

1 MATTHEW RODRIQUEZ  
Acting Attorney General of California  
2 JANE ZACK SIMON  
Supervising Deputy Attorney General  
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Deputy Attorney General  
4 State Bar No. 190263  
455 Golden Gate Avenue, Suite 11000  
5 San Francisco, CA 94102-7004  
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E-mail: Ana.Gonzalez@doj.ca.gov  
7 *Attorneys for Complainant*

8  
9 **BEFORE THE**  
**MEDICAL BOARD OF CALIFORNIA**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against,

Case No. 800-2020-072401

13 **JERRY DEAN CRUM, M.D.**  
14 **P.O. Box 46**  
15 **Hermiston, OR 97838**

**DEFAULT DECISION**  
**AND ORDER**

16 **Physician's and Surgeon's Certificate No. G**  
17 **87585**

[Gov. Code, §11520]

18 One.

19  
20 **FINDINGS OF FACT**

21 1. On March 3, 2021, Complainant William Prasifka, in his official capacity as the  
22 Executive Director of the Medical Board of California, Department of Consumer Affairs, filed  
23 Accusation No. 800-2020-072401 against Jerry Dean Crum, M.D. (Respondent) before the  
24 Medical Board of California.

25 2. On October 7, 2005, the Medical Board of California (Board) issued Physician's and  
26 Surgeon's Certificate No. G 87585 to Respondent. The Physician's and Surgeon's Certificate  
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1 expired on February 28, 2017, and has not been renewed. (Exhibit Package, Exhibit 1<sup>1</sup>, license  
2 certification.)

3 3. On March 3, 2021, Respondent was duly served with an Accusation, alleging causes  
4 for discipline against Respondent. (Exhibit Package, Exhibit 2, Accusation and proof of service.)

5 4. On March 3, 2021, an employee of the Medical Board of California sent by Certified  
6 Mail a copy of the Accusation No. 800-2020-07240s1, Statement to Respondent, Notice of  
7 Defense in blank, and Request for Discovery, to Respondent's address of record with the Board,  
8 which was and is, P.O. Box 46, Hermiston, OR 97838. The United States Post Office (USPS)  
9 tracking system noted the package was undelivered, and returned to the sender, on April 1, 2021.  
10 (Exhibit Package, Exhibit 2, Accusation, proof of service; Exhibit 3, USPS tracking printout;  
11 Exhibit 4, California Medical Board Address of Record.)

12 5. There was no response to the Accusation. On March 18, 2021, an employee of the  
13 Attorney General's Office sent a Courtesy Notice of Default, by certified mail, addressed to  
14 Respondent at the address of record above, as well as to an Oregon address associated with  
15 Respondent: 236 E. Newport Ave., Hermiston, OR 97838. The Courtesy Notice of Default  
16 advised Respondent of the service of the Accusation, and provided him with an opportunity to file  
17 a Notice of Defense and request relief from default. The USPS tracking system noted the package  
18 sent to Respondent's address of record was "available for pickup" but there is no record that the  
19 package was picked up. The USPS tracking system noted the package sent to the other address  
20 associated with Respondent was delivered on March 22, 2021. The return receipt post card has a  
21 signature and date of delivery of March 22, 2021. (Exhibit Package, Exhibit 5, Courtesy Notice  
22 of Default, proof of service; Exhibit 6, USPS tracking printout for address of record; Exhibit 7,  
23 USPS tracking printout and post card receipt for associated address.)

24 6. Service of the Accusation was effective as a matter of law under the provisions of  
25 Government Code section 11505, subdivision (c).

26 ///

27 \_\_\_\_\_  
28 <sup>1</sup> The evidence in support of this Default Decision and Order is submitted herewith as the  
"Exhibit Package."





1 XAVIER BECERRA  
Attorney General of California  
2 JANE ZACK SIMON  
Supervising Deputy Attorney General  
3 ANA GONZALEZ  
Deputy Attorney General  
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Telephone: (415) 510-3608  
6 Facsimile: (415) 703-5480  
E-mail: Ana.Gonzalez@doj.ca.gov  
7 Attorneys for Complainant

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9 **BEFORE THE**  
**MEDICAL BOARD OF CALIFORNIA**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 800-2020-072401

13 **Jerry Dean Crum, M.D.**  
14 **P.O. Box 46**  
**Hermiston, OR 97838-0046**

**A C C U S A T I O N**

15 **Physician's and Surgeon's Certificate**  
16 **No. G 87585,**

17 Respondent.

18  
19 **PARTIES**

20 1. William Prasifka (Complainant) brings this Accusation solely in his official capacity  
21 as the Executive Director of the Medical Board of California, Department of Consumer Affairs  
22 (Board).

23 2. On or about October 7, 2005, the Medical Board issued Physician's and Surgeon's  
24 Certificate Number G 87585 to Jerry Dean Crum, M.D. (Respondent). The Physician's and  
25 Surgeon's Certificate is delinquent, having expired on February 28, 2017, and has not been  
26 renewed.

27 ///

28 ///

1 **JURISDICTION**

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

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

9 5. Section 2305 of the Code provides, in part, that the revocation, suspension, or other  
10 discipline, restriction or limitation imposed by another state upon a license to practice medicine  
11 issued by that state, or the revocation, suspension, or restriction of the authority to practice  
12 medicine by any agency of the federal government, that would have been grounds for discipline  
13 in California under the Medical Practice Act, constitutes grounds for discipline for unprofessional  
14 conduct.

15 6. Section 141 of the Code states:

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

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

28 **CAUSE FOR DISCIPLINE**

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

7. On October 2, 2020, the Oregon Medical Board (Oregon Board), imposed discipline  
on Respondent's Oregon medical license. The stipulated order issued by the Oregon Board  
limited Respondent's orthopedics practice to an office-based, outpatient, non-operative practice

1 only. The discipline was based on conduct described in the June 16, 2020, Oregon Complaint and  
2 Notice of Proposed Disciplinary Action (Notice), which described violations of the Oregon  
3 Medical Practice Act. In summary, Respondent breached the standard of care for two patients,  
4 failed to timely comply with the Oregon Board's order for evaluation, and showed deficiencies  
5 when evaluated. More specifically, one patient was exposed to risk of harm when the Respondent  
6 failed to adequately assess the patient's range of motion preoperatively, failed to perform a  
7 functional evaluation, failed to assess comorbidities such as diabetes, failed to obtain  
8 postoperative x-rays, and failed to recognize the patient's high likelihood of severe hypertrophic  
9 synovitis and fraying of the labrum preoperatively. The second patient was also exposed to risk  
10 of harm when the Respondent failed to adequately assess range of motion preoperatively, failed to  
11 adequately perform and document pre-operative functional evaluations, failed to adequately  
12 address comorbidities such as diabetes, and failed to obtain postoperative x-rays to assess surgical  
13 results. Further, the Oregon Board ordered Respondent to complete an evaluation at the Center  
14 for Personalized Education for Physicians (CPEP) in Colorado within a specified time.  
15 Respondent failed to comply with the Oregon Board's ordered evaluation within the time  
16 specified; and when evaluated, Respondent was found to have conditions that could interfere with  
17 his performance of outpatient surgical procedures. Additionally, UC San Diego's Physician  
18 Assessment and Clinical Education (PACE) program evaluated Respondent and found he  
19 demonstrated average surgical skills with some significant deficiencies, specifically some below-  
20 average technical skills and medical knowledge that was not up to date. A copy of the Oregon  
21 Medical Board Notice and Stipulated Order is attached as Exhibit A.

22 8. Respondent's conduct and the action of the Oregon Medical Board, as set forth in  
23 paragraph 7, above, constitute cause for discipline pursuant to sections 2305 and/or 141 of the  
24 Code.

25 **PRAYER**

26 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
27 and that following the hearing, the Medical Board of California issue a decision:  
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1. Revoking or suspending Physician's and Surgeon's Certificate Number G 87585, issued to Jerry Dean Crum, M.D.;
2. Revoking, suspending or denying approval of Jerry Dean Crum, M.D.'s authority to supervise physician assistants and advanced practice nurses;
3. Ordering Jerry Dean Crum, 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: MAR 03 2021

  
\_\_\_\_\_  
WILLIAM PRASIFKA  
Executive Director  
Medical Board of California  
Department of Consumer Affairs  
State of California  
*Complainant*

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**Exhibit A**  
**Oregon Medical Board Notice and Stipulated Order**



# Oregon

Kate Brown, Governor

**Medical Board**  
1500 SW 1st Avenue, Suite 620  
Portland, OR 97201  
(971) 673-2700  
FAX (971) 673-2670  
[www.oregon.gov/omb](http://www.oregon.gov/omb)

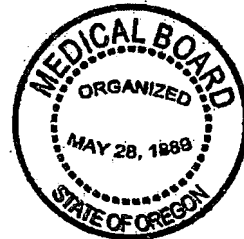
## Certification of True Copy

I certify that the enclosed documents are true and correct copies of the originals on file with the Oregon Medical Board.

  
\_\_\_\_\_  
Signature

11-17-20  
\_\_\_\_\_  
Date

Angela Allen  
Accounts Receivable



RECEIVED  
MEDICAL BOARD OF OR  
2020 NOV 20 PM 3:55  
DISCIPLINE UNIT





# Oregon

Kate Brown, Governor

**Medical Board**  
1500 SW 1st Avenue, Ste 620  
Portland, OR 97201-5847  
(971) 673-2700  
FAX (971) 673-2670  
[www.oregon.gov/OMB](http://www.oregon.gov/OMB)

November 17, 2020

Medical Board of California  
Attn: Sharee Woods  
2005 Evergreen ST. Suite 1200  
Sacramento, CA 95815-5401

Fax

REPORT NAME:                   **LICENSE VERIFICATION**  
REPORT SUBJECT:               **Jerry Dean Crum, MD**  
LICENSE #:                       **MD150347**

The Oregon Medical Board is responding to your inquiry regarding verification of licensure for the above-referenced Licensee. Enclosed is a License Verification Report for this Licensee.

There are public Board orders on file for this Licensee. Copies of the following Board Orders are also enclosed:

- Complaint and Notice; Dated 06/16/2020
- Stipulated Order; Dated 10/02/2020

If you have any questions regarding this License Verification Report, please contact the Board at (971) 673-2700, or toll free in Oregon at (877) 254-6263.

Sincerely,

Angela Allen  
Accounts Receivable Specialist

Enclosures

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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of )  
)  
JERRY DEAN CRUM, MD ) COMPLAINT & NOTICE OF PROPOSED  
LICENSE NO. MD150347 ) DISCIPLINARY ACTION  
)

1.

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

2.

The Board proposes to take disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), which may include the revocation of license, a \$10,000 civil penalty per violation, and assessment of costs, against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public or any condition that does or might adversely affect his ability to safely and skillfully practice medicine; ORS 677.190(13) gross or repeated acts of negligence; and ORS 677.190(17) willful violation of any Board rule, specifically OAR 847-001-0024(2) Compliance, or Board order.

3.

Licensee is a board-certified orthopedic surgeon practicing in Hermiston, Oregon.

Licensee's acts and conduct alleged to violate the Medical Practice Act are as follows:

3.1 Patient A, a 48-year-old male, first presented to Licensee with complaints of left shoulder pain on March 20, 2014. Patient A had a history of morbid obesity, insulin dependent diabetes mellitus, tobacco abuse, peripheral vascular disease, and coronary bypass surgery.

Licensee conducted a focused orthopedic consultation and work-up. Licensee initially had Patient

1 A try activity modification with physical therapy. Licensee noted 55 degrees of external rotation,  
2 good strength, and a lack of trauma. Licensee administered a steroid injection on April 30, 2014,  
3 with no chart note addressing the risks for blood sugar management of an insulin-dependent  
4 diabetic patient. On May 7, 2014, Licensee administered another steroid injection for carpal  
5 tunnel issues. On March 2, 2015, Patient A reported to Licensee that he had recurrent left  
6 shoulder pain after suffering a fall. A repeat MRI (magnetic resonance imaging) demonstrated no  
7 residual or recurrent labial tear. Licensee did not order an X-ray, but did order an MRI  
8 arthrogram, which showed a paucity of filling of the joint, which is most consistent with adhesive  
9 capsulitis of the shoulder. Licensee erroneously noted that the intra-articular contrast filling the  
10 subacromial-subdeltoid bursa implied a full-thickness rotator cuff tear. On April 23, 2015,  
11 Licensee took Patient A to surgery. Examination of the left shoulder showed severe hypertrophic  
12 synovitis and fraying of the labrum. The previous labial repair was seen to be intact and no  
13 obvious tear of the rotator cuff was visualized from inside the joint. Licensee identified a small  
14 rotator cuff tear and performed an open acromioplasty of the left shoulder with limited  
15 debridement of the synovium and labrum. Licensee did not order a post-operative X-ray.  
16 Licensee breached the standard of care in this case and exposed Patient A to the risk of harm by  
17 failing to adequately assess Patient A's range of motion preoperatively; failing to perform a  
18 functional evaluation; failing to assess Patient A's comorbidities, such as diabetes; failing to  
19 obtain postoperative x-rays; and failing to recognize Patient A's high likelihood of severe  
20 hypertrophic synovitis and fraying of the labrum preoperatively. Licensee's conduct violated ORS  
21 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any  
22 conduct or practice which does or might constitute a danger to the health or safety of a patient or  
23 the public; and breached the standard of care, in violation of ORS 677.190(13) gross or repeated  
24 acts of negligence.

25 3.2 The Board conducted a review of Licensee's care for Patients B – E, which  
26 revealed a pattern of practice that breached the standard of care in Licensee's documentation and  
27 delivery of orthopedic surgical care to include the following: failure to adequately assess range

1 of motion preoperatively; failure to adequately perform and document pre-operative functional  
2 evaluations; failure to adequately address comorbidities such as diabetes; and failure to obtain  
3 postoperative x-rays to assess surgical result. Each of these is considered a fundamental element  
4 of orthopedic practice and these failures represent breaches of the standard of practice that put  
5 patients in harm's way. Licensee's conduct violated ORS 677.190(1)(a) unprofessional or  
6 dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice which does or  
7 might constitute a danger to the health or safety of a patient or the public; and multiple breaches  
8 of the standard of care, in violation of ORS 677.190(13) gross or repeated acts of negligence.

9         3.3     On July 12, 2018, the Board ordered that Licensee successfully complete an  
10 evaluation at the Center for Personalized Education for Physicians in Colorado (CPEP) within 120  
11 days from the date the Order was signed by the Board Chair; and to enroll within 30 days from the  
12 date of the Order. Licensee failed to comply with this order within the time specified by the  
13 Board. Instead, Licensee underwent an evaluation at the UC San Diego PACE Program. The  
14 written evaluation report from PACE, dated August 7, 2018, concluded that Licensee  
15 demonstrated average surgical skills with some significant deficiencies, specifically some below-  
16 average technical skills and medical knowledge that was not up to date. Licensee subsequently  
17 enrolled for the CPEP evaluation on December 19, 2018, and completed the evaluation on  
18 February 28, 2019. The CPEP report found that Licensee performed well and demonstrated  
19 minimal educational needs; however, CPEP's review of Licensee's health information revealed  
20 conditions that could interfere with his performance of outpatient surgical procedures but would  
21 not impede office practice and office procedures such as joint injections. A health condition that  
22 could adversely affect Licensee's ability to safely and skillfully practice medicine constitutes  
23 unprofessional or dishonorable conduct in accordance with ORS 677.190(1)(a), as defined by  
24 ORS 677.188(4)(a) any condition that does or might adversely affect his ability to safely and  
25 skillfully practice medicine. Licensee's failure to comply with the Board's Order for Evaluation  
26 within the time specified violated ORS 677.190(17) willful violation of any Board rule,

27     ///

1 specifically OAR 847-001-0024(2) Compliance, or Board order, specifically the July 12, 2018,  
2 order for evaluation.

3 4.

4 Licensee is entitled to a hearing as provided by the Administrative Procedures Act  
5 (chapter 183), Oregon Revised Statutes. Licensee may be represented by counsel at the hearing.  
6 If Licensee desires a hearing, the Board must receive Licensee's written request for hearing  
7 within twenty-one (21) days of the mailing of this Notice to Licensee. Upon receipt of a request  
8 for a hearing, the Board will notify Licensee of the time and place of the hearing.

9 5.

10 5.1 If Licensee requests a hearing, Licensee will be given information on the  
11 procedures, right of representation, and other rights of parties relating to the conduct of the  
12 hearing as required under ORS 183.413(2) before commencement of the hearing.

13 5.2 If Licensee proceeds to a hearing, the Board proposes to assess against Licensee  
14 the Board's costs of this disciplinary process and action, including but not limited to all legal  
15 costs from the Oregon Department of Justice, all hearing costs from the Office of Administrative  
16 hearings, all costs associated with any expert or witness, all costs related to security and  
17 transcriptionist services for the hearing, and administrative costs specific to this proceeding in an  
18 amount not to exceed \$85,000.00, pursuant to ORS 677.205(2)(f).

19 6.

20 **NOTICE TO ACTIVE DUTY SERVICEMEMBERS:** Active Duty Servicemembers  
21 have a right to stay these proceedings under the federal Servicemembers Civil Relief Act. For  
22 more information contact the Oregon State Bar at 800-452-8260, the Oregon Military  
23 Department at 503-584-3571 or the nearest United States Armed Forces Legal Assistance Office  
24 through <http://legalassistance.law.af.mil>. The Oregon Military Department does not have a toll-  
25 free telephone number:

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7.

Failure by Licensee to timely request a hearing or failure to appear at any hearing scheduled by the Board will constitute waiver of the right to a contested case hearing and will result in a default order by the Board, including the revocation of his medical license and assessment of such penalty and costs as the Board deems appropriate under ORS 677.205. If a default order is issued, the record of proceeding to date, including Licensee's file with the Board and any information on the subject of the contested case automatically becomes a part of the contested case record for the purpose of proving a prima facie case per ORS 183.417(4).

DATED this 16 day of June, 2020.

OREGON MEDICAL BOARD  
State of Oregon

  
NICOLE KRISHNASWAMI, JD  
EXECUTIVE DIRECTOR



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BEFORE THE  
OREGON MEDICAL BOARD  
STATE OF OREGON

In the Matter of

JERRY DEAN CRUM, MD  
LICENSE NO. MD150347

}  
}  
}  
}  
} STIPULATED ORDER

1.

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

2.

On June 16, 2020, the Board issued a Complaint and Notice of Proposed Disciplinary Action (Notice) in which the Board proposed to take disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), which may include the revocation of license, a \$10,000 civil penalty per violation, and assessment of costs, against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public or any condition that does or might adversely affect his ability to safely and skillfully practice medicine; ORS 677.190(13) gross or repeated acts of negligence; and ORS 677.190(17) willful violation of any Board rule, specifically OAR 847-001-0024(2) Compliance, or Board order.

3.

Licensee and the Board desire to settle this matter by the entry of this Stipulated Order. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (Oregon Revised Statutes chapter 183), and fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. Licensee neither admits nor denies, but the Board finds that Licensee engaged

1 in conduct as described in the June 16, 2020, Notice, and that this conduct violated the Medical  
2 Practice Act, to wit ORS 677.190(1)(a), as defined in ORS 677.188(4)(a); ORS 677.190(13); and  
3 ORS 677.190(17), specifically OAR 847-001-0024(2). Licensee understands that this Order is a  
4 public record and is a disciplinary action that is reportable to the National Practitioner Data Bank  
5 and the Federation of State Medical Boards.

6 4.

7 Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order,  
8 subject to the following terms:

9 4.1 Licensee must limit his orthopedics practice to an office-based, outpatient, non-  
10 operative practice only.

11 4.2 Licensee must inform the Compliance Section of the Board of any and all practice  
12 sites, as well as any changes in practice address(es), employment, or practice status within 10  
13 business days. Additionally, Licensee must notify the Compliance Section of any changes in  
14 contact information within 10 business days.

15 4.3 Licensee must obey all federal and Oregon state laws and regulations pertaining  
16 to the practice of medicine.

17 4.4 Licensee stipulates and agrees that any violation of the terms of this Order shall  
18 be grounds for further disciplinary action under ORS 677.190(17).

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1           4.5    Licensee stipulates and agrees that this Order becomes effective the date it is  
2 signed by the Board Chair.

3                           IT IS SO STIPULATED this 7<sup>th</sup> day of July, 2020

4   
5 JERRY DEAN CRUM, MD

6  
7                           IT IS SO ORDERED this 2<sup>nd</sup> day of October, 2020.

8                           OREGON MEDICAL BOARD  
9                           State of Oregon

10   
11 KATHLEEN M. HARDER, MD  
12 Board Chair.

License Verification Details

Subject to **Terms and Conditions**. This site is a primary source for verification of license credentials consistent with Joint Commission and NCQA standards.

**Oregon Medical Board**  
 1500 SW 1st Ave  
 Suite 620  
 Portland, OR 97201  
 Phone: (971) 673-2700



Information current as of 11/17/2020 02:18:40 PM

Crum, Jerry Dean, MD

MD License: MD150347

**Originally Issued:** 12/28/2009      **Basis:** NBME  
**Current Status:** Active      **Expedited Endorsement:** No  
**Status Effective:** 1/1/2020  
**Expires:** 12/31/2021

Licensee Information

**Gender:** Male  
**Specialty :** Orthopedic Surgery  
*Specialty is self-reported by the licensee. It does not necessarily indicate specialty board certification.*  
**Supervising Physician Status :** Not Approved  
**Languages :** English, German

Practice Location(s)

Street	City, State Zip	County	Phone
236 E. Newport Ave.	Hermiston, OR 97838	Umatilla	541-289-7171.

Education

School Name	Location	Degree Date	Degree Earned
UNIFORMED SERVS UNIV OF HLTH SCIS	BETHESDA, MARYLAND USA	05/22/1982	MD

Post-Graduate Training

Training	School Name	Location	From	To	Specialty
Internship	Letterman Army Medical Center	San Francisco, CA United States	07/1982	06/1983	
Residency	Letterman Army Medical Center	San Francisco, CA United States	07/1986	05/1988	Orthopedic Surgery
Residency	University of Utah SOM	Salt Lake City, UT United States	07/1992	06/1995	Orthopedic Surgery

*The licensee may have completed additional education or training programs. Only those that have been verified with the primary source are shown.*

Board Orders

Please note that Corrective Action Orders, Corrective Action Agreements, and Consent Agreements are not disciplinary and are removed from this website upon completion. However, these are public documents available through a license verification request

Effective Date	End Date	Order Type
10/02/2020	Open	Stipulated Order

**Effective  
Date**

**End Date**

**Order Type**

On October 2, 2020, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; gross or repeated acts of negligence; and willful violation of any Board rule. This Order limits Licensee's orthopedic practice to an office-based, outpatient, non-operative practice only.

06/16/2020

10/02/2020

Complaint and Notice

On June 16, 2020, the Board issued a Complaint and Notice of Proposed Disciplinary Action alleging violations of the Medical Practice Act (state law) regarding unprofessional or dishonorable conduct; gross or repeated acts of negligence; and willful violation of any Board rule.

**Malpractice**

Malpractice claim information is compiled by the Oregon Medical Board from claim reports it receives from primary insurers; public bodies required to defend, save harmless and indemnify an officer, employee or agent of the public; a self-insured entity; or a health maintenance organization. Claim reporting and disclosure requirements are governed by ORS 742.400.

The settlement of a medical malpractice claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the provider. Therefore, there may be no disciplinary action appearing for a licensee, even though there is a closed malpractice claim on file. A payment in the settlement of a medical malpractice action does not create a presumption that medical malpractice occurred. This database represents information from reporters to date. Please note: Not all reporters may have submitted claim information to the Board.

For malpractice claim information, [click here](#).