.

4. Dr. Bullock violated Virginia Code §§ 54.1-2915(A)(3), (4), (12), (13), (16), (17) and (18), 54.1-3303(B), 54.1-3408(A), and 18 VAC 85-20-26(C) of the Board's Regulations, and the Prescribing Regulations in that between January 2024 and July 2026, contrary to the standard of care, and absent a bona fide practitioner-patient relationship, Dr. Bullock prescribed buprenorphine-nalox (C-III) to Patient A for the treatment of opioid use disorder.

a. As referenced herein, between October 2020 and June 2023, Dr. Bullock routinely prescribed an opioid (*i.e.*, tramadol) to Patient A. The last prescription for this opioid was written on June 16, 2023 (#180 tramadol 50 mg (20-day supply) with an MME of 90.0.) but was not filled until November 6, 2023. During his August interview, Dr. Bullock described Patient A as "needy" and claimed that he "had to watch her carefully." Predictably, approximately two (2) months later, on January 8, 2024, Dr. Bullock began prescribing buprenorphine-nalox (#60 8-2mg Tab 30) to Patient A for the treatment of opioid use disorder.

b. Records show that prior to the initiation of treatment for opioid use disorder, Dr. Bullock failed to, among other things, properly perform and document a thorough assessment, admittedly failed to perform an appropriate physical examination, failed to order and review urine drug screens, failed to obtain written informed consent and/or execute an appropriate treatment agreement, in violation of 18 VAC 85-21-140 and 18 VAC 85-21-170(A) and (B) of the Prescribing Regulations, and in violation of 18 VAC 85-20-26(C) of the Board's Regulations.

c. Records demonstrate that while prescribing Patient A buprenorphine-nalox (January 2024 to July 2026), Dr. Bullock co-prescribed alprazolam. Dr. Bullock failed to document in Patient A's medical records the extenuating circumstances for prescribing Patient A buprenorphine-nalox

along with a benzodiazepine and failed to document a tapering plan to achieve the lowest possible effective doses in violation of 18 VAC 85-21-150(D) of the Prescribing Regulations, and in violation of 18 VAC 85-20-26(C) of the Board's Regulations.

5. Dr. Bullock violated Virginia Code §§ 54.1-2915(A)(1), (3), (4), (12), (13), (16) and (18), 54.1-3303(B), 54.1-3408(A), and 18 VAC 85-20-26(C) of the Board's Regulations, in that between June 2024 and March 2025, contrary to the standard of care, and absent a bona fide practitioner-patient relationship, Dr. Bullock provided "medication management and counseling" to Patient I.

a. On March 18, 2024, Patient I began residing in a Virginia memory care facility ("Facility 1"). Among other conditions, Patient I had been diagnosed with Alzheimer's.

b. On October 20, 2025, the Resident Services Coordinator ("Individual 3") was interviewed by DHP Investigator 3. According to Individual 3, she would contact Dr. Bullock when a resident's primary provider wrote an order for psychiatric services. Once the order was written, Individual 3 would notify Dr. Bullock and send him the resident's medication list, face sheet and insurance cards. Individual 3 identified Patient I as a patient of Dr. Bullock.¹⁰ Individual 3 added that Dr. Bullock never came to the facility and never saw any residents in-person. Dr. Bullock did not have access to the residents' medical records and the only information he had regarding the residents was what Individual 4 or another nurse would report to him. According to Individual 3, Dr. Bullock "never saw or laid eyes" on Patient I, nor did Dr. Bullock ever speak to Patient I.

¹⁰ According to Patient I's spouse ("Individual 4") she never consented to nor was she informed that Dr. Bullock was treating her husband. The facilities Regional Director of Operations ("Individual 5") admitted that staff asked Individual 4 to sign a blank "Provider Choice" consent form upon Patient I's admission to the facility. Later, staff added Dr. Bullock's name to the signed consent form without informing Individual 4.

c. According to Dr. Bullock, Patient I's initial evaluation was conducted on June 3, 2024, and that "visits" occurred monthly. Records from Stepping Stone indicate that Dr. Bullock last treated Patient I on March 27, 2025. As mentioned above, during the entire time Dr. Bullock was "treating" Patient I, he never saw or spoke to Patient I. Nevertheless, for each visit, as part of his mental status examination, Dr. Bullock falsely documented that Patient I:

"[a]ppeared [his] stated age. Emotionally the patient appeared dysphoric. Attitude in the interview consisted of cooperation. The patient showed no signs of psychomotor agitation, retardation or bizarre behavior. The patient presented with speech that was normal in rate, rhythm and articulation. Language skills were within normal limits. Mood was depressed affect was depressed. The patient appears to be aware of their present condition."

d. Moreover, Dr. Bullock documented numerous other falsehoods such as Patient I "reported" to be more stable, that Patient I "presents" with some depression, at times confusion, that they discussed healthy boundaries, lifestyle changes and/or that Patient I demonstrated "self-reflection."

6. Dr. Bullock violated Virginia Code § 54.1-2915(A)(1), (3), (4), (12), (13), (16) and (18), and 18 VAC 85-20-26(C) of the Board's Regulations, and the Prescribing Regulations in that he failed to maintain timely, accurate and/or complete records for Patients A-J, as detailed herein:¹¹

a. As mentioned above, on July 24, 2026, Dr. Bullock provided DHP Investigator 2 with treatment summaries for Patients A-F. Additionally, Dr. Bullock provided medical records, through all three (3) DHP Investigators, for Patients A-J, which he implied were complete. The records provided by Dr. Bullock for Patients A-D and F were electronically signed on July 21, 2026. A portion of Patient E's records had no date, while others were also electronically signed on July 21, 2026. Further, records for Patients G-J did not contain a signature date at all. Dr. Bullock claimed that he "does not always sign off on his charts due to billing." During the August interview, Dr. Bullock was asked to provide an audit

¹¹ The record keeping violations alleged in paragraphs 1-5, inclusive of sub-parts, are incorporated herein by reference.

trail for the records of Patients A-J, with which to confirm the authenticity, accuracy and veracity of the records. No audit trail was provided by Dr. Bullock.

b. In his treatment summary for Patient A, Dr. Bullock wrote that Patient A's initial evaluation was conducted on February 10, 2022. However, the PMP shows that on October 9, 2020, Dr. Bullock began prescribing alprazolam and tramadol to Patient A; 16 months prior to the date Dr. Bullock identified as the date of Patient A's initial evaluation. This "pre-evaluation" treatment was not included in the records produced by Dr. Bullock.

c. In his treatment summary for Patient B, Dr. Bullock wrote that Patient B's initial evaluation was conducted on April 27, 2022. However, the records Dr. Bullock provided primarily date back to January 13, 2023. The records Dr. Bullock provided do include visits for June-September of 2022; however, they are out of chronological order and are randomly placed within the overall record. Regardless, there are still approximately 4 months of treatment records unaccounted for. Additionally, the PMP shows that on August 5, 2021, Dr. Bullock began prescribing alprazolam and hydrocodone to Patient B; eight (8) months prior to the date Dr. Bullock has identified as the date of Patient B's initial evaluation. This "pre-evaluation" treatment was not included in the records produced by Dr. Bullock.

d. In his treatment summary for Patient C, Dr. Bullock wrote that Patient C's initial evaluation was conducted on February 23, 2022. However, the PMP shows that on August 7, 2021, Dr. Bullock began prescribing dextroamp-amphetamin, temazepam and/or gabapentin to Patient C; more than six (6) months prior to the date Dr. Bullock has identified as the date of Patient C's initial evaluation. This "pre-evaluation" treatment was not included in the records produced by Dr. Bullock.

e. In his treatment summary for Patient E, Dr. Bullock wrote that Patient E's initial evaluation was conducted on January 2, 2022. However, the PMP shows that on November 12, 2021, Dr. Bullock began prescribing clonazepam to Patient E; approximately six (6) weeks prior to the date Dr.

Bullock has identified as the date of Patient E's initial evaluation. This "pre-evaluation" treatment was not included in the records produced by Dr. Bullock.

f. In his treatment summary for Patient F, Dr. Bullock wrote that Patient F's initial evaluation was conducted on February 8, 2022. However, the PMP shows that on August 26, 2021, Dr. Bullock began prescribing alprazolam to Patient F; approximately six (6) months prior to the date Dr. Bullock has identified as the date of Patient F's initial evaluation. This "pre-evaluation" treatment was not included in the records produced by Dr. Bullock.

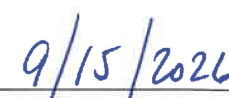
g. Further, on July 26, 2026, five days after Dr. Bullock electronically signed the treatment records of Patients B-D, numerous treatment notes of theirs were edited, without explanation, by an LCSW at Stepping Stone.

h. The vast majority of the treatment notes for Patients A-J lack substance and consist of little more than one sentence which was repetitively "cut and pasted" from previous treatment notes; a practice Dr. Bullock was advised to discontinue in December 2021.

See Confidential Attachment for the names of the patients and/or individuals referenced above.



Jennifer Deschenes, J.D., M.S.
Deputy Executive Director
Virginia Board of Medicine



Date