BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
Stephen Raymond Bunker, M.D.	)	**Case No. 800-2016-022398**
Physician's and Surgeon's Certificate No. G 36647	)	
Respondent	)	

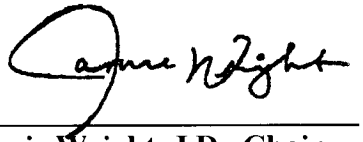
DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on February 17, 2017.

IT IS SO ORDERED January 19, 2017.

MEDICAL BOARD OF CALIFORNIA



By: _____
Jamie Wright, J.D., Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: STEPHEN RAYMOND BUNKER, M.D. Physician's and Surgeon's Certificate No. G36647, Respondent.	Case No. 800-2016-022398 OAH No. 2016081058

PROPOSED DECISION

Administrative Law Judge Diane Schneider, State of California, Office of Administrative Hearings, heard this matter on December 1, 2016, in Oakland, California.

Deputy Attorney General Carolyne Evans represented complainant Kimberly Kirchmeyer, the Executive Director of the Medical Board of California, Department of Consumer Affairs.

Albert J. Garcia, Attorney at Law, represented respondent Stephen Raymond Bunker, M.D., who was present.

The record closed and the matter was submitted on December 1, 2016.

FACTUAL FINDINGS

1. On June 12, 1978, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. G36647 (certificate) to respondent Stephen Raymond Bunker, M.D. The certificate expired on May 31, 2014, and has not been renewed.

2. On July 21, 2016, complainant Kimberly Kirchmeyer, acting in her official capacity as Executive Director of the Board, issued an accusation against respondent. The accusation alleges that respondent's certificate is subject to discipline because of actions

taken by the Texas Medical Board against respondent's license to practice medicine in Texas. Respondent requested a hearing, and this hearing followed.

Action and findings by the Texas Medical Board

3. On December 1, 1981, the Texas Medical Board (Texas Board) issued to respondent a license to practice medicine (Texas Medical License No. G-0961).

4. On April 12, 2016, the Texas Board issued a Mediated Agreed Order (Texas Order) that resolved pending charges against respondent. The Texas Order found that respondent failed to maintain adequate medical records in that he "failed to accurately document the extent of venous disease which formed the basis of his recommendation of vein procedures." Respondent was 66 years old when the Texas Order was issued.

5. Respondent is primarily engaged in the practice of interventional radiology. He is board-certified in nuclear medicine by the American Board of Nuclear Medicine, and in diagnostic radiology and nuclear radiology by the American Board of Radiology.

6. Pursuant to the Texas Order, respondent was required to have his practice monitored for six consecutive billing cycles; he was fined $1,000; and he was required to complete four hours of continuing medical education in medical ethics within one year from the date of entry of the Texas Order. (The Texas Order was entered on April 12, 2016.)

7. The Texas Order noted the following four factors in mitigation: respondent did not have any record of prior discipline before the Texas Board; he established a quality assurance program to safeguard the review and accuracy of all diagnostic exams and findings; he installed a new medical records system that facilitates a more detailed recording specific to each patient; and he cooperated in the investigation with the Texas Board, and in so doing, saved money and resources for the State of Texas.

Respondent's evidence

8. Respondent received his undergraduate degree in 1971 from the University of California, Berkeley (U.C. Berkeley). Respondent began a doctorate program in biophysics at U.C. Berkeley, but withdrew in order to attend medical school at Creighton University School of Medicine. He became licensed to practice medicine in California in 1978, and in Texas in 1981.

9. Respondent practiced nuclear medicine for 36 years. For seven years, from 2007 to 2014, he was the Chief of the Division of Nuclear Medicine, Department of Radiology, at California Pacific Medical Center (C.P.M.C.)

10. Respondent has no history of discipline, and he has not had any malpractice claims filed against him.

11. Respondent relocated to Texas to be closer to his three children and eight grandchildren. He had planned on retiring there but changed his plans because the economic recession made it difficult for him to retire. At the time of the Texas Order respondent was practicing interventional radiology in Round Rock, Texas, specializing in the diagnosis and treatment of lower extremity venous insufficiency.

12. Respondent's testimony was forthright and credible in all respects. He acknowledges that his medical record-keeping system was inaccurate and deficient. He explained that the problems occurred because his electronic medical record system reported venous insufficiency in one numerical fashion, while his separately-generated ultrasound reports reported specific reflux times in another fashion. As a result, the electronic medical record and the ultrasound contained different figures, which was confusing. Respondent has cured this problem by instituting a quality assurance program, including purchasing a new electronic medical records system, to ensure that the medical records are now consistent, accurate, and tailored to each patient. No patients were misdiagnosed or received inappropriate treatment as a result of the deficiency in his medical record-keeping.

13. Respondent has complied with his probation conditions. He plans on completing the four-hour medical ethics class before the deadline of April 12, 2017.

14. A chart monitor report for the monitoring period of May through July 2016, fully corroborates respondent's testimony that he has remedied his charting errors. The chart monitor report provides a detailed analysis of each aspect of record-keeping, and states that respondent has addressed his documentation errors "quite effectively." The report did not note any deficiencies or contain recommendations for improvement.

15. In a letter dated September 27, 2016, Rick Romoff, Manager of Compliance for the Texas Board, states that respondent has been in compliance with the Texas Order.

16. Two physicians who are familiar with respondent's work submitted letters of recommendation:

a. Jerome A. Barakos, M.D., is the Director of Neuroimaging at C.P.M.C. In a letter dated November 25, 2015, Dr. Barakos states that he has worked closely with respondent for about 20 years; he has reviewed the Texas Order; and he has spoken with respondent personally about the Texas disciplinary matter. In supporting respondent without reservation. Dr. Barakos describes respondent as "one of the most respected physicians at CPMC," whose "considerate and thoughtful commitment to patient care . . . has served as a role model to his fellow physicians."

b. Myron Marx, M.D., is a diagnostic and interventional radiologist at C.P.M.C. He has known respondent for 10 years and offers respondent his "strong support." Dr. Marx describes respondent as an "excellent nuclear medicine physician" who "was professional at all times." Dr. Marx is familiar with the Texas Order and opines that the "issues raised seem uncharacteristic of the man I know."

17. Gerald Conners testified at hearing. He is a retired biomedical engineer and has known respondent for 26 years. He has a very high opinion of respondent, and ranks him at the "top level" of physicians. Conners is aware of respondent's charting errors and understands that respondent has corrected them.

18. Respondent has no plans to relocate to California, as he wishes to remain near his family in Texas.

LEGAL CONCLUSIONS

1. The standard of proof applied in making the factual findings set forth above is clear and convincing evidence to a reasonable certainty.

2. Business and Professions Code[1] section 141, subdivision (a), applies generally to licenses issued by agencies that are part of the Department of Consumer Affairs, such as the Board. It provides, in relevant part, as follows:

> For any licensee holding a license issued by a board under the jurisdiction of the department, a disciplinary action by another state . . . for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action by the respective state licensing board.

The disciplinary action of the Texas Board was based on acts substantially related to the practice of medicine. Cause exists under section 141 to take disciplinary action against respondent's certificate, by reason of the matters set forth in Factual Finding 4.

3. Section 2305, which applies specifically to licenses issued by the Board, provides in relevant part as follows:

> The revocation, suspension, or other discipline, restriction, or limitation imposed by another state upon a license or certificate to practice medicine issued by that state . . . that would have been grounds for discipline in California of a licensee under this chapter, shall constitute grounds for disciplinary action for unprofessional conduct against the licensee in this state.

The conduct to which respondent stipulated in the Texas proceeding, as set forth in Factual Finding 4, constitutes cause for disciplinary action in California under section 2266

---

[1] All references are to the Business and Professions Code unless otherwise indicated.

(failure to maintain adequate records). Accordingly, cause exists under section 2305 to take disciplinary action against respondent's certificate.

Disciplinary considerations

4. Cause for discipline having been established, the issue is the appropriate level of discipline to impose. At the outset, it is noted that the purpose of these proceedings is to protect the public from dishonest, immoral, disreputable or incompetent practitioners and not to punish the respondent. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Thus, the controlling question is what degree of discipline is necessary to carry out the Board's duty to protect the public?

The Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (11th ed., 2011) appear to recommend a minimum penalty of stayed revocation and five years' probation, subject to appropriate terms and conditions, for respondent's failure to maintain adequate records. Complainant argues that respondent should receive the minimum penalty. Respondent maintains that the facts of the case warrant a deviation from the guidelines and asks that a public reprimand be issued pursuant to section 2227, subdivision (a)(4). For the reasons explained below, respondent's argument is persuasive.

While respondent erred by failing to maintain accurate medical records, it is found that a public reprimand is the appropriate discipline in this case. Respondent has practiced medicine for about 38 years and has held impressive positions without any disciplinary history; respondent takes responsibility for his inadequate medical records; he remediated the inadequacies by instituting a quality assurance program to ensure review and accuracy of his diagnostic exams and findings; he put in place a new electronic medical records system which allows for a more tailored reading for each patient; he cooperated with the Texas Board's investigation; he has been in compliance with the Texas Order; his chart monitor states that his charting is now satisfactory in all respects; and respondent's expertise and professionalism over his long career as a nuclear medicine physician have earned him the respect of his peers. In consideration of these factors, a public reprimand is sufficient to protect the public interest. To find otherwise would constitute excessive discipline. Because respondent's charting is now satisfactory, it is unnecessary to require him to complete coursework in medical record-keeping.

ORDER

Respondent Stephen Raymond Bunker, M.D., is publicly reprimanded pursuant to Business and Professions Code section 2227, subdivision (a)(4).

DATED: December 28, 2016

DocuSigned by:
Jill Schlichtmann
D0097D9409484D9...

For DIANE SCHNEIDER
Administrative Law Judge
Office of Administrative Hearings

KAMALA D. HARRIS
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
CAROLYNE EVANS
Deputy Attorney General
State Bar No. 289206
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-1211
Facsimile: (415) 703-5480
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Stephen Raymond Bunker, M.D.** **601 Twisted Oak Drive** **Horseshoe Bay, TX 78657** **Physician's and Surgeon's Certificate No. G36647,** Respondent.	Case No. 800-2016-022398 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about June 12, 1978, the Board issued Physician's and Surgeon's Certificate Number G36647 to Stephen Raymond Bunker, M.D. (Respondent). The Physician's and Surgeon's Certificate expired on May 31, 2014, and has not been renewed.

///

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides, in part, that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper..

5. Section 2305 of the Code states:

"The revocation, suspension, or other discipline, restriction or limitation imposed by another state upon a license or certificate to practice medicine issued by that state, or the revocation, suspension, or restriction of the authority to practice medicine by any agency of the federal government, that would have been grounds for discipline in California of a licensee under this chapter [Chapter 5, the Medical Practice Act] shall constitute grounds for disciplinary action for unprofessional conduct against the licensee in this state."

6. Section 141 of the Code states:

"(a) For any licensee holding a license issued by a board under the jurisdiction of the department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or another country shall be conclusive evidence of the events related therein.

"(b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by that board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government, or another country."

///

///

CAUSE FOR DISCIPLINE

(Discipline, Restriction, or Limitation Imposed by Another State)

7. On or about April 5, 2016, the Texas Medical Board issued a "Mediated Agreed Order" (Texas Order). The Texas Order found that Respondent failed to accurately document the extent of venous disease which formed the basis of his recommendation of vein procedures. As a result of Respondent's unprofessional conduct, the Texas Medical Board required that Respondent's practice be monitored for six consecutive monitoring cycles, he was fined $1000.00, and he was required to complete additional continuing medical education in medical ethics.

8. Respondent's conduct and the actions of the Texas Medical Board as set forth in paragraph 7, above, and within the Texas Medical Board's documents, attached as Exhibit A, constitute unprofessional conduct and cause for discipline pursuant to sections 2305 and/or 141 of the Code.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G36647, issued to Stephen Raymond Bunker, M.D.;

2. Revoking, suspending or denying approval of Stephen Raymond Bunker, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Stephen Raymond Bunker, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: July 21, 2016

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

EXHIBIT A

LICENSE NO. G-0961

IN THE MATTER OF	BEFORE THE
THE LICENSE OF	
STEPHEN RAYMOND BUNKER, M.D.	TEXAS MEDICAL BOARD

MEDIATED AGREED ORDER

On the 4th day of March, 2016, came on to be heard before the Texas Medical Board (the Board), duly in session, the matter of the license of Stephen Raymond Bunker, M.D. (Respondent).

On February 17, 2015, Respondent appeared in person, with counsel Stacey Simmons, at an Informal Show Compliance Proceeding and Settlement Conference in response to a letter of invitation from the staff of the Board. The Board's representatives were Frank Denton, a member of the Board, and Melissa Tonn, M.D., a member of a District Review Committee (Panel). Ketan Patel represented Board staff.

The matter did not settle at the ISC, and the Board filed a formal complaint at the State Office of Administrative Hearings ("SOAH") on August 25, 2015. Prior to this matter going to trial, the parties agreed to mediation. The mediation was held on December 14, 2015. Respondent appeared in person with counsel, Stacey Simmons. The Board was represented by Melissa Tonn, M.D., a member of a District Review Committee, and staff attorney, Heather Detrixhe Barham.

Upon the recommendation of the Board's representatives and with the consent of Respondent, the Board makes the following Findings of Fact and Conclusions of Law and enters this Mediated Agreed Order.

BOARD CHARGES

Board Staff charged that Respondent was overly aggressive in recommending procedures that were not medically necessary and for failing to accurately document findings in support of his recommendations for eight patients.

BOARD HISTORY

Respondent has not previously received a disciplinary order from the Board.

Upon the recommendation of the Board's representatives and with the consent of Respondent, the Board makes the following Findings and Conclusions of Law and enters this Agreed Order.

FINDINGS

The Board finds the following:

1. General Findings:
   a. Respondent received all notice required by law. All jurisdictional requirements have been satisfied. Respondent waives any defect in notice and any further right to notice or hearing under the Medical Practice Act, Title 3, Subtitle B, Texas Occupations Code (the Act) or the Rules of the Board.
   b. Respondent currently holds Texas Medical License No. G-0961. Respondent was originally issued this license to practice medicine in Texas on December 1, 1981. Respondent is not licensed to practice in any other state.
   c. Respondent is primarily engaged in the practice of interventional radiology. Respondent is board certified in nuclear medicine by the American Board of Nuclear Medicine and in both diagnostic radiology and in nuclear radiology by the American Board of Radiology, members of the American Board of Medical Specialties.
   d. Respondent is 66 years of age.

2. Specific Panel Finding: With respect to the patients at issue, Respondent failed to accurately document the extent of venous disease which formed the basis of his recommendation of vein procedures.

3. Mitigating Factors:
   a. Respondent has not had any prior disciplinary actions by the Board.
   b. Respondent has instituted a quality assurance program to ensure review and accuracy of all diagnostic exams and findings.

c. Respondent has put in place a new electronic medical records system which allows for more tailored recording specific to each patient.

d. Respondent has cooperated in the investigation of the allegations related to this Agreed Order. Respondent's cooperation, through consent to this Agreed Order, pursuant to the provisions of Section 164.002 the Act, will save money and resources for the State of Texas. To avoid further investigation, hearings, and the expense and inconvenience of litigation, Respondent agrees to the entry of this Agreed Order and to comply with its terms and conditions.

CONCLUSIONS OF LAW

Based on the above Findings, the Board concludes that:

1. The Board has jurisdiction over the subject matter and Respondent pursuant to the Act.

2. Section 164.051(a)(3) of the Act authorizes the Board to take disciplinary action against Respondent for Violation of Rule 165.1(a), failure to maintain an adequate medical record.

3. Section 164.001 of the Act authorizes the Board to impose a range of disciplinary actions against a person for violation of the Act or a Board rule.

4. Section 164.002(a) of the Act authorizes the Board to resolve and make a disposition of this matter through an Agreed Order.

5. Section 164.002(d) of the Act provides that this Agreed Order is a settlement agreement under the Texas Rules of Evidence for purposes of civil litigation.

ORDER

Based on the above Findings and Conclusions of Law, the Board ORDERS that Respondent shall be subject to the following terms and conditions:

1. Respondent shall be subject to the following terms and conditions for six consecutive monitoring cycles (defined below). Respondent's practice shall be monitored by a physician (monitor), in accordance with §164.001(b)(7) of the Act. The Compliance Division of

the Board shall designate the monitor and may change the monitor at any time for any reason. The monitor shall have expertise in a similar specialty area as Respondent. The Compliance Division shall provide a copy of this Order to the monitor, together with other information necessary to assist the monitor.

a. As requested by the Compliance Division, Respondent shall prepare and provide complete legible copies of selected patient medical and billing records (selected records). The Compliance Division shall select records for at least 30 patients seen by Respondent during each three-month period following the last day of the month of entry of this Order (reporting period). The Compliance Division may select records for more than 30 patients, up to 10 percent of the patients seen during a reporting period. If Respondent fails to see at least 30 patients during any three-month period, the term of this Order shall be extended until Respondent can submit a sufficient number of records for a monitor to review.

b. The monitor shall perform the following duties:

1) Personally review the selected records;

2) Prepare written reports documenting any perceived deficiencies and any recommendations to improve Respondent's practice of medicine or assist in the ongoing monitoring process. Reports shall be submitted as requested by the Compliance Division; and

3) Perform any other duty that the Compliance Division determines will assist the effective monitoring of Respondent's practice.

c. The Compliance Division shall provide to Respondent a copy of any deficiencies or recommendations submitted by the monitor. Respondent shall implement the recommendations as directed by the Compliance Division. If the chart monitor recommends that Respondent restrict or suspend his or her practice of medicine, Respondent shall be required to personally appear before a panel of Board representatives, upon written request mailed to Respondent's last known address on file with the Board at least 10 calendar days before the requested appearance date. Such appearance shall be for the purpose of consideration of the chart monitor's recommendations of restriction or suspension and held in accordance with 22 TEX. ADMIN. CODE §187.44. Based upon the panel's findings and recommendations, the Board may modify this Order so that Respondent's practice is restricted or suspended, in accordance with the chart

monitor's recommendations, or take any other action that may be appropriate to resolve the issues presented.

d. The monitor shall be the agent of the Board, but shall be compensated by the Respondent through the Board. Such compensation and any costs incurred by the monitor shall be paid by Respondent to the Board and remitted by the Board to the monitor. Respondent shall not charge the compensation and costs paid to the monitor to any patients.

e. A "monitoring cycle" begins when the Compliance Division selects patient records for review, and concludes when Respondent receives the monitor's report for that group of records and has made payment for the costs of that monitoring cycle.

2. Within one year from the date of the entry of this Order, Respondent shall enroll in and successfully complete at least four hours of continuing medical education (CME) approved for Category I credits by the American Medical Association in medical ethics, approved in writing in advance by the Executive Director or their designee. To obtain approval for the course, Respondent shall submit in writing to the Compliance Department information on the course, to include at least a reasonably detailed description of the course content and faculty, as well as the course location and dates of instruction. Respondent shall submit documentation of attendance and successful completion of this requirement to the Compliance Department on or before the expiration of the time limit set forth for completion of the course. The CME requirements set forth in this paragraph shall be in addition to all other CME required for licensure maintenance.

3. Respondent shall pay an administrative penalty in the amount of $1,000 within 60 days of the date of the entry of this Order. The administrative penalty shall be paid in a single payment by cashier's check or money order payable to the Texas Medical Board and shall be submitted to the Board for routing so as to be remitted to the Comptroller of Texas for deposit in the general revenue fund. Respondent's failure to pay the administrative penalty as ordered shall constitute grounds for further disciplinary action by the Board, and may result in a referral by the Executive Director of the Board for collection by the Office of the Attorney General.

4. At all times while Respondent is under the terms of this Order, Respondent shall give a copy of this Order to all hospitals, nursing homes, treatment facilities, and other health care entities where Respondent has privileges, has pending an application for privileges, applies for privileges, or otherwise practices. Within 30 days of being first contacted by the Compliance

Division of the Board following entry of this Order, Respondent shall provide to the Compliance Division of the Board documentation, including proof of delivery, that the Order was delivered to all such facilities.

5. The time period of this Order shall be extended for any period of time that: (a) Respondent subsequently practices exclusively outside the State of Texas; (b) Respondent's license is subsequently cancelled for nonpayment of licensure fees; (c) this Order is stayed or enjoined by Court Order; or (d) for any period of time longer than 60 consecutive days that Respondent does not actively practice medicine. If Respondent leaves Texas to practice elsewhere or ceases active practice for more than 60 consecutive days, Respondent shall immediately notify the Board in writing. Upon Respondent's return to active practice or return to practice in Texas, Respondent shall notify the Board in writing. When the period of extension ends, Respondent shall be required to comply with the terms of this Order for the period of time remaining on the Order. Respondent shall pay all fees for reinstatement or renewal of a license covering the period of extension or tolling.

6. Respondent shall comply with all the provisions of the Act and other statutes regulating the Respondent's practice.

7. Respondent shall fully cooperate with the Board and the Board staff, including Board attorneys, investigators, compliance officers, consultants, and other employees or agents of the Board in any way involved in investigation, review, or monitoring associated with Respondent's compliance with this Order. Failure to fully cooperate shall constitute a violation of this order and a basis for disciplinary action against Respondent pursuant to the Act.

8. Respondent shall inform the Board in writing of any change of Respondent's office or mailing address within 10 days of the address change. This information shall be submitted to the Registration Department and the Compliance Department of the Board. Failure to provide such information in a timely manner shall constitute a basis for disciplinary action by the Board against Respondent pursuant to the Act. Respondent agrees that 10 days notice of a Probationer Show Compliance Proceeding to address any allegation of non-compliance of this Agreed Order is adequate and reasonable notice prior to the initiation of formal disciplinary action. Respondent waives the 30-day notice requirement provided by §164.003(b)(2) of the Medical Practice Act and agrees to 10 days notice, as provided in 22 Texas Administrative Code §187.44(4).

9. Any violation of the terms, conditions, or requirements of this Order by Respondent shall constitute unprofessional conduct likely to deceive or defraud the public, or to injure the public, and shall constitute a basis for disciplinary action by the Board against Respondent pursuant to the Act.

10. Respondent shall be permitted to supervise and delegate prescriptive authority to physician assistants and advanced practice nurses and to supervise surgical assistants

11. The above-referenced conditions shall continue in full force and effect without opportunity for amendment, except for clear error in drafting, for one year following the date of the entry of this Order. If, after the passage of the one-year period, Respondent wishes to seek amendment or termination of these conditions, Respondent may petition the Board in writing. The Board may inquire into the request and may, in its sole discretion, grant or deny the petition without further appeal or review. Petitions for modifying or terminating may be filed only once a year thereafter.

RESPONDENT WAIVES ANY FURTHER HEARINGS OR APPEALS TO THE BOARD OR TO ANY COURT IN REGARD TO ALL TERMS AND CONDITIONS OF THIS AGREED ORDER. RESPONDENT AGREES THAT THIS IS A FINAL ORDER.

THIS ORDER IS A PUBLIC RECORD.

(SIGNATURE PAGES FOLLOW)

I, STEPHEN RAYMOND BUNKER, M.D., HAVE READ AND UNDERSTAND THE FOREGOING AGREED ORDER. I UNDERSTAND THAT BY SIGNING, I WAIVE CERTAIN RIGHTS. I SIGN IT VOLUNTARILY. I UNDERSTAND THIS AGREED ORDER CONTAINS THE ENTIRE AGREEMENT AND THERE IS NO OTHER AGREEMENT OF ANY KIND, VERBAL, WRITTEN OR OTHERWISE.

DATED: April 5, 2016.

Stephen Raymond Bunker, M.D.
STEPHEN RAYMOND BUNKER, M.D.
Respondent

STATE OF Texas §
§
COUNTY OF Travis §

SWORN TO AND ACKNOWLEDGED BEFORE ME, the undersigned Notary Public, on this 5th day of April, 2016.

NOTARY PUBLIC STATE OF TEXAS
PAMELA L. CLAYTON
My Commission Expires
August 02, 2016
(Notary Seal)

Pamela L. Clayton
Signature of Notary Public

SIGNED AND ENTERED by the presiding officer of the Texas Medical Board on this 12 day of April, 2016.

Michael Arambula, M.D., Pharm.D., President
Texas Medical Board

STATE OF TEXAS
COUNTY OF TRAVIS

I, Charlotte Rodriguez certify that I am an official assistant custodian of records for the Texas Medical Board and that this is a true and correct copy of the original, as it appears on file in this office.

Witness my official hand and seal of the Board.

This 24th, Day of May, 2016

Charlotte Rodriguez
Assistant Custodian of Records