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

In the Matter of the Accusation Against:	)	
BRIAN MICHAEL MANJARRES, M.D.	)	**Case No. 800-2016-020907**
Physician's and Surgeon's Certificate No. A 100304	)	
Respondent	)	

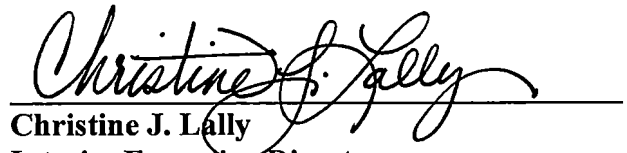
DECISION

The attached Stipulated Surrender of License and Disciplinary 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 January 1, 2020.

IT IS SO ORDERED December 12, 2019.

MEDICAL BOARD OF CALIFORNIA



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

In the Matter of the Accusation Against: **BRIAN MICHAEL MANJARRES, M.D.** **1357 7th Ave., Suite A** **San Diego, CA 92101** **Physician's and Surgeon's Certificate No. A 100304** Respondent.	Case No. 800-2016-020907 OAH No. 2019050021 **STIPULATED SURRENDER OF LICENSE AND DISCIPLINARY ORDER**

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

PARTIES

1. Christine Lally is the Interim Executive Director of the Medical Board of California (Board). Former Executive Director Kimberly Kirchmeyer brought this action solely in her then official capacity as Executive Director of the Board.[1] Christine Lally is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Jason J. Ahn, Deputy Attorney General.

[1] Kimberly Kirchmeyer became Director of the California Department of Consumer Affairs effective October 28, 2019.

2. Brian Michael Manjarres, M.D. (Respondent) is representing himself in this proceeding and has chosen not to exercise his right to be represented by counsel.

3. On or about June 1, 2007, the Board issued Physician's and Surgeon's Certificate No. A 100304 to 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. 800-2016-020907 and will expire on August 31, 2020, unless renewed.

JURISDICTION

4. On March 13, 2019, Accusation No. 800-2016-020907 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 13, 2019. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2016-020907 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, and fully understands the charges and allegations in Accusation No. 800-2016-020907. Respondent also has carefully read, and fully understands the effects of this Stipulated Surrender of License and Disciplinary Order.

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

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

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CULPABILITY

8. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2016-020907 and that he has thereby subjected his license to disciplinary action.

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

10. Respondent further agrees that if he ever petitions for reinstatement of his Physician's and Surgeon's Certificate No. A 100304, or if an accusation is filed against him before the Medical Board of California, all of the charges and allegations contained in First Amended Accusation No. 800-2016-020907 shall be deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the state of California or elsewhere.

CONTINGENCY

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

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

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13. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Executive Director on behalf of the Board does not, in her discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

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

15. The parties agree that copies of this Stipulated Surrender of License and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

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

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 100304, issued to Respondent Brian Michael Manjarres, M.D., is surrendered and accepted by the Board.

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

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

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

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations, and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2016-020907 shall be deemed to be true, correct, and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2016-020907 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

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ACCEPTANCE

I have carefully read the Stipulated Surrender of License and Order. I fully 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 fully agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 12/4/2019

BRIAN MICHAEL MANJARRES, 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: 12/5/19

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

JASON J. AHN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2016-020907

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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO March 13 2019
BY ANALYST

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

In the Matter of the Accusation Against:	Case No. 800-2016-020907
Brian Michael Manjarres, M.D. **Namaste Medical Group** **1357 7th Avenue, Suite A** **San Diego, CA 92101** **Physician's and Surgeon's Certificate No. A 100304,** Respondent.	**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 June 1, 2007, the Medical Board issued Physician's and Surgeon's Certificate No. A 100304 to Brian Michael Manjarres, M.D. (Respondent). The Physician's and

Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2020, unless 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 2234 of the Code, states:

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

"...

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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6. Section 2239 of the Code states:

"(a) The use or prescribing for or administering to himself or herself, of any controlled substance; or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, or to any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely or more than one misdemeanor or any felony involving the use, consumption, or self administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of such unprofessional conduct."

"..."

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."

8. Unprofessional conduct under Business and Professions Code section 2234 is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. Respondent has subjected his Physician's and Surgeon's Certificate No. A 100304 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patients A,[1] B, C, D, and E, as more particularly alleged hereinafter:

Patient A

10. On or about September 30, 2014, Patient A presented to Respondent. There is no physical examination documented other than vital signs. Notations indicate that Patient A had pain in his shoulder, back, and knee. There are no assessments or diagnoses noted. Respondent prescribed a topical compound cream.

11. On or about October 14, 2014, Patient A completed new patient intake forms, which indicated, among other things, that Patient A was under the care of a psychiatrist. Patient A signed a Buprenorphine[2] consent form, and a consent for IV and injection vitamins. Patient A completed an Attention Deficit Hyperactivity Disorder Questionnaire, Androgen Deficiency in Aging Males (ADAM) Questionnaire, and Men's Health Questionnaire. There is no documentation stating that Respondent reviewed and/or discussed these consent forms with Patient A.

12. On or about October 20, 2014, Patient A returned to Respondent for concerns about Sexually Transmitted Disease(s). A physical examination was not performed and/or there is no documentation of a physical examination performed. There is no questioning and/or documentation of questioning regarding specific symptoms or exposures. Respondent failed to order and/or failed to document having ordered laboratory tests. Respondent counseled Patient A regarding safe sex practices and prescribed Azithromycin[3] 2 grams orally, for one dose with three refills.

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[1] References to "Patients A~E" are used to protect patient privacy.

[2] Buprenorphine is used to treat dependence/addiction to opioids.

[3] Azithromycin is an oral tablet used to treat infections caused by bacteria.

13. On or about November 25, 2014, Patient A presented to Respondent for depression. Respondent noted that Patient A was taking Viibryd, an antidepressant, and that Patient A was receiving treatment from a psychiatrist. Respondent noted decreased sleep and decreased quality of life. Respondent prescribed Wellbutrin[4] XL 300 mg per day and advised Patient A to start hormone replacement therapy and growth hormone. Respondent prescribed anabolic steroids Oxandrolone[5] and Stanozolol.[6] Patient A did not have any diagnoses which may indicate use of anabolic steroids, including, but not limited to, delayed puberty, failure to gain weight, or aplastic anemia.[7] Respondent failed to review with Patient A and/or failed to document having reviewed with Patient A potential adverse effects of using anabolic steroids. Respondent failed to monitor and/or failed to document having monitored for kidney or liver damage while Patient A was on anabolic steroids. Except for vital signs, Respondent failed to conduct a physical examination and/or failed to document having conducted a physical examination. Respondent failed to counsel Patient A and/or failed to document having counseled Patient A regarding the risks of testosterone or growth hormones. Respondent failed to question and/or failed to document having questioned Patient A about alcohol consumption or seizures, which would render Wellbutrin contraindicated. An informed consent form regarding testosterone was not signed until February 2017, nearly two years after testosterone treatment began.

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[4] Wellbutrin (Bupropion hydrochloride) is an antidepressant used to treat depression.

[5] Oxandrolone is an anabolic steroid that promotes growth of muscle tissue. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022.

[6] Stanozolol is a synthetic steroid that was withdrawn from the U.S. market in 2010. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022.

[7] Aplastic anemia is a rare disease which develops as a result of bone marrow damage.

14. On or about December 23, 2014, Patient A visited Respondent. Respondent prescribed Ritalin[8] 20 mg three times a day and Percocet[9] 10/325 one to two every six hours for musculoskeletal, non-radicular back pain. Respondent also prescribed Xanax[10] 2 mg one twice a day for anxiety and insomnia, and Cialis[11] 5 mg one a day as needed for Erectile dysfunction. Other than vital signs, Respondent failed to conduct a physical examination and/or failed to document having conducted a physical examination. Respondent failed to order laboratory testing and/or failed to document having ordered laboratory testing. Respondent failed to discuss and/or failed to document having discussed the risks of newly prescribed medications. Respondent failed to review CURES report(s).[12]

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[8] Methylphenidate (Ritalin®), a central nervous system stimulant, 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 to treat attention deficit hyperactivity disorder (ADHD) 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.)

[9] Percocet® (oxycodone and acetaminophen), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of moderate to moderately severe pain. The Drug Enforcement Administration has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The Federal Drug Administration has issued a black box warning for Percocet® which warns about, among other things, addiction, abuse and misuse, and the possibility of "life-threatening respiratory distress."

[10] 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.)

[11] Cialis (Tadalafil) is a drug used to treat erectile dysfunction and enlarged prostate.

[12] CURES is the Controlled Substances Utilization Review and Evaluation System (CURES), a database of schedule II, III, and IV controlled substance prescriptions dispensed in California, serving the public health, regulatory oversight agencies, and law-enforcement.

15. On or about February 23, 2015, Patient A returned to Respondent for severe acne that was worsening with testosterone. Respondent prescribed Claravis,[13] 30 mg one twice a day #60 with three refills. Respondent failed to conduct a physical examination and/or failed to document having conducted a physical examination. Respondent failed to order laboratory testing and/or failed to document having ordered laboratory testing. Respondent failed to change and/or document change in the prescribed dosage of testosterone, if any.

16. On or about February 25, 2015, Patient A presented to Respondent for erectile dysfunction and ADHD.[14] Respondent failed to conduct a physical examination and/or failed to document having conducted a physical examination. Respondent failed to order laboratory testing and/or failed to document having ordered laboratory testing. Respondent prescribed Adderall[15] and Cialis.

17. On or about April 25, 2015, Respondent prescribed Tramadol[16] and three refills of azithromycin. Respondent also refilled Xanax and Ritalin prescriptions.

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[13] Claravis (Isotretinoin) is an oral medicine for treating the most severe form of acne.

[14] Attention Deficit Hyperactivity Disorder (ADHD) is a chronic condition that makes it difficult for a person to pay attention and control impulsive behaviors.

[15] 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.

[16] Tramadol Hydrochloride (Ultram®, Ultracet®), an opioid analgesic, 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 treatment of moderate to severe pain. The FDA-approved labeling under the Drug Abuse and Dependence section provides warns, among other things, that "[t]ramadol hydrochloride may induce psychic and physical dependence ... Dependence and abuse, including drug-seeking behavior and taking illicit actions to obtain the drug are not limited to those patients with prior history of opioid dependence. The risk in patients with substance abuse has been observed to be higher. Tramadol hydrochloride is associated with craving and tolerance development. Withdrawal symptoms may occur if tramadol hydrochloride is discontinued abruptly."

18. On or about July 2, 2015, Patient A reported penile discharge and pain with urination and ejaculation. Respondent made a diagnosis of "presumed STD" and prescribed three refills of azithromycin.

19. On or about September 17, 2015, Patient A presented to Respondent with "testicular pain." Respondent diagnosed the patient with epididymitis[17] and prescribed an antibiotic, Ciprofloxacin,[18] for 14 days with two refills. Respondent prescribed 3 refills of azithromycin. Respondent failed to conduct a physical examination and/or failed to document a physical examination conducted. Respondent failed to order and/or failed to document ordering urinalysis or laboratory studies. Respondent failed to discuss or failed to document having discussed the results of the urinalysis or laboratory studies, if any.

20. On or about September 23, 2015, Patient A visited Respondent for "decreased erections" and benign prostatic hypertrophy (BPH).[19] Respondent failed to conduct a physical examination and/or failed to document having conducted a physical examination. Respondent failed to order laboratory testing and/or failed to document having ordered laboratory testing.

21. On or about February 28, 2017, Patient A presented to Respondent for a urinary tract infection after complaining of pain with urination. Respondent failed to conduct and/or failed to document having conducted a physical examination of Patient A. Respondent failed to order a urinalysis or culture and/or failed to document having ordered a urinalysis or culture.

22. Thereafter, Patient A continued to see Respondent for ongoing pain, anxiety, insomnia and hormone replacement and refills of controlled substances, through December 31, 2017.

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[17] Epididymitis is an inflammation of the tube at the back of the testicle that stores and carries sperm.

[18] Ciprofloxacin is used to treat bacterial infections in many different parts of the body.

[19] Benign prostatic hyperplasia (BPH) also called prostate gland enlargement is a common condition for men as they grow older.

Medical Record-Keeping

23. During the course of his care and treatment of Patient A, approximately from September 2014 through December 31, 2017, Respondent used a pre-printed form for each visit which did not have a section for a physical examination other than vital signs. Patient A's birthdate or other identifier is not included on the visit documentations. There is no section on the form for an assessment or diagnosis. The Subjective Portion of the form was often scant and included little or no review of systems or details about the presenting complaints other than what is pre-printed on the form. There was no documentation of any labs ordered, lab results, phone calls with patient, or billing records.

Prescribing and Monitoring of Testosterone Replacement Therapy

24. During the course of his care and treatment of Patient A, approximately from September 2014 through December 31, 2017, Respondent did not adequately evaluate and/or discuss or failed to document having adequately evaluated and/or discussed whether Patient A's underlying depression, opiate use, hypertension, or marijuana use was causing Patient A's reported symptoms indicative of low testosterone, such as fatigue, depression, backache, sleep problems, lack of energy and feeling sad. Respondent failed to perform any evaluations and/or failed to document having perform any evaluations. Respondent failed to conduct and/or failed to document having conducted a testicular or prostate examination. Respondent failed to order any blood testing, failed to engage in further workup to determine the cause of the "low testosterone" such as karyotyping,[20] LH and FSH levels,[21] repeat testosterone levels, hematocrit,[22] or PSA.[23] Respondent failed to alter the medication dose or instructions even though Patient A complained

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[20] Karyotyping is the determination of a karyotype, e.g., to detect chromosomal abnormalities.

[21] Among other things, luteinizing hormone (LH) and follicle-stimulating hormone (FSH) levels are measured to assist with diagnosing a low testosterone in post-pubertal males.

[22] Hematocrit refers to the ratio of the volume of red blood cells to the total volume of blood.

[23] PSA refers to prostate specific antigen. A test for PSA may be used to screen for cancer of the prostate.

of a number of symptoms that may have been side effects of excessive testosterone such as labile mood and acne.

Prescribing Chronic Opiates for Chronic Pain

25. During the course of his care and treatment of Patient A, approximately from September 2014 through December 31, 2017, Respondent failed to perform any physical examinations and/or failed to document having performed any physical examinations to determine the cause(s) of Patient A's back pain. Respondent failed to order and/or failed to document having ordered any imaging studies or refer Patient A for orthopedic or surgical evaluation, physical therapy, or epidural injections for the pain. Respondent failed to prescribe prescription modalities such as Lyrica,[24] gabapentin,[25] or tricyclic antidepressants as non-opiate alternatives. Respondent did not adequately monitor Patient A's CURES reports. Respondent failed to adequately review with Patient A and/or failed to document having adequately reviewed with Patient A the risks of opiate addiction. Respondent did not have a written pain management contract other than a Buprenorphine contract. Until on or about June 13, 2016, Respondent failed to perform urine drug screening. Respondent did not perform screening for opiate addiction or dependence disorder even though Patient A had red flags for opiate addiction such as a history of mental health issues, seeing multiple providers, willingness to pay cash for medications or visits, going on and off medications, and using mind-altering medications such as marijuana and benzodiazepines.

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[24] Lyrica is a medication that can be used to treat nerve and muscle pain.

[25] Gabapentin is a medication that can be used to relieve nerve pain.

Prescribing Chronic Benzodiazepines

26. During the course of his care and treatment of Patient A, approximately from September 2014 through December 31, 2017, Respondent failed to discuss with Patient A and/or failed to document having discussed with Patient A risks of benzodiazepines, including, but not limited to, overdose, whether to use it in combination of other medications, whether concurrent usage increases the risk of sedation, confusion, respiratory depression and intentional and unintentional death. Respondent failed to assess and/or failed to document having assessed the effectiveness of Benzodiazepines and whether or not Patient A was experiencing side effects. Respondent failed to adequately review CURES reports. Respondent failed to coordinate and/or failed to document his coordination of care with Patient A's psychiatrist.

Treatment of Sexually Transmitted Infection(s)

27. During the course of his care and treatment of Patient A, approximately from September 2014 through December 31, 2017, Respondent prescribed Patient A eleven course of antibiotics without performing any physical examinations and/or without documenting physical examinations performed, if any. Respondent failed to obtain and/or failed to document having obtained a thorough sexual history of Patient A. Respondent failed to perform and/or failed to document having performed any laboratory testing. Respondent failed to test Patient A for gonorrhea and HIV even though Patient is at high-risk for both. Respondent failed to advise Patient A and/or failed to document having advised Patient A to have his partner treated.

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Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder (ADHD)

28. During the course of his care and treatment of Patient A, approximately from September 2014 through December 31, 2017, Respondent failed to perform any evaluations other than one Adult ADHD Self-Report Scale Symptoms checklist[26] provided to Patient A on or about October 14, 2014. Respondent failed to review and/or failed to document having reviewed DSM criteria[27] for ADHD. Respondent failed to gather information and/or failed to document having gathered information such as how Patient A's symptoms affect Patient A's function, how he was originally diagnosed or at what age. Respondent failed to obtain prior medical records confirming the ADHD diagnosis. Respondent failed to discuss and/or failed to document having discussed Patient A's "ADHD" with his psychiatrist. Respondent did not adequately attempt to rule out other potential causes for Patient A's poor concentration. Respondent failed to adequately check CURES reports to determine whether Patient A was receiving the same ADHD medications from his psychiatrist.

Diagnosis and Treatment of Benign Prostatic Hypertrophy (BPH)[28]

29. When Patient A presented to Respondent on or about September 23, 2015, for "decreased erections," Respondent failed to perform a physical examination and/or failed to document having conducted a physical examination; Respondent failed to complete and/or failed to document having completed a urinalysis; Respondent failed to ask questions and/or failed to document having asked questions about the specific symptoms related to the prostate issues; Respondent failed to order Prostate Specific Antigen (PSA) blood testing, which aids in evaluation of possible prostate cancer; Respondent failed to conduct and/or failed to document having conducted a prostate examination.

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[26] The Adult ADHD Self-Report Scale Symptoms Checklist is a tool used to help screen for ADHD in adult patients.

[27] The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is the 2013 update to the Diagnostic and Statistical Manual of Mental Disorders, the taxonomic and diagnostic tool published by the American Psychiatric Association.

[28] Benign prostatic hyperplasia (BPH) is an age-associated prostate gland enlargement that can cause urination difficulty.

Informed Consent

30. On or about October 14, 2014, Patient A signed a "written informed consent" for Buprenorphine treatment and IV and Injection medications. However, Respondent never prescribed Buprenorphine or IV medications to Patient A. The consent form related to injection testosterone does not discuss side effects of the hormone therapy or alternative treatments. During the course of his care and treatment of Patient A, approximately from September 2014 through December 31, 2017, Respondent failed to discuss with Patient A and/or failed to document having discussed with Patient A the risks and benefits of the medications he prescribed to Patient A, including but not limited to, Percocet, Oxycodone, isotretinoin, testosterone, Xanax, Ambien, Ritalin, and Adderall.

Urine Toxicology Screening for Controlled Substances

31. Respondent administered four in-house urine toxicology screenings from September 2014 through December 31, 2017. Respondent did not send any of the four screenings to an outside laboratory. Respondent himself performed the urine screenings instead of a medical assistant or a nurse.

Prescribing and Monitoring Anabolic Steroids

32. Respondent prescribed anabolic steroids Oxandrolone and Stanozolol starting on or about November 25, 2014, through February 24, 2017, without any clear indication as Patient A did not have any documented diagnoses such as delayed puberty, failure to gain weight, or aplastic anemia. Respondent failed to review and/or failed to document having reviewed potential adverse effects even though Patient A had a number of conditions that could be worsened by the anabolic steroids such as hypertension,[29] depressions, and hypogonadism.[30] Respondent failed to monitor and/or failed to document having monitored possible kidney or liver damage while Patient A was on anabolic steroids.

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[29] Hypertension refers to high blood pressure.

[30] Hypogonadism refers to a failure of the gonads, testes in men and ovaries in women, to function properly.

33. Respondent prescribed the following controlled substances to Patient A:

Date	Drug Name	Quantity
9/17/14	Methylphenidate Hydrochloride 36 MG	15
9/30/14	Methylphenidate Hydrochloride 20 MG	90
10/14/14	Oxycodone and Acetaminophen 325 MG/ 10 MG	60
10/20/14	Methylphenidate Hydrochloride 20 MG	90
11/25/14	Methylphenidate Hydrochloride 20 MG	90
12/15/14	Oxandrolone (Powder)	0.5625
12/15/14	Testosterone Cypionate (Powder)	2.06
12/23/14	Alprazolam 2 MG	60
12/23/14	Methylphenidate Hydrochloride 20 MG	90
12/23/14	Oxycodone and Acetaminophen 325 MG / 10 MG	90
1/30/15	Alprazolam 2 MG	60
1/30/15	Methylphenidate Hydrochloride 20 MG	90
2/4/15	Oxandrolone (Powder)	0.5625
2/4/15	Testosterone Cypionate (Powder)	2.06
2/26/15	Amphetamine Salt Combo 30 MG	60
3/27/15	Amphetamine Salt Combo 30 MG	60
4/16/15	Testosterone Cypionate (Powder)	2.06
4/25/15	Alprazolam 2 MG	60
4/25/15	Methylphenidate HCL 20 MG	90
5/26/15	Alprazolam 2 MG	60
5/26/15	Methylphenidate HCL 20 MG	90
6/1/15	Testosterone Cypionate (Powder)	2.06
7/14/15	Alprazolam 2 MG	60
7/14/15	Methylphenidate HCL 20 MG	90

8/7/15	Testosterone Cypionate	2.06
8/21/15	Alprazolam 2 MG	60
8/21/15	Methylphenidate HCL 20 MG	90
8/21/15	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	90
8/21/15	Zolpidem Tartrate 10 MG	30
8/27/15	Compound	45
10/20/15	Alprazolam 2 MG	60
10/20/15	Methylphenidate HCL 20 MG	90
10/20/15	Oxycodone HCL 20 MG	90
11/20/15	Alprazolam 2 MG	60
11/20/15	Methylphenidate HCL 20 MG	90
11/20/15	Oxycodone HCL 20 MG	90
11/30/15	Compound	2
12/4/15	Compound	45
12/4/15	Testosterone Cypionate (Powder)	2.06
12/18/15	Alprazolam 2 MG	60
12/18/15	Methylphenidate HCL 20 MG	90
12/18/15	Oxycodone HCL 20 MG	90
1/20/16	Compound	5
1/20/16	Stanozolol Micronized (Powder)	0.25
1/20/16	Testosterone Cypionate (Powder)	1.03
1/26/16	Alprazolam 2 MG	60
1/26/16	Methylphenidate HCL 20 MG	90
1/26/16	Oxycodone HCL 20 MG	90
2/18/16	Compound	45
2/28/16	Alprazolam 2 MG	60
2/28/16	Oxycodone HCL 20 MG	90

2/29/16	Testosterone Cypinoate (Powder)	1.03
3/25/16	Methylphenidate HCL 20 MG	120
3/26/16	Alprazolam 2 MG	60
3/27/16	Oxycodone HCL 20 MG	90
4/25/16	Methylphenidate HCL 20 MG	120
4/25/16	Stanozolol Micronized	Powder
5/14/16	Oxycodone HCL 20 MG	90
5/16/16	Compound	2
5/23/16	Alprazolam 2 MG	60
5/26/16	Testosterone Cypionate (Powder)	2
5/27/16	Stanozolol Micronized	Powder
5/31/16	Methylphenidate HCL 20 MG	90
6/3/16	Compound	45
6/10/16	Testosterone Cypionate (Powder)	2
6/13/16	Oxycodone HCL 20 MG	120
6/23/16	Alprazolam 2 MG	90
6/24/16	Amphetamine Salt Combo 20 MG	90
7/10/16	Methylphenidate HCL 20 MG	90
7/24/16	Alprazolam 2 MG	60
8/5/16	Stanozolol Micronized	Powder
9/12/16	Compound	10
9/12/16	Compound	45
9/15/16	Stanozolol Micronized	Powder
10/5/16	Methylphenidate HCL 20 MG	90
10/5/16	Oxycodone HCL 20 MG	120
10/18/16	Stanozolol Micronized	Powder
10/27/16	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	120

11/5/16	Methylphenidate HCL 20 MG	90
11/23/16	Compound	1
11/23/16	Oxycodone HCL 20 MG	120
12/7/16	Methylphenidate HCL 20 MG	90
12/23/16	Alprazolam 2 MG	60
12/29/16	Oxycodone HCL 20 MG	100
1/4/17	Methylphenidate HCL 20 MG	90
1/19/17	Alprazolam 2 MG	60
2/17/17	Alprazolam 2 MG	90
2/17/17	Methylphenidate HCL 20 MG	90
2/21/17	Oxycodone HCL 20 MG	90
2/24/17	Testosterone Cypionate (Powder)	2
2/24/17	Stanozolol Micronized	Powder
2/24/17	Oxandrolone	Powder
3/28/17	Compound	10
4/1/17	Alprazolam 2 MG	90
4/1/17	Methylphenidate HCL 20 MG	90
4/1/17	Oxycodone HCL 20 MG	120
4/7/17	Compound	30
5/4/17	Alprazolam 2 MG	90
5/4/17	Oxycodone HCL 20 MG	90
5/4/17	Methylphenidate HCL 20 MG	90
6/5/17	Alprazolam 2 MG	60
6/5/17	Oxycodone HCL 20 MG	120

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34. Respondent committed gross negligence in his care and treatment of Patient A, which included, but was not limited to, the following:

(a) Respondent had inadequate medical record-keeping;

(b) Respondent did not properly provide testosterone replacement treatment;

(c) Respondent failed to properly prescribe opiates;

(d) Respondent failed to properly treat Patient A's sexually transmitted infection(s);

(e) Respondent failed to properly diagnose and/or treat Patient A's purported Attention Deficit Hyperactivity Disorder;

(f) Respondent failed to properly diagnose and/or treat Patient A's purported Benign Prostatic Hypertrophy; and

(g) Respondent failed to properly prescribe anabolic steroids.

Patient B

35. Respondent provided care and treatment to Patient B from about October 2014 to about July 2017.[31] On or about October 14, 2014, Patient B presented to Respondent with a complaint of left shoulder pain. Review of Systems noted decreased sleep, appetite, physical activity, and concentration. Other than vital signs, Respondent failed to conduct and/or failed to document having conducted a physical examination. Respondent failed to document Assessment or Diagnosis. Respondent refilled Mixed Androgen and Growth Hormone Releasing Peptide[32] for "shoulder healing" and advised Patient B to continue "HRT [hormone replacement therapy]" without documenting what this would involve.

36. On or about November 14, 2014, Patient B returned to Respondent for chronic left shoulder pain. Review of systems noted that Patient B had irritability, was depressed, and had decreased sleep, physical activity, and concentration. There is no mention of erectile dysfunction or hair loss, or any questioning regarding history of drug use. Respondent failed to conduct

[31] This statement is based on available medical records.

[32] Growth Hormone Releasing Peptides (GHRP) constitute a group of synthetic peptides that stimulate the growth hormone secretion.

and/or failed to document having conducted a physical examination. Respondent failed to order and/or or review and/or failed to document having ordered and/or reviewed laboratory tests. Respondent failed to document any assessment or diagnosis other than "ICD-9 code 719.41," which represents "pain in shoulder region." Respondent prescribed Cialis, Finasteride,[33] and Percocet. Respondent failed to obtain and/or failed to document having obtained a written informed consent regarding opiates. Thereafter, Respondent continued to prescribe Percocet every month or every other month and the dosage was increased to 10 mg in May of 2015 due to increased pain. In August of 2015, Respondent increased the amount of Percocet prescribed to #120 per month and again to #160 per month as of March 4, 2016.

37. On or about January 5, 2015, Patient B presented to Respondent complaining of a cough, congestion, fever, chills. Other than vital signs, Respondent failed to conduct and/or failed to document having conducted a physical examination. The vital signs indicated a heart rate of 68 and temperature of 101 degrees, Fahrenheit. Respondent diagnosed Patient B with "Upper Respiratory Infection, most likely bacterial." Respondent gave Patient B an IV "Myer's Cocktail,"[34] prescribed Robitussin AC,[35] Tessalon Peries,[36] Azithromycin #6 with 1 refill. Respondent failed to conduct and/or failed to document having conducted a lung exam. Respondent failed to order and/or failed to document having ordered x-rays.

38. On or about March 19, 2015, Patient B saw Respondent complaining of persistent shoulder pain and "worsening ADHD that is affecting his work." Review of systems noted depression, and decreased sleep, appetite, physical activity, and concentration. Respondent

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[33] Finasteride is a medication that can be used to treat enlarged prostate (benign prostatic hyperplasia).

[34] Myers' cocktail refers to use of an intravenous vitamin and mineral formula for treatment of a wide range of clinical conditions.

[35] Robitussin AC (Guaifenesin and Codeine) is a combination medication used to temporarily treat coughing and chest congestion symptoms caused by the common cold, flu or other breathing illnesses.

[36] Tessalon Peries is a medication used to treat coughs caused by the common cold and other breathing problems.

diagnosed Patient B with ADHD and shoulder pain. Respondent prescribed Vyvanse[37] 20 mg once a day, Adderall 30 mg, and refilled Percocet. Respondent did not administer an ADHD Self Report Scale Symptoms Checklist.

39. On or about December 2, 2015, Respondent increased the prescription for Vyvanse from 30 mg to 70 mg one per day and continued Adderall at 30 mg ½ to one pill every afternoon. Respondent did not administer an ADHD Self Report Scale Symptoms Checklist.

40. On or about March 27, 2017, Respondent performed a urine toxicology screening, which showed positive for oxycodone and marijuana. Respondent made a notation, "Patient not taking Ativan and Adderall and Vyvanse which he takes at times. On Percocet for shoulder pain. No diversion noted. Has Script for MJ." Respondent also noted, "[Patient B] told needs to decrease Percocet use" but continued to prescribe Percocet at 10/325 #150 per month until July 2017.

Medical Record-Keeping

41. During the course of his care and treatment of Patient B, approximately from October 2014 through July 2017, Respondent used a pre-printed form for each visit which did not have a section for physical examination other than vital signs. Patient B's birthdate or other identifier is not included on the visit documentations. There is no section on the form for an assessment or diagnosis. The Subjective Portion of the form was often scant, included little or no review of systems or details about the presenting complaints other than what is pre-printed on the form. There was no documentation of any labs ordered, lab results, phone calls with patient, or billing records.

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[37] Vyvanse is a medication used to treat ADHD.

Prescribing and Monitoring Steroid (Including Androgen) and Hormone Treatment

42. During the course of his care and treatment of Patient B, approximately from October 2014 through July 2017, Respondent prescribed Patient B "HRT [hormone replacement therapy]." Patient B did not have diagnoses such as delayed puberty, failure to gain weight, or aplastic anemia. Respondent failed to conduct physical examinations or order laboratory studies to corroborate the diagnosis of any hormone deficiency. Respondent failed to adequately investigate the underlying cause(s) of Respondent's purported low testosterone levels. Respondent failed to adequately discuss and/or failed to document having discussed potential adverse effects. Respondent failed to monitor and/or failed to document having monitored Patient B for elevated hematocrit levels, kidney or liver damage, while Patient B was on these medications.

Treatment of Shoulder Pain

43. During the course of his care and treatment of Patient B, approximately from October 2014 through July 2017, Respondent failed to make and/or failed to document having made a definitive diagnosis of Patient B's shoulder pain, other than noting "ICD9 code" for "pain in the shoulder region" on or about November 14, 2014. Respondent failed to conduct physical examinations and/or failed to document having conducted physical examinations. Respondent failed to coordinate care with other providers and/or failed to document having coordinated care with other providers such as orthopedic surgeons. Respondent failed to order or review imaging studies and/or request imaging studies from other providers. Respondent failed to refer and/or failed to document having referred Patient B for physical therapy or other non-opiate interventions.

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Prescribing and Monitoring of Opiates

44. During the course of his care and treatment of Patient B, approximately from October 2014 through July 2017, Respondent failed to adequately investigate the cause(s) of Patient B's shoulder pain. For most of the treatment period, Patient B was on 50 mg of Oxcycodone per day, even though Patient B did not have any evidence of pathology necessitating this amount of dosage. Respondent failed to adequately monitor CURES reports. Respondent failed to review with Patient B and/or failed to document having reviewed with Patient B the risks of opiates. Respondent administered only one urine drug screening on or about March 27, 2017, during the time he treated Patient B. Respondent failed to perform and/or failed to document having performed screening(s) for opiate addiction or dependence disorder even though Patient B had a number of "red flags" for opiate addiction such as steadily increasing dosage and amount of medications, being a young male with a history of depression, seeing multiple providers, and using mind-altering substances such as marijuana and benzodiazepines. Respondent failed to ask or failed to document having asked the patient about a family history related to addiction and Patient B's drug or alcohol use. Respondent failed to adequately inform Patient B and/or failed to document having adequately informed Patient B regarding the risks of concurrent usage of opiates with marijuana or benzodiazepines.

Treatment of Insomnia

45. During the course of his care and treatment of Patient B, approximately from October 2014 through July 2017, Respondent prescribed Ativan and Ambien for Patient B's insomnia. Respondent failed to obtain and/or failed to document having obtained a thorough history regarding Patient B's sleep pattern and other factors which may affect his sleep such as stress, caffeine intake, exercise, and work hours. Respondent did not adequately attempt to rule out other underlying causes of insomnia such as presence of thyroid disease or depression. Respondent did not adequately attempt first-line treatment options such as doxepin or TCAs (tri-cyclic antidepressants) before prescribing controlled substances.

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Treatment of Upper Respiratory Infection

46. On or about January 5, 2015, Respondent prescribed antibiotic Azithromycin for five days with 1 refill even though Patient B had no signs or symptoms indicating a bacterial infection. Respondent failed to perform a lung examination and/or failed to document having performed a lung examination. Respondent failed to order and/or failed to document having ordered x-rays.

Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder (ADHD)

47. During the course of his care and treatment of Patient B, approximately from October 2014 through July 2017, Respondent failed to review and/or failed to document having reviewed the DSM criteria regarding Patient B's ADHD. Respondent failed to ask and/or failed to document having asked Patient B about how Patient B's ADHD symptoms affect his function, how he was originally diagnosed or at what age. Respondent failed to obtain prior medical records confirming Patient B's ADHD diagnosis. Respondent failed to rule out or failed to document having ruled out other potential causes of Patient B's poor concentration such as untreated depression, opiate use, and marijuana use.

48. Respondent prescribed the following controlled substances to Patient B:

Date	Drug Name	Quantity
10/14/14	Dextroamph Sacc/Amph Asp / Dextroam S 30 MG	30
10/14/14	Oxycodone and Acetaminophen 325 MG / 10 MG	45
11/14/14	Oxycodone and Acetaminophen 325 MG / 10 MG	60
12/8/14	Progesterone (Powder)	0.5
12/8/14	Testosterone Cypionate (Powder)	0.5
12/18/14	Dextroamph Sacc/Amph Asp / Dextroam S 30 MG	60
12/18/14	Oxycodone and Acetaminophen 325 MG / 10 MG	60
2/2/15	Dextroamph Sacc/Amph Asp / Dextroam S 30 MG	60
2/9/15	Oxycodone and Acetaminophen 325 MG / 10 MG	60
3/20/15	Oxycodone HCL - Acetaminophen 325 MG / 10 MG	60

3/20/15	Vyvanse 20 MG	30
5/1/15	Oxycodone HCL - Acetaminophen 325 MG / 10 MG	60
6/12/15	Lorazepam 1 MG	60
6/12/15	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	60
7/11/15	Lorazepam 1 MG	60
7/11/15	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	60
8/7/15	Lorazepam 1 MG	30
8/10/15	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	120
10/10/15	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	120
10/10/15	Vyvanse 20 MG	29
12/7/15	Amphetamine Salt Combo 30 MG	30
12/7/15	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	120
12/7/15	Vyvanse 70 MG	30
1/30/16	Ampehtamine Salt Combo 30 MG	30
1/30/16	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	120
3/14/16	Lorazepam 1 MG	30
3/14/16	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	160
5/10/16	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	150
5/10/16	Zolpidem Tartrate 12.5 MG	30
7/27/16	Stanozolol Micronized	Powder
8/11/16	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	150
8/24/16	Stanozolol Micronized	Powder
9/14/16	Stanozolol Micronized	Powder
10/12/16	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	150
10/20/16	Stanozolol Micronized (Powder)	1
11/23/16	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	150
12/29/16	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	150

2/1/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	150
2/1/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	150
3/2/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	150
3/28/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	150
4/24/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	150
5/18/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	150
6/11/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	150
7/13/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	156

49. Respondent committed gross negligence in his care and treatment of Patient B, which included, but was not limited to, the following:

(a) Respondent had inadequate medical record-keeping;

(b) Respondent failed to properly provide steroid and hormone therapy;

(c) Respondent failed to properly treat Patient B's shoulder pain; and

(d) Respondent failed to properly prescribe opiates to Patient B.

Patient C

50. On or about May 19, 2015, Patient C presented to Respondent with a history of chronic shoulder pain and Post Traumatic Stress Disorder (PTSD). Patient C completed the new patient intake form, Androgen Deficiency in Aging Males (ADAM) Questionnaire, the Men's Health Questionnaire, a testosterone therapy consent form, an ADHD Self-Report Scale Symptoms checklist and Buprenorphine agreement. Patient C's noted main concerns were "energy, stronger sex drive." Other than vital signs, Respondent failed to conduct and/or failed to document having conducted a physical examination. Respondent failed to make and/or failed to document having made any diagnoses or assessments. Respondent's stated plan was to initiate Ativan nightly for insomnia, Finasteride for hair loss, Cialis daily for ED [erectile dysfunction] and BPH (benign prostatic hypertrophy], begin Anastrozole, MAI3 [a combination steroid product], GHRP [growth hormone releasing peptide], and HCG [human chorionic

gonadotropin],[38] and Flurbiprofen[39] topical cream for shoulder pain.

51. On or about June 15, 2015, Patient C returned to Respondent complaining of anxiety and insomnia. Respondent prescribed Xanax #30, 2 mg tablets, one at night for sleep. By September 2015, Respondent increased the Xanax prescription to 2 mg three times a day. On June 30, 2016 Patient C had worsening insomnia and Respondent decreased Xanax prescription from 3 to two tablets per day and added Ambien 10 mg for sleep. In August of 2016, Respondent stopped prescribing Xanax to Patient C and replaced it with Ativan 1mg one to two nightly, for insomnia. On or about September 26, 2016, Respondent resumed prescribing Xanax #90 to 120 tablets per prescription.

52. On or about June 20, 2015, Patient C returned to Respondent. Respondent noted, "Patient here for URI, will give Z-pack and continue MAI package [mixed androgen.]" Respondent prescribed Azithromycin 250 mg #6. Other than vita signs excluding temperature, Respondent failed to conduct and/or failed to document having conducted a physical examination. Respondent failed to order and/or failed to document having ordered x-rays or other tests.

53. On June 27, 2015, Patient C visited Respondent for left shoulder pain. The pain level noted was a 6 [out of ten], and Patient C reported decreased range of motion and that he was better with rest and medications and worse with movement. Patient C also reported a decrease in sleep, appetite, physical activity, patience, and concentration. Respondent performed a trigger point injection of the shoulder with Kenalog,[40] Lidocaine,[41] and Marcaine.[42] Respondent prescribed Percocet 10/325 one to two every six hours, as needed, for left shoulder pain. Respondent failed to counsel and/or failed to document having counseled Patient C regarding the risk of the medications. On or about October 30, 2015 Respondent increased the prescription for

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[38] Human chorionic gonadotropin (HCG) is used to cause ovulation and to treat infertility in women and to increase sperm count in men.

[39] Flurbiprofen can be used to treat pain and arthritis.

[40] Kenalog injection can be used to reduce inflammation and pain.

[41] Lidocaine injection is a local anesthetic that works by blocking nerve signals in your body.

[42] Marcaine injection is a numbing medicine that can be used as a local anesthetic.

Percocet to two per day. In or around February 2016, Respondent increased prescription for Percocet to # 90 per month noting, "pain worse." In September of 2016, Respondent increased prescription for Percocet to # 120 per month without any documented reason(s). Respondent failed to refer Patient C to any specialists and/or failed to document having referred Patient C to any specialists. Respondent failed to order and/or failed to document having ordered imaging studies of Patient C's left shoulder. Respondent failed to conduct any neurologic examination assessing for strength or nerve impingement.

54. On or about July 13, 2015, Patient C returned to Respondent for acne on his back and chest. Respondent prescribed Doxycycline[43] 100 mg twice a day, #60 with three refills. On or about January 4, 2016, Respondent changed this prescription to Keflex[44] 500 mg twice a day #40 with 3 refills. Respondent advised Patient C to use salicylic acid wash and to use oral antibiotics short-term. On or about September 26, 2016, Respondent refilled Keflex #40 with 3 refills.

55. On or about August 24, 2015, Patient C visited Respondent for "ADHD symptoms." Other than vital signs, Respondent failed to conduct a physical examination and/or failed to document having conducted a physical examination. Other than the ADHD Self-Report Scale Symptoms checklist completed at the initial visit in May 2015, there were no other ADHD Self-Report Scale Symptoms checklist. Respondent started Patient C on Adderall 20 mg ½ tablet twice a day #30, and also gave a "Myer's Cocktail" and IV Hydration in the office. Respondent advised Patient C to continue all of the hormones and steroids.

56. Respondent performed four urine toxicology screenings in his office on June 1, 2016, April 12, 2017, December 4, 2017, and April 6, 2018. Respondent failed to adequately review CURES reports.

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[43] Doxycycline is a medication that can be used to treat and prevent infections.

[44] Keflex is an antibiotic that can be used to treat infections.

Medical Record-Keeping

57. During the course of his care and treatment of Patient C, approximately from May 19, 2015 through April 6, 2018, Respondent used a pre-printed form for each visit which did not include a section for physical examination, other than vital signs. There is no section for an assessment or diagnosis. The Subject portion of the form is often scant and includes little or no review of systems or details about the presenting complaints, other than what is pre-printed on the form. Other than vital signs and one documented physical examination on or about April 6, 2018, there are no documented physical examinations during the nearly three years of treatment provided to Patient C. There were no phone calls documented, no billing records, CURES reports, or consultations with other physicians. Some of the handwritten entries are illegible and many are unsigned.

Prescribing and Monitoring Steroid (Including Androgen) and Hormone Treatments

58. During the course of his care and treatment of Patient C, approximately from May 19, 2015 through April 6, 2018, Respondent prescribed Patient C "HRT" [hormone replacement therapy] without documenting what exactly is being prescribed and why. Patient C had no documented diagnoses such as delayed puberty, failure to gain weight, or aplastic anemia. Respondent failed to document how and whether physical examinations and/or laboratory studies, if any, corroborate Patient C's purported diagnosis of hormone deficiency, if any. Respondent failed to adequately investigate and/or failed to document having adequately investigated the underlying cause(s) of Patient C's purported hormone deficiency. Respondent failed to monitor and/or document having failed to monitor Patient C for elevated hematocrit levels, kidney or liver damage while Patient C was on these medications. Respondent failed to obtain a written informed consent, before initiating hormone replacement therapy with Patient C.

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Treatment of Shoulder Pain

59. During the course of his care and treatment of Patient C, approximately from May 19, 2015 through April 6, 2018, Respondent failed to make a definitive diagnosis regarding Patient C's shoulder pain, other than noting on or about June 27, 2015, ICD 10 code 719.41 for "pain in the left shoulder." Respondent had only one documented physical examination on or about April 6, 2018. Respondent failed to order imaging studies or request them from Patient C's other providers. Although Respondent did recommend non-opiate treatment options such as ice, rest, and heat, Respondent failed to refer Patient C for other treatment modalities such as steroid injections or orthopedic evaluation.

Prescribing and Monitoring of Opiates

60. During the course of his care and treatment of Patient C, approximately from May 19, 2015 through April 6, 2018, Respondent began prescribing Percocet to Patient C in 2015 and increased the amount from 10 mg #60 per month to #120 per month starting on or about December 6, 2016, without clear indications other than noting, "increased pain." Respondent failed to adequately investigate and/or failed to document having adequately investigated the cause(s) for pain. Respondent failed to review CURES reports. Respondent failed to review and/or failed to document having reviewed risks of opiates with Patient C. The urine drug screening tests were not sent out to an outside laboratory for confirmation.

Prescribing Chronic Benzodiazepines

61. During the course of his care and treatment of Patient C, approximately from May 19, 2015 through April 6, 2018, Respondent prescribed Xanax to Patient C from on or about June 17, 2015 through April 6, 2018 and Ativan intermittently for "anxiety and insomnia." Respondent failed to adequately consider other safer alternatives such has SSRIs[45] for anxiety or Doxepin[46] or

[45] Selective serotonin reuptake inhibitors (SSRIs) are a class of drugs that are typically used as antidepressants in the treatment of major depressive disorder and anxiety disorders.

[46] Doxepin is a medication used to treat mental/mood problems such as depression and anxiety.

tricyclics[47] for insomnia. Respondent failed to advise and/or failed to document having advised Patient C regarding the risks of overdose or addiction.

Treatment of Insomnia

62. During the course of his care and treatment of Patient C, approximately from May 19, 2015 through April 6, 2018, Respondent failed to obtain and/or failed to document having obtained information regarding Patient C's sleep pattern and relevant factors such as stress, caffeine intake, exercise, work shift. Respondent failed to adequately rule out and/or failed to document having adequately rule out potential underlying causes of insomnia and depression. Respondent failed to adequately attempt first-line treatment options such as Doxepin or tricyclics before prescribing controlled substances.

Treatment of Upper Respiratory Infection

63. Respondent treated Patient C for "Upper Respiratory Infections" on or about June 20, 2015 and on or about May 17, 2017. Respondent failed to perform and/or failed to document having performed any lung examinations. Respondent failed to order and/or failed to document having ordered any x-rays. Patient C did not display any signs or symptoms suggesting a bacterial infection and had no indication for antibiotics. At the subject interview conducted on August 22, 2018, Respondent stated that he "treats appropriately with antibiotics."

Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder (ADHD)

64. During the course of his care and treatment of Patient C, approximately from May 19, 2015 through April 6, 2018, Respondent failed to review and/or failed to document having reviewed the DSM criteria regarding Patient C's ADHD. Respondent failed to ask and/or failed to document having asked Patient C about how Patient C's ADHD symptoms affect his function, how he was originally diagnosed or at what age. Respondent failed to rule out or failed to document having ruled out other potential causes of Patient C's poor concentration such as untreated depression, opiate use, and marijuana use. Respondent failed to discuss and/or failed to document having discussed risks and benefits of medications and/or safer alternatives to the

[47] Tricyclic antidepressants (TCAs) are a class of medications that are used primarily as antidepressants.

medications Respondent prescribed to Patient C for Patient C's purported ADHD. Respondent did not adequately monitor and document side effects or efficacy of the medications he prescribed for Patient C's purported ADHD.

Treatment of Anxiety

65. During the course of his care and treatment of Patient C, approximately from May 19, 2015 through April 6, 2018: Respondent prescribed benzodiazepines to Patient C, to be taken two to three times per day for Patient C's anxiety symptoms. Respondent failed to adequately investigate and/or failed to document having adequately investigated Patient's symptoms or rule out underlying physical causes. Respondent failed to refer and/or failed to document having referred Patient C to a mental health professional. Respondent failed to prescribe safer alternative medications for treatment of anxiety such as SSRIs or Buspar.[48]

Treatment of Acne

66. On or about July 13, 2015 and on or about January 4, 2016 Respondent treated Patient C for acne. Respondent treated Patient C's acne with oral antibiotics Doxycycline and Keflex and provided prescriptions with refills enough for at least twelve months. Respondent failed to try safer topical medications before prescribing Doxycycline and Keflex. Respondent failed to recommend and/or failed to document having recommended Patient C to use Doxycycline and Keflex with Benzoyl Peroxide.[49] Respondent failed to adequately consider whether Patient C's acne was an adverse effect of the excess testosterone Respondent prescribed and if so, altering the testosterone dose accordingly.

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[48] Buspar is a medication that can be used to treat anxiety.

[49] Benzoyl Peroxide is a medication that can be used to treat acne and other skin conditions.

Diagnosis and Treatment of Benign Prostatic Hypertrophy (BPH)

67. During the course of his care and treatment of Patient C, approximately from May 19, 2015 through April 6, 2018, Respondent failed to conduct and/or failed to document having conducted a physical examination to confirm the existences of an enlarged prostate and to rule out other causes that may result in symptoms similar to BPH such as prostate cancer, anal lesions, and prostate infections. Respondent failed to question and/or failed to document having questioned Patient C regarding specific symptoms related to the prostate such as changes with urination. Respondent failed to order Prostate Specific Antigen (PSA) blood test to rule out prostate cancer. Respondent failed to perform and/or failed to document having performed a prostate exam to confirm the prostate enlargement, which is the basis for the diagnosis of Benign Prostatic Hypertrophy. Respondent failed to conduct and/or failed to document having conducted a thorough endocrine evaluation to rule out potential malignancies.

68. Respondent prescribed the following controlled substances to Patient C:

Date	Drug Name	Quantity
5/19/15	Lorazepam 1 MG	30
6/17/15	Alprazolam 2 MG	30
6/27/15	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	45
7/10/15	Compound	2
7/10/15	Compound	2
7/10/15	Hydroxocobalamin HCL Powder	0.5
7/30/15	Alprazolam 2 MG	30
8/15/15	Compound	2
8/15/15	Compound	2
8/15/15	Hydroxocobalamin HCL Powder	0.5
8/27/15	Ampehtamine Salt combo 20 MG	30
9/24/15	Alprazolam 2 MG	60

10/2/15	Nandrolone Decanoate Powder	1
10/2/15	Stanozolol Micronized Powder	0.5
10/2/15	Testosterone Cypionate Powder	2.06
11/5/15	Alprazolam 2 MG	90
11/5/15	Amphetamine Salt Combo 20 MG	30
11/5/15	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	60
11/20/15	Testosterone Cypionate Powder	2.06
12/16/15	Alprazolam 2 MG	60
12/16/15	Amphetamine Salt Combo 20 MG	60
12/16/15	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	60
12/16/15	Stanozolol Micronized Powder	0.5
2/14/16	Endocet 325 MG / 10 MG	90
2/18/16	Stanozolol Micronized Powder	0.25
3/3/16	Testosterone Cypionate Powder	2.06
3/11/16	Alprazolam 2 MG	90
3/11/16	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	90
4/1/16	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	90
4/1/16	Alprazolam 2 MG	60
4/1/16	Alprazolam 2 MG	60
4/1/16	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	90
4/28/16	Testosterone Cypionate Powder	2
4/28/16	Compound	2
4/28/16	Stanozolol Micronized	Powder
5/1/16	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	90
5/1/16	Alprazolam 2 MG	60
5/1/16	Dextroamph Sacc – Amph Asp – Dextroam S 20 MG	60
5/16/16	Compound	2

6/1/16	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	90
6/1/16	Alprazolam 2 MG	90
6/1/16	Alprazolam 2 MG	90
6/1/16	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	90
6/1/16	Phentermine HCL 37.5 MG	90
6/30/16	Alprazolam 2 MG	60
6/30/16	Vyvanse 70 MG	30
6/30/16	Zolpidem Tartrate 10 MG	20
6/30/16	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	90
7/12/16	Testosterone Powder	2
7/27/16	Nandrolone Decanoate Powder	2
8/26/16	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	90
8/26/16	Lorazepam 1 MG	60
9/14/16	Compound	10
9/27/16	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	90
9/27/16	Alprazolam 2 MG	120
10/20/16	Nandrolone Decanoate Powder	2
11/7/16	Testosterone Cypionate Powder	2
11/8/16	Alprazolam 2 MG	90
11/8/16	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	90
11/8/16	Vyvanse 70 MG	30
11/23/16	Compound	1
12/6/16	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	120
12/6/16	Alprazolam 2 MG	90
12/16/16	Stanozolol Micronized	Powder
1/11/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	120
1/11/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	120

1/11/17	Dextroamph Sacc – Amph Asp – Dextroam S 30 MG	60
1/11/17	Dextroamph Sacc – Amph Asp – Dextroam S 30 MG	60
1/26/17	Alprazolam 2 MG	90
1/26/17	Alprazolam 2 MG	90
3/6/17	Dextroamph Sacc – Amph Asp – Dextroam S 20 MG	60
3/6/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	120
3/6/17	Dextroamph Sacc – Amph Asp – Dextroam S 20 MG	60
3/6/17	Alprazolam 2 MG	60
3/6/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	120
3/6/17	Alprazolam 2 MG	60
3/9/17	Compound	1
4/12/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	120
4/12/17	Alprazolam 2 MG	60
4/12/17	Dextroamph Sacc – Amph Asp – Dextroam S 30 MG	60
4/12/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	120
4/12/17	Alprazolam 2 MG	60
4/12/17	Dextroamph Sacc – Amph Asp – Dextroam S 30 MG	60
5/11/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	120
5/11/17	Alprazolam 2 MG 60	60
5/11/17	Amphetamine Salt Combo 30 MG	60
6/10/17	Alprazolam 2 MG	60
6/10/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	120
6/10/17	Amphetamine Salt Combo 30 MG	60
6/15/17	Compound	1
7/20/17	Alprazolam 2 MG	60
7/20/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	120
7/20/17	Amphetamine Salt Combo 30 MG	60

9/28/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	120
2/1/18	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	120
4/6/18	Alprazolam 2 MG	60

69. Respondent committed gross negligence in his care and treatment of Patient C, which included, but was not limited to, the following:

(a) Respondent had inadequate medical record-keeping;

(b) Respondent failed to properly provide adequate steroid and hormone therapy;

(c) Respondent failed to properly treat Patient C's shoulder pain;

(d) Respondent failed to properly prescribe opiates to Patient C; and

(d) Respondent failed to properly diagnose and/or treat Patient C's purported Benign Prostatic Hypertrophy.

Patient D

70. On or about December 7, 2014, Patient D presented to Respondent complaining of abdomen and sinus pain, congestion, and headache. Patient D had a history of an MRSA[50] sinus infection and polycystic ovarian syndrome (PCOS).[51] Patient D also reported feeling nausea, sad and irritable, having a poor concentration, and a decreased appetite, sleep, and activity. Other than vital signs, Respondent failed to conduct and/or failed to document having conducted a physical examination. Respondent failed to conduct and/or failed to document having conducted a pelvic examination. Respondent failed to document the information contained in the 500 pages of Patient D's prior medical records Respondent allegedly reviewed. Respondent diagnosed Patient D with polycystic ovarian syndrome (PCOS) and prescribed Patient D Percocet 5/325 mg ½ to 1 tablet every six hours as needed for abdominal pain. Respondent also prescribed Norco 10/325 one to two tablets every six hours as needed for "PCOS." Respondent advised Patient D to alternate between the two medications for pain relief. Respondent failed to adequately review

[50] Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium that causes infections in different parts of the body.

[51] Polycystic ovarian syndrome (PCOS) is a common health problem caused by an imbalance of reproductive hormones.

CURES reports. Respondent failed to execute a Controlled Substance Agreement.

71. Patient D returned to Respondent on or about February 24, 2015 for cough, fever, and chills. A temperature was not recorded in the medical records. The only physical examination noted was decreased breath sounds and rales[52] in the bilateral lung fields. Respondent diagnosed Patient D with "Bronchitis"[53] and prescribed "moxi or levofloxacin"[54] for 5 to 10 days and advised her to return as needed.

72. On or about May 12 and 13, 2015, Patient D visited Respondent complaining of ear and facial pain, menstrual cramps, headache, and nausea. Respondent failed to conduct and/or failed to document having conducted a physical examination. Respondent failed to document any assessments or diagnoses. Respondent prescribed Zofran for nausea and advised Patient D to return as needed. Respondent failed to order or review and/or failed to document having ordered and reviewed any laboratory studies.

73. On or about May 17, 2015, Patient D returned to Respondent. No chief complaint was documented. Other than vital signs, Respondent failed to conduct and/or failed to document having conducted a physical examination. Respondent failed to document any assessments or diagnoses. Respondent prescribed Xanax 0.5 mg every eight hours as needed for "cramps" and the ICD9 code for polycystic ovarian syndrome.

74. On or about June 16, 2015, Respondent noted that Patient D was being treated by an ear, nose, and throat specialist. Respondent prescribed Vicoprofen[55] 7.5/200 every six hours as needed for PCOS, and Norco[56] 10/325 #60 for PCSO.

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[52] Rale refers to an abnormal rattling sound heard when examining unhealthy lungs with a stethoscope.

[53] Bronchitis is an inflammation of the bronchial tubes, the airways that carry air to your lungs.

[54] Levofloxacin is an antibiotic that can be used to treat infections.

[55] Vicoprofen is a pain reliever and nonsteroidal anti-inflammatory drug that can be used to treat pain.

[56] Hydrocodone APAP (Vicodin®, Lortab® and Norco®) is a hydrocodone combination of hydrocodone bitartrate and acetaminophen which was formerly a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous

75. Respondent continued to treat Patient D regularly until approximately December 12, 2016. Respondent continued to prescribe Percocet, Vicoprofen, and Norco for Patient D's polycystic ovarian syndrome. Respondent typically prescribed two narcotics at a time and advised Patient D to alternate between the two. Respondent continued to prescribe Xanax at 2 mg #90 per month. Respondent failed to coordinate care with Patient D's mental health provider(s).

76. On or about October 13, 2016 and December 12, 2016 Respondent performed two urine toxicology screenings at his office, both of which were positive for Xanax, oxycodone, opiates, and marijuana.

Medical Record-Keeping

77. During the course of his care and treatment of Patient D, approximately from December 7, 2014 through December 12, 2016, Respondent used a pre-printed form for each visit which did not include a section for physical examination, other than vital signs. There is no section on the forms for an assessment or diagnosis. The Subject portion of the form is often scant and includes little or no review of systems or details about the presenting complaints, other than what is pre-printed on the form. Other than vital signs, there are no documented physical examinations. There were no phone calls documented, no billing records, CURES reports, or consultations with other physicians. Some of the handwritten entries are illegible. Many of the entries are repeated verbatim from visit to visit.

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drug pursuant to Business and Professions Code section 4022. On August 22, 2014, the DEA published a final rule rescheduling hydrocodone combination products (HCPs) to schedule II of the Controlled Substances Act, which became effective October 6, 2014. Schedule II controlled substances are substances that have a currently accepted medical use in the United States, but also have a high potential for abuse, and the abuse of which may lead to severe psychological or physical dependence. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain. In addition to the potential for psychological and physical dependence there is also the risk of acute liver failure which has resulted in a black box warning being issued by the Federal Drug Administration (FDA). The FDA black box warning provides that "Acetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury are associated with use of the acetaminophen at doses that exceed 4000 milligrams per day, and often involve more than one acetaminophen containing product."

Treatment of Polycystic Ovarian Syndrome (PCOS)

78. During the course of his care and treatment of Patient D, approximately from December 7, 2014 through December 12, 2016, Respondent failed to order and/or review and/or failed to document having ordered and reviewed laboratory tests, or ultrasound(s) to confirm the diagnosis of PCOS. Respondent failed to adequately address potentially significant complications of PCOS such as diabetes and endometrial cancer.[57] The medical records do not mention any complaints or evidence of hirsutism (male type hair growth), acne, infertility, or patient's menses. Respondent failed to fully evaluate Patient D's symptoms. Respondent failed to perform any pelvic examinations. Respondent prescribed narcotic medications even though they were not indicated for Patient D.

Prescribing and Monitoring of Opiates

79. During the course of his care and treatment of Patient D, approximately from December 7, 2014 through December 12, 2016, Respondent began prescribing Percocet and Norco in 2014 and increased the dose over time to 180 per month, starting on or about August 2, 2016 (Percocet) and starting on or about June 3, 2016 (Norco). Respondent also prescribed Vicoprofen and Oxycodone often in combination with Norco and/or Percocet. Respondent failed to document why Patient D was prescribed two short-acting opiates. Respondent failed to adequately determine and/or failed to document having adequately determined the diagnosis of the abdominal pain or the elbow pain. Respondent failed to try safer alternatives such as NSAIDs[58], physical therapy for the elbow, hormonal manipulation for the PCOS, before initiating opiate treatment. Respondent failed to adequately review CUREs reports. Respondent failed to discuss and/or failed to document having discussed the risks of opiates with Patient D. Respondent did not have a controlled substances agreement with Patient D. Respondent failed to screen and/or failed to document having screened Patient D for opiate dependence. Respondent failed to advise and/or failed to document having advised Patient D of the risks of concurrent usage of opiates with marijuana or benzodiazepines.

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[57] Endometrial cancer is a type of cancer that begins in the lining of the womb (uterus).

[58] Nonsteroidal anti-inflammatory drugs, or NSAIDs can be used to reduce pain.

Prescribing of Chronic Benzodiazepines

80. During the course of his care and treatment of Patient D, approximately from December 7, 2014 through December 12, 2016, Respondent prescribed Xanax to Patient D for "cramps" initially, then later for "anxiety." Respondent failed to consider and/or prescribe safer alternatives such as SSRIs for anxiety or NSAIDs or hormonal manipulation for cramps. Respondent failed to advise and/or failed to document having advised Patient D of the risks of overdose or addiction. Respondent failed to adequately review CURES reports.

Treatment of Anxiety

81. During the course of his care and treatment of Patient D, approximately from December 7, 2014 through December 12, 2016, Respondent failed to adequately investigate Patient D's anxiety symptoms. Respondent failed to prescribe safer alternatives to Xanax such as SSRI's or Buspar. Respondent failed to follow up on whether Patient D was following Respondent's purported recommendation to see a counselor.

Prescribing Fluconazole[59]

82. Respondent prescribed 46 pills of Fluconazole to Patient D between March 2015 and June 2016. Respondent failed to conduct and/or failed to document having conducted any physical examinations or pelvic examinations. There is no documentation of Patient D complaining of vaginal symptoms indicative of vaginal yeast infection(s). Respondent did not make an appropriate diagnosis of vaginal yeast infection(s), if any. Respondent failed to confirm diagnosis of vaginal yeast infections, if any. Respondent failed to inform and/or failed to document having informed Patient D of possible complications that may be caused by the fact that Patient D is taking Fluconazole along with large quantities of acetaminophen (contained in Percocet and Norco). Respondent failed to evaluate and/or failed to document having evaluated Patient D's liver function.

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[59] Fluconazole is an antifungal that can be used to treat and prevent fungal infections.

83. Respondent prescribed the following medications to Patient D:

Date	Drug Name	Quantity
12/10/14	Acetaminophen – Hydrocodone Bitartrat 325 MG / 10 MG	60
12/10/14	Oxycodone and Acetaminophen 325 MG / 5 MG	5
1/10/15	Hydrocodone Bitartrate – Ibuprofen 7.5 MG - 200 MG	60
1/10/15	Oxycodone and Acetaminophen 325 MG / 5 MG	60
2/10/15	Alprazolam 0.5 MG	20
2/10/15	Hydrocodone Bitatrate-Ibuprofen 7.5 MG / 200 MG	60
2/24/15	Hydrocodone Bitatrate-Ibuprofen 7.5 MG / 200 MG	60
2/24/15	Oxycodone and Acetaminophen 325 MG / 5 MG	60
3/23/15	Acetaminophen – Hydrocodone Bitartrate 325 MG / 10 MG	60
3/23/15	Alprazolam 0.5 MG	20
3/23/15	Hydrocodone Bitatrate-Ibuprofen 7.5 MG / 200 MG	90
5/12/15	Acetaminophen – Hydrocodone Bitartrate 325 MG / 10 MG	60
5/12/15	Hydrocodone Bitatrate-Ibuprofen 7.5 MG / 200 MG	120
5/18/15	Alprazolam 0.5 MG	20
7/21/15	Acetaminophen – Hydrocodone Bitartrate 325 MG / 10 MG	60
7/21/15	Hydrocodone Bitartrate-Ibuprofen 7.5 MG / 200 MG	120
8/20/15	Acetaminophen – Hydrocodone Bitartrate 325 MG / 10 MG	60
8/26/15	Hydrocodone Bitartrate-Ibuprofen 7.5 MG / 200 MG	120
9/24/15	Hydrocodone Bitartrate – Acetaminophen 3	60
9/26/15	Hydrocodone Bitartrate-Ibuprofen 7.5 MG / 200 MG	120
10/2/15	Alprazolam 0.5 MG	30
10/23/15	Hydrocodone Bitartrate – Acetaminophen 325 MG / 10 MG	60
10/28/15	Alprazolam 0.5 MG	30
10/30/15	Hydrocodone Bitartrate-Ibuprofen 7.5 MG / 200 MG	120

11/13/15	Alprazolam 0.5 MG	30
11/13/15	Hydrocodone Bitartrate – Acetaminophen 325 MG / 10 MG	60
11/24/15	Hydrocodone Bitartrate-Ibuprofen 7.5 MG / 200 MG	120
12/10/15	Alprazolam 1 MG	60
12/10/15	Hydrocodone Bitartrate- Acetaminophen 325 MG / 10 MG	90
12/28/15	Hydrocodone Bitartrate- Acetaminophen 325 MG / 10 MG	90
12/28/15	Hydrocodone Bitartrate-Ibuprofen 7.5 MG / 200 MG	120
1/10/16	Alprazolam 1 MG	60
1/28/16	Hydrocodone Bitartrate- Acetaminophen 325 MG / 10 MG	90
1/28/16	Hydrocodone Bitartrate-Ibuprofen 7.5 MG / 200 MG	120
2/21/16	Hydrocodone Bitartrate- Acetaminophen 325 MG / 10 MG	120
2/24/16	Alprazolam 1 MG	60
2/25/16	Hydrocodone Bitartrate-Ibuprofen 7.5 MG / 200 MG	120
3/17/16	Hydrocodone Bitartrate- Acetaminophen 325 MG / 10 MG	120
3/22/16	Alprazolam 1 MG	60
3/22/16	Hydrocodone Bitartrate-Ibuprofen 7.5 MG / 200 MG	120
4/14/16	Hydrocodone Bitartrate- Acetaminophen 325 MG / 10 MG	120
4/14/16	Hydrocodone Bitartrate-Ibuprofen 7.5 MG / 200 MG	120
4/14/16	Acetaminophen – Hydrocodone Bitartrate 325 MG / 10 MG	120
5/11/16	Alprazolam 1 MG	30
5/11/16	Hydrocodone Bitartrate- Acetaminophen 325 MG / 10 MG	120
5/11/16	Hydrocodone Bitartrate-Ibuprofen 7.5 MG / 200 MG	120
6/3/16	Alprazolam 1 MG	60
6/3/16	Hydrocodone Bitartrate- Acetaminophen 325 MG / 10 MG	180
6/24/16	Hydrocodone Bitartrate- Acetaminophen 325 MG / 10 MG	180
7/18/16	Alprazolam 1 MG	60
7/18/16	Acetaminophen – Hydrocodone Bitartrate 325 MG / 10 MG	120

8/2/16	Acetaminophen – Hydrocodone Bitartrate 325 MG / 10 MG	240
10/10/16	Oxycodone HCL 20 MG	90
10/10/16	Hydrocodone Bitartrate- Acetaminophen 325 MG / 10 MG	180
10/13/16	Alprazolam 0.5 MG	60
10/26/16	Alprazolam 1 MG	90
10/26/16	Hydrocodone Bitartrate- Acetaminophen 325 MG / 10 MG	180
10/26/16	Oxycodone HCL 20 MG	60
12/12/16	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	180
12/12/16	Alprazolam 2 MG	90
1/3/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	180
1/8/17	Alprazolam 2 MG	90
2/3/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	180
2/7/17	Alprazolam 2 MG	90
2/28/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	180
3/21/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	180
3/21/17	Alprazolam 2 MG	90
4/18/17	Alprazolam 2 MG	3
4/18/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	12
4/19/17	Alprazolam 2 MG	28
4/19/17	Oxycodone HCL – Acetaminophen 325 MG / 10 MG	84

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84. Respondent committed gross negligence in his care and treatment of Patient D, which included, but was not limited to, the following:

(a) Respondent had inadequate medical record-keeping;

(b) Respondent did not properly diagnose and/or treat Patient D's polycystic ovarian syndrome;

(c) Respondent failed to properly prescribe opiates to Patient D;

(d) Respondent failed to properly prescribe benzodiazepines to Patient D; and

(e) Respondent failed to properly prescribe Fluconazole to Patient D.

Patient E

85. Respondent treated Patient E between about October 2014 until June 23, 2016, during the time Patient E was married to Respondent. Patient E was treated for hypothyroidism,[60] Attention Deficit Hyperactivity Disorder, hypogonadism (low testosterone), anxiety, insomnia, and depression. Respondent prescribed Patient E antibiotics, Levothyroxine,[61] Finasteride,[62] Growth hormone releasing peptide,[63] Human chorionic gonadotropin,[64] Albuterol,[65] Edex,[66] Anastrozole, Qnasal,[67] Wellbutrin, Linzess,[68] topical analgesic creams, Vyvanse, Adderall, Oxycontin, Xanax, Ketamine powder and mixed androgens/testosterone. Respondent failed to provide an official termination of physician-patient relationship to Patient E when Respondent stopped treating Patient E on or about June 23, 2016.

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[60] Hypothyroidism is an underactive thyroid gland.

[61] Levothyroxine is a medication that can be used to treat hypothyroidism.

[62] Finasteride is a medication that can be used to treat enlarged prostate.

[63] Growth hormone releasing peptide stimulates the body's secretion of growth hormone (GH).

[64] Human chorionic gonadotropin (HCG) is used to cause ovulation and to treat infertility in women and to increase sperm count in men.

[65] Albuterol is a medication that can be used for treatment of asthma symptoms.

[66] Edex is a medication that can be used to treat impotence.

[67] Qnasl is a medication used to treat allergy symptoms.

[68] Linzess is a medication that is used to treat certain type of bowel problems.

86. Respondent prescribed the following controlled substances to Patient E:

Date	Drug Name	Quantity
8/9/14	Alprazolam 2 MG	60
8/9/14	Vyvanse 70 MG	30
8/16/14	Oxycodone and Acetaminophen 325 MG / 10 MG	60
8/20/14	Compound	1
8/20/14	Compound	1
8/20/14	Hydroxocobalamin HCL Powder	0.5
9/7/14	Alprazolam 2 MG	30
9/7/14	Dextroamph Sacc / Amph Asp / Dextroam S 30 MG	60
9/7/14	Vyvanse 30 MG	30
9/7/14	Vyvanse 70 MG	30
10/10/14	Compound	1
10/10/14	Compound	1
10/10/14	Hydroxocobalamin HCL Powder	0.5
11/17/14	Alprazolam 2 MG	60
12/2/14	Progesterone Powder	0.5
12/2/14	Testosterone Cypionate Powder	0.5
12/7/14	Alprazolam 2 MG	60
2/9/15	Alprazolam 2 MG	90
2/20/15	Dextroamph Sacc / Amph Asp / Dextroam S 30 MG	30
2/20/15	Vyvanse 30 MG	30
2/24/15	Ketamine HCL Powder	12
2/25/15	Compound	5
2/25/15	Nandrolone Decanoate Powder	1
2/25/15	Testosterone Cypionate Powder	1.03

3/31/15	Ketamine HCL Powder	12
4/12/15	Amphetamine Salt Combo 30 MG	60
4/12/15	Oxycodone HCL 30 MG	90
4/13/15	Alprazolam 2 MG	90
5/28/15	Ketamine HCL Powder	12
6/23/15	Ketamine HCL Powder	12
7/13/15	Dextroamph Sacc / Amph Asp / Dextroam S 30 MG	60
7/21/15	Ketamine HCL Powder	12
8/6/15	Oxycodone HCL 20 MG	60
12/24/15	Dextroamph Sacc / Amph Asp / Dextroam S 30 MG	30
3/8/16	Alprazolam 2 MG	90
3/8/16	Dextroamph Sacc / Amph Asp / Dextroam S 30 MG	30
3/8/16	Vyvanse 70 MG	30
5/17/16	Compound	2

87. Respondent committed gross negligence in his care and treatment of Patient E, which included, but was not limited to, the following:

(a) Respondent inappropriately treated a family member by treating chronic, non-acute and/or non-emergency medical conditions, on a repeated basis, and/or prescribing controlled substances, and/or treating mental health condition(s).

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

88. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 100304 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient A, B, C, D, and E as more particularly alleged herein:

Patient A

89. Paragraphs 9 through 34, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(a) Respondent failed to properly prescribe benzodiazepines to Patient A;

(b) Respondent failed to obtain a proper informed consent; and

(c) Respondent failed to properly perform urine toxicology screening for controlled substances.

Patient B

90. Paragraphs 35 through 49, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(a) Respondent did not properly treat Patient B's insomnia;

(b) Respondent did not properly treat Patient B's upper respiratory infection; and

(c) Respondent did not properly diagnose and/or treat Patient B's purported Attention Deficit Hyperactivity Disorder.

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Patient C

91. Paragraphs 50 through 69, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(a) Respondent did not properly prescribe benzodiazepines to Patient C;

(b) Respondent did not properly treat Patient C's insomnia;

(c) Respondent did not properly treat Patient C's upper respiratory infection;

(d) Respondent did not properly diagnose and/or treat Patient C's purported Attention Deficit Hyperactivity Disorder; and

(e) Respondent did not properly treat Patient C's anxiety.

Patient D

92. Paragraphs 70 through 84, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(a) Respondent did not properly treat Patient D's anxiety.

Patient E

93. Paragraphs 85 through 87, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(a) Respondent inappropriately treated a family member by treating chronic, non-acute and/or non-emergency medical conditions, on a repeated basis, and/or prescribing controlled substances, and/or treating mental health conditions.

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THIRD CAUSE FOR DISCIPLINE

(Incompetence)

94. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 100304 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he was incompetent in his care and treatment of Patients A, B, C, and D, as more particularly alleged hereinafter:

Patient A

95. Paragraphs 9 through 34 above, are incorporated by reference and realleged as if fully set forth herein.

96. Respondent was incompetent, in his care and treatment of patient A, including, but not limited to, the following:

(a) Respondent displayed a lack of knowledge in his care and treatment of Patient A's Sexually Transmitted Infection(s).

Patient B

97. Paragraphs 35 through 49 above, are incorporated by reference and realleged as if fully set forth herein.

98. Respondent was incompetent, in his care and treatment of Patient B, including, but not limited to, the following:

(a) Respondent displayed a lack of knowledge regarding opiate monitoring, dependence, and inherent risks of opiates; and

(b) Respondent displayed a lack of knowledge in his care and treatment of Patient B's upper respiratory infection.

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Patient C

99. Paragraphs 50 through 69 above, are incorporated by reference and realleged as if fully set forth herein.

100. Respondent was incompetent, in his care and treatment of Patient C, including, but not limited to, the following:

(a) Respondent displayed a lack of knowledge regarding opiate monitoring, dependence, and inherent risks of opiates;

(b) Respondent displayed a lack of knowledge in his care and treatment of Patient C's upper respiratory infection;

(c) Respondent displayed a lack of knowledge in his care and treatment of Patient C's anxiety; and

(d) Respondent displayed a lack of knowledge in his care and treatment of Patient C's acne.

Patient D

101. Paragraphs 70 through 84 above, are incorporated by reference and realleged as if fully set forth herein.

102. Respondent was incompetent, in his care and treatment of Patient D, including, but not limited to, the following:

(a) Respondent displayed a lack of knowledge in his care and treatment of Patient D's polycystic ovarian syndrome; and

(b) Respondent displayed a lack of knowledge regarding opiate monitoring, dependence, and inherent risks of opiates.

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FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

103. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 100304 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of Patient A, B, C, D, and E, as more particularly alleged in paragraphs 9 through 87, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Self-Prescription of Controlled Substance)

104. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 100304 to disciplinary action under sections 2227, 2234, and 2238, as defined by 2239, subdivision (a), of the Code, and under Health and Safety Code section 11170 in that he prescribed a controlled substance to himself, as more particularly alleged hereinafter:

105. On or about September 14, 2016, Respondent prescribed Ketamine[69] to himself.

106. On or about August 29, 2016, Respondent prescribed Stanozolol[70] to himself.

107. On or about July 27, 2016, Respondent prescribed Ketamine to himself.

108. On or about July 27, 2016, Respondent prescribed Stanozolol to himself.

109. On or about May 4, 2016, Respondent prescribed Ketamine to himself.

110. On or about April 28, 2016, Respondent prescribed Stanozolol to himself.

111. On or about December 22, 2015, Respondent prescribed Stanozolol to himself.

112. On or about February 25, 2015, Respondent prescribed Testosterone Cypionate[71] to himself.

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[69] Ketamine is a schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (g), and a dangerous drug pursuant to Business and Professions Code section 4022.

[70] Stanozolol is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022.

[71] Testosterone is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022.

113. On or about February 25, 2015, Respondent prescribed Nandrolone decanoate[72] to himself.

114. On or about December 31, 2014, Respondent prescribed Ketamine to himself.

SIXTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

115. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 100304 to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 9 through 114, above, which are hereby incorporated by reference as if fully set forth herein.

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[72] Nandrolone is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022.

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 No. A 100304, issued to Brian Michael Manjarres, M.D.;

2. Revoking, suspending or denying approval of Brian Michael Manjarres, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Brian Michael Manjarres, 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: March 13, 2019

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