

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

**In the Matter of the Accusation  
Against:**

**Mark Daniel Cook, M.D.**

**Physician's and Surgeon's  
Certificate No. A 60965**

**Case Nos.: 800-2017- 039585,  
800-2020-072482, 800-2021-  
083681**

**Respondent.**

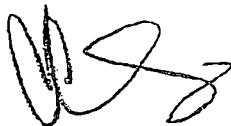
**DECISION**

**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 for the Case Numbers identified above.**

**This Decision shall become effective at 5:00 p.m. on April 24, 2024.**

**IT IS SO ORDERED: March 25, 2024.**

**MEDICAL BOARD OF CALIFORNIA**



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**Laurie Rose Lubiano, J.D., Chair  
Panel A**

1 ROB BONTA  
Attorney General of California  
2 STEVE DIEHL  
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9 **BEFORE THE**  
10 **MEDICAL BOARD OF CALIFORNIA**  
11 **DEPARTMENT OF CONSUMER AFFAIRS**  
12 **STATE OF CALIFORNIA**

13 In the Matter of the Accusation Against:

14 **MARK DANIEL COOK, M.D.**  
15 **1425 West H St. Ste. 200**  
**Oakdale, CA 95361**

16 **Physician's and Surgeon's Certificate**  
17 **No. A 60965**

18 Respondent.

Case No. 800-2017-039585  
OAH No. 2021010154

Case No. 800-2020-072482  
OAH No. 2023030746

Case No. 800-2021-083681  
OAH No. 2023080549

19  
20 **STIPULATED SETTLEMENT AND**  
21 **DISCIPLINARY ORDER**

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

24 **PARTIES**

25 1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of  
26 California (Board). He brought these actions solely in his official capacity and is represented in  
27 this matter by Rob Bonta, Attorney General of the State of California, by Michael C. Brummel,  
28 Supervising Deputy Attorney General.

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2. Respondent Mark Daniel Cook, M.D. (Respondent) is represented in this proceeding by attorney Robert F. Hahn, whose address is 2550 Ninth Street, Suite 101, Berkeley, CA 94710-2551.

3. On or about October 2, 1996, the Board issued Physician's and Surgeon's Certificate No. A 60965 to Mark Daniel Cook, 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. 800-2017-039585, and will expire on August 31, 2024, unless renewed.

### **JURISDICTION**

4. Accusation No. 800-2017-039585 was filed before the Board. The Accusation and all other statutorily required documents were properly served on Respondent on October 8, 2020. Respondent timely filed his Notice of Defense contesting the Accusation. First Amended Accusation No. 800-2017-039585 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on December 9, 2022, and was deemed controverted pursuant to Government Code Section 11507 in light of the fact that Respondent timely filed his Notice of Defense contesting the original Accusation No. 800-2017-039585. A copy of First Amended Accusation No. 800-2017-039585 is attached as Exhibit A and incorporated herein by reference.

5. Accusation No. 800-2020-072482 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 17, 2023. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2020-072482 is attached as Exhibit B and incorporated herein by reference.

6. Accusation No. 800-2021-083681 was filed before the Board. The Accusation and all other statutorily required documents were properly served on Respondent on July 13, 2023. Respondent timely filed his Notice of Defense contesting the Accusation. First Amended Accusation No. 800-2021-083681 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on November 30, 2023, and was deemed controverted pursuant to

1 Government Code Section 11507 in light of the fact that Respondent timely filed his Notice of  
2 Defense contesting the original Accusation No. 800-2021-083681. A copy of First Amended  
3 Accusation No. 800-2021-083681 is attached as Exhibit C and incorporated herein by reference.

#### 4 **ADVISEMENT AND WAIVERS**

5 7. Respondent has carefully read, fully discussed with counsel, and understands the  
6 charges and allegations in First Amended Accusation No. 800-2017-039585, Accusation No. 800-  
7 2020-072482, and First Amended Accusation No. 800-2021-083681. Respondent has also  
8 carefully read, fully discussed with his counsel, and understands the effects of this Stipulated  
9 Settlement and Disciplinary Order.

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

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

#### 18 **CULPABILITY**

19 10. Respondent understands and agrees that the charges and allegations in First Amended  
20 Accusation No. 800-2017-039585, Accusation No. 800-2020-072482, and First Amended  
21 Accusation No. 800-2021-083681, except those contained in the First Amended Accusation in  
22 Case No. 800-2017-039585, paragraph 24, subsections n through w, if proven at a hearing,  
23 constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

24 11. Respondent agrees that, at a hearing, Complainant could establish a prima facie case  
25 or factual basis for the charges in First Amended Accusation No. 800-2017-039585, Accusation  
26 No. 800-2020-072482, and First Amended Accusation No. 800-2021-083681, except those  
27 contained in the First Amended Accusation in Case No. 800-2017-039585, paragraph 24,  
28 subsections n through w, and that Respondent hereby gives up his right to contest those charges.

12. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in First Amended Accusation No. 800-2017-039585, Accusation No. 800-2020-072482, and First Amended Accusation No. 800-2021-083681, except those contained in the First Amended Accusation in Case No. 800-2017-039585, paragraph 24, subsections n through w, a true and correct copy of each is attached hereto as Exhibit A, Exhibit B, and Exhibit C, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 60965 to disciplinary action.

13. ACKNOWLEDGMENT. Respondent acknowledges the Disciplinary Order below, requiring the disclosure of probation pursuant to Business and Professions Code section 2228.1, serves to protect the public interest.

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

## CONTINGENCY

15. 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 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 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.

16. This Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in First Amended Accusation No. 800-2017-039585, Accusation No. 800-2020-072482, and First Amended Accusation No. 800-2021-

1 083681, except those contained in the First Amended Accusation in Case No. 800-2017-039585,  
2 paragraph 24, subsections n through w, shall be deemed true, correct and fully admitted by  
3 respondent for purposes of any such proceeding or any other licensing proceeding involving  
4 Respondent in the State of California.

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

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

11 **DISCIPLINARY ORDER**

12 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 60965 issued  
13 to Respondent Mark Daniel Cook, M.D. is revoked. However, the revocation is stayed and  
14 Respondent is placed on probation for ten (10) years on the following terms and conditions:

15 1. **PATIENT DISCLOSURE**. Before a patient's first visit following the effective date  
16 of this order and while the respondent is on probation, the respondent must provide all patients, or  
17 patient's guardian or health care surrogate, with a separate disclosure that includes the  
18 respondent's probation status, the length of the probation, the probation end date, all practice  
19 restrictions placed on the respondent by the board, the board's telephone number, and an  
20 explanation of how the patient can find further information on the respondent's probation on the  
21 respondent's profile page on the board's website. Respondent shall obtain from the patient, or the  
22 patient's guardian or health care surrogate, a separate, signed copy of that disclosure. Respondent  
23 shall not be required to provide a disclosure if any of the following applies: (1) The patient is  
24 unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure  
25 and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the  
26 copy; (2) The visit occurs in an emergency room or an urgent care facility or the visit is  
27 unscheduled, including consultations in inpatient facilities; (3) Respondent is not known to the  
28 patient until immediately prior to the start of the visit; (4) Respondent does not have a direct

1 treatment relationship with the patient.

2 2. ACTUAL SUSPENSION. As part of probation, Respondent is suspended from the  
3 practice of medicine for 60 days beginning the sixteenth (16th) day after the effective date of this  
4 decision.

5 3. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not  
6 order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by  
7 the California Uniform Controlled Substances Act, except for those drugs listed in Schedules III,  
8 IV, and V of the Act. Upon successful completion of the prescribing practices course described  
9 in Condition 6, this restriction shall be lifted and Respondent may prescribe controlled substances  
10 as permitted by the DEA.

11 Respondent shall not issue an oral or written recommendation or approval to a patient or a  
12 patient's primary caregiver for the possession or cultivation of marijuana for the personal medical  
13 purposes of the patient within the meaning of Health and Safety Code section 11362.5. If  
14 Respondent forms the medical opinion, after an appropriate prior examination and medical  
15 indication, that a patient's medical condition may benefit from the use of marijuana, Respondent  
16 shall so inform the patient and shall refer the patient to another physician who, following an  
17 appropriate prior examination and medical indication, may independently issue a medically  
18 appropriate recommendation or approval for the possession or cultivation of marijuana for the  
19 personal medical purposes of the patient within the meaning of Health and Safety Code section  
20 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that  
21 Respondent is prohibited from issuing a recommendation or approval for the possession or  
22 cultivation of marijuana for the personal medical purposes of the patient and that the patient or  
23 the patient's primary caregiver may not rely on Respondent's statements to legally possess or  
24 cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully  
25 document in the patient's chart that the patient or the patient's primary caregiver was so  
26 informed. Nothing in this condition prohibits Respondent from providing the patient or the  
27 patient's primary caregiver information about the possible medical benefits resulting from the use  
28 of marijuana.

1           4.    CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO  
2 RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled  
3 substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any  
4 recommendation or approval which enables a patient or patient's primary caregiver to possess or  
5 cultivate marijuana for the personal medical purposes of the patient within the meaning of Health  
6 and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and  
7 address of the patient; 2) the date; 3) the character and quantity of controlled substances involved;  
8 and 4) the indications and diagnosis for which the controlled substances were furnished.

9           Respondent shall keep these records in a separate file or ledger, in chronological order. All  
10 records and any inventories of controlled substances shall be available for immediate inspection  
11 and copying on the premises by the Board or its designee at all times during business hours and  
12 shall be retained for the entire term of probation.

13           5.    EDUCATION COURSE. Within 60 calendar days of the effective date of this  
14 Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee  
15 for its prior approval educational program(s) or course(s) which shall not be less than 40 hours  
16 per year, for each year of probation. The educational program(s) or course(s) shall be aimed at  
17 correcting any areas of deficient practice or knowledge and shall be Category I certified. The  
18 educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to  
19 the Continuing Medical Education (CME) requirements for renewal of licensure. Following the  
20 completion of each course, the Board or its designee may administer an examination to test  
21 Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65  
22 hours of CME of which 40 hours were in satisfaction of this condition.

23           6.    PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective  
24 date of this Decision, Respondent shall enroll in a course in prescribing practices approved in  
25 advance by the Board or its designee. Respondent shall provide the approved course provider  
26 with any information and documents that the approved course provider may deem pertinent.  
27 Respondent shall participate in and successfully complete the classroom component of the course  
28 not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully



1 complete any other component of the course within one (1) year of enrollment. The prescribing  
2 practices course shall be at Respondent's expense and shall be in addition to the Continuing  
3 Medical Education (CME) requirements for renewal of licensure.

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

9 Respondent shall submit a certification of successful completion to the Board or its  
10 designee not later than 15 calendar days after successfully completing the course, or not later than  
11 15 calendar days after the effective date of the Decision, whichever is later.

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

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

26 Respondent shall submit a certification of successful completion to the Board or its  
27 designee not later than 15 calendar days after successfully completing the course, or not later than  
28 15 calendar days after the effective date of the Decision, whichever is later.

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

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

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

19           9.     PROFESSIONAL BOUNDARIES PROGRAM. Within 60 calendar days from the  
20 effective date of this Decision, Respondent shall enroll in a professional boundaries program  
21 approved in advance by the Board or its designee. Respondent, at the program's discretion, shall  
22 undergo and complete the program's assessment of Respondent's competency, mental health  
23 and/or neuropsychological performance, and at minimum, a 24 hour program of interactive  
24 education and training in the area of boundaries, which takes into account data obtained from the  
25 assessment and from the Decision(s), Accusation(s) and any other information that the Board or  
26 its designee deems relevant. The program shall evaluate Respondent at the end of the training  
27 and the program shall provide any data from the assessment and training as well as the results of  
28 the evaluation to the Board or its designee.

1 Failure to complete the entire program not later than six (6) months after Respondent's  
2 initial enrollment shall constitute a violation of probation unless the Board or its designee agrees  
3 in writing to a later time for completion. Based on Respondent's performance in and evaluations  
4 from the assessment, education, and training, the program shall advise the Board or its designee  
5 of its recommendation(s) for additional education, training, psychotherapy and other measures  
6 necessary to ensure that Respondent can practice medicine safely. Respondent shall comply with  
7 program recommendations. At the completion of the program, Respondent shall submit to a final  
8 evaluation. The program shall provide the results of the evaluation to the Board or its designee.  
9 The professional boundaries program shall be at Respondent's expense and shall be in addition to  
10 the Continuing Medical Education (CME) requirements for renewal of licensure.

11 The program has the authority to determine whether or not Respondent successfully  
12 completed the program.

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

18 Respondent shall not practice medicine until Respondent has successfully completed the  
19 program and has been so notified by the Board or its designee in writing.

20 10. PSYCHIATRIC EVALUATION. Within 30 calendar days of the effective date of  
21 this Decision, and on whatever periodic basis thereafter may be required by the Board or its  
22 designee, Respondent shall undergo and complete a psychiatric evaluation (and psychological  
23 testing, if deemed necessary) by a Board-appointed board certified psychiatrist, who shall  
24 consider any information provided by the Board or designee and any other information the  
25 psychiatrist deems relevant, and shall furnish a written evaluation report to the Board or its  
26 designee. Psychiatric evaluations conducted prior to the effective date of the Decision shall not  
27 be accepted towards the fulfillment of this requirement. Respondent shall pay the cost of all  
28 psychiatric evaluations and psychological testing.

Respondent shall comply with all restrictions or conditions recommended by the evaluating psychiatrist within 15 calendar days after being notified by the Board or its designee.

Respondent shall not engage in the practice of medicine until notified by the Board or its designee that Respondent is mentally fit to practice medicine safely. The period of time that Respondent is not practicing medicine shall not be counted toward completion of the term of probation.

11. MONITORING – PRACTICE. 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

1 cease the practice of medicine within three (3) calendar days after being so notified. Respondent  
2 shall cease the practice of medicine until a monitor is approved to provide monitoring  
3 responsibility.

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

10 If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of  
11 such resignation or unavailability, submit to the Board or its designee, for prior approval, the  
12 name and qualifications of a replacement monitor who will be assuming that responsibility within  
13 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60  
14 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a  
15 notification from the Board or its designee to cease the practice of medicine within three (3)  
16 calendar days after being so notified. Respondent shall cease the practice of medicine until a  
17 replacement monitor is approved and assumes monitoring responsibility.

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

23 12. THIRD PARTY CHAPERONE. During probation, Respondent shall have a third  
24 party chaperone present while consulting, examining or treating female patients. Respondent  
25 shall, within 30 calendar days of the effective date of the Decision, submit to the Board or its  
26 designee for prior approval name(s) of persons who will act as the third party chaperone.

27 If Respondent fails to obtain approval of a third party chaperone within 60 calendar days of  
28 the effective date of this Decision, Respondent shall receive a notification from the Board or its

1 designee to cease the practice of medicine within three (3) calendar days after being so notified.  
2 Respondent shall cease the practice of medicine until a chaperone is approved to provide  
3 monitoring responsibility.

4 Each third party chaperone shall sign (in ink or electronically) and date each patient  
5 medical record at the time the chaperone's services are provided. Each third party chaperone  
6 shall read the Decision(s) and the Accusation(s), and fully understand the role of the third party  
7 chaperone.

8 Respondent shall maintain a log of all patients seen for whom a third party chaperone is  
9 required. The log shall contain the: 1) patient initials, address and telephone number; 2) medical  
10 record number; and 3) date of service. Respondent shall keep this log in a separate file or ledger,  
11 in chronological order, shall make the log available for immediate inspection and copying on the  
12 premises at all times during business hours by the Board or its designee, and shall retain the log  
13 for the entire term of probation.

14 Respondent is prohibited from terminating employment of a Board-approved third party  
15 chaperone solely because that person provided information as required to the Board or its  
16 designee.

17 If the third party chaperone resigns or is no longer available, Respondent shall, within five  
18 (5) calendar days of such resignation or unavailability, submit to the Board or its designee, for  
19 prior approval, the name of the person(s) who will act as the third party chaperone. If Respondent  
20 fails to obtain approval of a replacement chaperone within 30 calendar days of the resignation or  
21 unavailability of the chaperone, Respondent shall receive a notification from the Board or its  
22 designee to cease the practice of medicine within three (3) calendar days after being so notified.  
23 Respondent shall cease the practice of medicine until a replacement chaperone is approved and  
24 assumes monitoring responsibility.

25 Respondent shall provide written notification to Respondent's patients that a third party  
26 chaperone shall be present during all consultations, examination, or treatment with female  
27 patients. Respondent shall maintain in the patient's file a copy of the written notification, shall  
28 make the notification available for immediate inspection and copying on the premises at all times

1 during business hours by the Board or its designee, and shall retain the notification for the entire  
2 term of probation.

3 13. PROHIBITED PRACTICE. During probation, Respondent is prohibited from  
4 practicing or attempting to practice, advertises or holds himself out as practicing, any system or  
5 mode of treating the sick or afflicted in this state, or diagnoses, treats, operates for, or prescribes  
6 for any ailment, blemish, deformity, disease, disfigurement, disorder, injury or other physical or  
7 mental condition of any person as set for in Business and Professions Code Section 2052, on any  
8 persons that are related to him by blood, marriage, or reside with him. After the effective date of  
9 this Decision, all persons being treated by the Respondent shall be notified that the Respondent is  
10 prohibited from practicing or attempting to practice, advertises or holds himself out as practicing,  
11 any system or mode of treating the sick or afflicted in this state, or diagnoses, treats, operates for,  
12 or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury or other  
13 physical or mental condition of any person as set for in Business and Professions Code Section  
14 2052, on any persons that are related to him by blood, marriage, or reside with him. Any new  
15 patients must be provided this notification at the time of their initial appointment.

16 Respondent shall maintain a log of all patients to whom the required oral notification was  
17 made. The log shall contain the: 1) patient's name, address and phone number; 2) patient's  
18 medical record number, if available; 3) the full name of the person making the notification; 4) the  
19 date the notification was made; and 5) a description of the notification given. Respondent shall  
20 keep this log in a separate file or ledger, in chronological order, shall make the log available for  
21 immediate inspection and copying on the premises at all times during business hours by the Board  
22 or its designee, and shall retain the log for the entire term of probation.

23 14. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the  
24 Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the  
25 Chief Executive Officer at every hospital where privileges or membership are extended to  
26 Respondent, at any other facility where Respondent engages in the practice of medicine,  
27 including all physician and locum tenens registries or other similar agencies, and to the Chief  
28 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.

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

16. 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.

17. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, amended accusations, legal reviews, investigation(s), and subpoena enforcement, as applicable, in the amount of \$200,000.00 (two hundred thousand dollars). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Payment must be made in full within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board of California not to exceed three years. Any and all requests for a payment plan shall be submitted in writing by respondent to the Board. Failure to comply with the payment plan shall be considered a violation of probation.

The filing of bankruptcy by respondent shall not relieve respondent of the responsibility to repay investigation and enforcement costs, including expert review costs (if applicable).

18. 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.

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1       19.   GENERAL PROBATION REQUIREMENTS.

2       Compliance with Probation Unit

3       Respondent shall comply with the Board's probation unit.

4       Address Changes

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

10      Place of Practice

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

14      License Renewal

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

17      Travel or Residence Outside California

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

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

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

27      21.   NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or  
28      its designee in writing within 15 calendar days of any periods of non-practice lasting more than

1 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is  
2 defined as any period of time Respondent is not practicing medicine as defined in Business and  
3 Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct  
4 patient care, clinical activity or teaching, or other activity as approved by the Board. If  
5 Respondent resides in California and is considered to be in non-practice, Respondent shall  
6 comply with all terms and conditions of probation. All time spent in an intensive training  
7 program which has been approved by the Board or its designee shall not be considered non-  
8 practice and does not relieve Respondent from complying with all the terms and conditions of  
9 probation. Practicing medicine in another state of the United States or Federal jurisdiction while  
10 on probation with the medical licensing authority of that state or jurisdiction shall not be  
11 considered non-practice. A Board-ordered suspension of practice shall not be considered as a  
12 period of non-practice.

13 In the event Respondent's period of non-practice while on probation exceeds 18 calendar  
14 months, Respondent shall successfully complete the Federation of State Medical Boards's Special  
15 Purpose Examination, or, at the Board's discretion, a clinical competence assessment program  
16 that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model  
17 Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

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

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

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

25 22. COMPLETION OF PROBATION. Respondent shall comply with all financial  
26 obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the  
27 completion of probation. This term does not include cost recovery, which is due within 30  
28 calendar days of the effective date of the Order, or by a payment plan approved by the Medical

1 Board and timely satisfied. Upon successful completion of probation, Respondent's certificate  
2 shall be fully restored.

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

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

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

25 26. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for  
26 a new license or certification, or petition for reinstatement of a license, by any other health care  
27 licensing action agency in the State of California, all of the charges and allegations contained  
28 First Amended Accusation No. 800-2017-039585, Accusation No. 800-2020-072482, and First

Amended Accusation No. 800-2021-083681, except those contained in the First Amended Accusation in Case No. 800-2017-039585, paragraph 24, subsections n through w, 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.

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DATED: \_\_\_\_\_

MARK DANIEL COOK, M.D.  
*Respondent*


DATED: \_\_\_\_\_

ROBERT F. HAHN  
*Attorney for Respondent*

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

Respectfully submitted,

ROB BONTA  
Attorney General of California  
STEVE DIEHL  
Supervising Deputy Attorney General



MICHAEL C. BRUMMEL  
Supervising Deputy Attorney General  
*Attorneys for Complainant*

20

1 ACCEPTANCE

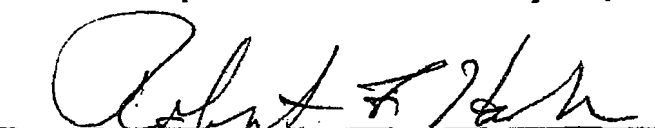
2 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully  
3 discussed it with my attorney, Robert F. Hahn. I understand the stipulation and the effect it will  
4 have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and  
5 Disciplinary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

7  
8 DATED: 12/29/23

  
9 MARK DANIEL COOK, M.D.  
Respondent

10 I have read and fully discussed with Respondent Mark Daniel Cook, M.D. the terms and  
11 conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order.  
12 I approve its form and content.

13 DATED: 12/29/23

  
14 ROBERT F. HAHN  
Attorney for Respondent

15  
16 ENDORSEMENT

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

19 DATED: \_\_\_\_\_

Respectfully submitted,

20  
21 ROB BONTA  
Attorney General of California  
22 STEVE DIEHL  
Supervising Deputy Attorney General

23  
24 MICHAEL C. BRUMMEL  
25 Supervising Deputy Attorney General  
26 Attorneys for Complainant

27 FR2020300931  
28 95546423

**Exhibit A**

**Accusation No. 800-2017-039585**

1 ROB BONTA  
Attorney General of California  
2 STEVE DIEHL  
Supervising Deputy Attorney General  
3 MICHAEL C. BRUMMEL  
Deputy Attorney General  
4 State Bar No. 236116  
California Department of Justice  
5 2550 Mariposa Mall, Room 5090  
Fresno, CA 93721  
6 Telephone: (559) 705-2307  
Facsimile: (559) 445-5106  
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 First Amended Accusation  
13 Against:

14 **Mark Daniel Cook, M.D.**  
15 **1425 West H St. Ste. 200**  
**Oakdale, CA 95361**

16 **Physician's and Surgeon's Certificate**  
**No. A 60965,**

17 Respondent.

Case No. 800-2017-039585

**FIRST AMENDED ACCUSATION**

18  
19 **PARTIES**

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

23 2. On or about October 2, 1996, the Medical Board issued Physician's and Surgeon's  
24 Certificate Number A 60965 to Mark Daniel Cook, M.D. (Respondent). The Physician's and  
25 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought  
26 herein and will expire on August 31, 2024, unless renewed.

27 ///

28 ///



[illegible]

4. Section 2227 of the Code states:

(1) Have his or her license revoked 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.

(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.

## STATUTORY PROVISIONS

(a) Any physician and surgeon, psychotherapist, alcohol and drug abuse counselor or any person holding himself or herself out to be a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor, who engages in an act of sexual intercourse, sodomy, oral copulation, or sexual contact with a patient or client, or with a former patient or client when the relationship was terminated primarily for the purpose of engaging in those acts, unless the physician and surgeon, psychotherapist, or alcohol and drug abuse counselor has referred the patient or client to an independent and objective physician and surgeon, psychotherapist, or alcohol and drug abuse counselor recommended by a third-party physician and surgeon, psychotherapist, or alcohol and drug abuse counselor for treatment, is guilty of sexual exploitation by a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor.

1 (b) Sexual exploitation by a physician and surgeon, psychotherapist, or alcohol  
and drug abuse counselor is a public offense:

2 (1) An act in violation of subdivision (a) shall be punishable by imprisonment  
3 in a county jail for a period of not more than six months, or a fine not exceeding one  
thousand dollars (\$1,000), or by both that imprisonment and fine.

4 (2) Multiple acts in violation of subdivision (a) with a single victim, when the  
5 offender has no prior conviction for sexual exploitation, shall be punishable by  
imprisonment in a county jail for a period of not more than six months, or a fine not  
6 exceeding one thousand dollars (\$1,000), or by both that imprisonment and fine.

7 (3) An act or acts in violation of subdivision (a) with two or more victims shall  
be punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the  
8 Penal Code for a period of 16 months, two years, or three years, and a fine not  
exceeding ten thousand dollars (\$10,000); or the act or acts shall be punishable by  
9 imprisonment in a county jail for a period of not more than one year, or a fine not  
exceeding one thousand dollars (\$1,000), or by both that imprisonment and fine.

10 (4) Two or more acts in violation of subdivision (a) with a single victim, when  
the offender has at least one prior conviction for sexual exploitation, shall be  
11 punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal  
Code for a period of 16 months, two years, or three years, and a fine not exceeding  
12 ten thousand dollars (\$10,000); or the act or acts shall be punishable by imprisonment  
in a county jail for a period of not more than one year, or a fine not exceeding one  
13 thousand dollars (\$1,000), or by both that imprisonment and fine.

14 (5) An act or acts in violation of subdivision (a) with two or more victims, and  
the offender has at least one prior conviction for sexual exploitation, shall be  
15 punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal  
Code for a period of 16 months, two years, or three years, and a fine not exceeding  
16 ten thousand dollars (\$10,000).

17 For purposes of subdivision (a), in no instance shall consent of the patient or  
client be a defense. However, physicians and surgeons shall not be guilty of sexual  
18 exploitation for touching any intimate part of a patient or client unless the touching is  
outside the scope of medical examination and treatment, or the touching is done for  
19 sexual gratification.

20 (c) For purposes of this section:

21 (1) "Psychotherapist" has the same meaning as defined in Section 728.

22 (2) "Alcohol and drug abuse counselor" means an individual who holds himself  
or herself out to be an alcohol or drug abuse professional or paraprofessional.

23 (3) "Sexual contact" means sexual intercourse or the touching of an intimate  
24 part of a patient for the purpose of sexual arousal, gratification, or abuse.

25 (4) "Intimate part" and "touching" have the same meanings as defined in  
Section 243.4 of the Penal Code.

26 (d) In the investigation and prosecution of a violation of this section, no person  
27 shall seek to obtain disclosure of any confidential files of other patients, clients, or  
former patients or clients of the physician and surgeon, psychotherapist, or alcohol  
28 and drug abuse counselor.

1 (e) This section does not apply to sexual contact between a physician and  
2 surgeon and his or her spouse or person in an equivalent domestic relationship when  
that physician and surgeon provides medical treatment, other than psychotherapeutic  
treatment, to his or her spouse or person in an equivalent domestic relationship.

3 (f) If a physician and surgeon, psychotherapist, or alcohol and drug abuse  
4 counselor in a professional partnership or similar group has sexual contact with a  
5 patient in violation of this section, another physician and surgeon, psychotherapist, or  
alcohol and drug abuse counselor in the partnership or group shall not be subject to  
action under this section solely because of the occurrence of that sexual contact.

6 6. Section 726 defines sexual abuse, misconduct, or relations with a patient or others,  
7 and states:

8 (a) The commission of any act of sexual abuse, misconduct, or relations with a  
9 patient, client, or customer constitutes unprofessional conduct and grounds for  
disciplinary action for any person licensed under this division or under any initiative  
act referred to in this division.

10 (b) This section shall not apply to consensual sexual contact between a licensee  
11 and his or her spouse or person in an equivalent domestic relationship when that  
12 licensee provides medical treatment, other than psychotherapeutic treatment, to his or  
her spouse or person in an equivalent domestic relationship.

13 7. Excessive prescription or administration of drugs is defined in Section 725, and  
14 states:

15 (a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or  
16 administering of drugs or treatment, repeated acts of clearly excessive use of  
17 diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or  
18 treatment facilities as determined by the standard of the community of licensees is  
unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist,  
physical therapist, chiropractor, optometrist, speech-language pathologist, or  
audiologist.

19 (b) Any person who engages in repeated acts of clearly excessive prescribing or  
20 administering of drugs or treatment is guilty of a misdemeanor and shall be punished  
21 by a fine of not less than one hundred dollars (\$100) nor more than six hundred  
dollars (\$600), or by imprisonment for a term of not less than 60 days nor more than  
180 days, or by both that fine and imprisonment.

22 (c) A practitioner who has a medical basis for prescribing, furnishing,  
23 dispensing, or administering dangerous drugs or prescription controlled substances  
shall not be subject to disciplinary action or prosecution under this section.

24 (d) No physician and surgeon shall be subject to disciplinary action pursuant to  
25 this section for treating intractable pain in compliance with Section 2241.5.

26 8. Unprofessional conduct is defined in Section 2234, and states:

27 The board shall take action against any licensee who is charged with unprofessional  
28 conduct. In addition to other provisions of this article, unprofessional conduct  
includes, but is not limited to, the following:

1 (a) Violating or attempting to violate, directly or indirectly, assisting in or  
2 abetting the violation of, or conspiring to violate any provision of this chapter.

3 (b) Gross negligence.

4 (c) Repeated negligent acts. To be repeated, there must be two or more  
5 negligent acts or omissions. An initial negligent act or omission followed by a  
6 separate and distinct departure from the applicable standard of care shall constitute  
7 repeated negligent acts.

8 (1) An initial negligent diagnosis followed by an act or omission medically  
9 appropriate for that negligent diagnosis of the patient shall constitute a single  
10 negligent act.

11 (2) When the standard of care requires a change in the diagnosis, act, or  
12 omission that constitutes the negligent act described in paragraph (1), including, but  
13 not limited to, a reevaluation of the diagnosis or a change in treatment, and the  
14 licensee's conduct departs from the applicable standard of care, each departure  
15 constitutes a separate and distinct breach of the standard of care.

16 (d) Incompetence.

17 (e) The commission of any act involving dishonesty or corruption that is  
18 substantially related to the qualifications, functions, or duties of a physician and  
19 surgeon.

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

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

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

27 10. Section 2228.1, subdivision (a)(1)(A) provides the means for a licensee to disclose  
28 probation status, and states, in pertinent part,

“...the board shall require a licensee to provide a separate disclosure that includes the  
licensee's probation status, the length of the probation, the probation end date, all  
practice restrictions placed on the licensee by the board, the board's telephone  
number, and an explanation of how the patient can find further information on the  
licensee's probation on the licensee's profile page on the board's online license  
information Internet Web site, to a patient or the patient's guardian or health care  
surrogate before the patient's first visit following the probationary order while the  
licensee is on probation pursuant to a probationary order made on and after July 1,  
2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted  
findings or prima facie showing in a stipulated settlement establishing any of the  
following:

1 (A) The commission of any act of sexual abuse, misconduct, or relations with a  
2 patient or client as defined in Section 726 or 729.

3 11. Section 2246 states: Any proposed decision or decision issued under this article that  
4 contains any finding of fact that the licensee engaged in any act of sexual exploitation, as  
5 described in paragraphs (3) to (5), inclusive, of subdivision (b) of Section 729, with a patient shall  
6 contain an order of revocation. The revocation shall not be stayed by the administrative law  
7 judge.

### 8 COST RECOVERY

9 12. Section 125.3 of the Code provides, in pertinent part, that the Board may request the  
10 administrative law judge to direct a licensee found to have committed a violation or violations of  
11 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and  
12 enforcement of the case<sup>1</sup>, with failure of the licensee to comply subjecting the license to not being  
13 renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be  
14 included in a stipulated settlement.

### 15 DEFINITIONS

16 13. Adderall®, a mixture of d-amphetamine and l-amphetamine salts in a ratio of 3:1, is a  
17 central nervous system stimulant of the amphetamine class, and is a Schedule II controlled  
18 substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous  
19 drug pursuant to Business and Professions Code section 4022. When properly prescribed and  
20 indicated, it is used for attention-deficit hyperactivity disorder and narcolepsy. According to the  
21 DEA, amphetamines, such as Adderall®, are considered a drug of abuse. "The effects of  
22 amphetamines and methamphetamine are similar to cocaine, but their onset is slower and their  
23 duration is longer." (Drugs of Abuse – A DEA Resource Guide (2011), at p. 44.) Adderall® and  
24 other stimulants are contraindicated for patients with a history of drug abuse.

25 ///

26 \_\_\_\_\_  
27 <sup>1</sup> As of November 18, 2021, Section 125.3 of the Code has been amended to remove  
28 subsection (k), which precluded the Board from collecting costs. The Board may collect  
investigation, prosecution, and other costs incurred for a disciplinary proceeding against a  
licensee beginning January 1, 2022.

1           14. Quetiapine (Seroquel XR®) is indicated in adults for (1) adjunctive therapy to  
2 antidepressants in major depressive disorder; (2) acute depressive episodes in bipolar disorder; (3)  
3 acute manic or mixed episodes in bipolar I disorder, as either monotherapy or adjunct therapy to  
4 lithium or divalproex; (4) maintenance treatment of bipolar I disorder as an adjunct to lithium or  
5 divalproex; and (5) schizophrenia. It is also indicated in children and adolescents (10-17 years)  
6 for acute manic episodes in bipolar I disorder, as monotherapy; and in adolescents (13-17 years)  
7 for schizophrenia. Patients should be periodically reassessed to determine the need for treatment  
8 and the appropriate dose. Seroquel XR® is not approved for use in pediatric patients under ten  
9 years of age. The most commonly observed adverse reactions in clinical trials for children and  
10 adolescents were somnolence, dizziness, fatigue, increased appetite, nausea, vomiting, dry mouth,  
11 tachycardia, and weight gain. Other adverse reactions include increased risk of suicidal thought  
12 and behavior in children, Neuroleptic Malignant Syndrome, metabolic changes, hyperglycemia  
13 and diabetes mellitus, dyslipidemia, tardive dyskinesia, hypotension, falls, increases in blood  
14 pressure in children and adolescents, leukopenia, neutropenia, and agranulocytosis. Quetiapine is  
15 a dangerous drug within the meaning of Business and Professions Code section 4022.

16           15. Lithium carbonate is not indicated for the treatment of conditions other than manic  
17 episodes of Bipolar Disorder, and Manic Depressive illness. It is indicated as a maintenance  
18 treatment for individuals with a diagnosis of Bipolar Disorder in order to reduce the frequency of  
19 manic episodes and diminish the intensity of those episodes which may occur. Lithium toxicity is  
20 closely related to serum lithium levels, and can occur at doses close to therapeutic levels.  
21 Lithium carbonate is a dangerous drug within the meaning of Business and Professions Code  
22 section 4022.

23           16. Divalproex sodium (Depakote®) is an anticonvulsant used to treat seizure disorders,  
24 manic episodes associated with bipolar disorder, and to prevent migraine headaches in adults and  
25 children 10 years of age and older. Depakote® is not indicated for treatment of conditions other  
26 than seizure disorders, manic episodes associated with bipolar disorder, and migraine headache  
27 prevention. Side effects can be serious and sometimes fatal, including continuing liver damage  
28 despite stopping taking the drug. Fatal liver damage is especially likely in children younger than

1 two years old. Other side effects include, but are not limited to, fatal pancreatic inflammation,  
2 suicidal thoughts or actions, bleeding problems, high ammonia blood levels, low body  
3 temperature, allergic reactions, drowsiness or sleepiness. Depakote is a dangerous drug within  
4 the meaning of Business and Professions Code section 4022.

5 17. Acetaminophen and codeine (Tylenol® with codeine, Tylenol 3®) is a combination  
6 of two medicines used to treat moderate to severe pain. Codeine is an opioid pain medication,  
7 commonly referred to as a narcotic. Acetaminophen is a less potent pain reliever that increases  
8 the effects of codeine. Codeine has a high potential for abuse. Codeine is a Schedule II  
9 controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health  
10 and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of  
11 Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and  
12 Professions Code section 4022. Respiratory depression is the chief hazard from all opioid agonist  
13 preparations.

14 18. Zolpidem tartrate (Ambien®), a centrally acting hypnotic-sedative, is a Schedule IV  
15 controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a  
16 dangerous drug pursuant to Business and Professions Code section 4022. When properly  
17 prescribed and indicated, it is used for the short-term treatment of insomnia characterized by  
18 difficulties with sleep initiation.

19 19. Alprazolam (Xanax®) is in the class of benzodiazepine medications. It affects  
20 chemicals in the brain that may be unbalanced in people with anxiety. Xanax is used to treat  
21 anxiety disorders, panic disorders, and anxiety caused by depression. Xanax has the potential for  
22 abuse. Xanax is a Schedule IV controlled substance pursuant to Health and Safety Code section  
23 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section  
24 4022.

25 20. Valium® (diazepam), a benzodiazepine, is a centrally acting hypnotic-sedative that is  
26 a Schedule IV controlled substance pursuant to Health and Safety Code section 11057,  
27 subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.  
28 When properly prescribed and indicated, it is used for the management of anxiety disorders or for

1 the short-term relief of anxiety. Concomitant use of Valium® with opioids “may result in  
2 profound sedation, respiratory depression, coma, and death.” The Drug Enforcement  
3 Administration (DEA) has identified benzodiazepines, such as Valium®, as a drug of abuse.  
4 (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

5 21. Acetaminophen and oxycodone (Endocet®, Percocet®, Roxicet®) is a combination  
6 of two medicines used to treat moderate to severe pain. Oxycodone is an opioid pain medication,  
7 commonly referred to as a narcotic. Acetaminophen is a less potent pain reliever that increases  
8 the effects of oxycodone. Oxycodone has a high potential for abuse. Oxycodone is a Schedule II  
9 controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health  
10 and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of  
11 Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and  
12 Professions Code section 4022. Oxycodone should be used with caution and started in a reduced  
13 dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently receiving other central  
14 nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines,  
15 other tranquilizers, and alcohol. The Drug Enforcement Administration (“DEA”) has identified  
16 opioids, such as oxycodone, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011  
17 Edition), at p. 41.) Respiratory depression is the chief hazard from all opioid agonist  
18 preparations.

19 22. Phentermine HCL (Lonamin®, Fastin®, Adipex®), an anorectic, is a Schedule IV  
20 controlled substance pursuant to Health and Safety Code section 11057, subdivision (f), and a  
21 dangerous drug pursuant to Business and Professions Code section 4022. When properly  
22 prescribed and indicated phentermine HCL is used as a short term adjunct in a regimen of weight  
23 reduction based on exercise, behavioral modification, and caloric restriction. According to the  
24 DEA fact sheet for anorectic drugs, phentermine can produce amphetamine-like effects and is  
25 frequently encountered on the illicit market.

26 ///

27 ///

28 ///



**FACTUAL ALLEGATIONS**

**23. *PATIENT A*<sup>2</sup>**

- a) In 2015, Patient A had sole custody of her 7-year-old daughter (Patient B), after being widowed. In approximately 2015, Patient A married Respondent. Respondent and Patient A conceived a son by frozen embryo transplantation who was born in February of 2017.
- b) According to Respondent's medical billing records, Patient A saw Respondent for medical treatment while she was pregnant on or about January 17, 2017; February 10, 2017; and February 16, 2017 (the day their son was born). However, there are no medical records from Respondent showing any treatment on these dates.
- c) On February 23, 2017, one week after Patient A's C-section delivery, Respondent treated her for an incisional hernia and referred her to a surgeon.
- d) On or about April 13, 2017, Patient A was seen by Respondent for a complete annual exam, including a breast and pelvic exam. She was noted to have edema from her recent pregnancy and delivery, and was given Pitocin IM and Reglan. This is the first and only annual exam noted in Respondent's medical records.
- e) On or about September 5, 2017, Respondent treated Patient A for a rash and a history of allergies.
- f) Patient A filled the following prescriptions for controlled substances, issued by Respondent:

Date	Prescription	Dose	Quantity	Days Supply
11-17-2015	Acetaminophen-Codeine Phosphate	300 mg/ 60 mg	100	17
2-25-2016	Zolpidem Tartrate	10 mg	30	30
4-14-2016	Oxycodone HCL – Acetaminophen	325 mg/ 10 mg	60	7
5-4-2016	Alprazolam	2 mg	90	30
6-2-2016	Zolpidem Tartrate	10 mg	30	30
6-13-2016	Diazepam	10 mg	90	30

<sup>2</sup> Patients are referred to by letter to preserve their privacy.

1	7-24-2016	Zolpidem Tartrate	10 mg	30	30
2	10-11-2016	Alprazolam	2 mg	90	30
3	12-7-2016	Zolpidem Tartrate	10 mg	90	90
4	12-7-2016	Diazepam	10 mg	90	30
5	2-18-2017	Oxycodone HCL – Acetaminophen	325 mg/ 5 mg	60	15
6	3-1-2017	Oxycodone HCL – Acetaminophen	325 mg/ 10 mg	120	30
7	5-1-2017	Phentermine HCL	37.5 mg	90	90
8	8-7-2017	Diazepam	10 mg	90	30

- 9
- 10 g) In addition, Respondent prescribed 30 mg of Adderall® daily to Patient A on or about the
- 11 following dates: December 10, 2015; August 5, 2016; September 22, 2016; October 5,
- 12 2016; November 12, 2016; December 11, 2016; January 6, 2017; February 23, 2017; and
- 13 March 29, 2017. Respondent also prescribed 37.5 mg of phentermine (quantity 90) to
- 14 Patient A on or about May 1, 2017, approximately three months after she gave birth to
- 15 their son.
- 16 h) Based on Respondent's November 17, 2015 prescription of codeine phosphate, Patient A
- 17 was taking approximately 320 to 480 mg of codeine per day.
- 18 i) None of Respondent's medical records for Patient A mention the prescriptions listed
- 19 above. There are no medical records, exams, or definitive diagnoses made related to
- 20 Patient A's prescriptions. Respondent's medical records fail to provide any
- 21 documentation of informed consent, discussion of side effects or alternatives, pain
- 22 contracts, drug testing, or plans to taper.
- 23 j) During his interview with Board Investigators, Respondent disputed Patient A's April 14,
- 24 2016 prescription for oxycodone, which stated she was to take 60 pills over the course of
- 25 7 days, equating to 8 to 9 pills of 325 mg/ 10 mg of oxycodone per day. Respondent
- 26 stated that he did not know where the seven days came from in the prescription or how the
- 27 pharmacist came up with that number.
- 28

- 1 k) It is the standard of care when prescribing controlled substances to provide clear  
2 documentation in the medical record of the performance of a history and physical, along  
3 with careful diagnosis and planned management, specialist consultation as needed, obtain  
4 informed consent (e.g., pain contract), include tapering plans, consider drug testing, look  
5 for adverse side effects, and look for abuse or diversion of medications.
- 6 l) Respondent failed to properly prescribe controlled substances to Patient A. Respondent  
7 regularly prescribed significant amounts of opiates and benzodiazepines and failed to  
8 document any diagnosis in Patient A's medical records. The only diagnoses are inferred  
9 from his written prescriptions which state Adderall® is for "ADD," diazepam is for  
10 "muscle spasm and stress headaches," and oxycodone is for "severe surgery site pain."  
11 The most complete note from the only annual examination on or about April 13, 2017,  
12 contains no notations or explanations of his prescriptions of high dose prescriptions of  
13 oxycodone. In addition, there is no notation or explanation in Respondent's medical  
14 records regarding the reason for prescribing phentermine to Patient A on or about May 1,  
15 2017.
- 16 m) It is the standard of care to avoid prescribing opiates and benzodiazepines in combination,  
17 due to the increased risk of synergistic effects of sedation, possibility of overdose,  
18 respiratory depression, and death. The combination of zolpidem and oxycodone is in the  
19 serious interaction category which calls for using an alternative rather than prescribing  
20 both consecutively. This is due to the high risk of profound sedation, respiratory  
21 depression, coma, and hypotension. Oxycodone and alprazolam require close monitoring  
22 because they both increase sedation. In addition, a physician cannot reasonably be  
23 dispassionately objective in prescribing controlled substances to a spouse as multiple  
24 factors will sway his clinical judgement, such as pleasing his spouse or subconsciously  
25 denying the possibility of serious issues in said spouse.
- 26 n) Respondent issued numerous prescriptions of opiates and benzodiazepines in combination  
27 to Patient A. For example, on or about December 7, 2016, Respondent prescribed Patient  
28 A with 10 mg of zolpidem daily and 30 mg of diazepam daily; such a combination may

1 cause additive central nervous system depression. On or about April 14, 2016,  
2 Respondent prescribed Patient A with 10 mg of oxycodone daily. Two weeks and four  
3 days later, on or about May 4, 2016, Respondent additionally prescribed Patient A with 30  
4 mg of zolpidem daily. Then, on or about June 2, 2016, Respondent increased Patient A's  
5 zolpidem dosage to 10 mg daily and again increased, on or about June 13, 2016, to 30 mg  
6 daily. Moreover, on or about December 7, 2016, Respondent prescribed Patient A with 10  
7 mg of zolpidem daily for three months. Approximately two months later, on February 18,  
8 2017, Respondent prescribed Patient A with 10 mg (4-6 pills daily) of oxycodone.  
9 Approximately 14 days later, on March 1, 2017, Respondent increased her oxycodone  
10 dosage prescribing 120 pills. The dosage of 40 mg of oxycodone daily equates to  
11 approximately a morphine equivalent dose of 60 mg daily, which is considered an  
12 addictive level with a high risk of overdose and abuse.

- 13 o) On or about January 8, 2020, during an interview with Board Investigators, Respondent  
14 stated under oath that Patient A's fertility physician "asked me if I would follow [Patient  
15 A] and provide for her medications in Oakdale so she wouldn't have to drive each time  
16 over to Palo Alto to see him." When asked if the treating fertility physician asked  
17 Respondent to write prescriptions for minivelle, progesterone, and letrozole, Respondent  
18 stated, "Yes sir, that's correct. Exclusively." However, Patient A's fertility physician  
19 informed Board Investigators that he "never allowed, consented, consulted nor directed  
20 [Respondent] to prescribe, continue to prescribe, nor treat [Patient A] on his behalf as a  
21 physician. He did not supervise nor allow [Respondent] to continue to prescribe drugs  
22 related to fertilization." In addition, Patient A's medical records had no evidence that  
23 Respondent was directed by a specialist physician to administer progesterone injections or  
24 other fertility treatments.

25 **24. PATIENT B**

- 26 a) At approximately the age of seven, Patient B became Respondent's stepdaughter after her  
27 mother married him in the summer of 2015. Respondent gave Patient B a diamond ring,  
28

1 similar to an engagement ring, and she wore it on her ring finger. Respondent told Patient  
2 A that it was a sentimental gift between a father and a daughter.

3 b) At the age of three, Patient B and/or her biological parents saw an LCSW counselor twice  
4 over concerns that Patient B suffered from ADHD<sup>3</sup>. Patient B's biological parents were  
5 not interested in medications, and Patient B seemed better at her preschool by the second  
6 visit.

7 c) Respondent's medical records for Patient B comprise of only one visit on or about October  
8 17, 2016. According to Respondent's notes Patient B's history showed a "diagnosis of  
9 ADHD at [] hospital at age of two." Respondent's medical records state Patient B was  
10 already prescribed 30 mg of Adderall®, taking half a tablet twice daily. However, there  
11 are no medical records to support this, and Respondent initiated ADHD therapy on his  
12 own. Respondent noted that Patient B's immunization history was "none." However,  
13 Patient B's prior medical records show many immunizations from birth to 2013.  
14 Respondent's exam notations were normal and his assessment was, "well child, ADHD,  
15 sick building syndrome and chronic sinus/allergic rhinitis." Respondent never ordered  
16 any laboratory testing or EKG's. Respondent's noted plan was to continue current  
17 medications at present dosages.

18 d) Patient B obtained the following controlled substances based on prescriptions issued by  
19 Respondent:

Date	Prescription	Dose	Quantity	Days Supply
12-10-2015	Mixed Amphetamine Salts	15 mg	8	8
12-29-2015	Mixed Amphetamine Salts	15 mg	30	30
2-2-2016	Mixed Amphetamine Salts	15 mg	30	30
3-1-2016	Amphetamine Salt Combo	30 mg	30	30

27 <sup>3</sup> Attention deficit hyperactivity disorder (ADHD) is a mental health disorder that can  
28 cause above-normal levels of hyperactive and impulsive behaviors. People with ADHD may also  
have trouble focusing their attention on a single task or sitting still for long periods of time.

Date	Prescription	Dose	Quantity	Days Supply
4-2-2016	Amphetamine Salt Combo	30 mg	30	30
5-4-2016	Amphetamine Salt Combo	30 mg	30	30
6-13-2016	Mixed Amphetamine Salts	30 mg	30	30
7-6-2016	Amphetamine Salt Combo	30 mg	30	30
8-6-2016	Amphetamine Salt Combo	30 mg	30	30
9-12-2016	Amphetamine Salt Combo	30 mg	30	30
10-11-2016	Amphetamine Salt Combo	30 mg	30	30
11-12-2016	Amphetamine Salt Combo	30 mg	30	30
12-12-2016	Amphetamine Salt Combo	30 mg	30	30
1-10-2017	Amphetamine Salt Combo	30 mg	30	30
2-23-2017	Amphetamine Salt Combo	30 mg	30	30
3-29-2017	Amphetamine Salt Combo	30 mg	30	30
5-1-2017	Mixed Amphetamine Salts	30 mg	30	30
5-9-2017	Amphetamine Salt Combo	30 mg	30	30
6-7-2017	Amphetamine Salt Combo	30 mg	30	30
7-2-2017	Amphetamine Salt Combo	30 mg	60	30
7-28-2017	Dextroamph Sacc-Amph ASP-Dextroam S	30 mg	30	30

e) According to Respondent's medical records, he began prescribing Patient B with 20 mg of Adderall® for ADHD on or about August 28, 2015. The starting dose for Adderall® is typically 5-10 mg. Respondent continued Patient B's Adderall® prescriptions monthly through approximately July of 2017.

f) Respondent's first record of an office visit for Patient B occurred on or about October 17, 2016, over one year after he began prescribing psychotropic medications for her. Respondent failed to obtain a baseline EKG, which most pediatricians would obtain to

1 monitor the slight risk of cardiomyopathy. Respondent failed to perform any laboratory  
2 work on Patient B. Laboratory monitoring is necessary, as dosage modification is  
3 required based on toxicity and possible issues. Respondent failed to order any  
4 confirmatory tests (e.g., Conner Scale<sup>4</sup>), or provide a referral for confirmatory tests that  
5 Patient B in fact had ADHD or bipolar disorder.

6 g) The following day, on or about October 18, 2016, Patient B was seen by a psychiatrist at a  
7 children's health medical practice. Respondent and Patient A accompanied her. The  
8 history provided was that Patient B was a sweet, social, and hyperactive child, up to the  
9 age of seven. After Patient B witnessed domestic abuse between her biological father and  
10 mother in approximately 2014, Patient B stopped talking for several months and would  
11 only sing and stutter. Patient B then saw a counselor and made significant progress.  
12 However, in approximately 2015, Patient B's father committed suicide and her mother  
13 (Patient A) married Respondent. When Patient A was approximately five to six months  
14 pregnant, Patient B regressed at home and the overall impression was post-traumatic stress  
15 disorder (PTSD), with Respondent "managing her medications in their rural community."  
16 In addition, Patient B was noted to experience symptoms consistent with Dysphoric Mood  
17 Dysregulation Disorder except that they only occurred around Respondent and Patient A,  
18 which led more towards symptoms of Oppositional Defiant Disorder with an unspecified  
19 Bipolar Disorder. Further counseling was recommended and the psychiatrist noted that  
20 Patient B's "emotional, social and family functioning are at high risk for further medical  
21 and psychological complications and progression." It was recommended that Adderall®  
22 dose reduction be considered based on patient irritability. The psychiatrist recommended  
23 quetiapine (Seroqual®) 25 mg at bedtime titrating by 25 mg weekly to a maximum dose  
24 of 100 mg nightly. During an interview with Board Investigators, the psychiatrist stated  
25 the Respondent initiated the referral and Respondent "did most of the talking at the visit."

26  
27 <sup>4</sup> The Conners Comprehensive Behavior Rating Scale (CBRS) is a tool used to gain a better  
28 understanding of academic, behavioral and social issues that are seen in young children between ages six  
to eighteen years old. It is frequently used to assist in the diagnosis of Attention Deficit Hyperactivity  
Disorder (ADHD).

1 The psychiatrist advised that Patient B's medications were to be managed by a trained  
2 psychiatrist, stating it was beyond the scope of a primary care physician to manage  
3 psychotropic medications for a child. The psychiatrist referred Patient B to a physician in  
4 Modesto, and provided Respondent with names for therapists. Subsequently, Patient B's  
5 referral appointment with the Modesto physician was canceled and Patient B was  
6 thereafter never seen, nor was her medication managed by a trained psychiatrist.

7 h) That same day, on or about October 18, 2016, Respondent (a primary care physician and  
8 not a trained psychiatrist) began managing Patient B's psychotropic medications.  
9 Respondent prescribed Patient B quetiapine (Seroqual®) 25 mg, quantity of 120, equating  
10 to possibly 1-4 per day, and 25 to 100 mg daily. On or about October 25, 2016,  
11 Respondent increased Patient B's dosage of quetiapine to 100 mg daily, with a quantity of  
12 30. Respondent noted that Patient B had an excellent response to quetiapine and suffered  
13 from "anxiety/panic/agitation." On or about November 25, 2016, Respondent again  
14 increased Patient B's dosage to 200 mg per day, by increasing the dosage quantity to 60.  
15 On or about January 6, 2017; February 1, 2017; and March 29, 2017, Respondent  
16 continued to prescribe Patient B with 200 mg of quetiapine daily. The psychiatrist who  
17 saw Patient B on or about October 18, 2016, had recommended a maximum dosage of 100  
18 mg of quetiapine daily. However, Respondent eventually prescribed Patient B with 400  
19 mg of quetiapine daily. The safety and efficacy of quetiapine is not established prior to  
20 the age of ten. Side effects of quetiapine include dizziness, fatigue, blood pressure  
21 elevation, lipid elevation, dry mouth, headache and somnolence, QT interval prolongation,  
22 and risk of extrapyramidal (Parkinsonian) side effects. Respondent made no chart notes  
23 regarding these prescriptions, made no diagnoses, and failed to follow the  
24 recommendations of the psychiatrist.

25 i) In addition, on or about March 1, 2016, Respondent added more psychotropic medications  
26 and prescribed Patient B with 300 mg of lithium, two to three times per day. Patient B  
27 was eight-years-old at the time. Respondent began prescribing her lithium without having  
28 any diagnosis for bipolar disorder from specialists. Lithium causes significant side



1 effects, including an elevated white cell count, polyuria and polydipsia, dry mouth, hand  
2 tremors, confusion, memory issues, headaches, weakness, gastrointestinal symptoms, and  
3 EKG changes. Careful monitoring is necessary, especially with blood levels to avoid  
4 toxicity, along with kidney and thyroid tests; Respondent failed to perform any of these  
5 tests. The lithium prescription was concurrent with the Adderall® prescription, which  
6 was increased to 30 mg, on or about March 1, 2016. Of note, lithium combined with  
7 Adderall® can cause a serotonin syndrome or increased agitation and high fever. On or  
8 about June 13, 2016, Respondent again currently prescribed Patient B 300 mg of lithium  
9 and 30 mg of Adderall®.

10 j) On or about June 2, 2016, Respondent added more psychotropic medications and prescribed  
11 Patient B 500 mg of Depakote twice daily, with a quantity of 60. Depakote is not  
12 recommended for children under the age of ten, due to serious side effects, including but  
13 not limited to, permanent liver damage, life-threatening pancreatitis, suicidal thought, and  
14 blood and metabolic disorders. Patient B was eight at the time.

15 k) In prescribing of all of these psychotropic agents to Patient B, Respondent made no chart  
16 notes discussing any of these medications, except one mention that Patient B was already  
17 taking Adderall® during the one office visit on or about October 17, 2016. Respondent  
18 failed to make any diagnoses regarding Patient B. Respondent failed to follow the  
19 recommendations of the psychiatrist, and against her recommendation, he began solely  
20 managing Patient B's psychotropic prescriptions despite such management being beyond  
21 the scope of his practice. The psychiatrist recommended quetiapine with a maximum dose  
22 of 100 mg daily; instead, Respondent increased Patient B's dosage up to 400 mg daily and  
23 added additional psychotropic medications (Lithium and Depakote). Respondent failed to  
24 properly monitor Patient B while she was taking the numerous medications he prescribed.  
25 Respondent's prescribing of numerous psychotropic medications to Patient B was an  
26 extreme departure from the standard of care and caused definite harm to Patient B both  
27 physically and psychologically.

1 l) During his interview with Board investigators, Respondent claimed that he did not know  
2 what occurred during the meeting with the psychiatrist because he spent the whole time  
3 outside playing with Patient B, while the mother (Patient A) spoke with the psychiatrist.  
4 Nonetheless, Respondent told Board investigators that he provided the Seroquel  
5 prescription based upon the recommendations of the psychiatrist, and the psychiatrist  
6 herself told Board investigators that Respondent had done "most of the talking" during the  
7 visit.

8 m) On or about August 20, 2017, Patient A and Respondent separated.

9 n) On or about September 12, 2017, Patient B told her mother (Patient A) that she wished she  
10 could have locked her bedroom door at Respondent's home. When Patient A asked why,  
11 Patient B responded that Respondent would not let her use the bathroom when he slept in  
12 her bed and that Respondent slept in her bed with her wearing only his underwear. Patient  
13 B went on to explain that Respondent would put his hands together and, "get  
14 comfortable." When asked what "getting comfortable" meant, Patient B put both of her  
15 hands together in a praying motion, laid down on her back, placed her clasped hands in  
16 her genital area and started "gyrating" her body up and down while shifting her head left  
17 to right. Patient B also reported this to her nanny/house cleaner.

18 o) On or about September 14, 2017, Patient A drove Patient B to Child Protective Services  
19 (CPS) in Modesto and told Patient B that she needed to tell them what happened. Patient  
20 B responded, "I don't want to tell them that, I don't trust you." Against her will, Patient B  
21 was escorted by Patient A into CPS in order to file a report. Patient B was interviewed by  
22 a CPS staff member, and when asked about her private parts, she refused to name them.  
23 When Patient B was asked about her private parts, she immediately stated "her stepdad  
24 [Respondent] did not do any of those things." When questioned about what "those things  
25 meant," Patient B stated that Respondent would not sleep in the king-sized bed with her  
26 mother. Instead, he slept in her bed with her for two hours each night. She denied that  
27 anyone had ever touched her "private parts or made her feel uncomfortable." She reported  
28 that if someone did, she would tell her mother. The CPS staff member concluded the

- 1 interview and returned Patient B to her mother (Patient A). After they left CPS, Patient A  
2 and Patient B returned and requested that CPS re-interview Patient B. The CPS staff  
3 refused, "not being sure what the mother had discussed with [Patient A] and then coming  
4 back." The CPS staff member stated another employee would follow-up with them.
- 5 p) On or about September 18, 2017, another CPS employee interviewed Patient B at her  
6 school. Patient B stated that she was frightened, but the CPS employee calmed her fears  
7 and told her that she was not in trouble, but that he would like to ask her some questions.  
8 Patient B told CPS that Respondent liked to sleep in her bedroom, and he does not like  
9 sleeping with her mother (Patient A). Patient B stated that Respondent has never touched  
10 her inappropriately; however, she has seen him many times while sleeping put his hands  
11 in a "prayer way" between his legs and would be shaking. Patient B demonstrated what  
12 was described as convulsing. Patient B stated that she was always scared when  
13 Respondent put his hands between his legs. Patient B stated that she was able to see  
14 Respondent's hands because the night light was always on.
- 15 q) On or about September 23, 2017, an Oakdale Police Officer responded to Patient A's  
16 report of Respondent's alleged lewd and lascivious acts with a child. The officer asked  
17 Patient A why Respondent slept in Patient B's bed and Patient A responded that during  
18 the past two years that she had been married to Respondent, they had only had sexual  
19 intercourse approximately 12 times.
- 20 r) On or about October 5, 2017, an Oakdale Police Department detective interviewed Patient  
21 A. She reported that Respondent took a special interest in Patient B and chose to sleep in  
22 her bedroom at night. Patient B began wetting herself and defecating in her pants.  
23 Respondent and Patient A's relationship became strained over their two-year marriage and  
24 Respondent showed no interest in being intimate with Patient A. After Respondent  
25 moved out of the home, Patient B told her about Respondent "convulsing" at night in her  
26 bed with his hands between his legs.
- 27 s) On or about October 11, 2017, the Stanislaus Family Justice Center conducted a recorded  
28 interview with Patient B, who was nine-years-old at the time. Patient B stated that she

1 was "really thinking that [Respondent] was going to be a good dad," but when she was  
2 approximately seven-years-old, Respondent began coming into her bedroom at bedtime  
3 and closed the door behind him. Respondent had Patient B recite the prayer, "Now I lay  
4 me down to sleep," take off his clothes (leaving on his underpants), and then would sit in  
5 the bed with his hands in his underpants, touching his "private parts." Patient B described  
6 that Respondent would move and make "convulsing" motions, and he would moan loudly.  
7 Patient B stated that Respondent would not allow her to get out of bed and sometimes  
8 would place his hand on her shoulder or stomach. Patient B stated that Respondent did  
9 this several times throughout the night, sometimes waking her. When asked how many  
10 times this occurred, Patient B replied, "730." When asked if she was scared, Patient B  
11 responded that Respondent was 6 foot 4 inches tall and asked the interviewer to put  
12 herself in Patient B's place. Patient B stated that her mother (Patient A) was tired and sick  
13 during that time because she was pregnant with her baby brother.

14 t) On October 19, 2017, Patient A made a pre-text call to Respondent with police officers on  
15 the line with her. Patient A stated, "I guess I know why you'd never sleep in the same  
16 room as me, how could you do this?" Respondent replied by saying something about a  
17 housewife show and a referral he may have to give. It appeared to the officer that  
18 Respondent did not know whom he was speaking with. Patient A stated, "What are you  
19 talking about?" Based on Respondent's tone, the officer thought Respondent seemed to  
20 know that authorities were listening to the call. Respondent stated, "Goodbye," and hung  
21 up the phone. The next day Respondent provided the officer a typed letter detailing the  
22 pre-text phone call; however, Respondent claimed in his letter that he made statements  
23 that he did not in fact make during the recorded call.

24 u) On February 9, 2018, Patient A took Patient B to a children's hospital. Patient B disclosed  
25 that Respondent masturbated next to her. Patient B also disclosed that Respondent would  
26 lay behind her, hold her down, and stick his penis in her anus. Then, he would tell her to  
27 stay in bed and he would take a shower.

1 v) On February 20, 2018, when Patient B was approximately nine years old, she was again  
2 interviewed. Patient B stated that when they moved in with Respondent he started coming  
3 into her bedroom on her first night there. Patient B reiterated that Respondent would  
4 make her say the prayer, "Now I lay me down to sleep," and then Respondent would  
5 climb into bed with her and "touch his private parts" inside his underwear. She could see  
6 him holding his "private parts in his hand" and move while making a "strange moaning  
7 noise." Patient B described the movement. Sometimes Respondent would put his hand  
8 on her stomach. Respondent would stop after approximately 15 minutes and then fall  
9 asleep in her bed. Patient B stated that Respondent did the same thing the next night and  
10 "he did more the next time." Patient B described that Respondent came into her room and  
11 closed the door, and had her pray with him, and then he made her climb into her bed with  
12 him. Respondent "grabbed" Patient B "super fast" and "put [her] on [her] side." He  
13 pulled down her pajamas and underwear, Patient B stated that she "tried to get out of  
14 there," but Respondent "wouldn't let go of [her.]" Respondent did not say a word.  
15 Respondent had a "clear bottle" with clear liquid, and he would put some of it in his hands  
16 and rub it "all over" his "private parts." Then, Respondent "put his private parts inside  
17 [her] bum." Patient B said it hurt so bad that she felt like she was going to faint. She also  
18 felt like she was "going to scream," but she was "so scared that [she] couldn't even  
19 scream." Respondent got out of bed and raised his voice, telling Patient B to "stay in  
20 bed," and he went to take a shower in her bathroom. Patient B obeyed because she was  
21 "too scared to move." Patient B felt sticky and uncomfortable after Respondent put his  
22 "private part inside her bum." After Respondent finished showering, he got back into bed  
23 with Patient B, and touched his private parts with both hands again, while moaning and  
24 moving. Then, Respondent would face away from Patient B and fall asleep. Respondent  
25 took showers only after he put his "private part inside of [her] bum." Patient B stated that  
26 in the morning, she would find, "little brown particles" in her shower; she cleaned it up  
27 with a wet cloth. Patient B explained that Respondent would "only put his private parts  
28 inside of [her] bum, like every other night, but he never skipped a night touching his

1 private parts." Patient B stated that her "bum hurt" in the mornings and she would have  
2 "accidents" in her pants. Patient B "couldn't wipe" and when she did, there was "blood on  
3 the toilet paper." Patient B clarified that she thinks Respondent's private part is "called a  
4 penis."

5 w) On July 2, 2020, Board Investigators interviewed 11-year-old Patient B. Patient B felt  
6 that after Respondent married her mother, he "was going to be good because he was nice  
7 and he was a doctor." Respondent gave Patient B a ring and put it on her ring finger.  
8 Patient B described that every other night, Respondent would come into her bedroom at  
9 night and make her pray with him. She saw him undress down to his underwear and get  
10 into her bed, lying next to her. Respondent put both of his hands together and put them in  
11 his underwear in his pubic area. She saw him move his hands up and down in short rubs  
12 and could feel his body move. Patient B was "frozen" and "felt paralyzed from fear,"  
13 until she eventually fell asleep. Patient B stated that it lasted for a while, but could not  
14 specify a specific amount of time. This occurred for the first time when Patient B was  
15 approximately seven years old. On alternate nights, when Respondent did not place his  
16 hands in his groin area while in bed with her, Patient B stated Respondent would climb  
17 into her bed and make her "bum" or anus hurt. After a while, Respondent stopped and  
18 Patient B would be in pain. Respondent would typically get up from her bed and take a  
19 shower in her attached bathroom at the "big house," or a bath in the kitchen bathroom in  
20 the "little house." Patient B would eventually fall asleep. When she woke up in the  
21 morning, Respondent would be gone. Her "bum" would still hurt in the morning and she  
22 would be in pain throughout the day and have uncontrollable "accidents," where she  
23 defecated in her underwear. Patient B would then hide her underwear. She only  
24 experienced "accidents" on nights that Respondent made her "bum" hurt. Respondent  
25 would alternate his behavior, one night touching himself and the next night making her  
26 "bum" hurt. Patient B only recalled two times when Respondent did not climb into bed  
27 with her. It was during the summer when she was eight, and they stayed in two adjacent  
28 cabins by the lake; Respondent and her mother stayed in one cabin and Patient B and her

1 nanny stayed in the other cabin. When they moved back to "the little house," after the  
2 summer, Patient B recalled that she slept on an inflatable mattress in the playroom or on  
3 the futon in the living room. Patient B told her mother about what Respondent had been  
4 doing to her after a couple of weeks had passed and she was confident that Respondent  
5 was not returning to her home.

6 **FIRST CAUSE FOR DISCIPLINE**

7 **(Sexual Exploitation)**

8 25. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under sections  
9 2246 and 729, in that Respondent is guilty of sexual exploitation of Patient B. The facts and  
10 circumstances are alleged in paragraph 23 above, which are hereby incorporated by reference and  
11 realleged as if fully set forth herein.

12 **SECOND CAUSE FOR DISCIPLINE**

13 **(Sexual Misconduct)**

14 26. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under section  
15 726, in that Respondent committed acts of sexual abuse and misconduct with Patient B. The facts  
16 and circumstances are alleged in paragraph 23 above, which are hereby incorporated by reference  
17 and realleged as if fully set forth herein.

18 **THIRD CAUSE FOR DISCIPLINE**

19 **(Gross Negligence)**

20 27. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under section  
21 2234, subdivision (b) in that Respondent was grossly negligent in his care and treatment of  
22 Patient A and Patient B, as more particularly alleged in paragraphs 22 and 23 which are hereby  
23 incorporated by reference and realleged as if fully set forth herein.

24 a) Regarding Patient A, Respondent was grossly negligent in his care and treatment of  
25 her, including but not limited to: failing to document any history, physical  
26 examination, diagnosis, or treatment plan related to his prescribing of multiple  
27 controlled substances; failing to discuss side effects or alternatives; failing to make  
28 specialist consultations and/or referrals; failing to obtain informed consent; failing

1 to create and maintain a pain contract; failing to include tapering plans; failing to  
2 consider and utilize drug testing; failing to follow-up and look for adverse side  
3 effects; failing to ensure proper use of the medications; failing to discuss the long  
4 period of Adderall® use in his notations; and failing to note and/or explain the high  
5 doses of oxycodone he prescribed.

6 b) Regarding Patient B, Respondent was grossly negligent in his care and treatment of  
7 her, including but not limited to: prescribing psychotropic medications; failing to  
8 follow the recommendations of the psychiatrist by prescribing psychotropic  
9 medications; failing to follow the recommendations of the psychiatrist in the dosage  
10 of psychotropic medications; failing to obtain a baseline EKG; failing to request  
11 laboratory blood work in order to monitor psychotropic medication dosages and  
12 possible toxicity; kidney issues, and thyroid issues; failing to request or administer  
13 confirmatory tests for ADHD and/or bipolar disorder diagnosis, prescribing lithium  
14 and Adderall® concurrently; prescribing Depakote when she was seven, which is  
15 not recommended to children under the age of ten; prescribing Seroquel when she  
16 was seven, which is not recommended to children under the age of ten; increasing  
17 the Seroquel dosage from the recommended maximum of 100 mg daily up to 400  
18 mg daily; failing to chart any notes of the psychotropic medications beyond the one  
19 note on October 17, 2016 regarding Adderall®; failing to substantiate any  
20 diagnoses; failing to properly monitor her on her medications; prescribing  
21 medication to Patient B while she was his step-daughter, when he could not be  
22 properly objective; and causing physical and psychological harm to Patient B.

#### 23 **FOURTH CAUSE FOR DISCIPLINE**

##### 24 **(Repeated Negligent Acts)**

25 28. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under section  
26 2234, subdivision (c), in that he was repeatedly negligent in the care and treatment of Patient A  
27 and Patient B, as more particularly alleged in paragraphs 22 and 23 which are hereby  
28 incorporated by reference and realleged as if fully set forth herein.



1 a) Regarding Patient A, Respondent committed repeated negligent acts, including but  
2 not limited to: prescribing opiates and benzodiazepines in combination which is a  
3 serious interaction, thereby increasing the risk of synergistic effects of sedation,  
4 with the possibility of overdose, respiratory depression and death; prescribing  
5 opiates and benzodiazepines while psychiatrists concurrently prescribe alprazolam  
6 and amphetamines; prescribing a morphine equivalent dose of 60 mg daily, which is  
7 an addictive level with a high risk of overdose and abuse; failing to document any  
8 history, physical examination, diagnosis, or treatment plan related to his prescribing  
9 of multiple controlled substances; failing to discuss side effects or alternatives;  
10 failing to make specialist consultations and/or referrals; failing to obtain informed  
11 consent; failing to create and maintain a pain contract; failing to include tapering  
12 plans; failing to consider and utilize drug testing; failing to follow-up and look for  
13 adverse side effects; failing to ensure proper use of the medications; failing to  
14 discuss the long period of Adderall® use in his notations; and failing to note and/or  
15 explain the high doses of oxycodone he prescribed; and prescribing sedatives to his  
16 spouse, when a physician cannot reasonably be dispassionately objective.

17 c) Regarding Patient B, Respondent was grossly negligent in his care and treatment of  
18 her, including but not limited to: prescribing psychotropic medications; failing to  
19 follow the recommendations of the psychiatrist by prescribing psychotropic  
20 medications; failing to follow the recommendations of the psychiatrist in the dosage  
21 of psychotropic medications; failing to obtain a baseline EKG; failing to request  
22 laboratory blood work in order to monitor psychotropic medication dosages and  
23 possible toxicity; kidney issues, and thyroid issues; failing to request or administer  
24 confirmatory tests for ADHD and/or bipolar disorder diagnosis, prescribing lithium  
25 and Adderall® concurrently; prescribing Depakote when she was seven, which is  
26 not recommended to children under the age of ten; prescribing Seroquel when she  
27 was seven, which is not recommended to children under the age of ten; increasing  
28 the Seroquel dosage from the recommended maximum of 100 mg daily up to 400

1 mg daily; failing to chart any notes of the psychotropic medications beyond the one  
2 note on October 17, 2016 regarding Adderall®; failing to substantiate any  
3 diagnoses; failing to properly monitor her on her medications; prescribing  
4 medication to Patient B while she was his step-daughter, when he could not be  
5 properly objective; and causing physical and psychological harm to Patient B.

6 **FIFTH CAUSE FOR DISCIPLINE**

7 **(Dishonesty)**

8 29. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under section  
9 2234, subdivision (e), in that Respondent committed an act or acts involving dishonesty or  
10 corruption that is substantially related to the qualifications, functions, or duties of a physician and  
11 surgeon. The facts and circumstances are alleged in paragraph 22 and are incorporated by  
12 reference as if fully set forth. Additional circumstances are as follows:

13 30. On or about January 8, 2020, Respondent stated under oath to Board Investigators  
14 that Patient A's fertility physician "asked me if I would follow [Patient A] and provide for her  
15 medications in Oakdale so she wouldn't have to drive each time over to Palo Alto to see him."  
16 Respondent clarified that Patient A's fertility physician asked Respondent to write prescriptions  
17 for minivelle, progesterone, and letrozole. Patient A's fertility physician informed Board  
18 Investigators that he never allowed, consented, consulted, nor directed Respondent to prescribe,  
19 continue to prescribe, nor treat Patient A on his behalf as a physician.

20 **PRAYER**

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

23 1. Revoking or suspending Physician's and Surgeon's Certificate Number A 60965,  
24 issued to Mark Daniel Cook, M.D.;

25 2. Revoking, suspending or denying approval of Mark Daniel Cook, M.D.'s authority to  
26 supervise physician assistants and advanced practice nurses;

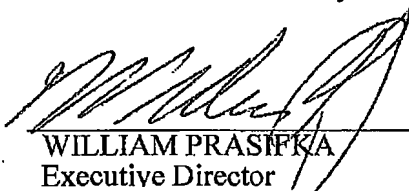
27 ///

28 ///

1           3.     Ordering Mark Daniel Cook, M.D., to pay the Board the costs of the investigation and  
2 enforcement of this case incurred beginning on January 1, 2022, and if placed on probation, to  
3 pay the Board the costs of probation monitoring; and

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

5  
6 DATED: **DEC 09 2022**

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

**Exhibit B**

**Accusation No. 800-2020-072482**

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Attorney General of California  
2 STEVE DIEHL  
Supervising Deputy Attorney General  
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*Attorneys for Complainant*  
8

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

13 In the Matter of the Accusation Against:

Case No. 800-2020-072482

14 **Mark Daniel Cook, M.D.**  
15 **1425 West H St. Ste. 200**  
**Oakdale, CA 95361**

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

16 **Physician's and Surgeon's Certificate**  
17 **No. A 60965,**

Respondent.

18  
19  
20 **PARTIES**

21 1. Reji Varghese (Complainant) brings this Accusation solely in his official capacity as  
22 the Interim Executive Director of the Medical Board of California, Department of Consumer  
23 Affairs (Board).

24 2. On or about October 2, 1996, the Medical Board issued Physician's and Surgeon's  
25 Certificate Number A 60965 to Mark Daniel Cook, M.D. (Respondent). The Physician's and  
26 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought  
27 herein and will expire on August 31, 2024, unless renewed.

28 ///

## 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 2004 of the Code states:

The board shall have the responsibility for the following:

(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

(f) Approving undergraduate and graduate medical education programs.

(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

(h) Issuing licenses and certificates under the board's jurisdiction.

(i) Administering the board's continuing medical education program.

5. Section 2220 of the Code states:

Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in

1 damages in excess of a cumulative total of thirty thousand dollars (\$30,000) with  
2 respect to any claim that injury or damage was proximately caused by the physician's  
3 and surgeon's error, negligence, or omission.

4 (c) Investigating the nature and causes of injuries from cases which shall be  
5 reported of a high number of judgments, settlements, or arbitration awards against a  
6 physician and surgeon.

7 6. Section 2228.1 of the Code states:

8 (a) On and after July 1, 2019, except as otherwise provided in subdivision (c),  
9 the board and the Podiatric Medical Board of California shall require a licensee to  
10 provide a separate disclosure that includes the licensee's probation status, the length  
11 of the probation, the probation end date, all practice restrictions placed on the licensee  
12 by the board, the board's telephone number, and an explanation of how the patient can  
13 find further information on the licensee's probation on the licensee's profile page on  
14 the board's online license information internet website, to a patient or the patient's  
15 guardian or health care surrogate before the patient's first visit following the  
16 probationary order while the licensee is on probation pursuant to a probationary order  
17 made on and after July 1, 2019, in any of the following circumstances:

18 (1) A final adjudication by the board following an administrative hearing or  
19 admitted findings or prima facie showing in a stipulated settlement establishing any  
20 of the following:

21 (A) The commission of any act of sexual abuse, misconduct, or relations with a  
22 patient or client as defined in Section 726 or 729.

23 (B) Drug or alcohol abuse directly resulting in harm to patients or the extent  
24 that such use impairs the ability of the licensee to practice safely.

25 (C) Criminal conviction directly involving harm to patient health.

26 (D) Inappropriate prescribing resulting in harm to patients and a probationary  
27 period of five years or more.

28 (2) An accusation or statement of issues alleged that the licensee committed any  
of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a  
stipulated settlement based upon a nolo contendere or other similar compromise that  
does not include any prima facie showing or admission of guilt or fact but does  
include an express acknowledgment that the disclosure requirements of this section  
would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall  
obtain from the patient, or the patient's guardian or health care surrogate, a separate,  
signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to  
subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the  
disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a  
guardian or health care surrogate is unavailable to comprehend the disclosure and  
sign the copy.

1 (2) The visit occurs in an emergency room or an urgent care facility or the visit  
is unscheduled, including consultations in inpatient facilities.

2 (3) The licensee who will be treating the patient during the visit is not known to  
3 the patient until immediately prior to the start of the visit.

4 (4) The licensee does not have a direct treatment relationship with the patient

5 (d) On and after July 1, 2019, the board shall provide the following  
6 information, with respect to licensees on probation and licensees practicing under  
probationary licenses, in plain view on the licensee's profile page on the board's  
online license information internet website.

7 (1) For probation imposed pursuant to a stipulated settlement, the causes  
8 alleged in the operative accusation along with a designation identifying those causes  
by which the licensee has expressly admitted guilt and a statement that acceptance of  
9 the settlement is not an admission of guilt.

10 (2) For probation imposed by an adjudicated decision of the board, the causes  
for probation stated in the final probationary order.

11 (3) For a licensee granted a probationary license, the causes by which the  
12 probationary license was imposed.

13 (4) The length of the probation and end date.

14 (5) All practice restrictions placed on the license by the board.

15 (e) Section 2314 shall not apply to this section.

## 16 STATUTORY PROVISIONS

17 7. Section 2234 of the Code, states:

18 The board shall take action against any licensee who is charged with  
19 unprofessional conduct. In addition to other provisions of this article, unprofessional  
conduct includes, but is not limited to, the following:

20 (a) Violating or attempting to violate, directly or indirectly, assisting in or  
21 abetting the violation of, or conspiring to violate any provision of this chapter.

22 (b) Gross negligence.

23 (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  
24 separate and distinct departure from the applicable standard of care shall constitute  
repeated negligent acts.

25 (1) An initial negligent diagnosis followed by an act or omission medically  
26 appropriate for that negligent diagnosis of the patient shall constitute a single  
negligent act.

27 (2) When the standard of care requires a change in the diagnosis, act, or  
28 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.

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.

### **COST RECOVERY**

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

### **PERTINENT DRUGS AND DEFINITIONS**

10. Adderall®, a mixture of d-amphetamine and l-amphetamine salts in a ratio of 3:1, is a central nervous system stimulant of the amphetamine class, and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for attention-deficit hyperactivity disorder and narcolepsy. According to the DEA, amphetamines, such as Adderall®, are considered a drug of abuse. "The effects of amphetamines and methamphetamine are similar to cocaine, but their onset is slower and their duration is longer." (Drugs of Abuse – A DEA Resource Guide (2011), at p. 44.) Adderall and other stimulants are contraindicated for patients with a history of drug abuse.

1        11. Benzodiazepines are a class of agents that work on the central nervous system, acting  
2 on select receptors in the brain that inhibit or reduce the activity of nerve cells within the brain.  
3 Valium, diazepam, alprazolam, and temazepam are all examples of benzodiazepines. All  
4 benzodiazepines are Schedule IV controlled substances and have the potential for abuse,  
5 addiction, and diversion.

6        12. Clonidine® lowers blood pressure by decreasing the levels of certain chemicals in  
7 your blood. This allows your blood vessels to relax and your heart to beat more slowly and  
8 easily. It is used to treat hypertension (high blood pressure). Clonidine is a dangerous drug  
9 within the meaning of Business and Professions Code section 4022.

10       13. Controlled Substance Utilization Review and Evaluation System 2.0 (CURES) is a  
11 database of Schedule II, III, and IV controlled substance prescriptions dispensed in California  
12 serving the public health, regulatory and oversight agencies and law enforcement. CURES 2.0 is  
13 committed to the reduction of prescription drug abuse and diversion without affecting legitimate  
14 medical practice or patient care.

15       14. Gabapentin (Neurontin®, Gralise®, Horizant®) is a medicine used to treat partial  
16 seizures, nerve pain from shingles, and restless leg syndrome. It works on the chemical  
17 messengers in your brain and nerves. Gabapentin is a dangerous drug within the meaning of  
18 Business and Professions Code section 4022.

19       15. Hydroxyzine reduces activity in the central nervous system. It is used as a sedative to  
20 treat anxiety and tension. Hydroxyzine is a dangerous drug within the meaning of Business and  
21 Professions Code section 4022.

22       16. Lisinopril® is an angiotensin-converting enzyme (ACE) inhibitor used to treat high  
23 blood pressure in adults and children who are at least six years old. Lisinopril is a dangerous drug  
24 within the meaning of Business and Professions Code section 4022.

25       17. Modafinil (Provigil®) is a central nervous system stimulant that promotes  
26 wakefulness. Central nervous system stimulants are medicines that stimulate the brain, speeding  
27 up both mental and physical processes. Modafinil is a Schedule IV controlled substance pursuant  
28 to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to

1 Business and Professions Code section 4022. When properly prescribed and indicated, it is used  
2 to treat excessive sleepiness caused by sleep apnea, narcolepsy, or shift work sleep disorder.

3 18. Oxycodone (Oxaydo®, OxyContin®, Oxyfast®, Roxicodon®, Xtampza ER®) is a  
4 white odorless crystalline power derived from an opium alkaloid. It is a pure agonist opioid  
5 whose principal therapeutic action is analgesia. Other therapeutic effects of oxycodone include  
6 anxiolysis, euphoria, and feelings of relaxation. Oxycodone is a Schedule II controlled substance  
7 and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, a  
8 Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of  
9 Federal Regulations, and a dangerous drug as defined in Business and Professions Code section  
10 4022. When properly prescribed and indicated, oxycodone is used for the management of pain  
11 severe enough to require daily, around-the-clock, long-term opioid treatment for which alternative  
12 treatment options are inadequate. Respiratory depression is the chief hazard from all opioid  
13 agonist preparations. The risk of respiratory depression and overdose is increased with the  
14 concomitant use of benzodiazepines or when prescribed to patients with pre-existing respiratory  
15 depression. Oxycodone should be used with caution and started in a reduced dosage (1/3 to 1/2  
16 of the usual dosage) in patients who are concurrently receiving other central nervous system  
17 depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other  
18 tranquilizers, and alcohol. The Drug Enforcement Administration (DEA) has identified  
19 oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p.  
20 41.)

21 19. Seroquel® (quetiapine) is an antipsychotic medicine that changes the chemical  
22 actions in the brain. It is used to treat schizophrenia, bipolar disorder, and in combination with  
23 antidepressant medications, it is used to treat major depressive disorder in adults. Seroquel is a  
24 dangerous drug within the meaning of Business and Professions Code section 4022.

25 20. Trazodone (Desyrel®, Desyrel Dividose®, Oleptro®) is an antidepressant that  
26 belongs to a group of drugs called serotonin receptor antagonists and reuptake inhibitors (SARIs).  
27 It is used to treat major depressive disorder. It is a dangerous drug pursuant to Business and  
28 Professions Code section 4022.

21. Vyvanse® (lisdexamfetamine) is a central nervous system stimulant that affects chemicals in the brain and nerves that contribute to hyperactivity and impulse control. It is used to treat attention deficit hyperactivity disorder (ADHD) in adults and in children who are at least 6 years old. Vyvanse® may be habit-forming, and it is a drug of abuse. Oxycodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

22. Xanax® (alprazolam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders. Concomitant use of Xanax® with opioids “may result in profound sedation, respiratory depression, coma, and death.” The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Xanax®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

23. Zolpidem tartrate (Ambien®) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a sedative used to treat insomnia and has potential for abuse.

## FACTUAL ALLEGATIONS

2020

24. On or about September 22, 2020, at approximately 2139 hours, Sheriff's deputies arrived at Respondent and Patient C<sup>1</sup>'s shared residence due to a domestic dispute. Patient C stated that she needed help moving out of the house because she did not feel safe leaving without assistance from the police. She stated that she married Respondent in Mexico, but they were not

<sup>1</sup> Patient names are redacted to protect their privacy. Allegations related to Patient A and B are currently pending in Accusation No. 800-2017-039585.

1 legally married in the United States. Patient C told the deputies that there was a history of  
2 domestic violence between the two of them, and that Respondent had assaulted her with a  
3 wooden paddle. Shortly thereafter, Patient C stated that no physical altercation had occurred.  
4 Patient C stated that she was concerned about not taking her medication that Respondent was  
5 prescribing to her, and that it would make everything better. When asked what medication she  
6 was taking, Patient C only identified her blood pressure medication. Later the same night, Patient  
7 C called the police several times stating that the incident was a misunderstanding and that she  
8 wanted the police to delete the report against Respondent.

9       25. On or about September 28, 2020, at approximately 0428 hours, officers responded to  
10 the home of Respondent and Patient C. Respondent called 911 to report that his wife, Patient C,  
11 was naked and had punched him during an argument. Dispatchers noted that they could hear  
12 Patient C screaming in the background that Respondent dragged her outside by her hair.  
13 Respondent was wearing medical scrubs when the police interviewed him. He stated that he was  
14 sleeping on the couch when he awoke to Patient C yelling at him about red ants being in the  
15 house. He assured her that there were no red ants, and that if there were, it was due to her  
16 children visiting them the week prior. Respondent stated that he tried to go back to sleep, but  
17 Patient C hit him near his lower left jaw. Patient C continued to yell at him about their  
18 relationship, and he grabbed her by the arms and shoulders and forced her outside of their  
19 residence for fear that she would continue to assault him. Respondent said he suffered no injuries  
20 and was only experiencing minor pain. He told the officers that when he grabbed Patient C's  
21 shoulders he may have accidentally grabbed her hair while removing her from the residence.  
22 Respondent denied ingesting any drugs or alcohol, and would not provide the police officers any  
23 further information regarding Patient C's state of mind or use of substances. Respondent chose  
24 not to press charges, but did request an emergency protection order. He told officers that he had a  
25 15-minute audio recording of Patient C yelling at him and played some of the recording for  
26 officers. Officers noted that Respondent could be heard on the recording saying that Patient C  
27 raped him, but Respondent denied this and said that it was childish. Patient C admitted to the  
28 officers that she had consumed alcohol, valium, clonazepam, marijuana, smoked cigarettes,

1 admitted to slapping Respondent, and that she took any kinds of pills or narcotics she could find.  
2 Patient C told officers that she slapped him because he did not love her anymore and wanted a  
3 divorce. She added that she had made a false report to the police in the week prior as well.  
4 Patient C was arrested and served with an emergency protective order requiring her to stay away  
5 from Respondent. Respondent was provided with his own copy of the emergency protective  
6 order by officers. During transport to the jail, Patient C began to tell officers that she had bruises  
7 on her body from a previous assault by Respondent, but quickly changed her mind and did not  
8 want to tell them anything further. Patient C refused to allow the officers to take pictures of her  
9 injuries.

10 26. On or about September 28, 2020, at approximately 2010 hours, the same day as the  
11 prior call, police responded to the home shared by Respondent and Patient C due to report of a  
12 suicidal female. Respondent reported that he witnessed his wife, Patient C, ingest twenty to thirty  
13 blood pressure pills while talking about wanting to die. Patient C appeared agitated, slurred her  
14 speech, and found it difficult to focus and engage in her conversation with paramedics. Patient C  
15 denied depression, suicidal ideation or taking any medication, adding that Respondent was a liar.  
16 Respondent told officers that during an argument, Patient C ingested approximately 20-30 tablets  
17 of blood pressure medication without warning. Respondent stated that as a medical doctor, he  
18 recognized that the amount of Clonidine could be fatal without treatment and called for  
19 emergency services immediately. Respondent added that Patient C has no current specific  
20 psychiatric or mental health diagnoses, and that their marriage has been experiencing difficulty.  
21 Patient C was taken to the hospital pursuant to 5150 psychiatric hold based on Respondent's  
22 observations that she had taken the Clonidine pills.

23 27. On or about August 5, 2020, Patient C presented to Respondent for her first  
24 documented visit to establish care. The history stated that Patient C suffered from "severe  
25 chronic ADHD, insomnia, anxiety and grief." Patient C's history included giving birth to four  
26 children, undergoing a tonsillectomy and adenoidectomy at age 19, wisdom teeth extraction at  
27 age 32, and a motor vehicle accident at age 15 causing a left humerus fracture requiring surgery,  
28 two chest tubes, and the loss of her father. Respondent noted that her ADHD was previously

1 treated with Dexedrine 15 mg twice a day (BID), and that she had taken Adderall 30 mg 1 to 1 ½  
2 tablets per day for fifteen years. Respondent documented a history of insomnia that was  
3 previously treated with Ambien, temazepam, Lunesta, and Sonata. Patient C had a history of  
4 anxiety that was previously treated with “all” benzodiazepines according to the record, most  
5 effectively treated with Klonopin 2 mg twice daily. Patient C worked at a renal dialysis clinic as  
6 a registered nurse. The review of systems was normal with the exception of ADHD, insomnia,  
7 anxiety, and daily grief. Respondent did not identify any current medications taken. Patient C’s  
8 BMI was normal, and her blood pressure was elevated at 128/104. The general examination  
9 noted that her “mood appears euthymic, affect appropriate, insight excellent, and no suicidal or  
10 homicidal ideation.” The assessment included a physical, ordering labs, severe ADHD, chronic  
11 insomnia, and chronic anxiety/grief. The plan was to treat Patient C with Adderall 30 mg bid,  
12 with a note that all her questions were answered, and that the risks and benefits were reviewed  
13 with Patient C before she agreed to proceed with treatment. Respondent prescribed Adderall 30  
14 mg, #60, ½ to 1 tablet two times daily, which was handwritten and filled by Patient C. Patient  
15 C’s EKG and CT calcium were normal except for a borderline Hgb A1C indicating borderline  
16 diabetes and a low TSH indicating possible hyperthyroidism. A CURES check by Respondent on  
17 this date in the medical record only revealed two prior prescriptions for Lunesta in 2019.  
18 Respondent documented a two page self-report scale completed by Patient C in support of an  
19 ADHD diagnosis, but the form noted that it was only a checklist and required a thorough clinical  
20 evaluation prior to a diagnosis of ADHD. Patient C signed an access to records form that listed  
21 Respondent as her husband, and allowed Respondent to receive medical information from other  
22 staff at the office regarding Patient C. Patient C refilled her Adderall prescriptions on September  
23 9, 2020, October 21, 2020, and November 18, 2020. Patient C refilled her Phentermine 37.5 mg  
24 #30 on August 16, 2020, and September 26, 2020. Patient C filled her Xanax 2 mg #30 on  
25 November 5, 2020. The prescription records show that Respondent also prescribed propranolol  
26 120 mg extended release daily, a one-year supply, clonidine .2 mg #270, with four refills.  
27 Notably, the record was not electronically signed by Respondent until October 19, 2020, over two  
28 months later.

1        28. On or about August 5, 2020, Respondent prescribed Patient C Adderall.

2        29. On or about November 4, 2020, at approximately 2330, a CHP officer observed  
3 Respondent driving northbound on US-395. The vehicle was intermittently stopping on the right  
4 shoulder, stopping approximately three times for five to ten seconds each time. The vehicle was  
5 fluctuating in speed between fifty and seventy miles per hour, and was the only vehicle on the  
6 roadway at the time. As the officer passed the vehicle, it began to intermittently activate the  
7 emergency flashers three times and the officers noticed that the vehicle registration was expired.  
8 Officers approached the vehicle and found that the interior of the vehicle was disheveled and  
9 drenched with a whitish liquid. Respondent, in the drivers seat, had severe red scratches on the  
10 top of his head that appeared fresh and nearly bleeding. Dr. Cook identified himself, and stated  
11 that his wife, Patient C, was completely inebriated and experiencing a manic episode.  
12 Respondent stated that she was acting out of control and sitting in the back of the vehicle naked.  
13 Respondent's eyes appeared red and watery, and his face was wet. Officers contacted Patient C  
14 who was seated in the middle of the third row seat of the Honda Pilot. Patient C was wearing  
15 clothes, her head appeared to have minor swelling, her hair was disheveled, and she stated that  
16 she was not naked. Officers asked Respondent to step out of the vehicle to provide a statement.  
17 Respondent told the officers that he had been married to Patient C for seven or eight months. He  
18 stated that they lived together in a home in Oakdale, and that their relationship was tumultuous.  
19 Respondent stated that Patient C was "completely inebriated and is experiencing a manic  
20 episode." Dr. Cook told them about a previous domestic violence situation that he and Patient C  
21 were both involved in three weeks prior in Stanislaus County. Respondent would not tell the  
22 officers what became of the Stanislaus County Sherriff's Department investigation or what  
23 reports were taken in the prior incident. Respondent stated that he and Patient C had travelled  
24 from Oakdale to Bishop, in order to visit her children. Respondent stated that they booked a  
25 room at the Creekside Inn in Bishop. He stated that on November 4, 2020, Patient C dropped her  
26 children off at an unknown location in Bishop and returned to the hotel. When she returned she  
27 was very upset, and Respondent stated that he could tell that she had been drinking. Respondent  
28 stated that he tried to console her, but she only became more aggressive and hit her own head on



1 the door in the hotel. Respondent would not tell the officers how he got scratches on his own  
2 head, but did say that it happened at the Creekside Inn earlier in the evening. Respondent stated  
3 that he hit Patient C, but admitted that he pushed her in self-defense as she approached him.  
4 Respondent stated that he spanked her on her 'bare bottom' as a punishment for out of control  
5 behavior. Respondent stated that he activated the emergency lights of the vehicle to get the  
6 attention of law enforcement because Patient C was continuing to act out of control. Respondent  
7 declined to provide the officers with any other detail.

8 30. The officers interviewed Patient C separately at the scene of the stop. Patient C sat in  
9 the right front passenger seat of the vehicle during the interview. Patient C stated that she had  
10 first met Respondent on May 24, 2020, after connecting online, and they now lived together in  
11 Oakdale. Patient C said that Respondent always says they are married, but they are not actually  
12 married. Respondent had thrown her out of the house several times in the past. She stated that  
13 they were staying at the Creekside Inn in located in Bishop while visiting with her children who  
14 live with their biological father. Patient C stated that they drove from Oakdale on November 2,  
15 2020, and were returning home to Oakdale. In addition to seeing her children, she also attended a  
16 court appearance in Bishop during her trip. Patient C stated that Respondent had made her pack  
17 up all the belongings in the hotel room prior to returning to Oakdale. Respondent took her car  
18 and left. Respondent threatened to leave Patient C in Bishop with all her belongings. When  
19 Respondent returned to the hotel room and found that Patient C had not finished packing and  
20 cleaning, Respondent had become angry. Respondent called her children filthy and would not  
21 help her pack or clean the room. Respondent slammed the door in her face several times at the  
22 hotel. Patient C stated that Respondent had been "torturing" her for months, and had choked her  
23 many times before. Patient C stated that she just wanted to move back to Bishop. Patient C  
24 stated that while they were driving, Respondent tried to throw her out of the car, and eventually  
25 threw her cell phone out of the car. She stated that Respondent was punching her in the face, and  
26 demonstrated the punching in her face with her fists for the officers. She reported that he was  
27 also pulling her hair. Patient C stated that she was not afraid of Respondent right now, but she  
28 was earlier when they were driving. Patient C stated that she activated the emergency lights on

1 the vehicle to get help from law enforcement. She admitted to hitting Respondent in the face with  
2 a wet t-shirt in self-defense. During the interview officers observed a scratch and bruising on the  
3 top right of Patient C's forehead, and her face appeared to have minor swelling. Patient C's  
4 pupils appeared dilated, had a slow reaction to light, and she appeared to be avoiding eye contact  
5 when talking. Her speech was erratic, and she had difficulty recounting the events in  
6 chronological order.

7 31. On or about November 5, 2020, Respondent and Patient C were both arrested by the  
8 California Highway Patrol (CHP) for violation of Penal Code section 273.5 (co-habitant abuse).  
9 They were handcuffed, and transported to the hospital for a Covid-19 screening prior to  
10 incarceration. While traveling to the hospital, Patient C stated that she accidentally hit her head  
11 against the computer in the patrol vehicle, that the arrest was unjustified, and all the evidence  
12 should be sequestered. Patient C urinated in the patrol vehicle during transport to the hospital.  
13 While at the hospital, Respondent complained of chest pain, but declined medical attention.  
14 Officers were unable to get pictures of Patient C's injuries, but they took photos of Respondent's  
15 injuries. The parties were advised of their rights and admitted into the county jail.

16 32. On or about November 9, 2020, Sheriff's deputies contacted Patient C to conduct a  
17 follow-up interview regarding the prior allegation of rape against Respondent. Patient C, who  
18 was in jail during the interview, stated that she lied about being raped by Respondent because she  
19 was mad at the time. She stated that she was under the influence of marijuana, and had a lot of  
20 anxiety on that night. Patient C stated that she would obviously have sex with Respondent, as he  
21 was her husband. She added that she was under the influence of marijuana at the time she made  
22 the original report. Patient C said she was lying when she made the complaint of rape and wanted  
23 the charges to be dropped against her husband, Respondent.

24 33. On or about November 9, 2020, the Board received information from CHP that  
25 Respondent had been arrested for violation of Penal Code section 273.5 (co-habitant abuse) on or  
26 about November 5, 2020, and that during the investigation of this charge, Respondent admitted to  
27 being the primary care doctor for his new co-habitant, who he referred to as his wife.

28 ///

1        34. On or about November 17, 2020, the medical record contains documentation of  
2 discussions with the pharmacy regarding a refill of clonidine for Patient C. Although clonidine is  
3 typically prescribed as .2 mg every 6 hours as needed for a systolic blood pressure of 160,  
4 Respondent had only prescribed one pill per day.

5        35. On or about December 12, 2020 at 0750, Respondent texted Patient C stating "I will  
6 pray for you and you're going to need it you kidnapped me and locked me in my own room and  
7 house tonight you prevented me from leaving to exit away from the danger of you said such mean  
8 evil vile ruthless vindictive vicious things that it is unfathomable how you had any kind of  
9 relationship with anybody else..." Patient C responded by telling Respondent that it was an  
10 emergency and she needed him to prescribe her something so she could sleep. She then added  
11 that "Lunesta works best" followed by specifying that it should be in 3 mg tablets, or Xanax.  
12 Respondent stated, "No I will not prescribe any additional controlled substances for you ever  
13 again I already told you that... You need a psychiatrist and an addiction counselor...and rehab."  
14 Patient C persisted, telling Respondent that she was desperate. Respondent wrote, "I tried 100  
15 times to help you last night and this morning every time you made promises that you broke every  
16 time you lied and did not provide what you kept promising... You are completely dangerous to  
17 me dangerous to you dangerous to everybody around you when you exited the driveway in my  
18 car and raced off with me holding onto the door handle you caught my hand in the door handle  
19 and ran over my foot." Patient C later asked him to pick up tobacco and medicine. She texted  
20 Respondent stating, "You torture me too." Respondent stated "I'm not talking with you you  
21 destroyed and tortured me to even be with you."

22        36. On or about December 12, 2020, at 0759, Respondent texted Patient C explaining that  
23 he had tried everything he could to help her, even providing a back rub and giving her "10 tablets  
24 of clonidine which would make any man sleep for days." Respondent called Patient C vicious  
25 and vindictive, and accused her of stealing his car key. The text conversation continued with  
26 Respondent suggesting that she should leave, and not call his office or his service anymore.  
27 Patient C referenced an old apartment, which Respondent described as, "an apartment in El  
28 Dorado Hills in which you said you took up seeing the high amounts of drugs and sat for days at a

1 time staring at the walls contemplating suicide....Obscene.” Patient C later stated at 0803, “I  
2 have no choice I’m 100% depending on you.” At 0806, Patient C texted, “I love you please bring  
3 my clonidine.” Respondent replied by telling her that he is not able to help her and that she is  
4 beyond his ability to help any longer.

5 37. On or about December 12, 2020, the medical records note that Patient C was having a  
6 panic attack. Later notes indicate that her panic attack had improved, but that she was calling  
7 again, yelling about wanting to cancel her upcoming appointment with Respondent and fire him  
8 as a doctor. Following that entry, Patient C called again to ask Dr. W for a Xanax refill, claiming  
9 that she had received Xanax at Mammoth Lakes four day earlier. Patient C was directed to  
10 contact Respondent.

11 38. On or about December 15, 2020, at 1514, Patient C texted Respondent stating, “I  
12 think we should get married legally and say something like I moved away here for whatever  
13 reason and you are not financially helping me for the courts business and keep mine private.”  
14 Respondent replied by marking her message as “loved.” Patient C replied, “Just don’t say  
15 anything about marriage to the courts.” Patient C continued to text multiple times, later stating,  
16 that “being legally married is not important to you.” She then stated that she is legally single.  
17 Following numerous texts from Patient C, Respondent asked her if she is back on  
18 methamphetamines at 1754. Patient C responded that she is done “playing married” with  
19 Respondent. Respondent discussed a marriage ceremony in Rosarito, Mexico, to which Patient C  
20 stated that she still wanted “a real wedding, a Christian wedding.” At 1804, Patient C texted  
21 Respondent stating that “no amount of money could have bought my way out of dbhc [Doctors  
22 Behavioral Health Center, the mental health facility she was placed in following the 5150 hold].”  
23 Respondent replied, “Yes and I offered any amount of money to that doctor to keep you out of  
24 there... Then when they put you in there I argued with your doctor ... to let you out immediately  
25 for outpatient treatment....But you got there on your own merits I didn’t put you in there...”  
26 Respondent later stated that he offered the doctor a month off to take her husband to Hawaii.  
27 Following numerous additional texts, Respondent recounted that Patient C was “active psychotic”  
28 ///

1 and "running around in the front yard naked after an apparent suicide attempt." Patient C  
2 responded, "For you."

3 39. On or about December 15, 2020, at 1812, Patient C texted Respondent that she  
4 wanted valium because she "has to deal with her abusing boyfriend who lied and continues to lie"  
5 to her. Patient C then asked him for Adderall and said that if he is lucky he can stay her  
6 boyfriend and then they can get married in America. Respondent replied at 1817, "No  
7 amphetamines as you get psychotic." Patient C denied that she gets psychotic then told  
8 Respondent to leave the babies alone, and called him a trashy and filthy man in multiple text  
9 messages.

10 40. On or about December 22, 2020, at 0903, Patient C texted Respondent stating, "I will  
11 just plead guilty and tell the courts I am a liar and I'm not married to you then?" She added that  
12 this is related to her upcoming court date, that she will lie if that is what it takes, then claimed that  
13 he abandoned her again when he doesn't respond. Patient C stated that she should probably see a  
14 psychiatrist so that she doesn't steal medications anymore, and that she was hitting him in the first  
15 place because he stole her street medication. At 0944, Patient C said that she is going to cancel  
16 her appointment at his office "unless you can fill my narcotics please." She followed the text up  
17 with another that says just joking, with a question mark.

18 41. On or about December 22, 2020, at 1026, Patient C texted Respondent to tell him that  
19 he could have been eating breakfast with her, but instead she will be alone in jail. She stated, "No  
20 I see why attorney warned me [*sic*]." Respondent later disliked the statement about the attorney.

21 42. On or about December 23, 2020, at 0911, Patient C texted Respondent "911,"  
22 followed by several pictures and a text that states, "Tell it to the police this time." At  
23 approximately 0915, Patient C texted Respondent stating "Good you have a daddy that loves  
24 you," followed by a text message that referenced Respondent's former step-daughter whom he is  
25 accused of committing sexual misconduct against. Patient C then said that she and the former  
26 step-daughter have the "same daddy and it's not [redacted]." At 0916, Respondent texted  
27 "coming here to institutionalize you." Respondent told Patient C that he received 240 texts from  
28 Patient C the day prior and that "it doesn't matter your still completely psychotic and drugged out

1 of your...on meth." At 0918, Patient C texted Respondent referring to the pending Accusation  
2 against Respondent alleging sexual misconduct and stated, "you're responsible." Respondent  
3 replied that she is sick, and Patient C stated "I'm Patient C<sup>2</sup> and you're gross negligence."  
4 Respondent replied, "You wish." Patient C continued to state that Respondent is "sick," that she  
5 knows it and his former wife (Patient A) knows it as well. Patient C stated, "You prey on me and  
6 [Patient B] and [Patient A]," followed by "Don't molest me." At 0921, Patient C texted  
7 Respondent, "No more molesting for you." Patient C continued to text Respondent repeatedly, to  
8 which Respondent stated at 0925, "I came home to you last night and you attacked me violently  
9 20 times... I have the videos for the police." Patient C replied "Please don't touch my private."  
10 Patient C later texted that she has called 911 and the police for help, and that she hates  
11 Respondent.

12 43. On or about December 23, 2020, at 0941, Respondent texted Patient C accusing her  
13 of stealing money from his bank account and destroying his televisions in a recent "tirade." At  
14 1255, Respondent texted, "I never confronted you last night... I just left after a dozen of your  
15 lunging attacks Also never struck back after 20 closed fist blows to my face and body while  
16 asleep at 2:00AM the night before and that is why I stayed to work late at the hospital last night!"  
17 Later the same day Patient C texted Respondent to state that she is "scared," she thinks her "brain  
18 is completely destroyed," and that she has no sense of self. She asked Respondent for help  
19 numerous times by text message.

20 44. On or about December 23, 2020, the medical records state that Patient C was  
21 suffering from a panic attack, and repeatedly was calling back and yelling at the staff on the  
22 phone calling them an incorrect name.

23 45. During the period of on or about August 5, 2020, through November 18, 2020, Patient  
24 C filled the following prescriptions for controlled substances:

25 ///

26  
27 <sup>2</sup> At the time of this text message, the Board had not yet brought any allegations related to Patient  
28 C, and the patient appears to have self-identified as "Patient C" in reference to the allegations  
related to Patients A and B in pending Accusation No. 800-2017-039585.

Date Filled	Drug Name	Strength	Form	Days' Supply	Quantity	Prescriber Name
8/5/2020	AMPHETAMINE SALT COMBO	30 MG	TAB	30	60	Respondent
8/16/2020	PHENTERMINE HCL	37.5 MG	TAB	30	30	Respondent
9/9/2020	AMPHETAMINE SALT COMBO	30 MG	TAB	30	60	Respondent
9/26/2020	PHENTERMINE HCL	37.5 MG	TAB	30	30	Respondent
10/21/2020	AMPHETAMINE SALT COMBO	30 MG	TAB	30	60	Respondent
11/5/2020	ALPRAZOLAM	2 MG	TAB	30	30	Respondent
11/18/2020	MIXED AMPHETAMINE SALTS	30 MG	CER	30	60	Respondent

### 2021

46. On or about January 6, 2021, Patient C presented to Respondent due to a stress reaction while at her workplace, the dialysis clinic. Respondent stated in his interview, that the cause of the stress reaction was that employees at the dialysis clinic had spoken to Patient C about the allegations against Respondent in the pending Accusation involving sexual misconduct. Respondent noted that this had created a "toxic and hostile work environment," which aggravated her existing medical problems. The review of systems was negative except for anxiety. Patient C's medications listed include clonidine .2 mg, take 1-2 every 6 hours as needed for systolic blood pressure over 180, hold if less than 120; Adderall 30 mg BID, and as needed for severe ADHD. Patient C's vital signs revealed an elevated blood pressure of 140/98. The general examination was noted to be normal. The assessment includes a hostile work environment, toxic work environment with work-related stress reaction, generalized anxiety disorder secondary to panic and insomnia. The plan was to extend her time off from work through February 7, 2021. The forms were completed and sent to Patient C's employer. Respondent noted that Patient C was being treated by a psychiatrist who prescribed Seroquel 400 mg nightly for insomnia, that Patient C had begun counseling and had a session that night. Respondent noted that Patient C was scheduled to return in one week. Patient C continued to be on disability at Respondent's recommendation through April 14, 2021. The CURES report revealed that Respondent was

1 prescribing Patient C modafinil (a stimulant given for obstructive sleep apnea, narcolepsy or shift  
2 work sleep disorder) 200 mg #30, one daily. Dr. N, the psychiatrist that previously treated Patient  
3 C in San Diego, began treating Patient C by telehealth with Respondent present. Dr. N began  
4 prescribing Adderall 20 mg #30, one daily on May 2, 2021, eventually increasing it to 30 mg  
5 daily. Respondent continued to prescribe modafinil on May 20, 2021, until Dr. N began  
6 prescribing it on August 2, 2021.

7 47. On or about January 14, 2021 at approximately 2012 hours, police officers responded  
8 to a report of an altercation at the home shared by Patient C and Respondent. Respondent stated  
9 that his wife struck him and bent his fingers causing him pain. Patient C was on the phone with  
10 Respondent when officers arrived and could be heard yelling over the phone. Officers learned  
11 that Respondent and Patient C were married, had no children in common and lived together.  
12 Patient C initially denied any wrongdoing, then later admitted that she attempted to break  
13 Respondent's fingers and slapped him on the left side of his face. Patient C admitted to drinking  
14 tequila during the evening but denied using any illegal drugs. She told officers that Respondent  
15 had been molesting her since the beginning of their marriage. She stated that Respondent  
16 provides her with prescription sedatives, and she believe that she is being molested and  
17 manipulated. Patient C stated that initially, Respondent would give her a pill and say, "take this,"  
18 so she would open her mouth and take it. She continued to take the pills, but began to wonder  
19 what Respondent was giving to her as they would make her tired. She told officers that  
20 Respondent has gone on dates with the daughters of other patients, and had seen pictures of  
21 children that were sent to him. She became erratic and was eventually placed under arrest.  
22 Respondent was provided with an emergency protective order against Patient C, and both parties  
23 were served with a copy of the order.

24 48. On or about February 19, 2021, Respondent obtained a restraining order against  
25 Patient C, that was effective for three years. Despite the order, he continued to have regular  
26 contact with Patient C.

27 49. On or about March 8, 2021, investigators contacted Patient C at the Stanislaus County  
28 Jail regarding the arrest of Respondent by the California Highway Patrol Bridgeport Office in



1 Mono County. Patient C voluntarily agreed to an interview. Patient C admitted that she is a  
2 substance abuser with drug-seeking habits that needs rehabilitation. Patient C stated that she  
3 would steal controlled substances from any source available. She stated that she stole  
4 benzodiazepine medications from Respondent's mother. She also stated that she has abused  
5 illegal drugs including heroin, methamphetamine, cannabis edibles, and Xanax (a  
6 benzodiazepine) that was purchased from the street. She stated that she is an abuser of  
7 oxycodone (an opiate) and Ambien (a sleeping pill) in combination, which she also obtains from  
8 the street. Patient C explained that she has been a habitual user of Adderall (a stimulant drug)  
9 since she was first prescribed Adderall at 17 years old. Patient C stated that she would purchase  
10 Adderall from the street and abuse the drug. Patient C stated that Respondent does not prescribe  
11 her opioids or benzodiazepines. In sum, Patient C stated that she was taking benzodiazepines,  
12 heroin, methamphetamine, cannabis edibles, Xanax, oxycodone, and Ambien. She stated that one  
13 time she stole ten thousand dollars from Respondent to purchase drugs and he caught her. As she  
14 tried to get away, the sheriff was called to her residence, which led to her current incarceration at  
15 Stanislaus County Jail. Patient C said that there had been multiple domestic violence calls to  
16 Respondent's residence near Oakdale, because she would behave out of control during her drug-  
17 induced frenzies. She insisted that Respondent is a good person and hopes to reconcile their  
18 relationship when she is released from jail and completes a rehabilitation program. Patient C  
19 repeated that she is not concerned with Respondent's behavior, and that it is her behavior that  
20 leads to contact with law enforcement. Patient C explained that on November 4, 2020, the day of  
21 the arrest in Mono County, she was in the middle of a drug-induced frenzy where she had  
22 consumed a vast amount of drugs including cannabis edibles, methamphetamine, Xanax (a  
23 benzodiazepine tranquilizer), and Ambien (a sedative/hypnotic). She stated that on that day she  
24 had consumed cannabis edibles and methamphetamine that was purchased on the street. Patient  
25 C added that she had consumed large quantities of Xanax and Ambien, some of which were  
26 purchased from the street, and some were stolen from Respondent's mother. After visiting with  
27 her children near the Bridgeport Indian reservation, she and Respondent took her children to the  
28 home of their father who had custody of the children following their divorce in 2019. Patient C

1 stated that it was late in the night after they dropped the children off, and she had to work in the  
2 morning in Modesto. Respondent drove them home during the night to their home in Oakdale.  
3 While Respondent was driving, Patient C reached into her pocket to take out a prescription bottle  
4 containing Ambien that she had previously stolen from Respondent's mother. Patient C said that  
5 she intended to take several pills to sleep on the way home. Respondent took the pills from her  
6 and put them in his front pocket. Patient C says that she became irate and aggressive and started  
7 physically fighting with Respondent while he was driving. Patient C reported that she tried to  
8 take the pills from his pocket while he was driving, causing the car to veer on the roadway. A  
9 CHP officer then investigated the incident and took statements from both of them. CHP arrested  
10 both of them and took them to the CHP office for fingerprinting. Patient C believes that it was all  
11 her fault and that the charges were dismissed.

12 50. On or about May 18, 2021, at approximately 2255, officers responded to the home  
13 shared by Respondent and Patient C due to a complaint of an altercation. When officers arrived,  
14 Respondent was in the front of his house wearing scrubs, a scrub hat, and a stethoscope and other  
15 items on a lanyard hanging around his neck. Respondent told officers that after the incident he  
16 changed into his work clothes. Respondent reported that he was lying in bed, nearly falling  
17 asleep, when Patient C entered the room and struck him in the face with a closed fist on his left  
18 cheek area. When he got up, she dumped a gallon of milk on to his head and on the bedroom  
19 floor. Respondent stated that Patient C was throwing household items at him in the room, and he  
20 waited outside for law enforcement. Respondent told officers that they had been married for  
21 about one year, and that Patient C was a heavy drinker. Patient C was arrested for domestic  
22 violence and taken to jail.

23 51. On or about June 4, 2021, Dr. N prescribed Patient C Seroquel, fluvoxamine, and  
24 gabapentin.

25 52. On or about August 18, 2021, Patient C's medical record noted that she had called the  
26 office and was incoherent. The notes stated that Patient C said "she had been in a Merced rehab,  
27 but left, had been in jail and was taken directly from jail to the rehab," loves Respondent, and

28 ///

1 "will do anything to save her marriage." Patient C requested to be referred to a rehab. A  
2 handwritten note adds, "I have been able to get [Patient C] back into Christian rehab."

3 53. On or about August 23, 2021 through October 19, 2021, Dr. G prescribed Patient C  
4 clonidine, gabapentin, trazodone, Lisinopril, Seroquel, and hydroxyzine.

5 54. On or about August 30, 2021, at approximately 1208, officers reported to the  
6 residence of Respondent and Patient C in response to complaints of spousal battery. Respondent  
7 told officers that he was sleeping when he awoke to Patient C punching and slapping his face. He  
8 stated that Patient C had broken into his residence, and stolen his vehicle, his wallet and  
9 \$10,000.00. Patient C told officers that during the evening on August 27, 2021, she arrived at the  
10 residence and was punched and slapped multiple times by Respondent about her head, face, and  
11 leg areas. She told officers that she was living with Respondent and driving his vehicle for the  
12 past two years with his permission due to their sexual dating relationship. Patient C stated that  
13 she is a registered nurse that works in Respondent's office and sees his patients. She denied  
14 taking Respondent's wallet or his money, which Respondent later located during the interview.  
15 Both Respondent and Patient C told officers conflicting versions of a physical altercation on  
16 August 27 and again on August 29, 2021. Officers determined that Patient C was at the residence  
17 in violation of an existing stay away order listing Respondent as the protected party. Respondent  
18 was placed under arrest for committing battery against Patient C, then immediately complained of  
19 chest pains requiring a transport to the hospital. Patient C was placed under arrest for committing  
20 battery against Respondent, and for violating the active restraining order. The same day, officers  
21 responded to the residence and the hospital to take photos of Respondent and Patient C's  
22 respective injuries. Respondent complained of pain on his cheeks/jawlines, but the officer did not  
23 see any marks, bruises or injuries. Patient C complained of pain in her right shin, upper left back,  
24 left wrist, right abdomen, nose, and stated she was slapped on the right side of her head above her  
25 ear. The officer only identified a small bruise on her right shin.

26 55. On or about November 11, 2021, Patient C presented to the emergency room for  
27 possible broken glass in her foot. Patient C left before x-rays could be taken and declined a  
28 tetanus booster.

56. On or about December 6, 2021, Dr. N switched Patient C's ADHD medication from Adderall to Vyvanse 30 mg daily, which continued through June 16, 2022.

57. During the period of on or about February 1, 2021, through December 23, 2021, Patient C filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Form	Days' Supply	Quantity	Prescriber Name
2/1/2021	MODAFINIL	200 MG	TAB	15	30	Respondent
3/23/2021	MODAFINIL	200 MG	TAB	30	30	Respondent
4/21/2021	MODAFINIL	200 MG	TAB	30	30	Respondent
5/2/2021	AMPHETAMINE SALT COMBO	20 MG	TAB	30	60	Dr. N
5/20/2021	MODAFINIL	200 MG	TAB	15	30	Respondent
6/23/2021	MIXED AMPHETAMINE SALTS	30 MG	CER	30	30	Dr. N
8/2/2021	MODAFINIL	200 MG	TAB	30	30	Dr. N
9/21/2021	MODAFINIL	200 MG	TAB	30	30	Dr. N
10/21/2021	MODAFINIL	200 MG	TAB	30	30	Dr. N
12/6/2021	VYVANSE	30 MG	CAP	14	14	Dr. N
12/23/2021	VYVANSE	30 MG	CAP	30	30	Dr. N

**2022**

58. On or about March 10, 2022, Respondent documented that Patient C had a negative PAP smear, negative HPV test, negative for sexually transmitted infections, negative for bacterial/trichomonas/fungal tests, negative urinalysis and culture, normal blood tests, elevated potassium of 6.1, elevated calcium of 10.6, mildly elevated liver enzyme of 41, and a normal TSH.

59. On or about May 10, 2022, the Board of Registered Nursing, Department of Consumer Affairs, filed an Accusation against the Registered Nurse License issued to Patient C. The Accusation was related to Patient C's criminal conviction for driving under the influence of alcohol on July 4, 2019; Patient C's dangerous use of alcohol during police contacts with Respondent on September 18, 2020, January 14, 2021, February 14, 2021; and unprofessional conduct during domestic violence incidents and violation of a restraining order related to her contacts with Respondent on January 14, 2021, February 14, 2021, February 29, 2021, August 7,

1 2021, and August 30, 2021. Patient C subsequently admitted the truth of each and every charge  
2 and allegation in the Accusation, and surrendered her Registered Nurse License effective  
3 December 6, 2022.

4 60. On or about May 25, 2022, the chart indicates that Patient C failed to show for an  
5 appointment. A note indicates that she had called to cancel the appointment.

6 61. On or about June 21, 2022, Patient C presented to Respondent for treatment.  
7 Respondent documented a significantly more complete patient history than what was included in  
8 the first visit. Respondent mentioned urgent hypertension since 2018, post-traumatic stress  
9 disorder, panic and anxiety issues since age 5-6 exacerbated by her father's death when she was  
10 fifteen. Respondent mentioned severe insomnia and severe shift work sleep disorder since age 4,  
11 a learning disability, a mood disorder with night sweats and nightly terrors. Respondent noted  
12 that Dr. N has followed her for ten years. The records indicate that Patient C had seasonal  
13 allergies and asthma since age two. Respondent wrote that she "denies significant alcohol,  
14 tobacco, or drugs," although in his interviews with police Respondent stated that she was quite  
15 inebriated during her November 4, 2020 arrest. Respondent stated that Patient C attended  
16 Celebrate Recovery weekly at her church. The record states that Patient C's uncle died by suicide  
17 at age 30, and her brother was disabled and had multiple psychiatric problems. Respondent  
18 documented that substance abuse history and mental health history was last reviewed on April 26,  
19 2022, but no record of this exists in her medical record. Patient C's medications were clonidine,  
20 modafinil, Seroquel, propranolol, amoxicillin, pyridium, bimatroprost eye drops, Phenergan  
21 suppositories. The examination shows no vitals or examination information other than a partial  
22 urine dipstick result. The assessment was a painful and frequent urination, and vaginal discharge.  
23 This visit was not signed electronically by Respondent.

24 62. On or about June 22, 2022, Patient C failed to show for an appointment. Labs were  
25 performed on this date that were negative for STI's, bacterial infections, parasite infections, but  
26 positive for a yeast infection.

27 ///

1           63. On or about July 7, 2022, Patient C presented for her final documented visit.  
2 Respondent did not document a patient history, just mention of the previous visits with the  
3 addition of metronidazole topical gel applied to the affected area daily. The examination only  
4 included vital signs, showing an increase in weight to 153.6 pounds. Respondent did not sign off  
5 on this visit electronically.

6           64. On or about July 7, 2022, investigators interviewed an employee at Respondent's  
7 office. The employee stated that Patient C was known to live with Respondent and would come  
8 into the office daily. Patient C appeared to be "high" about half of the time, but would usually  
9 stay in Respondent's office. The employee stated that Patient C's hair was matted down and she  
10 was regularly dressed in age inappropriate clothing – similar to something a 3 or 4 years old child  
11 would wear. On other occasions, she would wear medical scrubs while she was in the office.  
12 One time, she found Patient C spinning and dancing through the hallways of the medical practice.  
13 Another time, around February 2022, she had to help Patient C go the bathroom and return to  
14 Respondent's couch because she was too impaired to walk on her own.

15           65. On or about July 7, 2022, investigators interviewed the office manager at  
16 Respondent's practice. The office manager reported that it was her understanding that Patient C  
17 was Respondent's common law wife, and that she was in the office all the time. Patient C was  
18 regularly "completely out of it" at the office, and was required to stay in Respondent's private  
19 office. She believed that Patient C was nice, but would suddenly fly off the handle and become  
20 volatile. She told Respondent that Patient C should not be allowed to wander around the office,  
21 but she had to redirect Patient C back to Respondent's office several times. Respondent told the  
22 office manager that Patient C had been in rehab before, and that she was abusive towards him.  
23 The office manager provided investigators with two emails that she received from Respondent on  
24 October 23, 2020 that were intended for Patient C, but accidentally sent to her email. In one  
25 Respondent told Patient C, "You have deceived me again. Never again will I ever believe you or  
26 trust you. You love your methamphetamine and your drugs more than you love your family more  
27 than you love your own children. You love methamphetamine and black tar heroin more than  
28 you love God and his promises to us...his children." In another he wrote Patient C, "Your two

1 tablets here at the house and will give it to you right now turn your car around and come back  
2 now. I will give you five tablets right now! Do not buy more GHD [Sic] do not buy more black  
3 tar heroin do not buy more methamphetamine...”

4 66. On or about July 7, 2022, investigators interviewed a Physician Assistant working  
5 with Respondent at the medical practice. The Physician Assistant stated that she believes that  
6 Respondent is a pathological liar and should not be practicing medicine. She explained that he  
7 frequently left the building, leaving her to treat all of his patients alone. It was her understanding  
8 that Patient C met Respondent in July 2020 and participated in a commitment ceremony in  
9 Mexico, but that they were not legally married. She stated that Patient C was normal during the  
10 first two weeks she was in the office, but then engaged in increasingly unstable behaviors. The  
11 Physician Assistant is very concerned about all of the medications prescribed by Respondent to  
12 Patient C, especially the prescription for phentermine while Patient C only weighed 121 pounds.  
13 The Physician Assistant recalled that when Patient C was first seen on August 5, 2020, she was  
14 immediately started on Adderall and Phentermine. The only thing she saw recorded in the chart  
15 records at that time were a set of vital signs. She believes that Respondent added new  
16 information to the chart record in October 2020 well after the visit, and does not believe any of  
17 Respondent’s entries in Patient C’s medical chart. The Physician Assistant also believes that  
18 Respondent altered the chart notes for the visit on June 24, 2022. The Physician Assistant related  
19 that Respondent obtained a restraining order against Patient C, but did not follow it. The  
20 Physician Assistant stated that Patient C would live at the office every day, would scream at  
21 Respondent in the office, would call him as many as 70-80 times a day, and text him 20-98 times  
22 a day while he was in the office<sup>3</sup>. The Physician Assistant reported that Respondent asked her to  
23 review Patient C’s chart shortly after it was requested by the Medical Board for review. She  
24 refused to review Patient C’s medical chart because she believes that Respondent’s records were  
25 inaccurate. The Physician Assistant fears that Patient C is at risk of dying in the future due to  
26 causes related to Respondent’s prescribing.

27  
28 <sup>3</sup> She said she knew the messages were this frequent because Respondent leaves his phone  
on the counter in the office and she could see his messages.

67. On or about July 7, 2022, investigators interviewed a receptionist at Respondent's office. The receptionist stated that Respondent would alter her notes and records in the electronic health record relating to Patient C. After she discovered this she began signing her notes to prevent Respondent from changing the records. The receptionist related that while Patient C was in the office the staff began to notice items missing from their purses and suspected Patient C. She recalled Patient C often appearing to be "high" on medications while in the office.

68. On or about July 7, 2022, investigators interviewed a medical assistant at Respondent's office. She reported that Patient C was regularly in the office the entire eight hour workday and cause a great deal of drama. One time, Patient C asked her and another medical assistant to take pictures of her nude body in an examination room to document the abuse caused to Patient C by Respondent. The medical assistant reported that one day Patient C called the front desk 45 times to get Respondent to talk to her. The medical assistant took the pictures, but then they contacted the local Sheriff's Department to report the abuse. On July 7, 2022, when investigators made an unannounced site visit to the practice, Patient C was in the building but stepped out the back door when the investigators arrived. The medical assistant knew that Respondent was prescribing Seroquel, Adderall, and phentermine to Patient C. Shortly after the Medical Board requested Patient C's medical record, Respondent asked the medical assistant to review Patient C's chart to see if it "looked good," but she refused.

**2023**

69. On or about February 7, 2023, Respondent participated in a subject interview regarding his care and treatment of Patient C. Respondent stated that Patient C is his wife, and he would “do anything to try to help her.” Respondent stated that Patient C asked him to prescribe her the same medications that she previously received from Dr. N, and that he agreed to do so only until she started seeing Dr. N again, at which time he would only provide local care. Respondent described an arrangement that was made with Dr. N during their first phone call together for Dr. N to handle all of the prescribing related to Patient C’s psychiatric medicine, and Respondent would handle her primary care. Respondent claimed that there were “probably several times’ where Patient C was unable to reach Dr. N and needed an emergency refill of



1 something, so he would prescribe a controlled drug to Patient C. Respondent claimed that when,  
2 on August 5, 2023, he prescribed her Phentermine 11 days after prescribing Patient C Adderall,  
3 that he "had no knowledge of substance abuse." Respondent claimed that he asked for Dr. N to  
4 provide him records from her chart regarding Patient C, but he never received them. Respondent  
5 claimed that Patient C hid her history of substance abuse from him until June of 2022. Later in  
6 the interview, Respondent admitted that he learned that Patient C was using CBD gummies and  
7 alcohol on September 28, 2020, the night she was placed on a psychiatric hold due to a possible  
8 overdose. Respondent maintained that he saw no problems in treating Patient C, despite the fact  
9 of their intimate and volatile relationship. Respondent maintained that he could maintain  
10 complete objectivity in the treatment of Patient C, and even stated that his care was better than  
11 any other physician, because he could provide 24/7 monitoring for Patient C. Respondent  
12 claimed that he was not aware of Patient C's illicit drug use issues until approximately June of  
13 2022.

#### 14 **FIRST CAUSE FOR DISCIPLINE**

##### 15 **(Gross Negligence)**

16 70. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under section  
17 2234, subdivision (b), in that he committed gross negligence in the care and treatment of Patient  
18 C. The circumstances are set forth in paragraphs 24 through 69 above, which are incorporated by  
19 reference as if fully set forth. Additional circumstances are as follows:

20 71. Respondent claimed in his subject interview that he was unaware that Patient C was a  
21 drug addict until June 2022, despite observing firsthand for more than two years her numerous  
22 manic episodes, intoxication, arrests, alleged physical attacks, and obsessive texts and phone  
23 calls. Respondent knew from the beginning that Patient C was a drug addict, and continues to  
24 cover for her. The standard of care for physicians is to not prescribe controlled substances to a  
25 known addict, except in cases where the physician has special training in addiction medicine or is  
26 part of a program such as a methadone clinic. Respondent prescribed to Patient C, a known drug  
27 addict, for two years, which constitutes an extreme departure from the standard of care.

28 ///

1 Respondent's prescribing contributed to Patient C's drug addiction and delayed effective  
2 management of her addiction, causing harm to Patient C.

### 3 SECOND CAUSE FOR DISCIPLINE

#### 4 **(Repeated Negligent Acts)**

5 72. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under section  
6 2234, subdivision (c), in that he committed repeated negligent acts in the care and treatment of  
7 Patient C. The circumstances are set forth in paragraphs 24 through 71 above, which are  
8 incorporated by reference as if fully set forth. Additional circumstances are as follows:

9 73. Despite Respondent's claim that he could maintain objectivity, the evidence is clear  
10 that Respondent was not objective in comprehending Patient C's many problems, and in fact  
11 concealed her problems. Respondent claimed that he was not aware of Patient C's drug use  
12 issues until June of 2022, but the evidence establishes that this is untrue. On November 4, 2020,  
13 Respondent told police officers that Patient C was inebriated. On December 15, 2020,  
14 Respondent texted Patient C to question if she was back on methamphetamines. On September  
15 28, 2020, Respondent told the police that Patient C took an overdose of clonidine. On December  
16 23, 2020, Respondent texted Patient C to say that she was "completely psychotic and  
17 drugged...on meth." On May 18, 2021, Respondent told police that Patient C consumed two  
18 bottles of wine and unknown powdery drugs. Respondent minimized Patient C substance abuse  
19 by stating that it was only cannabis edibles with CBD, because many also contain THC, the  
20 hallucinogenic component of marijuana, and edibles can stay in the system for 12-24 hours.  
21 Respondent did not recognize that Patient C had no need to purchase CBD edibles on the street  
22 unless she was seeking THC-containing edibles. Respondent did not recognize that Patient C's  
23 CURES revealed a history of possible substance abuse before he started prescribing Adderall.  
24 Respondent was oblivious to Patient C's disruption of the medical office when the behavior was  
25 so evident to others working in the office.

26 74. The standard of care for a physician and surgeon is to avoid treating immediate  
27 family members due to numerous challenges including concerns about professional objectivity,  
28 patient autonomy, and informed consent. Respondent continued to treat Patient C, unaware of his

1 own lack of objectivity in managing her complex case. Respondent minimized, excused or  
2 covered over Patient C's issues. Patient C was unable to free herself from Respondent's  
3 treatment in order to obtain objective dispassionate care elsewhere. Respondent departed from  
4 the standard of care in his continuous treatment of Patient C. Respondent's treatment of Patient C  
5 contributed to her drug dependency, constricted lifestyle, and enmeshed himself into her ongoing  
6 problems. Respondent's treatment caused harm to Patient C.

7 75. The prescription of Clonidine to Patient C prescription required checking Patient C's  
8 blood pressure at least four times a day, but Respondent did not maintain any corresponding  
9 records to support that her blood pressure was regularly checked. Respondent greatly  
10 undertreated Patient C's hypertension, which required daily medicine to keep her blood pressure  
11 lower than 140/90. Respondent documented two elevated blood pressure readings while Patient  
12 C was already on medication for her blood pressure, but Respondent did not document any notes  
13 related to the readings and stated at his subject interview that he did not consider them.  
14 Respondent prescribed propranolol on June 21, 2022, presumably to treat hypertension, but did  
15 not take a blood pressure reading on that date. The prescription records show that propranolol  
16 was not filled by the patient until November 2020. Patient C's labs from August 5, 2020 reveal  
17 possible hyperthyroidism, which can cause agitation and many psychiatric symptoms, but  
18 Respondent made no mention of the abnormality and did not make plans for any follow-up.  
19 Patient C's potassium level was elevated in March of 2022, but Respondent never rechecked it.  
20 Patient C's calcium level was abnormally high in March of 2022, which required follow-up to  
21 rule out hyperparathyroidism, but Respondent never rechecked it. Patient C's liver enzymes were  
22 elevated in March of 2022, which necessitated a follow-up to rule out alcoholic liver injury or  
23 hepatitis, but Respondent did not recheck Patient C. Patient C presented with insomnia, but  
24 Respondent prescribed Modafinil, which is typically used for sleep apnea or narcolepsy,  
25 conditions not identified in Patient C. Respondent failed to coordinate for routine care of Patient  
26 C including regular breast exams and mammograms. Patient C presented to Respondent with  
27 significant psychosocial problems and multiple medications, often in combination with others, but  
28 Respondent failed to maintain detailed documentation of Patient C's treatment and referrals to

1 specialist providers. Respondent claims that he performed regular drug screens for Patient C, at  
2 his home, but failed to document those in the medical records.

3 76. Respondent's management of Patient C was primarily focused on her psychiatric  
4 issues. Respondent did not expand his problem list to include other concerns until he added a  
5 urine infection/vaginal discharge on June 21, 2022. Patient C presented with significant  
6 hypertension, for which Respondent prescribed Clonidine for a systolic pressure above 180 four  
7 times daily.

8 77. The standard of care for a primary care provider is to properly delineate all medical  
9 problems, obtain a proper history and physical, discuss all medical problems, order treatments for  
10 all problems, and engaged in a careful follow-up to assess the effectiveness of treatment.  
11 Respondent failed to document a complete problem list, undertreated Patient C's hypertension,  
12 and prescribed medications for medical problems absent documentation to support the  
13 prescribing. Respondent failed to involve a local specialist in managing Patient C's complex  
14 psychosocial problems. Respondent departed from the standard of care in managing Patient C's  
15 complex array of medical problems. Respondent's treatment of Patient C caused her harm by  
16 failing to properly treat her hypertension, and failing to adequately explore other medical  
17 concerns including her thyroid, parathyroid, and liver.

18 78. The standard of care is to carefully assess each and every medication prescribed to a  
19 patient, especially looking for harmful interactions when multiple medications are prescribed  
20 concurrently. Respondent failed to maintain well-documented records that stated his rationale for  
21 prescribing to Patient C. Respondent failed to appreciate the significant interactions that can  
22 occur in Patient C's poly-pharmacy and did not closely monitor for reactions to the medications.  
23 Patient C experienced a number of drug-induced frenzies when her medications were combined  
24 with alcohol, marijuana, and methamphetamine. Respondent failed to adequately document the  
25 rationale and effect of medication interactions in the care provided to Patient C, which constitutes  
26 a departure from the standard of care. Respondent's prescribing poly-pharmacy to Patient C  
27 caused her harm.

28 ///

1           79. Respondent treated Patient C for a two year period that included regular prescribing,  
2 but only three patient visits. The first on August 5, 2020, established Patient C as a Patient and  
3 marked the beginning of her prescriptions for Adderall. The second visit, on January 6, 2021,  
4 was scheduled to place Patient C on disability and remove her from her work. The third  
5 appointment, on June 21, 2022, was to treat Patient C's complaint of a vaginal discharge and  
6 possible urine infection. The fourth visit, on July 7, 2022, was cut short due to an unannounced  
7 office investigation by the Medical Board, during which Patient C escaped out the back of the  
8 office without engaging with investigators. Respondent did not fully appreciate Patient C's vitals  
9 on the first two visits, and the documented medical assessments were incomplete. Respondent's  
10 discussion of the treatment plan was too brief, only stating what medication would be prescribed.  
11 Respondent never documented a single chart record between visits to explain the prescribing of  
12 additional medications. Respondent claims that he provided treatment to Patient C at his home,  
13 but no records are documented in her chart. Respondent failed to maintain a list of all  
14 medications prescribed, and the date each medication was discontinued. Respondent stated that  
15 he requested documents from Patient C's psychiatrist, but they were never obtained, and  
16 Respondent failed to document a synopsis of the conversations with the psychiatrist.

17           80. The standard of care for managing patients is to maintain clear medical records,  
18 including a history, physical examination, assessment of all patient problems, a plan of treatment,  
19 documentation of follow-up visits, labs, x-rays, EKG's, specialist's notes and other therapeutics  
20 affecting the care of the patient. Respondent failed to maintain adequate medical records in the  
21 care and treatment of Patient C, which constitutes a departure from the standard of care.

### 22                                   **THIRD CAUSE FOR DISCIPLINE**

#### 23                                   **(Recordkeeping)**

24           81. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under sec  
25 section 2266, in that he failed to maintain adequate and accurate records of his care and treatment  
26 of Patient C. The circumstances are set forth in paragraphs 24 through 80 above, which are  
27 incorporated by reference as if fully set forth.

28           ///

1 PRAYER

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

- 4 1. Revoking or suspending Physician's and Surgeon's Certificate Number A 60965,  
5 issued to Mark Daniel Cook, M.D.;
- 6 2. Revoking, suspending or denying approval of Mark Daniel Cook, M.D.'s authority to  
7 supervise physician assistants and advanced practice nurses;
- 8 3. Ordering Mark Daniel Cook, M.D., to pay the Board the costs of the investigation and  
9 enforcement of this case, and if placed on probation, the costs of probation monitoring;
- 10 4. Ordering Respondent Mark Daniel Cook, M.D., if placed on probation, to provide  
11 patient notification in accordance with Business and Professions Code section 2228.1; and
- 12 5. Taking such other and further action as deemed necessary and proper.

13  
14 DATED: MAR 17 2023

  
\_\_\_\_\_  
REJI VARGHESE  
Interim Executive Director  
Medical Board of California  
Department of Consumer Affairs  
State of California  
Complainant

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19 FR2020300931  
20 95494876  
21  
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28

**Exhibit C**

**Accusation No. 800-2021-083681**

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7

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

12 In the Matter of the First Amended Accusation  
Against:

Case No. 800-2021-083681

**FIRST AMENDED ACCUSATION**

13 **Mark Daniel Cook, M.D.**  
14 **1425 West H St. Ste. 200**  
**Oakdale, CA 95361**

15 **Physician's and Surgeon's Certificate**  
16 **No. A 60965,**

17 Respondent.

18  
19 **PARTIES**

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

23 2. On or about October 2, 1996, the Medical Board issued Physician's and Surgeon's  
24 Certificate No. A 60965 to Mark Daniel Cook, M.D. (Respondent). The Physician's and  
25 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought  
26 herein and will expire on August 31, 2024, unless renewed.

27 ///

28 ///



## JURISDICTION

3. This First Amended 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 2004 of the Code states:

The board shall have the responsibility for the following:

(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

(f) Approving undergraduate and graduate medical education programs.

(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

(h) Issuing licenses and certificates under the board's jurisdiction.

(i) Administering the board's continuing medical education program.

5. Section 2220 of the Code states:

Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in

1 damages in excess of a cumulative total of thirty thousand dollars (\$30,000) with  
2 respect to any claim that injury or damage was proximately caused by the physician's  
3 and surgeon's error, negligence, or omission.

4 (c) Investigating the nature and causes of injuries from cases which shall be  
5 reported of a high number of judgments, settlements, or arbitration awards against a  
6 physician and surgeon.

#### 7 STATUTORY PROVISIONS

8 6. Section 2234 of the Code, states:

9 The board shall take action against any licensee who is charged with  
10 unprofessional conduct. In addition to other provisions of this article, unprofessional  
11 conduct includes, but is not limited to, the following:

12 (a) Violating or attempting to violate, directly or indirectly, assisting in or  
13 abetting the violation of, or conspiring to violate any provision of this chapter.

14 (b) Gross negligence.

15 (c) Repeated negligent acts. To be repeated, there must be two or more  
16 negligent acts or omissions. An initial negligent act or omission followed by a  
17 separate and distinct departure from the applicable standard of care shall constitute  
18 repeated negligent acts.

19 (1) An initial negligent diagnosis followed by an act or omission medically  
20 appropriate for that negligent diagnosis of the patient shall constitute a single  
21 negligent act.

22 (2) When the standard of care requires a change in the diagnosis, act, or  
23 omission that constitutes the negligent act described in paragraph (1), including, but  
24 not limited to, a reevaluation of the diagnosis or a change in treatment, and the  
25 licensee's conduct departs from the applicable standard of care, each departure  
26 constitutes a separate and distinct breach of the standard of care.

27 (d) Incompetence.

28 (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 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.

///

1 **COST RECOVERY**

2 8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the  
3 administrative law judge to direct a licensee found to have committed a violation or violations of  
4 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and  
5 enforcement of the case, with failure of the licensee to comply subjecting the license to not being  
6 renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be  
7 included in a stipulated settlement.

8 **DEFINITIONS**

9 9. The California Immunization Registry (CAIR) is a secure, confidential, statewide  
10 computerized immunization information system for California residents. The registry is accessed  
11 online to help providers and other authorized users track patient immunization records, reduce  
12 missed opportunities, and immunize Californians of all ages. The greater San Joaquin Valley  
13 utilizes the Regional Immunization Data Exchange (RIDE) system to access patient immunization  
14 records.

15 **FACTUAL ALLEGATIONS**

16 10. On or about September 2021, an employee at Oakdale Family Practice (OFP) noticed  
17 expired COVID-19 vaccine vials on the desk in Respondent's office. The employee notified  
18 other employees, who found the information noteworthy as OFP had decided not to administer  
19 COVID-19 vaccines due to storage issues. The employees saw the expired vaccine vials and later  
20 found discarded vaccine cards in the shred box. Employees had heard Respondent state that he  
21 was against Covid vaccinations, and wouldn't get one himself. Employee E.S. began copying  
22 vaccination records of patients who presented for Covid vaccines from Respondent, and believed  
23 that the patients were getting vaccine cards without actually getting the vaccination. Respondent  
24 treated some patients, not established with OFP, by providing Covid vaccinations for cash, but  
25 would not maintain any medical records for the visits.

26 11. On or about November 24, 2021, E.S. filed an online complaint with the Board  
27 alleging that Respondent was engaging in unprofessional conduct, including maintaining expired  
28 COVID-19 vaccine vials in a mini refrigerator in his office.

1           12. On or about July 7, 2022, Board investigators conducted a site visit of OFP. During  
2 the inspection, the investigators examined and photographed the mini-fridge in Respondent's  
3 office. The mini-fridge contained a small box that included three vials of Covid vaccines. The  
4 expiration date on the box was listed as April 27, 2022. There were no other objects in the mini-  
5 fridge. The mini-fridge had a temperature device on the door, connected to wires that went inside  
6 the mini-fridge. The current temperature of the mini-fridge during the inspection read 24.4  
7 degrees Celsius or 75 degrees Fahrenheit. The word "MAX" appeared directly above this  
8 reading. The mini-fridge contained a freezer section that had no door and was covered in  
9 significant frost accumulation that extended beyond the doorframe and outside the mini-fridge.  
10 The vials were in the back of the freezer section, and a wire was attached to a probe halfway into  
11 the upper section of the mini-fridge on the side. The mini-fridge contained three Janssen vials,  
12 five doses/vial, two on their side appearing full of clear fluid with intact blue protector caps, and  
13 one full vial whose blue protector cap had been removed.

14           13. During the office visit, numerous employees of OFP were interviewed. The office  
15 manager, A.Y., stated that Respondent was very vocal that Covid was a "farce." She stated that  
16 she never gave Covid vaccines, never witnessed any vaccinations in the office, and was not aware  
17 that he was administering vaccines to patients, but knew that he had a mini-fridge in his office.  
18 Another physician in the office, G.K., stated that Respondent made many anti-vaccination  
19 comments and she believed that he was against the Covid vaccine.

20           14. A physician assistant, C.C., explained that she believed Respondent received a  
21 government grant of \$55,000 to administer Covid vaccines, and that he administered them to  
22 patients from the supply in his mini-fridge. She was not aware of any instances in which  
23 Respondent provided expired vaccines to patients. C.C. stated that she did not have access to the  
24 mini-fridge or the RIDE system, and she had only provided a handful of Covid vaccinations  
25 herself.

26           15. A medical assistant, H.S., stated that OFP was not providing vaccinations to patients.  
27 H.S. stated that she was regularly using the RIDE system to document other vaccinations and  
28 noticed that Respondent had administered 70-80 vaccinations in the system. H.S. thought this

1 was strange because she believed that Respondent was against the vaccination, and there were no  
2 chart notes in the medical records for the patients when the vaccinations were administered. H.S.  
3 was aware that Respondent held travel clinics where he administered the Covid vaccine, but she  
4 never saw him administer one in person. H.S. stated that Respondent kept expired vaccines in the  
5 mini-fridge, and she didn't know how the temperatures were regulated or maintained. Numerous  
6 other employees told investigators OFP did not provide vaccinations.

7 16. According to the RIDE system, several patients received the Janssen COVID-19  
8 vaccine from Respondent.

9 **Patient 1<sup>1</sup>**

10 17. The RIDE system indicates that Patient 1 received the Covid vaccine from  
11 Respondent on October 4, 2021. In a phone interview, Patient 1 confirmed that she received the  
12 vaccine and reported a history of Guillian-Barre syndrome, seizures, and stroke. Patient 1's  
13 medical records for September 9, 2021, through October 6, 2021, were reviewed but contained no  
14 discussions or documentation of the Covid vaccination. In the medical records section for  
15 immunizations, it states "none."

16 **Patient 2**

17 18. The RIDE system indicates that Patient 2 received the COVID-19 vaccine from  
18 Respondent on October 23, 2021. Patient 2's medical records from OFP show that he had office  
19 visits on September 29, 2021, and October 11, 2021; telehealth appointments on September 22,  
20 2021, to discuss Covid questions; and October 1, 2021, for Covid vaccine questions. The records  
21 contain a negative test for COVID-19 antigens on October 5, 2021, and the telehealth notes refer  
22 to a discussion of a vaccine exception and a history of Guillian-Barre in childhood. The medical  
23 records contain no documentation of the COVID-19 vaccination or a discussion of the risks and  
24 benefits of the COVID-19 vaccination.

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28 <sup>1</sup> All patients referenced in this Accusation are referred to by number to protect their  
privacy.

1           **Patient 3**

2           19. On or about September 19, 2021, according to the RIDE system, Patient 3 received a  
3 Covid vaccine.

4           20. On or about November 8, 2022, Patient 3 spoke with investigators by phone and  
5 confirmed that he received the COVID-19 vaccine from either Respondent or his Physician  
6 Assistant (PA). Patient 3's records from OFP show three office visits on September 16,  
7 November 23, and November 29, 2021. Multiple vaccinations are mentioned in his medical  
8 record, but there is no documentation of the COVID-19 vaccine. The medical records contain no  
9 documentation of the COVID-19 vaccination or a discussion of the risks and benefits of the  
10 COVID-19 vaccination.

11           **Patient 4**

12           21. Patient 4 received a Covid vaccine from Respondent on October 4, 2021. He had  
13 office visits at OFP on September 22, and October 4, 2021, and a negative antibody test on  
14 September 22, 2021. The medical records contain no documentation of the COVID-19  
15 vaccination or a discussion of the risks and benefits of the COVID-19 vaccination.

16           **Patient 5**

17           22. Patient 5 received a Covid vaccine from Respondent on October 23, 2021, in her left  
18 deltoid. The vaccine logs documented the vaccination and the location where it was  
19 administered, but contained no other information regarding informed consent or Patient 5's  
20 medical history. OFP does not have any patient medical records other than the vaccine log for  
21 Patient 5. Respondent did not document any information relating to Patient 5's COVID-19  
22 vaccination and did not document any discussion of the risks and benefits of the COVID-19  
23 vaccination with this patient.

24           **All Patients**

25           23. On or about February 27, 2021, shortly after the Janssen Covid vaccine was released  
26 under an emergency use authorization to provide immunity for patients against the Sars-CoV-2  
27 virus, reports of blood-clot disorders and higher-than-expected cases of Guillian-Barre syndrome  
28 appeared. This resulted in a brief pause in the administration of the vaccine, then a resumption of

1 vaccinations with precautions. This underlies the importance of carefully documenting informed  
2 consent when administering this vaccine to at-risk patients.

3 24. Respondent did not document any provision of informed consent when administering  
4 the Sars-CoV-2 vaccine to his patients. Respondent did not document the administration of the  
5 vaccine to his patients in the patient medical records. Respondent did maintain a hand-written  
6 vaccine log that mentions the patient, identifying information for the patient, the site of  
7 administration, and the lot number, but it does not contain any information relating to informed  
8 consent. The RIDE documents do not provide any documentation regarding the provision of  
9 informed consent to patients regarding the Sars-CoV-2.

10 25. Respondent received Janssen (Johnson and Johnson) Sars-CoV-2 vaccines for  
11 administration to his patients. The Janssen vaccine was shipped at 34 to 46 degrees Fahrenheit  
12 and must be stored at the same temperature. If they are frozen upon arrival, they must be thawed  
13 for 1 to 2 hours prior to administration, and cannot be allowed to freeze again, which is something  
14 that can occur in a mini-fridge when stored on a cooling coil and protected from light. An un-  
15 punctured vial can be stored for 12 hours if kept at 47-77 degrees Fahrenheit. A punctured vial  
16 can be stored for up to six hours at 2 to 8 degrees C, or at room temperature for only up to two  
17 hours. The vial is to be discarded if not used during these time limits, even if unused doses are  
18 wasted if not used. While provisions for maintaining Janssen vaccines for additional months past  
19 the listed expiration date exist, they only apply to properly stored and un-punctured vials.  
20 Respondent stored his vaccines in a mini-fridge, which is specifically disallowed by the vaccine  
21 manufacturer. The American BioTech Supply Company stated, "The CDC prohibits storing  
22 vaccines in dormitory-style, bar-style, or combined refrigerator/freezer units under all  
23 circumstances, even temporarily. Dorm-style refrigerators have one exterior door and an  
24 evaporator plate (cooling coil) located in the icemaker compartment. The units also exhibit  
25 extreme temperature stability issues in storage areas. They also pose a risk for short and long-  
26 term freezing. Facilities cannot use these appliances to store vaccines bought with public funds."  
27 The photographs of Respondent's mini-fridge reveal frost buildup that can prevent a good air seal  
28 and a temperature of 76 degrees Fahrenheit on the monitor device. The temperature alone would

1 have required the three punctured vials to be discarded within 12 hours. Respondent failed to  
2 maintain a temperature log. Respondent failed to employ proper vaccine storage protocols and to  
3 rigorously monitor the conditions to ensure the effectiveness of the vaccines.

4 26. On or about February 7, 2023, Respondent spoke with investigators during their  
5 inspection of OFP. Respondent stated that he commonly treats 35-40 patients per day, and one  
6 time treated 78 patients in a single day. Respondent said that he received an \$11,500 personal  
7 grant from the Stanislaus County Health Department to order and administer COVID-19  
8 vaccines. He picked up the refrigerated vaccines himself and stored them in his mini-fridge  
9 because he didn't want to share the vaccines with other physicians. Respondent stated that he  
10 gave all of the vaccinations, other than a few that were provided by his PA, and he never  
11 administered an expired vaccine. Respondent stated that the vaccines were free, so he did not  
12 charge patients anything to administer the vaccination. Respondent claimed that he documented  
13 discussions with patients regarding the COVID-19 vaccination, especially for patients that were at  
14 risk, and that he would provide that information as it was not in the progress notes, patient charts,  
15 or vaccine logs.

#### 16 **FIRST CAUSE FOR DISCIPLINE**

##### 17 **(Gross Negligence)**

18 27. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under section  
19 2234, subdivision (b), of the Code, in that he committed gross negligence in the management,  
20 storage, and administration of the COVID-19 vaccine. The circumstances are set forth in  
21 paragraphs 11 through 26 above, which are incorporated by reference as if fully set forth.  
22 Additional circumstances are as follows:

23 28. Respondent utilized an improper refrigerator to store his Sars-CoV-2 vaccines.  
24 Respondent failed to employ sufficiently rigorous protocols to ensure the effectiveness of his  
25 vaccines for patients. Respondent risked the possibility of administering inactivated Sars-CoV-2  
26 vaccines to patients due to improper storage. Respondent's management of the Sars-CoV-2  
27 vaccine constitutes an extreme departure from the standard of care.

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1 PRAYER

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

4 1. Revoking or suspending Physician's and Surgeon's Certificate No. A 60965, issued  
5 to Respondent;

6 2. Revoking, suspending, or denying approval of Respondent's authority to supervise  
7 physician assistants and advanced practice nurses;

8 3. Ordering Respondent, to pay the Board the costs of the investigation and enforcement  
9 of this case, and if placed on probation, the costs of probation monitoring;

10 5. Taking such other and further action as deemed necessary and proper.

11  
12 DATED: NOV 30 2023

JENNA JONES FOR

13 REJI VARGHESE  
14 Executive Director  
15 Medical Board of California  
16 Department of Consumer Affairs  
17 State of California  
18 Complainant

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