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

In the Matter of the Accusation Against:	
David Leonard Belk, M.D.	**Case No. 800-2018-043450**
Physician's and Surgeon's Certificate No. A 66844	
Respondent.	

DECISION

The attached Stipulated Surrender of License and 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 September 30, 2021.

IT IS SO ORDERED July 29, 2021.

MEDICAL BOARD OF CALIFORNIA

William Prasifka
Executive Director

ROB BONTA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
LYNNE K. DOMBROWSKI
Deputy Attorney General
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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: **DAVID LEONARD BELK, M.D.** **2070 Clinton Avenue, 5th Floor** **Alameda, CA 94501** **Physician's and Surgeon's Certificate No. A 66844** Respondent.	Case No. 800-2018-043450 **STIPULATED SURRENDER OF LICENSE AND 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 Rob Bonta, Attorney General of the State of California, by Lynne K. Dombrowski, Deputy Attorney General.

2. DAVID LEONARD BELK, M.D. (Respondent) is represented in this proceeding by attorney Shannon V. Baker, whose address is: Rothschild Wishek + Sands LLP, 765 University Ave., Sacramento, CA 95825, E-mail: sbaker@rwslaw.com.

3. On October 30, 1998, the Board issued Physician's and Surgeon's Certificate No. A66844 to DAVID LEONARD BELK, 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. 800-2018-043450 and will expire on March 31, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2018-043450 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 March 24, 2021. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2018-043450 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2018-043450. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of his 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 him; the right to present evidence and to testify on his 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.

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

CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2018-043450, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent believes that he could present evidence disputing the factual basis for some of the charges in the Accusation. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges because he is in the process of closing his private practice and retiring from the practice of medicine.

10. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

11. The parties agree that the effective date for the Decision and for Respondent's surrender of license shall be no earlier than September 30, 2021.

CONTINGENCY

12. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his 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 Surrender 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.

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

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

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ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 66844, issued to Respondent DAVID LEONARD BELK, M.D., is surrendered and accepted by the Board.

1. Respondent shall lose all rights and privileges as a physician and surgeon in California as of the effective date of the Board's Decision and Order, which shall be September 30, 2021.

2. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

3. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent may file a petition for reinstatement after a period of at least two years has elapsed from the effective date of the Decision. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2018-043450 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

4. 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 agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2018-043450 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 licensure.

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ACCEPTANCE

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

DATED: 7/21/21

DAVID LEONARD BELK, M.D.
Respondent

I have read and fully discussed with Respondent DAVID LEONARD BELK, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 7/22/2021

SHANNON V. BAKER
Rothschild Wishek + Sands LLP
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: 07/23/2021

Respectfully submitted,

ROB BONTA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General

Lynne K. Dombrowski

LYNNE K. DOMBROWSKI
Deputy Attorney General
Attorneys for Complainant

SF2020401708

Exhibit A

Accusation No. 800-2018-043450

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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: **David Leonard Belk, M.D.** **2070 Clinton Avenue, 5th Floor** **Alameda, CA 94501** **Physician's and Surgeon's Certificate No. A 66844,** Respondent.	Case No. 800-2018-043450 **ACCUSATION**

PARTIES

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

2. On or about October 30, 1998, the Medical Board issued Physician's and Surgeon's Certificate Number A 66844 to David Leonard Belk, 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 March 31, 2022, unless renewed.

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3. At all times herein alleged, Respondent was board-certified in Internal Medicine. Since July 2003, Respondent has maintained a solo private practice specializing in general internal medicine for adults.

JURISDICTION

4. 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.

5. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
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> (1) Have his or her license revoked upon order of the board.
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> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

6. 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 that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The 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.

7. Section 2242 of the Code states, in pertinent part:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care. . . ."

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.

CALIFORNIA HEALTH AND SAFETY CODE

9. Section 11165.4 of the California Health and Safety Code, effective January 1, 2017, operative as of October 2, 2018, requires a health care practitioner to consult the CURES database to review a patient's controlled substance history before prescribing controlled substances (Schedule II – IV) to the patient for the first time, and at least once every four months thereafter, if the prescribing continues as treatment.

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10. Section 11190 of the California Health and Safety Code sets forth the required contents of a prescriber's record when issuing prescriptions for controlled substances, in pertinent part, as follows:

> (a) Every practitioner, other than a pharmacist, who prescribes or administers a controlled substance classified in Schedule II shall make a record that, as to the transaction, shows all of the following:
>
> (1) The name and address of the patient.
>
> (2) The date.
>
> (3) The character, including the name and strength, and quantity of controlled substances involved.
>
> (b) The prescriber's record shall show the pathology and purpose for which the controlled substance was administered or prescribed.

PERTINENT DRUGS/CONTROLLED SUBSTANCES

11. Carisoprodol, known by the trade name Soma, is a muscle-relaxant and sedative. It is a Schedule III controlled substance and narcotic as defined by section 11056, subdivision (e) of the Health and Safety Code, and a Schedule III controlled substance as defined by section 1308.13 (e) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. Since the effects of carisoprodol and alcohol or carisoprodol and other central nervous system depressants or psychotropic drugs may be addictive, appropriate caution should be exercised with patients who take more than one of these agents simultaneously.

12. Diazepam, known by the trade name Valium, is a psychotropic drug used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code and section 1308.14 of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Diazepam can produce psychological and physical dependence and it should be prescribed with caution particularly to addiction-prone individuals (such as drug addicts and alcoholics) because of the predisposition of such patients to habituation and dependence.

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13. Gabapentin, known by the trade name Neurontin, is an anticonvulsant that is used to prevent and control seizures and is also used to relieve nerve pain, peripheral neuropathy. It is a dangerous drug as defined in Business and Professions Code section 4022.

14. Hydrocodone bitartrate with acetaminophen, known by the trade names of Vicodin and Norco, combines hydrocodone bitartrate, a semisynthetic narcotic analgesic, with acetaminophen (Tylenol) which is a non-opiate, non-salicylate analgesic and antipyretic. It belongs to the class of medications called analgesics, opioid combos. It is used to treat symptoms of moderate to severe pain. It is a Schedule II controlled substance as defined by section 11055, subdivision (e) of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022.[1]

15. Hydromorphone hydrochloride, known by the trade name Dilaudid, is a hydrogenated ketone of morphine and is a narcotic analgesic used for relief of moderate to severe pain. It is a Schedule II controlled substance as defined by section 11055, subdivision (d) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (d) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. Patients receiving other narcotic analgesics, anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, tricyclic antidepressants and other central nervous system depressants, including alcohol, may exhibit an additive central nervous system depression. When such combined therapy is contemplated, the use of one or both agents should be reduced.

16. Methadone hydrochloride is a synthetic opioid analgesic with multiple actions quantitatively similar to those of morphine. Methadone may be administered as an injectable liquid or in the form of a tablet, disc, or oral solution. It is a Schedule II controlled substance as defined by section 11055, subdivision (c) of the Health and Safety Code, and by Section 1308.12 (c) of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Methadone can produce drug dependence of the morphine

[1] Effective 10/06/2014, all hydrocodone combination products were re-scheduled from Schedule III to Schedule II controlled substances by the Federal Drug Enforcement Agency ("DEA"), section 1308.12 (b)(1)(vi) of Title 21 of the Code of Federal Regulations.

type and, therefore, has the potential for being abused. Methadone should be used with caution and in reduced dosage in patients who are concurrently receiving other opioid analgesics.

17. Morphine sulfate, known by the trade name MSContin, is an opioid pain medication indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. Morphine is a Schedule II controlled substance as defined by section 11055, subdivision (b) of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022. Morphine is a highly addictive drug which may rapidly cause physical and psychological dependence and, as a result, creates the potential for being abused, misused, and diverted.

18. Oxycodone hydrochloride, known by the trade name OxyContin for its extended-release version, is a pure opioid agonist whose principal therapeutic action is analgesia. Other therapeutic effects of oxycodone include anxiolysis, euphoria, and feelings of relaxation. Oxycodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and by Section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Respiratory depression is the chief hazard from all opioid agonist preparations. OxyContin should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently receiving other central nervous system depressants, including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers, and alcohol.

19. Percocet 10/325 is a trade name for a combination of 10 mg. of acetaminophen (APAP or Tylenol) and 325 mg. of oxycodone hydrochloride. Percocet is a semisynthetic opioid analgesic combination drug with multiple actions qualitatively similar to those of morphine. It is a Schedule II controlled substance as defined by section 11055, subdivision (b)(1)(N), of the Health and Safety Code, and by Section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Acetaminophen is a non-opiate, non-salicylate analgesic and antipyretic that has been associated with cases of hepatoxicity.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient A[2]: Gross Negligence, Repeated Negligent Acts, Prescribing without Appropriate Examination and Medical Indication)

20. Respondent David Leonard Belk, M.D. is subject to disciplinary action for unprofessional conduct under Business and Professions Code sections 2234, subdivision (b) and/or subdivision (c), and/ or section 2242 in that Respondent's overall conduct, acts and/or omissions, with regard to Patient A constitutes gross negligence and/or repeated negligent acts and/or prescribing without an appropriate prior examination and medical indication, as more fully described herein below.

21. Patient A, a female who was born in 1959, has been Respondent's patient since at least December 2003.

22. On or about March 31, 2014, Respondent saw Patient A who reported seeing two pain specialists in the past month and that neither physician would take over her care for chronic pain management. Respondent noted the patient's vital signs were within normal limits. It was also documented that there was limited range of motion of most joints due to pain but no signs of acute inflammation. Respondent's diagnosis was chronic severe pain due to multiple etiologies with an unclear psychological component. Respondent noted encouraging the patient to follow-up with other pain specialists. Respondent also wrote in the progress note: "In spite of her severe chronic pain it's unlikely she's really benefited (sic) from her extreme narcotic regemine (sic)." It is noted that he was decreasing the Dilaudid prescribed from four times a day to three times a day, as recommended by one of the pain specialist physicians in a consultation report dated March 20, 2014.

23. Respondent's note of the March 31, 2014 visit does not contain any details of the patient's current medications or of the medications being prescribed/refilled by Respondent. According to his progress note from the prior month's visit on February 3, 2014, Respondent was

[2] To protect the patients' privacy rights, they will be identified by letters in this pleading. Respondent will be provided the patients' names through the discovery process.

prescribing monthly the following controlled substances to Patient A: #120 OxyContin 80 mg.; #240 oxycodone 30 mg.; #120 Dilaudid 8 mg.; and #360 methadone 10 mg.

24. In 2014, Patient A continued to see Respondent on a monthly basis with no change in her pain complaints and no significant change in her physical condition. Respondent continued to prescribe large quantities of controlled substances to Patient A.

25. On or about January 12, 2015, Respondent saw Patient A and noted a diagnosis of "DJD," degenerative joint disease. There were no changes in the patient's physical condition. The patient's vitals were within normal limits. Other than the vitals, no physical examination was documented, the progress note states "No changes in PE." Respondent's plan was to "Refill pain medications" without any specifics documented as to what was being prescribed.

26. In June, July, and August of 2015, Respondent noted a total of seven visits by Patient A for pain medication refills. During those visits, the patient's reported pain level varied between 4 – 6 out of 10. Respondent's assessment on June 4, 2015 was that the patient had "Chronic diffuse pain. Depression. Extreme dependence on narcotics."

27. For the July 2, 2015 visit, Respondent noted that he informed Patient A that the oxycodone and Norco would be tapered over several months to zero and that he would continue to prescribe OxyContin, Dilaudid, and methadone. Yet, at the patient's next visit on July 17, 2015, Respondent refilled the prescription for #150 Norco 10/325. He also refilled prescriptions at the visit on July 30, 2015. At the August 20, 2015 visit, Respondent noted issuing a prescription for #120 Norco 10/325, which was a reduction of one pill a day.

28. On August 26, 2015, Respondent saw Patient A and noted that she was unhappy with the tapering of medications and believed that he was "lying" to her. Respondent noted that he informed the patient of the "dangers of being on so many controlled substances." The progress note indicates vitals, including the patient's temperature of 100.2 and reported pain level of 5 out of 10. Respondent's assessment was "DJD and severe dependence on controlled substances." His subjective narrative stated that the patient was currently taking "large daily doses of five separate narcotics as well as valium and soma." His plan was to refill the prescriptions of

controlled substances while continuing to taper the oxycodone, with no details about the specific drugs and quantities that he prescribed.

29. According to the CURES database, in June through August 2015, Respondent prescribed the following controlled substances to Patient A: #420 Norco 325/10 mg.; #630 oxycodone 30 mg.; #360 OxyContin 80 mg.; #1,080 methadone 10 mg.; #270 Dilaudid 8 mg.; #450 Soma 350 mg.; and #120 Valium 10 mg.

30. From September through December 2015, Respondent saw Patient A on seven occasions with no change to her condition or pain complaints. Respondent's assessment was listed as "diffuse pain DJD" or "chronic pain," sometimes with a mention that the pain was due to lupus, without any detailed findings documented.

31. According to the CURES database, in September through December 2015, Respondent prescribed the following controlled substances to Patient A: #300 Norco 325/10 mg.; #420 oxycodone 30 mg.; #480 OxyContin 80 mg.; #1,440 methadone 10 mg.; #360 Dilaudid 8 mg.; #750 Soma 350 mg.; and #120 Valium 10 mg.

32. On or about January 15, 2016, Respondent saw Patient A who is noted to have a complaint of pain "everywhere," with her subjective pain level at 6 out of 10. Vitals were taken but there was no physical examination documented, simply a note that there was "no change in her condition." Respondent documented that he issued a refill prescription for #30 Norco for the last time. No other medications were mentioned in the note.

33. On or about January 21, 2016, Respondent saw Patient A who was there for her pain medication refills. Respondent noted that he was issuing the last refill for oxycodone, but he did not document any specific details as to what refills he prescribed. According to the CURES database, Respondent issued to Patient A and she filled the following prescriptions for controlled substances on January 21, 2016: #30 oxycodone 30 mg.; #120 OxyContin 80 mg.; #360 methadone 10 mg.; and #90 Dilaudid 8 mg.

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34. Throughout 2016, Respondent saw Patient A on monthly basis and refilled her pain medications. His diagnosis remained as chronic diffuse pain with DJD. There were no significant changes in the patient's condition.

35. According to the CURES database, from January through December 2016, Respondent prescribed and Patient A filled his prescriptions for the following controlled substances: #30 Norco 352/20 mg.; #30 oxycodone 30 mg.; #600 oxycodone 80 mg.; #960 OxyContin 80 mg.; #4,680 methadone 10 mg.; #1,170 Dilaudid 8 mg.; #2,100 Soma 350 mg.; and #480 Valium 10 mg.

36. On or about January 17, 2017, Respondent wrote a handwritten referral for Patient A to see a pain specialist due to severe chronic pain secondary to DJD.

37. On January 31, 2017, Respondent saw Patient A who complained about the cost of the OxyContin and asked to be switched to oxycodone. Respondent noted that the OxyContin would be discontinued and that, at the next "refill" he would issue a prescription for #270 oxycodone 30 mg. The progress note does not specify what current medications the patient was taking and what prescriptions were issued at that visit.

38. There is an inconsistency about the actual date of the patient's visit at the end of January 2017 because, according to the CURES database, Patient A filled the following controlled substances prescriptions from Respondent on January 30, 2017: #120 oxycodone 80 mg.; #360 methadone 10 mg.; and #90 Dilaudid 8 mg. The CURES report also shows that Patient A filled a prescription from Respondent for #150 Soma 350 mg. on January 16, 2017, which is not mentioned in Respondent's records for Patient A.

39. In Patient A's chart, Respondent has a report from a gastroenterologist that Patient A was seen by a gastroenterologist for rectal bleeding and constipation on or about February 27, 2017. It was noted in the report that the patient's constipation was a result of her narcotic use.

40. On or about March 1, 2017, Respondent saw Patient A who presented with one week of intermittent left-sided lower abdominal pain with rectal bleeding. Respondent documented that there was left lower quadrant tenderness without rebound. The plan was for the patient to

undergo a colonoscopy. Respondent did not document issuing any prescriptions at this visit and did not list the current medications that the patient was taking.

41. On March 1, 2017, according to the CURES database, Patient A filled the following prescriptions from Respondent: #270 oxycodone 30 mg.; #360 methadone 10 mg.; and #90 Dilaudid 8 mg.

42. Respondent's records for Patient A appear to contain two inaccurate progress notes in 2017. There are visit notes for both January 30, 2017 and March 31, 2017 in which Respondent noted that Patient A was there for a pain medication refill and that: "He [sic] continues to have severe shoulder pain unrelieved by OTC meds. Refilled Norco 10/325 mg #90." These two notes appear to pertain to a different patient because Patient A is a female and there is no record in the CURES database that Respondent prescribed Norco 10/325 to Patient A after January 15, 2016.

43. From April 2017 through at least July 2018, Respondent saw Patient A on a monthly basis and entered the same general note that the patient had "severe pain in multiple joints." Respondent did not document any physical examination or the patient's vitals. Respondent documented in each progress note that he prescribed the following controlled substances: #270 oxycodone 30 mg., #360 methadone 10 mg., #90 Dilaudid 8 mg.

44. There is no documentation in Respondent's medical records for Patient A that he issued regular monthly prescriptions for Soma and for Valium from June 2015 through at least July 2019.

45. In 2017, according to the CURES database, Patient A filled prescriptions from Respondent for a total of #1950 Soma 350 mg. and #240 Valium 10 mg. In 2017, Respondent also prescribed to Patient A: #120 oxycodone 80 mg.; #2970 oxycodone 30 mg.; #4320 methadone 10 mg.; and #1080 Dilaudid 8 mg.

46. In 2018, Respondent continued to see Patient A on approximately a monthly basis and refilled her pain medications. There were no significant changes in the patient's condition. His progress notes continued to provide scant information.

47. On or about August 17, 2018, Respondent saw Patient A, who continued to have "severe pain in multiple joints." Respondent noted that he reviewed the CURES database and

that he would start tapering the monthly oxycodone prescription by ten less tablets each month. He noted that he issued prescriptions for #260 oxycodone 30 mg., #360 methadone 10 mg., and #90 Dilaudid 8 mg.

48. From September through December 2018, Respondent continued to see Patient A monthly and continued to prescribe #360 methadone 10 mg. and #90 hydromorphone 8 mg. Respondent continued to reduce the quantity prescribed of oxycodone so that by the December 7, 2018 visit, he prescribed #200 tablets of oxycodone 30 mg. to Patient A. Respondent also documented reviewing the CURES database at each monthly visit, except for the November 9, 2018 visit.

49. In 2018, according to the CURES database, Patient A filled prescriptions from Respondent for a total of: #3320 oxycodone 30 mg.; #4680 methadone 10 mg.; #1170 Dilaudid 8 mg.; #2220 Soma 350 mg.; and #300 Valium 10 mg.

50. In 2019, Respondent continued to see Patient A whose condition did not change, described as "severe pain in multiple joints. Respondent documented that he reviewed the CURES database at each visit. Respondent prescribed to Patient A on a monthly basis the following controlled substances: #180 oxycodone 30 mg. and #90 hydromorphone 8 mg. Respondent reduced the monthly prescription for methadone 10 mg. by 30 tablets each month, so that he prescribed #360 methadone 10 mg. in January 2019 and got to #60 methadone 10 mg. by October 2019, which quantity he continued to prescribe to Patient A in November 2019 but did not refill after that visit.

51. On or about January 3, 2020, Respondent saw Patient A and noted that he prescribed #120 morphine ER 60 mg. and #60 Dilaudid 8 mg. There is no physical exam or vitals listed, except for the patient's subjective pain level of 9 out of 10.

52. On or about January 31, 2020, Respondent saw Patient A. His progress note states: "Patient continues to suffer from severe pain in multiple joints. Continue to taper. Checked CURES. Filled Morphine ER 100 mg. #60." There is no physical exam or vitals listed, except for the patient's subjective pain level of 9 out of 10. This is the last progress note for Patient A that Respondent produced to the Board during its investigation.

53. In January 2020, according to the CURES database, Patient A filled a prescription from Respondent for #150 Soma 350 mg. that is not documented in Respondent's medical records for Patient A.

54. During the course of his treatment of Patient A with controlled substances for chronic pain, Respondent never entered into an agreement with the patient about the prescribing, and never documented advising the patient of the risks of chronic prescribing of opioids in combination and of alternatives to the treatment, i.e. informed consent.

55. In summary, Respondent's overall conduct, through his acts and omissions, regarding Patient A, as set forth in paragraphs 20 through 54 herein, constitutes unprofessional conduct under section 2234 subdivision (b) [gross negligence] and/or subdivision (c) [repeated negligent acts] and/or section 2242 [furnishing dangerous drugs without appropriate examination and medical indication] and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient A as follows:

a. Respondent failed to adequately assess Patient A's risk of drug addiction and aberrancy before or during his treatment using long-term prescribing of opioids.

b. Respondent never discussed and never entered into a pain management agreement with the patient to establish the expectations and responsibilities of both Respondent and the patient regarding long-term therapy using controlled substances (opioids).

c. Respondent failed to adequately document a treatment plan and failed to conduct proper periodic review to assess the effectiveness of the treatment. Functional goals and adverse events were not clearly delineated. Prior to 2018, Respondent failed to provide appropriate continuation, titration and monitoring of his chronic opiate pain management.

d. Respondent failed to adequately monitor the patient's compliance with the prescribed treatment and never conducted random urine drug screens or other similar monitoring.

e. Respondent failed to obtain informed consent by informing the patient of the benefits, risks, and alternatives to the long-term opiate therapy and the chronic treatment using combinations of controlled substances. Respondent failed to inform the patient that her treatment

regimen, of extremely high levels of morphine equivalent doses, put her in an extremely high risk group for adverse events such as overdose.

f. Respondent concurrently prescribed opioids and benzodiazepines to Patient A without documenting a medical indication for the prescribing and without advising the patient of the risks of accidental drug overdose and of alternatives to the treatment.

g. Respondent failed to maintain adequate and accurate medical records for his treatment of Patient A. There were abnormal findings that were not consistently addressed and diagnoses that were not consistently charted. Appropriate physical examinations and findings were not documented. Most progress notes lacked details about relevant care, did not have reconciled medications listed, and failed to document all prescriptions that were issued.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient B: Gross Negligence, Repeated Negligent Acts, Prescribing without Appropriate Examination and Medical Indication)

56. Respondent David Leonard Belk, M.D. is subject to disciplinary action for unprofessional conduct under Business and Professions Code sections 2234, subdivision (b) and/or subdivision (c), and/ or section 2242 in that Respondent's overall conduct, acts and/or omissions, with regard to Patient B constitutes gross negligence and/or repeated negligent acts and/or prescribing without an appropriate prior examination and medical indication, as more fully described herein below.

57. On or about May 18, 2012, Respondent first saw Patient B, a male who was born in 1952. Respondent's handwritten note of the initial visit is not completely legible. It does not appear that a full history and physical examination was performed and documented. It is unclear what treatment was provided by Respondent.

58. Respondent saw the patient occasionally between May 18, 2012 and April 2019. His progress notes are scant, mostly handwritten and illegible.

59. On or about April 29, 2016, Respondent saw Patient B for pain medication "refills" for chronic severe back pain. It was noted that Patient B was a full-time caregiver for his father-in-law. Respondent prescribed #180 Percocet 10/325 mg. Other than a note that the patient's

subjective pain level was 5 out of 10, there were no subjective or objective findings and no physical examination was documented. There is an inconsistency in the progress note because Respondent electronically signed it on April 28, 2016 yet the note for the visit is dated April 29, 2016. So, it is unclear if Respondent actually saw the patient before prescribing a refill prescription for Percocet.

60. Between April 29, 2016 and December 9, 2016, Respondent saw Patient B on a monthly basis to refill the prescription for #180 Percocet 10/325 mg. The patient's subjective pain level remained unchanged at 4 out of 10. There were no subjective or objective findings and no physical examination was documented by Respondent in the progress notes.

61. On or about September 1, 2016, Respondent saw Patient B for a visit that was not for a pain medication refill but was for a follow-up regarding "diabetes, hyperlipidemia and hypertension." A physical examination is documented with no mention of the patient's back pain. The patient's subjective pain level is noted to be 3 out of 10. Respondent noted that the patient's conditions were controlled with medications and that the current medications would be continued, without specifically documenting the medications that were prescribed to the patient.

62. In 2017, Respondent continued to see Patient B on a monthly basis for medication refills. Respondent's progress notes all state: "Here for chronic back pain medication refill. Refilled Percocet 10/325 mg. #180." The only other note is the subjective pain level, which varied between 4 and 6 out of 10. There was no documentation of vitals, a physical examination, or other objective or subjective findings about the patient's condition, function, or other pain assessment.

63. On or about March 14, 2017, Respondent saw Patient B for a non-medication refill visit. It was a follow-up visit for conditions of diabetes, hyperlipidemia and hypertension. Respondent documented a physical exam and noted that the patient had been hospitalized for acute kidney injury from obstruction but was doing well. There was no mention of the patient's chronic back pain. No specific medications were listed. Respondent only noted that the same medication regimen was to be continued.

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64. From January 2018 through July 20, 2018, Respondent saw Patient B on a monthly basis with the same note that the visit was for "chronic back pain medication refill." There was no documentation of an examination or findings, except for a subjective pain level that varied between 6 and 7 out of 10. Respondent prescribed #180 Percocet 10/325 at each visit.

65. At the February, March, and April 2018 visits, Respondent noted that the prescriptions were to be dated for the following day, without documenting a reason for the post-dating.

66. On or about August 17, 2018, Respondent saw Patient B for a monthly visit for "chronic back pain medication refill" and noted that he had "checked CURES." Respondent noted that the plan was to begin tapering the Percocet by ten pills a month. Respondent issued a prescription for #170 Percocet 10/325 mg.

67. From September 2018 through December 2018, Respondent continued to see Patient B on a monthly basis and noted in each progress note that he checked the CURES database. No physical examination or findings were documented. Respondent continued to reduce the quantity of Percocet prescribed by ten tablets each month, except for the visits in November and December 2018 when Respondent prescribed the same quantity of #130 Percocet 10/325 mg.

68. From January 4, 2019 through November 5, 2019, Respondent continued to see Patient B on a monthly basis, except there is no progress note for a visit in September. Respondent's progress notes all state the same thing: "Patient continues to have chronic back. (sic) Checked CURES." Respondent continued to reduce the quantity of Percocet prescribed by ten tablets each month, so that the prescription issued at the November 5, 2019 visit was for #10 Percocet 10/325 mg.

69. The November 5, 2019 progress note is the most recent medical record for Patient B that Respondent produced to the Medical Board during its investigation.

70. According to the CURES database, Patient B has not received a controlled substance prescription from Respondent after November 2019.

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71. In summary, Respondent's overall conduct, through his acts and omissions, regarding Patient B, as set forth in paragraphs 56 through 70 herein, constitutes unprofessional conduct under section 2234 subdivision (b) [gross negligence] and/or subdivision (c) [repeated negligent acts] and/or section 2242 [furnishing dangerous drugs without appropriate examination and medical indication] and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient B as follows:

a. Respondent failed to adequately assess Patient B's risk of drug addiction and aberrancy before or during his treatment using long-term prescribing of opioids.

b. Respondent never discussed and never entered into a pain management agreement with the patient to establish the expectations and responsibilities of both Respondent and the patient regarding long-term therapy using controlled substances (opioids).

c. Respondent failed to adequately document a treatment plan and failed to conduct proper periodic review to assess the effectiveness of the treatment. Functional goals and adverse events were not clearly delineated. During his treatment of Patient B, at least prior to August 2018, Respondent failed to provide appropriate continuation, titration and monitoring of his chronic opiate pain management.

d. Respondent failed to adequately monitor the patient's compliance with the prescribed treatment and never conducted random urine drug screens or other similar monitoring.

e. Respondent failed to obtain informed consent by informing the patient of the benefits, risks, and alternatives to the long-term opiate therapy. Respondent failed to inform the patient that his treatment regimen, of high levels of morphine equivalent doses, put him in an extremely high risk group for adverse events such as overdose.

f. Respondent failed to maintain adequate and accurate medical records for his treatment of Patient B. There were diagnoses that were not consistently addressed. Most progress notes lacked details about relevant care and did not document appropriate physical examinations and findings to support a medical indication for the treatment. Many progress notes appeared to have been copied and pasted, without any additional current information.

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THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient C: Gross Negligence, Repeated Negligent Acts, Prescribing without Appropriate Examination and Medical Indication)

72. Respondent David Leonard Belk, M.D. is subject to disciplinary action for unprofessional conduct under Business and Professions Code sections 2234, subdivision (b) and/or subdivision (c), and/ or section 2242 in that Respondent's overall conduct, acts and/or omissions, with regard to Patient C constitutes gross negligence and/or repeated negligent acts and/or prescribing without an appropriate prior examination and medical indication, as more fully described herein below.

73. On or about March 12, 2015, Respondent saw Patient C, a male who was born in 1950, for a "refill" of his pain medications. It appears that it had been about two years since Respondent had seen the patient. It was noted that the patient "continues to have ankle and knee pain status post fall." No vitals, physical examination, or findings were documented. Respondent issued a prescription for #240 oxycodone 30 mg.

74. From that March 2015 visit through December 18, 2015, Respondent continued to see Patient C on approximately a monthly basis and prescribed #240 oxycodone 30 mg. at each visit. Respondent's progress notes for those nine visits contain the same general progress note without details as the March 12, 2015 progress note.

75. From January to December 22, 2016, Respondent continued to see Patient C on approximately a monthly basis and prescribed each month #240 oxycodone 30 mg. Respondent's progress notes for these "medication refill" visits contain the same general description that the patient continued to have "ankle and knee pain" without any documented examination or detailed findings.

76. On or about February 8, 2016, Patient C saw Respondent with a complaint of severe leg cramps at night. Respondent noted in the progress note that the patient said that the gabapentin helps but that he needed an increased dose. Respondent's plan was to increase gabapentin "to maximum of 600 mg. TID PRN." Prior to this progress note and after this date,

Respondent did not document in his monthly progress notes that Patient C was being prescribed gabapentin in addition to the oxycodone.

77. Between May 10, 2016 and October 27, 2016, Respondent also noted that the patient was having "hernia pain," but did not document any additional details or findings.

78. On or about December 22, 2016, Respondent saw Patient C and wrote the same general progress note that the patient had "chronic ankle and knee pain" without documenting an examination or other findings, except for noting a subjective pain level of 4 out of 10. However, Respondent prescribed #200 oxycodone 30 mg, which was a reduction from the prior #240 tablets monthly, without any documentation of his rationale or plan.

79. On or about January 12, 2017, Respondent saw Patient C for a "medication refill" visit and his progress note repeats the same general statement that the patient "continues to have chronic ankle and knee pain." Respondent noted that the patient lost his prescription coverage and so would be paying cash. Respondent issued a prescription for #160 oxycodone 30 mg. There is no other documentation of Respondent's treatment plan.

80. At the monthly visit on or about February 1, 2017, Respondent saw Patient C and his progress note is the same general statement as in prior months, that the patient continued to have chronic ankle and knee pain. There is no documentation of vitals, physical examination or other findings or assessments, particularly regarding the patient's condition as a result of the prior month's decreased dosage of oxycodone. Respondent increased the dosage prescribed to #240 oxycodone 30 mg.

81. On or about March 2, 2017, Respondent saw Patient C for a medication refill and made the same general note that the patient continued to have chronic ankle and knee pain. Another prescription for #240 oxycodone 30 mg. was issued by Respondent.

82. On or about March 27, 2017, Respondent saw Patient C for a follow-up visit regarding his hypertension. Respondent documented that the patient said that "he accidentally lost several of his oxycodone pills" and that he "[u]nderstands that he has a problem with drug. Starting to consider treatment program." Respondent's assessment was hypertension and

narcotics addiction. Respondent's documented plan was: "Recommend treatment. Need to check labs. Won't refill oxycodone until at least Friday."

83. From April through December 2017, Respondent continued to see Patient C on a monthly basis and continued to prescribe #240 oxycodone 30 mg. monthly. There is no mention in Respondent's progress notes regarding the status and treatment of Patient C's narcotics addiction or of any random lab testing for drug screening. Most of Respondent's progress notes merely stated that the patient continued "to have chronic pain in several areas" and included a subjective pain level of 4 or 5 out of 10, without any further details.

84. In July 2017, Respondent noted that Patient C had a 3 cm mass removed from his bladder. There are no further details documented.

85. From January through June 22, 2018, Respondent saw Patient C on about a monthly basis and issued prescriptions for #240 oxycodone 30 mg. Respondent's progress note for each of the visits is that the patient continued to have "chronic pain in several areas" with a subjective pain level of 5 out of 10, without any further details.

86. On or about June 28, 2018, Respondent saw Patient C for a follow-up visit after the patient had visited the ER after one week of nausea. The assessment was gastroenteritis and the plan was to take Reglan, as needed.

87. At the next monthly medication refill with Patient C on or about July 20, 2018, Respondent noted that the patient continued to have "chronic pain in several areas" with a subjective pain level of 4 out of 10. It was also noted that oxycodone was being tapered by ten pills a month, without any additional details or findings. Respondent issued a prescription for #230 oxycodone 30 mg.

88. Respondent has no progress note for a monthly visit with Patient C in August 2018. However, according to the CURES database, on August 17, 2018, Patient C filled Respondent's prescription for #220 oxycodone 30 mg.

89. Starting on or about October 12, 2018 through December 2018, Respondent's monthly progress notes for Patient C described his diagnosis as "chronic pain DJD" and included a note that CURES was checked.

90. From August to November 9, 2018, Respondent continued to reduce the monthly oxycodone prescription to Patient C by ten pills a month. However, Respondent issued prescriptions to Patient C for the same quantity, #190 oxycodone 30 mg., on both November 9, 2018 and December 5, 2018. Respondent's progress notes did not document any detailed findings or assessments about the patient's condition.

91. On or about January 2, 2019 and January 31, 2019, Respondent saw Patient C and issued refill prescriptions for #180 oxycodone 30 mg. Both of Respondent's progress notes state: "Patient continues to have chronic pain DJD, Checked CURES." Except for a subjective pain level of 3 out of 10, there is no documentation of findings or a physical examination or any assessment of a treatment plan.

92. In his progress notes of the monthly visits with Patient C on March 29, 2019 and on April 26, 2019, Respondent merely noted that the patient continued to have "chronic pain DJD," reported a pain level of 3 out of 10, and that he checked CURES. He issued monthly prescriptions for #160 oxycodone 30 mg.

93. On or about May 15, 2019, Respondent saw Patient C and documented a physical examination. He noted that the plan was to switch from oxycodone to morphine ER with low dose oxycodone "on the next refill" without any details about the planned dosages, or the patient's current medications.

94. On or about May 17, 2019, Respondent saw Patient C and changed the prescription regimen to: #90 oxycodone 10 mg. plus #90 morphine ER 60 mg. The progress note merely states the patient continued to have "chronic pain DJD," reported a subjective pain level of 3 out of 10, and noted that CURES was checked.

95. During monthly visits between June 14, 2019 through November 1, 2019, Respondent saw Patient C and continued to note that the patient "suffers from chronic pain DJD," with a reported pain level of 3 out of 10, and that CURES was checked, without any additional information. While consistently prescribing to Patient C the same monthly quantity of #90 morphine ER 60 mg., Respondent continued to reduce by ten tablets each month the quantity of

oxycodone 10 mg. prescribed, except for both October and November 2019 when he prescribed the same amount of #40 oxycodone 10 mg.

96. On or about November 1, 2019, Respondent saw Patient C and noted that the patient requested that the oxycodone refill issued that day be the last prescription for oxycodone. Respondent prescribed #30 oxycodone 10 mg. and #90 morphine ER 60 mg.

97. On or about December 13, 2019, Respondent saw Patient C and noted the purpose of the visit was to follow-up on the patient's hypertension and "chronic pain from multiple injuries." Respondent documented that the patient was fully aware that he had become addicted to opioids and that he was willing to get off them completely. Respondent's assessment was controlled hypertension and opioid dependence. Respondent noted that the patient's opioid use had decreased in the past 18 months from a morphine equivalent dose (MED) of 360 mg. daily to 195 mg. daily but that tapering was difficult because of persistent pain issues. Respondent noted that the patient did not want more opiate prescriptions and was concerned about being investigated by the California Department of Consumer Affairs. This is the most recent progress note for Patient C that Respondent produced to the Board during its investigation.

98. In summary, Respondent's overall conduct, through his acts and omissions, regarding Patient C, as set forth in paragraphs 72 through 97 herein, constitutes unprofessional conduct under section 2234 subdivision (b) [gross negligence] and/or subdivision (c) [repeated negligent acts] and/or section 2242 [furnishing dangerous drugs without appropriate examination and medical indication] and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient C as follows:

a. Respondent failed to adequately assess Patient C's risk of drug addiction and aberrancy before or during his treatment using long-term prescribing of opioids. Respondent did not seek to obtain records of the patient's previous treatment modalities prior to assuming the prescribing of opioids to Patient C.

b. Respondent never discussed and never entered into a pain management agreement with the patient to establish the expectations and responsibilities of both Respondent and the patient regarding long-term therapy using controlled substances (opioids).

c. Respondent failed to adequately document a treatment plan and failed to conduct proper periodic review to assess the effectiveness of the treatment. Functional goals and adverse events were not clearly delineated. During his treatment of Patient C, at least prior to July 2018, Respondent failed to provide appropriate continuation, titration and monitoring of his chronic opiate pain management.

d. Respondent failed to adequately monitor the patient's compliance with the prescribed treatment and never conducted random urine drug screens or other similar monitoring.

e. Respondent failed to obtain informed consent by informing the patient of the benefits, risks, and alternatives to the long-term opiate therapy. Respondent failed to inform the patient that his treatment regimen, of high levels of morphine equivalent doses, put him in an extremely high risk group for adverse events such as overdose.

f. Once he documented that Patient C was addicted to opiates, Respondent failed to consult with and/or refer the patient to a specialist in either addiction medicine or pain management.

g. Respondent failed to maintain adequate and accurate medical records for his treatment of Patient C. There were diagnoses that were not consistently addressed. Most progress notes lacked details about relevant care and did not document appropriate physical examinations and findings to support a medical indication for the treatment. Many progress notes appeared to have been copied and pasted, without any additional current information. Some progress notes did not list the medications prescribed.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Patients A, B, C: Failure to Maintain Adequate and Accurate Medical Records)

99. Respondent David Leonard Belk, M.D. is subject to disciplinary action, jointly and severally, for unprofessional conduct under Business and Professions Code section 2266 for his failure to maintain adequate and accurate medical records regarding his treatment of Patient A and/or Patient B and/or Patient C.

100. Paragraphs 20 through 98 are incorporated herein by reference, as if fully set forth.

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 66844, issued to David Leonard Belk, M.D.;

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

3. Ordering David Leonard Belk, 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 24 2021

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

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