XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
REBECCA D. WAGNER
Deputy Attorney General
State Bar No. 165468
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3760
Facsimile: (415) 703-5480
Attorneys for Complainant

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

In the Matter of the Accusation Against: **DAVID MILTON DENENNY, M.D** **1404 Southern Hills Ctr. # 307** **West Plains, MO 65775-2955** **Physician's and Surgeon's Certificate No. G 31715** Respondent.	Case No. 800-2018-049166 **DEFAULT DECISION AND ORDER** [Gov. Code §11520]

1. On July 18, 2019, an employee of the Medical Board of California (Board), served by Certified Mail a copy of the Accusation No. 800-2018-049166, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 on Respondent at Respondent's address of record with the Board, which was and is 1404 Southern Hills Ctr. # 307, West Plains, MO 65775-2955. The aforementioned documents were returned by the U.S. Postal Service marked "Not Deliverable as Addressed. Unable to Forward." The Board obtained an updated address for Respondent and on August 7, 2019, served the Accusation package by U. S. certified mail addressed to Respondent at P.O. Box 25331, Miami,

Florida 33102-5331. (Exhibit Package, Exhibit 1[1]: Accusation, the related documents, Declarations of Service, and envelope returned to the Board.)

2. Respondent did not file a Notice of Defense. On August 13, 2019, the Attorney General's Office served by U.S. certified mail a Courtesy Notice of Default on Respondent at the following addresses: 1404 Southern Hills Center #307, West Plains, MO 64775-2955; 1609 Porter Wagoner Blvd, West Plains, MO 65775-1805; 1301 15th Avenue W, Williston, ND 58801. Respondent was served via regular U.S. mail at P.O. Box 25331, Miami, FL 33102-5331. The Courtesy Notice of Default advised Respondent of the Accusation, and provided Respondent with an opportunity to request relief from default. On August 16, 2019, Carissa Mendoza signed the Certified Mail Return Receipt Form for delivery of the Accusation package mailed to 1301 15th Ave. W, Williston, ND 58801. (Exhibit Package, Exhibit 2: Courtesy Notice of Default and proof of service, Certified Mail Return Receipt Form.)

FINDINGS OF FACT

I.

Complainant Kimberly Kirchmeyer is the Executive Director of the Medical Board of California, Department of Consumer Affairs. The charges and allegations in Accusation No. 800-2018-049166 were at all times brought and made solely in the official capacity of the Board's Executive Director.

II.

On or about May 17, 1976, the Board issued Physician's and Surgeon's Certificate No. G 31715 to Respondent. The Physician's and Surgeon's Certificate expired on February 28, 2017, and has not been renewed. (Exhibit Package, Exhibit 3: Certificate of License.)

III.

Business and Professions Code section 118 states, in pertinent part:

> (b) The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed,

[1] The evidence in support of this Default Decision and Order is contained in the "Exhibit Package."

restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the license on any such ground.

IV.

On July 18, 2019, Respondent was served with an Accusation, alleging causes for discipline against Respondent. The Accusation and accompanying documents were duly served on Respondent. A Courtesy Notice of Default was thereafter served on Respondent.

V.

Government Code section 11506 states, in pertinent part:

> (c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

Respondent failed to file a Notice of Defense within 15 days after service upon him of the Accusation, and therefore waived his right to a hearing on the merits of Accusation No. 800-2018-049166.

VI.

The allegations of the Accusation are true as follows:

On October 10, 2018, the Missouri State Board of Registration for the Healing Arts entered into a Settlement Agreement with Respondent accepting his voluntary surrender of his medical license. (Exhibit Package, Exhibit 4: Certified copy of Settlement Agreement between the Missouri State Board of Registration for the Healing Arts and David M. Denenny, M.D.) The circumstances are as follows:

On or about July 3, 2014, in the State of Missouri, Respondent improperly treated Patient 1[2]'s right intertrochanteric femur fracture with an open reduction internal fixation by using a locking plate when he should have used an intramedullary nail or sliding hip screw. Respondent's improper treatment of Patient 1 resulted in the distal portion of the locking plate coming loose and screws backing out causing the original fracture fixation construct to fail.

[2] The patients are designated as Patients 1 through 3 to protect their privacy.

Between June, 2011 and May, 2012, Respondent failed to revise the treatment goal of Patient 2 when multiple computed tomographys (CTs) revealed persistent nonunion after he treated Patient 2's intertrochanteric femur fracture with intramedullary nailing; failed to utilize surgical intervention for the nonunion following treatment of infection; and failed to detect, treat and manage Patient 2's staph infection.

On February 13, 2015, Respondent failed to achieve sufficient reduction or adequate fixation when he performed a Kirschner wire (K-wire) fixation on Patient 3, who had sustained a wrist injury on December 15, 2015 resulting in a ligament tear. Respondent's treatment of Patient 3 resulted in a further loss of reduction over time.

In his treatment of Patient 1, Patient 2 and Patient 3, Respondent failed to use the degree of skill and learning ordinarily used in the same or similar circumstances by members of Respondent's profession. His actions constituted repeated negligence in the performance of the functions or duties of Respondent's profession and cause to discipline his license.

VII.

California Government Code section 11520 states, in pertinent part:

> (a) If the respondent either fails to file a notice of defense . . . or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent . . . .

Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on Respondent's express admissions by way of default and the evidence before it, contained in Exhibits 1, 2, 3, and 4, finds that the allegations in Accusation No. 800-2018-049166 are true.

DETERMINATION OF ISSUES

Respondent's conduct and the action of the Missouri State Board of Registration for the Healing Arts constitutes unprofessional conduct with the meaning of Business and Professions Code section 2305 and conduct subject to discipline within the meaning of Code section 141(a).

ORDER

IT IS SO ORDERED that Physician's and Surgeon's Certificate No. G 31715, heretofore issued to Respondent DAVID MILTON DENENNY, M.D, is revoked.

Respondent shall not be deprived of making a request for relief from default as set forth in Government Code section 11520, subdivision (c), for good cause shown. However, such showing must be made in writing by way of a motion to vacate the default decision and directed to the Medical Board of California at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815 within seven (7) days after service of the Decision on Respondent.

This Decision shall become effective on November 22, 2019 at 5:00 p.m.

It is so ORDERED October 25, 2019

KIMBERLY KIRCHMEYER
EXECUTIVE DIRECTOR
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

SF2019201323

XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
REBECCA D. WAGNER
Deputy Attorney General
State Bar No. 165468
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3760
Facsimile: (415) 703-5480
E-mail: Rebecca.Wagner@doj.ca.gov
Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO July 18 2019
BY [illegible] ANALYST

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

In the Matter of the Accusation Against: **David Milton Denenny, M.D.** **1404 Southern Hills Center # 307** **West Plains, MO 65775** **Physician's and Surgeon's Certificate No. G 31715,** Respondent.	Case No. 800-2018-049166 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about May 17, 1976, the Medical Board issued Physician's and Surgeon's Certificate Number G 31715 to David Milton Denenny, M.D. (Respondent). The Physician's and Surgeon's Certificate expired on February 28, 2017, and has not been renewed.

JURISDICTION

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

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or

privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. Section 2305 of the Code states:

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

6. Section 141 of the Code states:

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

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

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CAUSE FOR DISCIPLINE

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

7. Respondent David Milton Denenny, M.D. is subject to disciplinary action under sections 141(a) and/or 2305 of the Code in that on October 10, 2018, the Missouri State Board of Registration for the Healing Arts entered into a Settlement Agreement with Respondent accepting his voluntary surrender of his medical license. The circumstances are as follows:

8. On or about July 3, 2014, in the State of Missouri, Respondent improperly treated Patient 1[1]'s right intertrochanteric femur fracture with an open reduction internal fixation by using a locking plate when he should have used an intramedullary nail or sliding hip screw. Respondent's improper treatment of Patient 1 resulted in the distal portion of the locking plate coming loose and screws backing out causing the original fracture fixation construct to fail.

9. Between June, 2011 and May, 2012, Respondent failed to: revise the treatment goal of Patient 2 when multiple computed tomographys (CTs) revealed persistent nonunion after he treated Patient 2's intertrochanteric femur fracture with intramedullary nailing; utilize surgical intervention for the nonunion following treatment of infection; and detect, treat and manage Patient 2's staph infection.

10. On February 13, 2015, Respondent failed to achieve sufficient reduction or adequate fixation when he performed a Kirschner wire (K-wire) fixation on Patient 3, who had sustained a wrist injury on December 15, 2015 resulting in a ligament tear. Respondent's treatment of Patient 3 resulted in a further loss of reduction over time.

11. Respondent failed to use the degree of skill and learning ordinarily used in the same or similar circumstances by a member of Respondent's profession in the State of Missouri and this constituted repeated negligence in the performance of his function or duties in his profession, as described above in Paragraphs 8 through 10, in his treatment of Patient 1, Patient 2 and Patient 3.

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[1] The patients are designated in this document as Patients 1 through 3 to protect their privacy. Respondent knows the names of the patients and can confirm their identities through discovery.

12. Respondent's conduct and the action of the Missouri State Board of Registration for the Healing Arts, as set forth in Paragraphs 7 through 11, above, and within the actual Board documents attached as Exhibit A, constitutes unprofessional conduct with the meaning of 2305 and conduct subject to discipline within the meaning of section 141(a).

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 31715, issued to David Milton Denenny, M.D;

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

3. Ordering David Milton Denenny, M.D, if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: July 18, 2019

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

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Exhibit A

SETTLEMENT AGREEMENT BETWEEN THE MISSOURI STATE BOARD OF REGISTRATION FOR THE HEALING ARTS AND DAVID M. DENENNY, MD

COMES NOW David M. Denenny, MD, ("Licensee") and the Missouri State Board of Registration for the Healing Arts ("the Board"), and enter into this agreement for the purpose of resolving the issue of whether Licensee's physician and surgeon's license is subject to discipline. Licensee and the Board jointly stipulate and agree that a final disposition of this matter may be effectuated as described below pursuant to sections 536.060 and 621.045, RSMo.[1]

1. Licensee acknowledges that he understands the various rights and privileges afforded to him by law, including the right to a hearing of the charges; the right to appear and be represented by legal counsel; the right to have all charges against him proven upon the record by competent and substantial evidence; the right to cross-examine any witnesses appearing at the hearing; the right to present evidence on his own behalf; the right to a decision based upon the record concerning the charges pending against him; and the right to present evidence in mitigation of discipline at a hearing before the Board. Having been advised of these rights provided to him by operation of law, Licensee knowingly and voluntarily waives each and every one of these rights, freely enters into this agreement and agrees to abide by the terms of this document as it pertains to him.
2. Licensee acknowledges that he may, at the time this agreement is effective or within fifteen (15) days thereafter, submit this agreement to the Administrative Hearing Commission to determine whether the facts agreed to by the parties constitute grounds to discipline Licensee's license. Knowing of this right, Licensee hereby waives his right to review by the Administrative Hearing Commission.
3. Licensee acknowledges that he has been advised of his right to consult legal counsel in this matter and has done so.

[1] All statutory references are to the Revised Statutes of Missouri Cumulative Supplement (2013), unless otherwise stated.

4. The parties stipulate and agree that the consent order agreed to by the Board and Licensee in Part III is based only on the agreement set out in Parts I and II herein. Licensee understands that the Board may take further action against him based on facts or conduct not specifically mentioned in this document that is either presently known to the Board or later discovered.

5. Licensee understands and agrees that the Board will maintain this agreement as an open record as required by Chapters 324, 334 and 610, RSMo, and it will report this agreement to the National Practitioner's Data Bank ("NPDB") and the Federation of State Medical Boards ("FSMB").

I. JOINT STIPULATION OF FACTS

Based upon the foregoing, the Board and Licensee herein jointly stipulate and agree to the following:

6. The Board is an agency of the state of Missouri created and established pursuant to section 334.120, RSMo, for the purpose of executing and enforcing the provisions of Chapter 334, RSMo.

7. Licensee is licensed by the Board as a physician and surgeon, license number 2009014860, which was first issued on June 11, 2009. Licensee's license is lapsed, but it was current and active from June 11, 2009, to December 28, 2015.

Patient 1

8. On July 3, 2014, Licensee treated Patient 1's right intertrochanteric femur fracture with an open reduction internal fixation by using a locking plate.

9. A member of Licensee's profession exercising the degree of skill and learning ordinarily used under the same or similar circumstances would have used an intramedullary nail or sliding hip screw, instead of a locking plate to treat Patient 1's humeral shaft facture. Patient 2 was discharged on July 6, 2014.

10. An X-ray done on July 14, 2014, showed that the distal portion of the locking plate came loose and screws were backing out.

11. Licensee's choice of locking plate and placement of such in Patient 1 caused the original fracture fixation construct to fail.

12. Licensee's actions described in paragraphs in 8 through 11 constitute a failure to use that degree of skill and learning ordinarily used under the same or similar circumstances by the members of the licensee's profession.

Patient 2

13. On March 25, 2011, Licensee treated Patient 2's intertrochanteric femur fracture with intramedullary nailing by inserting a Gamma type Zimmer nail at the patient's left hip.
14. Licensee saw Patient 2 on May 19, 2011, and an X-ray showed there was slight superior migration of the intertrochanteric nail.
15. On June 22, 2011, Patient 2 returned to the hospital, complaining of continuous left hip pain; and a computed tomography (CT) of the pelvis revealed comminuted fracture of the intertrochanteric region of the left proximal femur with femoral neck facture, which was fragmented and irregular.
16. The above-referenced CT scan also revealed adjacent fluid collection that contained air, which represented breakdown of patient's prior fracture and possible infection such as osteomyelitis.
17. Subsequently, Licensee admitted Patient 2 into the hospital and removed the set screw and hip screw from the Gamma nail, despite what appeared to be an incomplete union.
18. Between January 20, 2012, and April 20, 2012, Patient 2 complained of left hip pain and multiple CT scans of the pelvis revealed a persistent nonunion—comminuted non-united fracture of the left proximal femur—fragmentation in the region of the femoral neck and surrounding soft tissue thickening, which indicated chronic osteomyelitis.
19. On May 7, 2012, Licensee performed a left total hip arthroplasty on Patient 2. After Patient 2 protruded into the left acetabulum, she was taken back on May 9, 2012, to the operation room where a Protusio cage fixation was obtained with bone grafting.
20. Licensee documented in the medical records that, during the preoperative preparation, the femur fractured at the tip of the prosthesis and there was a need for revision of the acetabular component;

and postoperatively, Patient 2 had a hip dislocation and an additional fracture of the femur at the distal end of the plate used to treat the original periprosthetic fracture.

21. Patient 2 was discharged from the hospital on May 22, 2012.

22. One (1) week after her discharge from the hospital, Patient 2 was admitted to another hospital where two (2) surgeons operated on Patient 2 for distal femur fracture and for removal of the acetabular and femoral hardware placed by Licensee.

23. During the surgery, the surgeons noted an organizing hematoma; and the culture taken from Patient 2's left hip revealed the organisms staphylococcus hominis, staphylococcus warneri and staphylococcus epidermidis ("staph infection").

24. A member of Licensee's profession exercising the degree of skill and learning ordinarily used under the same or similar circumstances would have:

    1) Revised the treatment goal between June 2011 and May 2012 when multiple CTs revealed persistent nonunion;

    2) Utilized surgical intervention for the nonunion following treatment of infection; and

    3) Detected, treated and managed the staph infection.

25. Licensee's actions described in paragraphs in 13 through 24 constitute a failure to use that degree of skill and learning ordinarily used under the same or similar circumstances by the members of the licensee's profession.

Patient 3

26. On February 13, 2015, Licensee performed Kirschner wire (K-wire) fixation on Patient 3, who sustained a wrist injury on December 15, 2015, and had a scapholunate ligament tear.

27. In treating Patient 3's scapholunate dissociation with K-wire fixation, Licensee failed to achieve sufficient reduction or adequate fixation.

28. A member of Licensee's profession exercising the degree of skill and learning ordinarily used under the same or similar circumstances would achieve sufficient reduction and adequate fixation or utilize a different method than K-wire fixation.

29. Licensee's actions caused Patient 3 to have further loss of reduction overtime, as noted on postoperative X-rays on or about July 6, 2015.

30. Licensee's actions and inactions described in paragraphs in 26 through 29 constitute a failure to use that degree of skill and learning ordinarily used under the same or similar circumstances by the members of the licensee's profession.

31. In his treatment of Patient 1, Patient 2 and Patient 3, Licensee failed to use the degree of skill and learning ordinarily used in the same or similar circumstances by members of Licensee's profession.

32. The above constitutes repeated negligence in the performance of the functions or duties of Licensee's profession, which is cause to discipline Licensee's license pursuant to section 334.100.2(5), RSMo.

II. JOINT CONCLUSIONS OF LAW

33. Cause exists to discipline Licensee's license pursuant to section 334.100.2(5), RSMo, which states:

> 334.100.2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621 against any holder of any certificate of registration or authority, permit or license required by this chapter or any person who has failed to renew or has surrendered the person's certificate of registration or authority, permit or license for any one or any combination of the following causes:
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> *******
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> (5) Any conduct or practice which is or might be harmful or dangerous to the mental or physical health of a patient or the public; or incompetency, gross negligence or repeated negligence in the performance of the functions or duties of any profession licensed or regulated by this chapter. For the purposes of this subdivision, "repeated negligence" means the failure, on more than one occasion, to use that degree of skill and learning ordinarily used under the same or similar circumstances by the member of the applicant's or licensee's profession;
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34. Licensee's conduct, as established by the foregoing facts, falls within the intendments of section 334.100.2(5), RSMo.

III. CONSENT ORDER

Based on the foregoing, the parties mutually agree and stipulate that the following shall constitute the order entered by the Board in this matter under the authority of sections 536.060 and 621.110, RSMo.

This agreement, including the order, will be effective immediately on the date entered and finalized by the Board. The following are the terms of the order:

35. The physician and surgeon's license issued by the Board to Licensee, number 2009014860, is hereby VOLUNTARILY SURRENDERED.

36. Within thirty (30) days of the effective date of this agreement, Licensee shall return his pocket card and license to the Board.

37. If Licensee is licensed in other jurisdictions, he shall forward written notice of this disciplinary action to the medical licensing authorities of those jurisdictions within thirty (30) days of the effective date of this agreement. Licensee shall submit a copy of the written notice to the Board contemporaneously with sending it to the relevant licensing authority. If Licensee is not licensed in other jurisdictions, he shall notify the Board of that fact, in writing, within thirty (30) days of the effective date of this agreement.

38. Licensee shall, within thirty (30) days of the effective date of this agreement, forward written notice of this disciplinary action to all employers, hospitals, nursing homes, out-patient centers, clinics, and any other facility where Licensee practices or has privileges. Licensee shall, contemporaneously with the giving of such notice, submit a copy of the notice to the Board for verification by the Board or its designated representative. If Licensee does not have an employer, staff privileges or practice at any facility, he shall notify the Board of that fact, in writing, within thirty (30) days of the effective date of this agreement.

39. Licensee shall, within thirty (30) days of the effective date of this agreement, forward written notice of this disciplinary action to any allied health care professionals supervised by Licensee. Licensee shall, contemporaneously with the giving of such notice, submit a copy of the notice to the Board for verification by the Board or its designated representative. If Licensee does not supervise any allied health professionals, he shall notify the Board of that fact, in writing, within thirty (30) days of the effective date of this agreement.

40. For purposes of this agreement and unless otherwise specified herein, all reports, documentation, evaluations, notices, or other materials Licensee is required to submit to the Board in this agreement

shall be forwarded to the State Board of Registration for the Healing Arts, Attention: Enforcement, P.O. Box 4, Jefferson City, Missouri 65102.

41. This agreement does not bind the Board or restrict the remedies available to it concerning any other violation of Chapter 334, RSMo, by Licensee not specifically mentioned in this document, either currently known to the Board or later discovered.

42. Licensee hereby waives and releases the Board, its members, and any of its employees, agents, or attorneys, including any former board members, employees, agents, and attorneys, of, or from, any liability, claim, actions, causes of action, fees, costs and expenses, and compensation, including, but not limited to any claims for attorney's fees and expenses, including any claims pursuant to section 536.087, RSMo, or any claim arising under 42 USC 1983, which may be based upon, arise out of, or relate to any of the matters raised in this agreement, or from the negotiation or execution of this agreement. The parties acknowledge that this paragraph is severable from the remaining portions of this agreement in that it survives in perpetuity even in the event that any court of law deems this agreement or any portion thereof void or unenforceable.

LICENSEE		BOARD	
David M. Denenny, MD Licensee	Date 10/08/2018	Connie Clarkston Executive Director	Date 10/10/18
Attorney for Licensee Missouri Bar No. 51728	Date 10/8/18	~~Hong Chan~~ Adam Grayson Outside ~~Associate General~~ Counsel Missouri Bar No. ~~67602~~ 61976	Date 10/8/18

EFFECTIVE THIS 10th DAY OF October, 2018.