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

In the Matter of the Accusation Against:	
Laleh Shaban, M.D.	**Case No. 800-2016-024893**
Physician's and Surgeon's License No. A 61606,	
Respondent.	

DECISION

The attached Stipulated Settlement and Disciplinary Order 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 December 31, 2020.

IT IS SO ORDERED: December 2, 2020.

MEDICAL BOARD OF CALIFORNIA

Kristina D. Lawson, J.D., Chair
Panel B

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Attorneys for Complainant

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

In the Matter of the Accusation Against: **LALEH SHABAN, M.D.** **4251 S. Higuera St., Ste 600** **San Luis Obispo, CA 93401-7700** **Physician's and Surgeon's Certificate No. A 61606** Respondent.	Case No. 800-2016-024893 OAH No. 2019100485 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Megan R. O'Carroll, Deputy Attorney General.

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2. Respondent Laleh Shaban, M.D. (Respondent) is represented in this proceeding by attorney Lauren D. Fierro, Esq., whose address is: 310 Golden Shore, Fourth Floor Long Beach, CA 90802.

3. On or about February 7, 1997, the Board issued Physician's and Surgeon's Certificate No. A 61606 to Laleh Shaban, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2016-024893, and will expire on July 31, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2016-024893 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on August 2, 2019. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2016-024893 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2016-024893. Respondent has also carefully read, fully discussed with her counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2016-024893, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

10. Respondent agrees that, at a hearing, Complainant could establish a prima facie case for the charges in the Accusation, and that Respondent hereby gives up her right to contest those charges.

11. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2016-024893, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected her Physician's and Surgeon's Certificate, No. A 61606 to disciplinary action.

12. Respondent agrees that her Physician's and Surgeon's Certificate is subject to discipline and she agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

13. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

14. Respondent agrees that if she ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against her before the Board, all of the charges and allegations contained in Accusation No. 800-2016-024893 shall be

deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

15. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

16. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 61606 issued to Respondent Laleh Shaban, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions:

1. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than

15 calendar days after the effective date of the Decision, whichever is later.

2. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data

obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

4. MONITORING - PRACTICE/BILLING. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of

Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of

such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

5. PROHIBITED PRACTICE. During probation, Respondent is prohibited from prescribing human chorionic gonadotropin (HCG) treatments or performing platelet-rich plasma (PRP) procedures until she has successfully completed the clinical competence assessment program. Respondent shall not prescribe human chorionic gonadotropin (HCG) treatments or perform platelet-rich plasma (PRP) procedures until respondent has successfully completed the program and has been so notified by the Board or its designee in writing.

6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

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7. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

8. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

9. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

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Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice ,Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model

Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing..

13. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

14. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the

application shall be treated as a petition for reinstatement of a revoked certificate.

16. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

17. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2016-024893 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Lauren D. Fierro. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: July 9, 2020

LALEH SHABAN, M.D.
Respondent

I have read and fully discussed with Respondent Laleh Shaban, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: July 9, 2020

Lauren D. Fierro
Attorney for Respondent

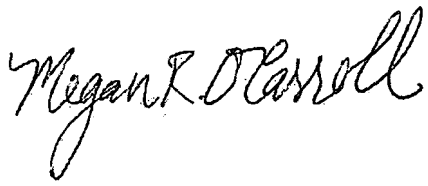
ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: 7/9/2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General



MEGAN R. O'CARROLL
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2016-024893

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
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STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Laleh Shaban, M.D.** **4251 S. Higuera St., Ste 600** **San Luis Obispo, CA 93401-7700** **Physician's and Surgeon's Certificate No. A 61606,** Respondent.	Case No. 800-2016-024893 **ACCUSATION**

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 February 7, 1997, the Medical Board issued Physician's and Surgeon's Certificate Number A 61606 to Laleh Shaban, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2020, unless 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 (Code) unless otherwise indicated.

4. Section 2227 of the Code provides 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 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> (d) Incompetence.
>
> (e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct which would have warranted the denial of a certificate.
>
> (g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program

described in Section 2052.5.

(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 2238 of the Code states:

A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

7. Section 2264 of the Code states:

The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct.

8. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

9. Title 21 of the Code of Federal Regulations, section 1306.04 provides, "A prescription may not be issued in order for an individual practitioner to obtain controlled substances for supplying the individual practitioner for the purpose of general dispensing to patients."

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

10. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that she was repeatedly negligent in her care and treatment of Patients 1, 2, 3, 4, and 5. The circumstances are as follows:

11. Respondent is Board-certified in Internal Medicine with a subspecialty in geriatric medicine. She runs a solo practice in San Luis Obispo, California, called Revive Medical Group, where she provides regenerative medicine and anti-aging medical services. She previously had multiple offices, including one in Morro Bay, but now only operates out of the office in San Luis Obispo.

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Patient 1

12. On or about November 16, 2017, Patient 1 went to Revive Medical Center in Morro Bay, California, seeking Botox treatment for cosmetic purposes. She had researched Botox treatment online before her visit. She was seen by a Nurse Practitioner in the practice who recommended she receive a different toxin treatment, Dysport. Patient 1 agreed, and received injections of Dysport from the Nurse Practitioner.

13. The medical records of Patient 1's visit contain a series of checklists and forms that Patient 1 and the provider filled out. Patient 1 provided personal and background information, including any history of allergies and previous treatment. The provider filled out a series of checklists, including a form indicating that the provider had verbally reviewed the risks and benefits, including side effects, of the treatments. Patient 1, however, reported that she was never advised of any possible side effects of the Dysport treatment. Patient 1 did not complete a written informed consent for treatment. After the treatment, Patient 1 reported to Respondent's Office that she had experienced side effects that she believed were caused by the Dysport treatment.

Patient 2

14. Patient 2 was a 52-year-old woman when she began seeing Respondent. Patient 2 paid a fee to become a member of Respondent's concierge practice, which Respondent advertised as a Patient Access Program, (PAP). The PAP was designed to provide patients with a range of yearly services, as well as same-day appointments and discounts on additional services, such as weight loss programs and cosmetic services. The fee to enroll in the PAP was $3,500.00. Patient 2 signed up for the PAP and paid the fee.

15. Patient 2 had a complex medical history. She reported having numerous past medical conditions including autoimmune disorders, several allergies, and chemical sensitivities. Respondent saw Patient 2 on or about December 14, 2016, and documented that she had, among other conditions, hypothyroidism, post-concussion syndrome, neuropathy, fatigue, anemia, celiac disease, Bell's palsy, and myasthenia gravis. Respondent did not make any diagnoses at that initial consultation. She documented a partial examination, noting hair loss, heart murmur, and a left foot plantar mole.

16. Patient 2's records contain an order, signed by Respondent, and dated December 14, 2016, for a thermogram. The initial consultation referenced the word thermogram, but contains no other information about it. There is no documentation of a discussion of the risks and benefits of the procedure, or alternative procedures.

17. Respondent recommended Patient 2 to return for "brain mapping," which was a Quantitative Electroencephalography (qEEG). At some point after this initial consultation on December 14, 2016, Patient 2 returned to Revive and underwent a qEEG. Patient 2 reported that she did not see Respondent when she returned to have the qEEG. Instead, it was performed by a non-licensed individual, M.S., with the title of "Health Coach." This procedure was not documented anywhere in the record. There is no documentation in the record that the procedure was performed, who performed it, or what the results were. There is no report of the procedure in the medical records. When Patient 2 was undergoing the qEEG, she asked M.S. about the gel that M.S. was using on her head during the procedure. M.S. did not appear to know what the ingredients were in the gel. There is a note in the medical record titled "Medical Physical" and "PAP Sheet," dated January 6, 2017, which is otherwise left completely blank.

18. After the qEEG, Patient 2 called Revive and reported that she was experiencing what she believed was a reaction to the gel. The patient contact log in the records show that between January 16 and January 18, 2017, Patient 2 made several telephone calls to Revive, and spoke with various members of the staff. On or about January 16, 2017, Patient 2 called and reported that she had not been able to get out of bed since the qEEG, and that her facial nerves were twitching. A member of staff returned Patient 2's call, leaving a message that other patients had not experienced any such reaction to the gel. On or about January 18, 2017, M.S. texted Respondent to tell her that Patient 2 would like a telephone call to discuss nerve damage from the gel. On or about January 18, 2017, Patient 2 called the office again and left a message with a staff member. Patient 2 was crying and complaining that Respondent had not returned her call personally. She asked for a refund of her PAP deposit. In the telephone log after the call from Patient 2, Respondent wrote a note stating "will send $ back."

19. On or about March 15, 2017, there is a phone call message note, signed by Respondent, stating that Patient 2 had called on January 18, 2017 expressing concerns about the gel. Respondent documented that Patient 2 had been refunded her money.

20. On or about March 27, 2017, Patient 2 had a series of emails with Health Coach M.S. M.S. sent Patient 2 an email with a report of the qEEG. Patient 2 sent a response to M.S. noting that she had told Respondent of her chemical sensitivities and that Respondent should not have ordered the procedure. M.S. responded that Respondent recommended she see a neurologist, and provided the contact information for three neurologists.

21. The medical records also contain a note indicating that Patient 2 had called on March 15, 2017, asking that Respondent see her for an appointment to evaluate the nerve damage. A return call note of March 16, 2017, stated that a staff member had returned Patient 2's call explaining that she was no longer a patient of Respondent's, and that Respondent could not see her. These telephone notes were signed by Respondent, with a date of April 19, 2017.

Patient 3

22. Patient 3 was a 22-year-old man when he first began seeing Respondent in December of 2016. He is the son of Patient 2. Patient 3, like his mother, signed up for Respondent's PAP, and paid the yearly fee of $3,500.00. Respondent indicated that if he and his mother signed up for the PAP she would be especially responsive to their needs.

23. Patient 3 had a history of knee problems. Before December of 2016, he had last received treatment for his knee at a walk-in clinic about two-and-a-half years previously. At that time, he had been told that his knee problems were related to his patella. Patient 3's father had experienced joint pain and had recommended to Patient 3 that he ask Respondent about a procedure known as Platelet Rich Plasma (PRP) injections.[1] Patient 3's father had tried the PRP injections in the past and felt that they benefited him, and he knew that that Respondent provided PRP injections as one of the procedures in her practice at Revive.

[1] PRP therapy is an alternative medicine treatment. It is premised on the theory that elements of an individual's own blood contain healing properties that can be harnessed by removing a blood sample, spinning the sample in a centrifuge to separate the elements of the blood, and then injecting back the individual's own platelets into injured areas.

24. Patient 3 had an appointment with Respondent on or about December 1, 2016. Respondent noted his chief complaint as "PRP for MCL knee."[2] Respondent documented that Patient 3 had a knee injury in April of 2014. Patient 3 stated that Respondent spent about 30 minutes with him at his initial December appointment. He reported that she "kind of" checked his knee. Respondent performed a very limited knee examination. She documented the knee circumference and that the right knee was larger than the left knee. She did not document whether there was a knee effusion.

25. Respondent did not document whether Patient 3 had been medically evaluated after the initial knee injury. She did not record any previous orthopedic consultation. She did not record if x-rays were taken. She did not record the location of the knee pain. She did not report in the history portion of the record whether the knee pain was right or left-sided. Respondent did not palpate for localized tenderness. She did not perform stress testing for instability of the knee joint or perform maneuvers to detect a meniscal injury. Respondent did not entertain a differential diagnosis or determine any diagnosis.

26. At the initial appointment on or about December 1, 2016, Patient 3's vital signs were documented as weight of 318 pounds, blood pressure of 130/86, oxygen saturation of 81, and temperature of 97.6. Respondent reported Patient 3's past medical history as Hashimoto's thyroiditis, history of cholecystectomy, digestive issues, and traumatic brain injury from a motor vehicle accident. Respondent wrote that she would obtain past records, a stool test, cholesterol testing, and a brain MRI to rule out pituitary tumors. Respondent noted that she would schedule Patient 3 for PRP of his right knee and strongly recommended he participate in a weight loss program.

27. After the initial appointment, Patient 3 returned for a PRP procedure on his right knee. He signed a form indicating his informed consent to the procedure. A procedure note, dated December 30, 2016, showed that Respondent injected 6cc of PRP from a 60 cc blood draw into Patient 3's right knee. Aftercare instructions were also documented. Respondent did not document which anatomical structure the PRP was injected into. Patient 3 recalled that he saw

[2] MCL stands for medial collateral ligament.

Respondent after the initial appointment and that she injected the PRP into his knee in about ten places. An unlicensed individual, F.S., was present during the first PRP injections by Respondent.

28. Patient 3 reported to Board investigators that he received a second and third round of PRP injections into his knee by F.S. on two different days after his first PRP injection with Respondent.

29. Respondent calls the weight loss program that she offers "Medical Weight Management" (MWM), and explains that it is a multifactorial treatment aimed at improving sleep and reducing stress as well as diet and exercise. The MWM program is six months long and begins with identifying and avoiding foods that cause inflammation. Another portion of the program includes injecting human chorionic gonadotropin (HCG), a hormone normally present in women at high levels in early pregnancy. This hormone is thought to reduce appetite and stimulate weight loss. Respondent explained that Health Coaches in her practice administer and furnish the HCG to patients in the MWM program.

30. Patient 3 began the MWM program at Revive on or about January 5, 2017. Patient 3 saw unlicensed Health Coaches at Revive for the MWM program, not Respondent. Respondent prescribed HCG to Patient 3, and he signed an informed consent form for the HCG injections. Patient 3 reported that Health Coaches met with him for most of his MWM program appointments. He reported that unlicensed Health Coach M.S. provided him with several pre-filled syringes of HCG at each appointment and instructed him on how to administer it to himself in his flank. During her interview with Board investigators, Respondent explained that Health Coaches provide information to patients in the MWM program about what to eat in the HCG diet, and instruct the patients on how to self-administer the HCG injections using an insulin syringe in the abdomen subcutaneously. She explained that the Health Coaches advise the patients to rotate sites on the abdomen to prevent scarring from repeated injections at a single site. The Health Coaches draw up the HCG from the vial, and give the patients seven syringes (a one week supply for daily injections), and the patients take the syringes home on ice. The records of Patient 3's

MWM program show Respondent listed as the provider, but they are electronically signed by Health Coach M.S. and T.F. who are listed as secondary providers.

31. Patient 3 saw Respondent for a medical evaluation on or about January 19, 2017. Respondent ordered IV vitamins, minerals, and amino acids. Patient 3 also met with another provider on January 19, 2017 to discuss his cholesterol test results and other laboratory tests. Respondent initialed the test results. The patient contact log showed that Patient 3 reported improvement in his knee after the PRP injection. Because of this, he was advised not to get an MRI of the knee. Respondent next saw Patient 3 on or about February 2, 2017. An EKG was performed on that date and signed off by L.S. Patient 3 had blood draws for a "food panel" on or about February 2, 2017. On or about February 24, 2017, Health Coach M.S. discussed the "food panel" test results with Patient 3.

32. Respondent saw Patient 3 on or about March 23, 2017 for a physical examination. Respondent did not document in the history any knee pain. Respondent did not include a musculoskeletal examination in the evaluation. Her assessment and plan were to continue the MWM program and be more compliant, to consider a sleep study, and to take intra-muscular Vitamin D. She assessed Patient 3 with metabolic syndrome and right knee pain due to re-injury. She indicated to offer further PRP injections if the knee did not improve.

33. On or about March 23, 2017, Patient 3 saw Health Coach M.S. M.S.'s medical record shows that Patient 3 began the second phase of the MWM program, which included the HCG injections on this date. His informed consent form for the HCG is dated March 23, 2017. Patient 3 saw M.S. again on or about April 6, 2017. She recorded vital signs and history. His weight had decreased to 308 pounds. M.S. recorded that she dispensed an additional seven days of HCG at the visit.

Patient 4

34. Patient 4 has been a patient of Respondent's for just under 20 years. For approximately the last five years, he has been a member of Respondent's concierge program, PAP. He has multiple medical problems including being overweight and having insulin resistance, osteopenia, low libido, sleep apnea and sarcopenia. He also has a pituitary adenoma.

Patient 4 told Board investigators that his orthopedic surgeon told him he will eventually require a knee replacement, and to take ibuprofen until he has the surgery in a few years. He stated that Respondent has prescribed him Percocet, three times per day, which allows him to take only three ibuprofen per day. The Controlled Substance Utilization Review and Evaluation System (CURES) shows that Respondent prescribed 100 tablets of Percocet 10/325 approximately every month between December of 2014 and November of 2017 to Patient 4.

35. On or about July 15, 2014, Respondent saw Patient 4 for right hip trochanteric bursitis. She recommended that he take Motrin 600 mg three times per day. On or about August 21, 2015, Respondent saw Patient 4 for a complete physical. The chief complaint was severe left knee pain. Respondent did not include either ibuprofen or Percocet on the list of medications Patient 4 was taking. Respondent performed a complete examination of Patient 4. She noted tenderness about the medial collateral ligament insertion and there was decreased range of motion of the knee. Her assessment and plan included possible stem cell therapy as a future option.

36. On or about September 12, 2016, Respondent had an appointment with Patient 4 for follow up on his blood pressure. The first paragraph of the note for this visit states, "He also has ADHD and is wondering if neurofeedback would be a good choice." Although there are no symptoms or examination notes relating to ADHD, Respondent wrote under the Assessment and Plan portion of the note: "2. ADHD. We have discussed neurofeedback. Once we are set up, we can contact him to see if he is interested." A handwritten note in Patient 4's medical records, dated February 2, 2017, requests routine refills and lists his current medication as of that date as including "blue Amphetamine Salts 10 mg ½ memory pill 5 mg AM." At that time, Patient 4 was seeing a psychiatrist, Dr. C, who was prescribing him Adderall. Respondent was aware of this.

37. On or about May 2, 2017, Dr. C wrote a letter to Respondent explaining that she was going to discharge Patient 4 from her practice and that her final prescription of Adderall 5 mg would be on May 6, 2017. Respondent documented an appointment with Patient 4 on or about June 16, 2017, in which she noted that Dr. C. discharged Patient 4 from her practice and that he needed a prescription for amphetamine salts at 10 mg and a referral to a therapist. Respondent wrote that she would start Patient 4 on amphetamine salts, half a tab in the morning and refer him

to a therapist. She gave Patient 4 the contact information for the therapist. The medical records show that Respondent prescribed Patient 4 30 tablets of amphetamine salts 10 mg, on or about June 16, 2017, August 29, 2017, and October 12, 2017.

38. On or about July 13, 2017, Respondent diagnosed Patient 4 with a left bicep injury. During Respondent's interview with Board investigators, she said that she referred Patient 4 to an orthopedic surgeon. Respondent recorded in Patient 4's notes that if he did not improve, she would schedule a Prolozone injection. On or about July 24, 2017, Patient 4 underwent a procedure for Prolozone therapy. The procedure note shows that it was injected into his biceps. There was no informed consent for the procedure.

39. On or about August 27, 2017, Respondent saw Patient 4 again for left knee pain. X-rays showed osteoarthritis. Respondent ordered physical therapy. On or about October 10, 2017, Respondent saw the patient for a complete physical. Respondent documented that Patient 4 had osteoarthritis, a right knee injury that was being managed with conservative treatment, and left fourth and fifth metatarsal shaft fractures. Patient 4's MRI report actually showed that he had fractures at the second and third metatarsals. Respondent did not list either ibuprofen or Percocet on Patient 4's medication list. None of Respondent's records for Patient 4 document that she set objectives for pain reduction, or conducted a periodic review while she was prescribing Percocet to Patient 4. She did not have a pain management agreement with Patient 4.

40. Patient 4's testosterone level was low to normal in 2015, and low in 2016. Respondent prescribed testosterone bioidentical cream on or about September 18, 2015. She wrote that he had insulin resistance, osteopenia, low libido, sleep apnea, and sarcopenia. On or about August 14, 2017, Respondent refilled Patient 4's topical testosterone cream. The record contains no written informed consent for treatment with testosterone, and there is no documentation that Respondent was verbally advised of the risks and benefits of the treatment.

Patient 5

41. Patient 5 became a patient of Respondent in approximately 2016. Patient 5 was very ill, and had a highly complex medical history. She was infected with mycobacterium avium

complex (MAC).[3] She also had recurrent pneumonia, chronic obstructive lung disease and a history of Actinomycosis.[4] Patient 5 was seeing a pulmonologist and had been hospitalized in the past for the recurrent pneumonia and respiratory illness.

42. Respondent obtained notes from Patient 5's treatment with the pulmonologist before she began seeing Respondent. The pulmonologist's notes showed that Patient 5's potassium level was 3.1 on or about April 8, 2015, and 3.5 on or about April 9, 2015. Patient 5's sputum culture showed non-TB mycobacteria. The pulmonologist had prescribed Patient 5 rifampin, an antibiotic.

43. Respondent documented an initial consultation with Patient 5, dated February 29, 2016. Patient 5 sought intravenous therapy with Respondent. Respondent noted a past medical history of Vitamin D deficiency, osteopenia, MAC, on azithromycin, rifampin, and ethambutol. Respondent noted that the pulmonologist had done a lung biopsy on April 15, 2016. Patient 5 had depression, for which she was on Wellbutrin. Her weight was 111 pounds and her blood pressure was 116/64. Patient 5 signed an informed consent form for intravenous treatments. During 2016 and 2017, she received many different types of intravenous treatments from Revive, with ingredients including vitamin C, B-vitamins, magnesium, trace minerals, amino acids, phosphatidylcholine, and glutathione. Patient 5 received multiple IV treatments each month through August of 2016.

44. Beginning in August of 2016, Respondent treated Patient 5 with gallium. A note on August 4, 2016 states, "I have discussed gallium 1 quick squirt in 1 quart of bottled water and to drink sips all day." Patient 5's pulmonologist noted on September 5, 2016, that she was on azithromycin, rifampin, and ethambutol. On or about September 9, 2016, Patient 5 asked to join the PAP to be part of Respondent's concierge practice. On or about September 15, 2016, a note from the pulmonologist said Patient 5 was still taking rifampin. On or about October 3, 2016, Patient 5's patient contact log indicated that Patient 5 is only taking 1 ounce of gallium instead of 2 ounces to improve her appetite. A note from October 11, 2016 indicated that Patient 5 was on

[3] MAC is a group of bacteria related to tuberculosis. In patients with weak immune systems, it can spread to many areas of the body and cause serious life-threatening illness.

[4] Actinomycosis is a bacteria that can cause sores, usually on the face or mouth.

gallium although she dropped her dose to a half due to appetite suppression. The gallium therapy is not mentioned in the assessment and plan of the record of that date. Respondent did not obtain informed consent before dispensing the gallium nitrate to Patient 5. She did not document in the medical record the source of the gallium nitrate. Patient 5's medical records show that she purchased the gallium nitrate from Respondent's practice directly.

45. Patient 5's serum calcium levels were measured in September 2016, and several times in November 2016. Her calcium levels were as follows:

September 23, 2016	9.7 mg/dl
November 22, 2016	8.8 mg/dl
November 23, 2016	8.1 mg/dl
November 24, 2016	7.7 mg/dl
November 25, 2016	8.4 mg/dl

A level below 8.8 mg/dl is defined as hypocalcemia. Respondent did not discuss in Patient 5's medical record the occurrence of hypocalcemia.

46. A hospital discharge note for Patient 5 stated that her actinomyces responded to one year of penicillin, but then seven years later she was diagnosed with MAC. She had been on rifampin, ethambutol and azithromycin for a year and a half with uncertain benefit. The discharge diagnosis was acute pneumonia with bilateral pleural effusions.

47. On or about December 2, 2016, Patient 5 had a post discharge appointment with her pulmonologist. At this appointment, the pulmonologist noted that Patient 5 was no longer taking her rifampin. Patient 5 reported to Respondent that she was frustrated with her current pulmonologist. A handwritten note in Patient 5's Revive records states that Patient 5 requires a more aggressive pulmonologist. Respondent had an office visit with Patient 5 on or about December 27, 2016, noting that Patient 5 had been quite ill, and hospitalized with bilateral lobar pneumonia. Her weight was 107.2 pounds. Her oxygen was low when walking. Respondent arranged for home oxygen.

48. On or about December 29, 2016, Patient 5 had a consultation with a different pulmonologist. This pulmonologist noted that he was the fifth or sixth pulmonologist Patient 5

had seen recently. A communication log from Respondent's office indicates that she spoke with Patient 5's initial pulmonologist who reported that Patient 5 was non-compliant. The pulmonologist agreed to keep Patient 5's PICC line in so that she could receive intravenous treatments at Respondent's office.

49. Patient 5 continued to not take rifampin in January and February 2017. She was hospitalized and intubated with a diagnosis of panic attack. She was prescribed Paxil. In February of 2017, Patient 5 lost consciousness and was taken to the hospital for a CT of the head. On or about February 24, 2017, Patient 5 received intravenous therapy from Respondent, including glutathione. On or about March 2, 2107, Patient 5 again lost consciousness. Respondent called in Florinef[5] for Patient 5. Patient 5 reported an amazing response to the Florinef. She said it made her feel much better. Respondent increased the dose of Florinef. On or about March 16, 2017, Patient 5's pulmonologist noted a marked improvement. He also noted she was not taking rifampin and was on paroxetine.

50. On or about March 21, 2017, Patient 5 had an office visit with Respondent. Respondent noted that Patient 5 was recently diagnosed with Addison's disease and has been placed on Florinef 0.1 mg twice a day and is doing well. Respondent further noted that Patient 5 had lost a lot of weight and was unable to tolerate any treatments given by her pulmonologist to treat her mycobacterium avium. Respondent assessed Patient 5 with "Addison's disease, most likely due to mycobacterium infection to adrenals. Patient will need an MRI of adrenals in 1-2 months." During her interview with Board investigators, Respondent stated that she diagnosed Patient 5 with Addison's disease based on her response to fludrocortisone.

51. In April of 2017, Patient 5 reported dizzy spells upon standing. On or about April 21, 2017, Patient 5 had another office visit with Respondent. Respondent noted she had Addison's disease[6], and had multiple syncopal episodes but seizures were ruled out. Throughout May, June and August of 2017, Patient 5 continued to be on Florinef and not take rifampin. Respondent adjusted the Florinef dose multiple times and prescribed ozone.

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[5] Florinef (fludrocortisone) is a corticosteroid medication used to treat adrenogenital syndrome, postural hypotension, and adrenal insufficiency.

[6] Addison's disease is also known as primary adrenal insufficiency and hypocortisolism.

52. On or about August 31, 2017, Patient 5 called Respondent's office to state that she was not well enough to drive to the office. She reported feeling dizzy. On or about September 6, 2017 during an office visit, Patient 5 reported that she had blacked out for a few hours. Her previous EEG and MRI were noted to be unremarkable. Respondent referred Patient 5 to a seizure specialist. She directed Patient 5 to do her blood work to set her adrenocorticotropic hormone (ACTH).[7] She prescribed DHEA, 10 mg.

53. On or about September 18, 2017, Patient 5 called Revive to request a referral to a psychiatrist for depression, and stated that she did not want to complete the ACTH test. On or about November 17, 2017, Respondent ordered a cortef taper and fludricort 0.1 mg twice a day as needed. On or about November 20, 2017, Respondent strongly advised Patient 5 to taper down the cortisone to 70 mg daily. Patient 5 was taking 80 mg daily. Respondent also advised staying off Florinef and only using it in emergencies. Respondent refilled Patient 5's hydrocortisone 5 mg with 480 tablets on or about November 27, 2017. She refilled the Florinef 0.1 mg with 100 tablets on this day as well.

54. On or about December 24, 2017, Patient 5 was discharged from the hospital with diagnoses of pneumonia and flu. Her discharge medications included hydrocortisone 40 mg in the morning, 20 mg at lunch and 10 mg in the evening. On or about February 1, 2018, Respondent had an office visit with Patient 5, assessing her with stable Addison's disease, on hydrocortisone and Paxil. She noted Patient 5 was on BHRT and was off Florinef. On or about February 2, 2018, Respondent refilled hydrocortisone, 480 tablets of 5 mg, with instructions to take 40 mg in the morning, 20 mg at lunch, and 20 mg at 3 in the afternoon, with three refills.

55. On or about April 5, 2018, Patient 5 reported that she dropped her dose of the hydrocortisone to one half of what Respondent prescribed. Respondent recommended she go back on the original dose. As of May 11, 2018, Patient 5 was not on rifampin, and was on Cortef for Addison's disease. Respondent advised a gradual decrease in the morning dose of Cortef. Patient 5 never completed her ACTH test or obtained an MRI of the adrenal glands.

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[7] ACTH is a hormone produced in the anterior, or front, pituitary gland in the brain. It regulates cortisol, which is released from the adrenal glands.

Departures From the Standard of Care

56. Respondent was repeatedly negligent in her acts and omissions including, but not limited to, the following:

(a) Failing to obtain informed consent for administering Dysport injections to Patient 1;

(b) Failing to obtain informed consent before conducting a qEEG of Patient 2;

(c) Failing to document the date of the qEEG in Patient 2's record;

(d) Failing to promptly return Patient 2's call or direct her to go to urgent care when she reported symptoms of a reaction to the qEEG gel;

(e) Not sending a written letter of termination to Patient 2 informing her of the last day the physician is able to render medical care, alternative sources of medical care, and information on how to obtain medical records;

(f) Failing to discuss the risks and benefits of thermography and mammography with Patient 2 and obtaining informed consent for thermography from Patient 2;

(g) Failing to accurately and adequately document Patient 3's MWM program and coordinate his care;

(h) Taking an inadequate history and physical of Patient 3's knee condition and failing to document a treatment plan for the condition;

(i) Allowing non-licensed "health coaches" to prepare and dispense HGC to Patient 3 for multiple days of treatment at once;

(j) Allowing an unlicensed individual to inject the PRP into Patient 3;

(k) Failing to comply with prescribing guidelines before prescribing Percocet to Patient 4;

(l) Maintaining inadequate documentation of Adderall prescriptions to Patient 4;

(m) Failing to obtain informed consent before prescribing testosterone to Patient 4;

(n) Failing to obtain informed consent before providing Prolozone treatment to Patient 4;

(o) Failing to document Patient 5's medical record with the indication for the extremely high doses of hydrocortisone she was prescribing to Patient 5;

(p) Failing to discuss the risks, including Cushing's syndrome, of high dose cortisone with Patient 5.

(q) Diagnosing Addison's disease in Patient 5 without first obtaining laboratory tests or imaging to confirm the diagnosis, or referring Patient 5 to an endocrinologist; and

(r) Failing, collectively, to obtain Patient 5's informed consent to taking gallium nitrate, to document in the medical record the source of the gallium nitrate, to monitor Patient 5's bloodwork during October 2016, and to document the hypocalcemia in Patient 5's medical record.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

57. Respondent is subject to disciplinary action under section 2234, subdivision (b), in that she was grossly negligent in her care and treatment of Patients 3 and 5. The circumstances are set forth in paragraphs 12 through 55, above, which are incorporated here by reference as if fully set forth herein. Additional circumstances are as follows:

58. Respondent was grossly negligent in her acts and omissions including, but not limited to, the following:

(a) Taking an inadequate history and physical of Patient 3's knee condition and failing to document a treatment plan for the condition before beginning treatment with PRP injections;

(b) Allowing non-licensed health coaches to prepare and dispense HGC to Patient 3 for multiple days of treatment at once;

(c) Allowing an unlicensed individual to inject the PRP into Patient 3;

(d) Diagnosing Addison's disease in Patient 5 without first obtaining laboratory tests or imaging to confirm the diagnosis, or referring Patient 5 to an endocrinologist; and

(e) Failing, collectively, to obtain Patient 5's informed consent to taking gallium nitrate, to document in the medical record the source of the gallium nitrate, to monitor Patient 5's bloodwork during October 2016, and to document the hypocalcemia in Patient 5's medical record.

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THIRD CAUSE FOR DISCIPLINE

(Assisting in the Unlicensed Practice of Medicine)

59. Respondent is subject to disciplinary action under section 2264 of the Code in that she aided and abetted the unlicensed practice of medicine by failing to adequately supervise medical assistants, "health coaches," and phlebotomists such that an unlicensed individual injected PRP into Patient 3 on multiple occasions, and unlicensed "health coaches" prepared and dispensed HGC to Patient 3 for multiple days of treatment at once on multiple occasions. The circumstances are set forth in paragraphs 12 through 55, above, which are incorporated here by reference as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

60. Respondent is subject to disciplinary action under section 2266 in that she failed to adequately and accurately maintain medical records. The circumstances are set forth in paragraphs 12 through 55, above, which are incorporated here by reference as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Drug Violations)

61. Respondent is subject to disciplinary action under section 2238 of the Code, in that she has violated a federal regulation regulating dangerous drugs. The circumstances are as follows:

62. On or about February 21, 2016, Respondent ordered diazepam for "office use" via prescription from Morro Bay Drug. Throughout 2014, Respondent obtained controlled substances, including diazepam and hydrocodone with acetaminophen for "office use." Several of these prescriptions included Respondent's own name as the patient. Several employees of Respondent's practice told Board investigators that Respondent would order controlled substances for patients in her practice under her own name. Many reported that nurses would furnish medications to patients, recording the administration in the patient's record, but not maintaining a log of the inventory for the drugs dispensed. During her interview with Board

investigators, Respondent stated that she kept track of the drugs administered to patients in her office with a log, but claimed that the log had been lost during the move from her Morro Bay practice to the San Luis Obispo office.

63. Respondent's failure to follow state and federal drug laws and regulations by obtaining prescriptions for office use from pharmacies, prescribing controlled substances to herself, and failing to maintain a log of the dispensing of inventory of medication from the office constitutes unprofessional conduct and subjects her license to discipline.

SIXTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

64. Respondent is subject to disciplinary action under section 2234 in that she engaged in conduct that breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 12 through 55, and 62 through 63 above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

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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 A 61606, issued to Laleh Shaban, M.D.;

2. Revoking, suspending or denying approval of Laleh Shaban, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Laleh Shaban, 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: August 2, 2019

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

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