

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

In the Matter of the Accusation Against:

Donald Clyde Willis, M.D.

Physician's and Surgeon's  
Certificate No. G 35712

Case No. 800-2017-036455

Respondent.

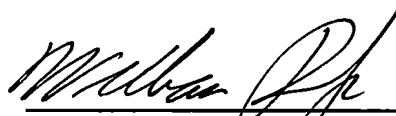
**DECISION**

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on November 25, 2020.

IT IS SO ORDERED November 19, 2020.

MEDICAL BOARD OF CALIFORNIA



\_\_\_\_\_  
William Prasifka  
Executive Director

1 XAVIER BECERRA  
Attorney General of California  
2 STEVE DIEHL  
Supervising Deputy Attorney General  
3 MICHAEL C. BRUMMEL  
Deputy Attorney General  
4 State Bar No. 236116  
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*Attorneys for Complainant*

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. 800-2017-036455

14 **DONALD CLYDE WILLIS, M.D.**  
15 **PO BOX 10818**  
16 **San Bernardino, CA 92423-0818**  
**Physician's and Surgeon's Certificate**  
**No. G 35712**

**STIPULATED SURRENDER OF  
LICENSE AND ORDER**

17 Respondent.

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

20 **PARTIES**

21 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of  
22 California (Board). He brought this action solely in his official capacity and is represented in this  
23 matter by Xavier Becerra, Attorney General of the State of California, by Michael C. Brummel,  
24 Deputy Attorney General.

25 2. Donald Clyde Willis, M.D. (Respondent) is representing himself in this proceeding  
26 and has chosen not to exercise his right to be represented by counsel.

27 3. On or about October 17, 1977, the Board issued Physician's and Surgeon's  
28 Certificate No. G 35712 to Donald Clyde Willis, M.D. (Respondent). The Physician's and

1 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in  
2 Accusation No. 800-2017-036455 and will expire on June 30, 2021, unless renewed.

3 **JURISDICTION**

4 4. Accusation No. 800-2017-036455 was filed before the Board, and is currently  
5 pending against Respondent. The Accusation and all other statutorily required documents were  
6 properly served on Respondent on September 9, 2020. Respondent timely filed his Notice of  
7 Defense contesting the Accusation. A copy of Accusation No. 800-2017-036455 is attached as  
8 Exhibit A and incorporated by reference.

9 **ADVISEMENT AND WAIVERS**

10 5. Respondent has carefully read, and understands the charges and allegations in  
11 Accusation No. 800-2017-036455. Respondent also has carefully read, and understands the  
12 effects of this Stipulated Surrender of License and Order.

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

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

22 **CULPABILITY**

23 8. Respondent admits the truth of each and every charge and allegation in Accusation  
24 No. 800-2017-036455, agrees that cause exists for discipline and hereby surrenders his  
25 Physician's and Surgeon's Certificate No. G 35712 for the Board's formal acceptance.

26 9. Respondent agrees that if he ever petitions for reinstatement of his Physician's and  
27 Surgeon's Certificate No. G 35712, all of the charges and allegations contained in Accusation No.  
28 800-2017-036455 shall be deemed true, correct and fully admitted by Respondent for purposes of

1 that reinstatement proceeding or any other licensing proceeding involving respondent in the State  
2 of California.

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

### 6 CONTINGENCY

7 11. Business and Professions Code section 2224, subdivision (b), provides, in pertinent  
8 part, that the Medical Board "shall delegate to its executive director the authority to adopt a ...  
9 stipulation for surrender of a license."

10 12. Respondent understands that, by signing this stipulation, he enables the Executive  
11 Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his  
12 Physician's and Surgeon's Certificate No. G 35712 without further notice to, or opportunity to be  
13 heard by, Respondent.

14 13. This Stipulated Surrender of License and Disciplinary Order shall be subject to the  
15 approval of the Executive Director on behalf of the Board. The parties agree that this Stipulated  
16 Surrender of License and Disciplinary Order shall be submitted to the Executive Director for his  
17 consideration in the above-entitled matter and, further, that the Executive Director shall have a  
18 reasonable period of time in which to consider and act on this Stipulated Surrender of License and  
19 Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands  
20 and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the  
21 time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

22 14. The parties agree that this Stipulated Surrender of License and Disciplinary Order  
23 shall be null and void and not binding upon the parties unless approved and adopted by the  
24 Executive Director on behalf of the Board, except for this paragraph, which shall remain in full  
25 force and effect. Respondent fully understands and agrees that in deciding whether or not to  
26 approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive  
27 Director and/or the Board may receive oral and written communications from its staff and/or the  
28 Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the

1 Executive Director, the Board, any member thereof, and/or any other person from future  
2 participation in this or any other matter affecting or involving respondent. In the event that the  
3 Executive Director on behalf of the Board does not, in his discretion, approve and adopt this  
4 Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it  
5 shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied  
6 upon or introduced in any disciplinary action by either party hereto. Respondent further agrees  
7 that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason  
8 by the Executive Director on behalf of the Board, Respondent will assert no claim that the  
9 Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review,  
10 discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or  
11 of any matter or matters related hereto.

12 **ADDITIONAL PROVISIONS**

13 15. This Stipulated Surrender of License and Disciplinary Order is intended by the parties  
14 herein to be an integrated writing representing the complete, final and exclusive embodiment of  
15 the agreements of the parties in the above-entitled matter.

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

19 17. In consideration of the foregoing admissions and stipulations, the parties agree the  
20 Executive Director of the Board may, without further notice to or opportunity to be heard by  
21 Respondent, issue and enter the following Disciplinary Order on behalf of the Board:

22 **ORDER**

23 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 35712, issued  
24 to Respondent Donald Clyde Willis, M.D., is surrendered and accepted by the Board.

25 1. The surrender of Respondent's Physician's and Surgeon's Certificate and the  
26 acceptance of the surrendered license by the Board shall constitute the imposition of discipline  
27 against Respondent. This stipulation constitutes a record of the discipline and shall become a part  
28 of Respondent's license history with the Board.

1           2.     Respondent shall lose all rights and privileges as a physician and surgeon in  
2 California as of the effective date of the Board's Decision and Order.

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

5           4.     If Respondent ever files an application for licensure or a petition for reinstatement in  
6 the State of California, the Board shall treat it as a petition for reinstatement. Respondent must  
7 comply with all the laws, regulations and procedures for reinstatement of a revoked or  
8 surrendered license in effect at the time the petition is filed, and all of the charges and allegations  
9 contained in Accusation No. 800-2017-036455 shall be deemed to be true, correct and admitted  
10 by Respondent when the Board determines whether to grant or deny the petition.

11          5.     If Respondent should ever apply or reapply for a new license or certification, or  
12 petition for reinstatement of a license, by any other health care licensing agency in the State of  
13 California, all of the charges and allegations contained in Accusation, No. 800-2017-036455 shall  
14 be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of  
15 Issues or any other proceeding seeking to deny or restrict licensure.

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ACCEPTANCE

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

DATED: Oct 24, 2020 Donald C. Willis  
DONALD CLYDE WILLIS, M.D.  
*Respondent*

ENDORSEMENT

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

DATED: \_\_\_\_\_ Respectfully submitted,  
XAVIER BECERRA  
Attorney General of California  
STEVE DIEHL  
Supervising Deputy Attorney General  
  
MICHAEL C. BRUMMEL  
Deputy Attorney General  
*Attorneys for Complainant*

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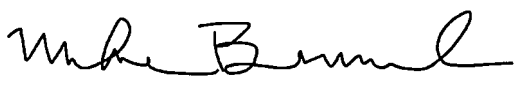
**ACCEPTANCE**

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

DATED: \_\_\_\_\_ DONALD CLYDE WILLIS, M.D.  
*Respondent*

**ENDORSEMENT**

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

DATED: November 2, 2020 Respectfully submitted,  
XAVIER BECERRA  
Attorney General of California  
STEVE DIEHL  
Supervising Deputy Attorney General  
  
MICHAEL C. BRUMMEL  
Deputy Attorney General  
*Attorneys for Complainant*

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**Exhibit A**

**Accusation No. 800-2017-036455**

1 XAVIER BECERRA  
Attorney General of California  
2 STEVE DIEHL  
Supervising Deputy Attorney General  
3 MICHAEL C. BRUMMEL  
Deputy Attorney General  
4 State Bar No. 236116  
2550 Mariposa Mall, Room 5090  
5 Fresno, CA 93721  
Telephone: (559) 705-2307  
6 Facsimile: (559) 445-5106  
E-mail: Michael.Brummel@doj.ca.gov  
7 Attorneys for Complainant

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

12 In the Matter of the Accusation Against:

Case No. 800-2017-036455

13 **Donald Clyde Willis, M.D.**  
14 **P.O. BOX 10818**  
**San Bernardino, CA 92423-0818**

**ACCUSATION**

15 **Physician's and Surgeon's Certificate**  
16 **No. G 35712,**

17 Respondent.

18  
19 **PARTIES**

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

23 2. On or about October 17, 1977, the Medical Board issued Physician's and Surgeon's  
24 Certificate Number G 35712 to Donald Clyde Willis, 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 June 30, 2021, unless renewed.

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1 JURISDICTION

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

5 4. Section 2227 of the Code states:

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

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

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

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

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

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

21 (b) Any matter heard pursuant to subdivision (a), except for warning letters,  
22 medical review or advisory conferences, professional competency examinations,  
23 continuing education activities, and cost reimbursement associated therewith that are  
24 agreed to with the board and successfully completed by the licensee, or other matters  
25 made confidential or privileged by existing law, is deemed public, and shall be made  
26 available to the public by the board pursuant to Section 803.1.

27 5. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

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

(1) An initial negligent diagnosis followed by an act or omission medically

1 appropriate for that negligent diagnosis of the patient shall constitute a single  
2 negligent act.

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

8 (d) Incompetence.

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

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

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

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

#### 19 FIRST CAUSE FOR DISCIPLINE

##### 20 (Gross Negligence)

21 7. Respondent's Physician's and Surgeon's Certificate Number G 35712 is subject to  
22 disciplinary action under section 2227, as defined by section 2234, subdivision (b), in that he  
23 committed act(s) and/or omission(s) constituting gross negligence. The circumstances are as  
24 follows:

25 8. At all times relevant to this Accusation, Respondent practiced at Family Planning  
26 Associates (FPA) at various clinics throughout California, including Bakersfield. Respondent's  
27 duties included performing surgical abortions. Respondent currently only practices gynecology  
28 in an office setting in Fresno and Modesto, and ceased the surgical side of his practice  
approximately three years ago. Respondent is Board Certified in obstetrics and gynecology.

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1 Patient A<sup>1</sup>

2 9. On or about February 3, 2017, Patient A presented to Respondent at approximately 28  
3 years old, G2P1, desiring an abortion. An ultrasound examination revealed the gestational age to  
4 be approximately 17 3/7 weeks. Respondent placed three dilapan osmotic dilators, and scheduled  
5 Patient A for a dilation and evacuation procedure the following day.

6 10. On or about February 4, 2017, Patient A presented for her dilation and evacuation  
7 procedure. The procedure itself was uncomplicated, and Respondent placed a Nexplanon  
8 contraceptive device at the conclusion of the procedure. Postoperatively, Patient A's bleeding  
9 began to increase. Respondent took Patient A back to the operating room, re-aspirated, and under  
10 ultrasound, a small amount of additional tissue was removed. Postoperatively, ultrasound  
11 revealed additional bleeding outside Patient A's uterus measuring approximately 6x5x3 cm.  
12 Respondent believed that this was intraperitoneal bleeding from perforation or adnexal bleeding  
13 secondary to "stretching of tissue." Respondent transferred Patient A to the hospital. The  
14 hospital did not find any evidence of intraperitoneal bleeding, signs of perforation, or free air.  
15 Patient A's blood count and vital signs remained stable, and she was eventually discharged.  
16 Respondent failed to document numerous pertinent facts in the medical record of Patient A  
17 related to her dilation and evacuation procedure. Respondent did not document the size of the  
18 dilator or the curette used in the operation. Respondent did not document the type of forceps  
19 used for decompression. Respondent did not document a description of the fetal tissue removed  
20 in regards to fetal parts in a operation that involved respiration. Respondent did not document an  
21 operative note for Patient A's respiration. In addition to the missing documentation in the  
22 operative note, Respondent's medical records for Patient A include many blank spaces on the  
23 preprinted medical record forms. Respondent did not document the Nexplanon insert within the  
24 handwritten portion of the dilation and evacuation procedure, although it is electronically entered  
25 in a separate section of the medical record. Respondent repeatedly failed to document pertinent  
26 information in the medical record of Patient A, which constitutes gross negligence.

27  
28 <sup>1</sup> To protect the privacy of the patient involved, the patient's name has not been included  
in this pleading. Respondent is aware of the identity of the patient referred to herein.

1 Patient B

2 11. On or about August 19, 2017, Patient B presented to Respondent at approximately 23  
3 years of age, G2P1, seeking an abortion. Respondent determined her gestational age to be  
4 approximately 14 2/7 weeks. Towards the end of the procedure, Respondent noted that Patient B  
5 was suddenly jerking, and the tenaculum caused a tear of the cervix with subsequent blood loss of  
6 approximately 200 ml. Respondent determined that he could not obtain the needed exposure and  
7 visualization at the clinic to address the bleeding due to Patient B's morbid obesity. Respondent  
8 called an ambulance and transferred Patient B to the hospital. Respondent was uncertain if the  
9 calvarium was in Patient B's uterus or vagina at the time of transfer. At the hospital, the  
10 emergency room staff immediately requested an OBGYN consultation, and Patient B was taken  
11 to the operating room for completion of the surgery. Tissue was removed by suction curettage,  
12 and the pathology report stated that "fetal tissue" was part of the specimen recovered. Patient B  
13 recovered without complication, and was discharged from the hospital.

14 12. Respondent did not document what was removed, and what was not removed ruling his  
15 incomplete dilation and evacuation surgery prior to transferring Patient B to the hospital.  
16 Respondent's failure to document these details, prevents subsequent physicians from knowing if  
17 the termination was completed. Respondent's failure to document what tissues were removed  
18 during surgery prior to transferring Patient B to the hospital constitutes gross negligence.

19 Patient C

20 13. On or about October 3, 2017, Patient C presented to Respondent for an abortion at 23  
21 years of age, G4P3, with a history of two prior cesarean sections. Respondent estimated the  
22 gestational age to be approximately 11 1/7 weeks. Respondent performed the surgery using  
23 Hegar dilators to dilate the opening to 11 mm, and a #11 cannula vacuum for suction, despite not  
24 being able to clearly visualize the external os of the cervix. During surgery, no tissue passed,  
25 blood loss was estimated at 500 ml, but there was no bleeding observed from her vagina.  
26 Respondent did not document any fetal tissue removed from Patient C. Patient C's vital signs  
27 became unstable, 911 was called, and she was transferred to the hospital. Patient C was treated  
28 for hemorrhagic shock at the hospital, and imaging revealed a right adnexal mass consistent with

1 an intraperitoneal hematoma. Patient C received 4 units of blood and proceeded to surgery. In  
2 surgery, Patient C suffered a cardiac arrest, was successfully resuscitated. The surgeons  
3 conducted an exploratory laparotomy, total abdominal hysterectomy, right salpingo-  
4 oophorectomy for a right sided uterine perforation and extensive damage to the right ovary and  
5 right fallopian tube. Patient C's pregnancy was removed with the uterus, and she received 10  
6 additional units of blood. Five days later, on October 8, 2017, Patient C was discharged from the  
7 hospital.

8 14. Respondent did not document an operative note for Patient C's surgery. Although  
9 there is a later entry in the medical record that Respondent suffered an injury, there is no  
10 documentation to correct or complete the operative note for Patient C's operation. Respondent's  
11 failure to document an operative note for Patient C's operation constitutes gross negligence

12 15. Respondent did not take into account potential risk factors for Patient C's surgery.  
13 Respondent should have considered any unstable vital signs, abnormal anatomy, medication use,  
14 or previously unspecified allergies. Respondent did not visual a normal cervical opening during  
15 Patient C's procedure, and was unable to perform the surgery safely without imaging or other  
16 assistance. Respondent could have rescheduled the surgery so that he could have the imaging  
17 assistance needed, but he elected to proceed by blindly dilating where he believed the cervical  
18 opening was located. Respondent perforated the uterus on the right side, causing major injury to  
19 the large vessels of the ovary and fallopian tube during the dilation, suction or both. Respondent  
20 characterized his error as causing the perforation, failing to recognize the error of proceeding  
21 blindly in surgery on a patient with distorted anatomy. Respondent's decision to proceed with  
22 Patient C's abortion, without the ability to discern the pathway to her uterus constitutes gross  
23 negligence.

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1 **SECOND CAUSE FOR DISCIPLINE**

2 **(Repeated Negligent Acts)**

3 16. Respondent's Physician's and Surgeon's Certificate Number G 35712 is subject to  
4 disciplinary action under section 2227, as defined by section 2234, subdivision (c), in that he  
5 committed act(s) and/or omission(s) constituting negligence. The circumstances alleged in  
6 paragraphs 8 through 15, which are hereby incorporated by reference and realleged as if fully set  
7 forth herein, and as follows:

8 **Patient B**

9 17. Respondent documented the reason for transferring Patient B to the hospital, but he  
10 did not attempt to directly communicate with the receiving physician or the OBGYN, who  
11 ultimately completed the surgery. Respondent wrote in the record, "call me if needed" and left  
12 his cell phone number. Respondent's failure to adequately communicate with hospital staff  
13 regarding Patient B's transfer to the hospital constitutes negligence.

14 **THIRD CAUSE FOR DISCIPLINE**

15 **(Failure to Maintain Adequate and Accurate Medical Records)**

16 18. Respondent's Physician's and Surgeon's Certificate Number G 35712 is subject to  
17 disciplinary action under section 2227, as defined by section 2266, in that he failed to maintain  
18 adequate and accurate records in the treatment of Patient A, Patient B, and Patient C. The  
19 circumstances alleged in paragraphs 8 through 15, which are hereby incorporated by reference  
20 and realleged as if fully set forth herein, and as follows:

21 **PRAYER**

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

24 1. Revoking or suspending Physician's and Surgeon's Certificate Number G 35712,  
25 issued to Donald Clyde Willis, M.D.;

26 2. Revoking, suspending or denying approval of Donald Clyde Willis, M.D.'s authority  
27 to supervise physician assistants and advanced practice nurses;

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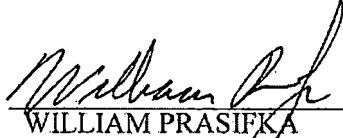


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3. Ordering Donald Clyde Willis, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED:     AUG 07 2020    

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

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