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Acting Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against,

Case No. 800-2020-072401

JERRY DEAN CRUM, M.D.
P.O. Box 46
Hermiston, OR 97838

**DEFAULT DECISION
AND ORDER**

**Physician's and Surgeon's Certificate No. G
87585**

[Gov. Code, §11520]

One.

FINDINGS OF FACT

1. On March 3, 2021, Complainant William Prasifka, in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs, filed Accusation No. 800-2020-072401 against Jerry Dean Crum, M.D. (Respondent) before the Medical Board of California.

2. On October 7, 2005, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. G 87585 to Respondent. The Physician's and Surgeon's Certificate

1 expired on February 28, 2017, and has not been renewed. (Exhibit Package, Exhibit 1¹, license
2 certification.)

3 3. On March 3, 2021, Respondent was duly served with an Accusation, alleging causes
4 for discipline against Respondent. (Exhibit Package, Exhibit 2, Accusation and proof of service.)

5 4. On March 3, 2021, an employee of the Medical Board of California sent by Certified
6 Mail a copy of the Accusation No. 800-2020-07240s1, Statement to Respondent, Notice of
7 Defense in blank, and Request for Discovery, to Respondent's address of record with the Board,
8 which was and is, P.O. Box 46, Hermiston, OR 97838. The United States Post Office (USPS)
9 tracking system noted the package was undelivered, and returned to the sender, on April 1, 2021.
10 (Exhibit Package, Exhibit 2, Accusation, proof of service; Exhibit 3, USPS tracking printout;
11 Exhibit 4, California Medical Board Address of Record.)

12 5. There was no response to the Accusation. On March 18, 2021, an employee of the
13 Attorney General's Office sent a Courtesy Notice of Default, by certified mail, addressed to
14 Respondent at the address of record above, as well as to an Oregon address associated with
15 Respondent: 236 E. Newport Ave., Hermiston, OR 97838. The Courtesy Notice of Default
16 advised Respondent of the service of the Accusation, and provided him with an opportunity to file
17 a Notice of Defense and request relief from default. The USPS tracking system noted the package
18 sent to Respondent's address of record was "available for pickup" but there is no record that the
19 package was picked up. The USPS tracking system noted the package sent to the other address
20 associated with Respondent was delivered on March 22, 2021. The return receipt post card has a
21 signature and date of delivery of March 22, 2021. (Exhibit Package, Exhibit 5, Courtesy Notice
22 of Default, proof of service; Exhibit 6, USPS tracking printout for address of record; Exhibit 7,
23 USPS tracking printout and post card receipt for associated address.)

24 6. Service of the Accusation was effective as a matter of law under the provisions of
25 Government Code section 11505, subdivision (c).

26 ///

27 _____
28 ¹ The evidence in support of this Default Decision and Order is submitted herewith as the
"Exhibit Package."

1 7. Respondent has not responded to service of the Accusation or the Notice of Default.
2 He has not filed a Notice of Defense. As a result, Respondent has waived his right to a hearing
3 on the merits to contest the allegations contained in the Accusation.

4 8. The allegations of the Accusation are true as follows based on public records of the
5 Oregon Medical Board which are Exhibit A to the Accusation. (Exhibit Package, Exhibit 2,
6 Accusation and Accusation Exhibit A: Oregon Disciplinary records.)

- 7 • On October 2, 2020, the Oregon Medical Board (Oregon Board), imposed discipline
8 on Respondent's Oregon medical license.
- 9 • The stipulated order limited Respondent's orthopedics practice to an office-based,
10 outpatient, non-operative practice only.
- 11 • The discipline was based on conduct described in the June 16, 2020, Oregon
12 Complaint and Notice of Proposed Disciplinary Action, which described breaches in
13 the standard of care for two patients.
- 14 • The complaint also described a failure to timely comply with the Oregon Board's
15 order for evaluation and, when evaluated, Respondent had deficiencies including
16 some below-average technical skills and medical knowledge that was not up to date.

17 **STATUTORY AUTHORITY**

18 9. Government Code section 11506 states, in pertinent part:

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

23 10. Respondent failed to file a Notice of Defense within 15 days after service upon him
24 of the Accusation, and therefore waived his right to a hearing on the merits of Accusation No.
25 800-2020-072401.

26 11. California Government Code section 11520 states, in pertinent part:
27
28

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

4 **DETERMINATION OF ISSUES**

5 1. The Board has jurisdiction to adjudicate this case by default, and pursuant to
6 Government Code section 11520, finds that Respondent is in default. The Board will take action
7 without further proceedings or hearing and, based on Respondent's admissions by way of default
8 and the evidence before the Board, contained in the Exhibit Package, finds that the allegations in
9 Accusation No. 800-2020-072401, are true and correct.

10 2. Respondent's conduct and the action of the Oregon Medical Board constitute cause
11 for discipline within the meaning of Business and Professions Code sections 2305 and 141(a).

12 **ORDER**

13 Physician's and Surgeon's Certificate No. G 87585, issued to JERRY DEAN CRUM, M.D.,
14 is hereby **REVOKED**.

15 Respondent shall not be deprived of making a request for relief from default as set forth in
16 Government Code section 11520(c) for good cause shown. However, such showing must be
17 made in writing by way of a motion to vacate the default decision and directed to the Medical
18 Board of California at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815 within seven
19 (7) days of the service of this Decision. The agency in its discretion may vacate the Decision and
20 grant a hearing on a showing of good cause, as defined in the statute.

21 This Decision shall become effective at 5:00 p.m. on **MAY 26 2021** .

22
23 It is so ORDERED **APR 26 2021**

24 

25 WILLIAM PRASIEKA
26 EXECUTIVE DIRECTOR
27 FOR THE MEDICAL BOARD OF
28 CALIFORNIA
 DEPARTMENT OF CONSUMER AFFAIRS

SF2021400190

1 XAVIER BECERRA
Attorney General of California
2 JANE ZACK SIMON
Supervising Deputy Attorney General
3 ANA GONZALEZ
Deputy Attorney General
4 State Bar No. 190263
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5 San Francisco, CA 94102-7004
Telephone: (415) 510-3608
6 Facsimile: (415) 703-5480
E-mail: Ana.Gonzalez@doj.ca.gov
7 *Attorneys for Complainant*

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

12 In the Matter of the Accusation Against:

Case No. 800-2020-072401

13 **Jerry Dean Crum, M.D.**
14 **P.O. Box 46**
Hermiston, OR 97838-0046

A C C U S A T I O N

15 **Physician's and Surgeon's Certificate**
16 **No. G 87585,**

17 Respondent.

18
19 **PARTIES**

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

23 2. On or about October 7, 2005, the Medical Board issued Physician's and Surgeon's
24 Certificate Number G 87585 to Jerry Dean Crum, M.D. (Respondent). The Physician's and
25 Surgeon's Certificate is delinquent, having expired on February 28, 2017, and has not been
26 renewed.

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1 only. The discipline was based on conduct described in the June 16, 2020, Oregon Complaint and
2 Notice of Proposed Disciplinary Action (Notice), which described violations of the Oregon
3 Medical Practice Act. In summary, Respondent breached the standard of care for two patients,
4 failed to timely comply with the Oregon Board's order for evaluation, and showed deficiencies
5 when evaluated. More specifically, one patient was exposed to risk of harm when the Respondent
6 failed to adequately assess the patient's range of motion preoperatively, failed to perform a
7 functional evaluation, failed to assess comorbidities such as diabetes, failed to obtain
8 postoperative x-rays, and failed to recognize the patient's high likelihood of severe hypertrophic
9 synovitis and fraying of the labrum preoperatively. The second patient was also exposed to risk
10 of harm when the Respondent failed to adequately assess range of motion preoperatively, failed to
11 adequately perform and document pre-operative functional evaluations, failed to adequately
12 address comorbidities such as diabetes, and failed to obtain postoperative x-rays to assess surgical
13 results. Further, the Oregon Board ordered Respondent to complete an evaluation at the Center
14 for Personalized Education for Physicians (CPEP) in Colorado within a specified time.
15 Respondent failed to comply with the Oregon Board's ordered evaluation within the time
16 specified; and when evaluated, Respondent was found to have conditions that could interfere with
17 his performance of outpatient surgical procedures. Additionally, UC San Diego's Physician
18 Assessment and Clinical Education (PACE) program evaluated Respondent and found he
19 demonstrated average surgical skills with some significant deficiencies, specifically some below-
20 average technical skills and medical knowledge that was not up to date. A copy of the Oregon
21 Medical Board Notice and Stipulated Order is attached as Exhibit A.

22 8. Respondent's conduct and the action of the Oregon Medical Board, as set forth in
23 paragraph 7, above, constitute cause for discipline pursuant to sections 2305 and/or 141 of the
24 Code.

25 PRAYER

26 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
27 and that following the hearing, the Medical Board of California issue a decision:
28

- 1 1. Revoking or suspending Physician's and Surgeon's Certificate Number G 87585,
- 2 issued to Jerry Dean Crum, M.D.;
- 3 2. Revoking, suspending or denying approval of Jerry Dean Crum, M.D.'s authority to
- 4 supervise physician assistants and advanced practice nurses;
- 5 3. Ordering Jerry Dean Crum, M.D., if placed on probation, to pay the Board the costs
- 6 of probation monitoring; and
- 7 4. Taking such other and further action as deemed necessary and proper.

8
9 DATED: **MAR 03 2021**



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

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Exhibit A
Oregon Medical Board Notice and Stipulated Order



Oregon

Kate Brown, Governor

Medical Board
1500 SW 1st Avenue, Suite 620
Portland, OR 97201
(971) 673-2700
FAX (971) 673-2670
www.oregon.gov/omb

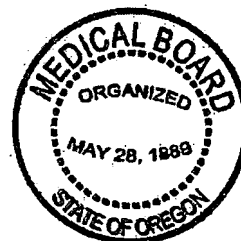
Certification of True Copy

I certify that the enclosed documents are true and correct copies of the originals on file with the Oregon Medical Board.


Signature

11-17-20
Date

Angela Allen
Accounts Receivable



RECEIVED
MEDICAL BOARD OF OR
2020 NOV 20 PM 3:55
DISCIPLINE UNIT





Oregon

Kate Brown, Governor

Medical Board

1500 SW 1st Avenue, Ste 620

Portland, OR 97201-5847

(971) 673-2700

FAX (971) 673-2670

www.oregon.gov/OMB

November 17, 2020

Medical Board of California

Attn: Sharee Woods

2005 Evergreen ST. Suite 1200

Sacramento, CA 95815-5401

Fax

REPORT NAME:

LICENSE VERIFICATION

REPORT SUBJECT:

Jerry Dean Crum, MD

LICENSE #:

MD150347

The Oregon Medical Board is responding to your inquiry regarding verification of licensure for the above-referenced Licensee. Enclosed is a License Verification Report for this Licensee.

There are public Board orders on file for this Licensee. Copies of the following Board Orders are also enclosed:

- Complaint and Notice; Dated 06/16/2020
- Stipulated Order; Dated 10/02/2020

If you have any questions regarding this License Verification Report, please contact the Board at (971) 673-2700, or toll free in Oregon at (877) 254-6263.

Sincerely,

Angela Allen

Accounts Receivable Specialist

Enclosures

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of)
JERRY DEAN CRUM, MD) COMPLAINT & NOTICE OF PROPOSED
LICENSE NO. MD150347) DISCIPLINARY ACTION

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the State of Oregon. Jerry Dean Crum, MD (Licensee) is a licensed physician in the State of Oregon.

2.

The Board proposes to take disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), which may include the revocation of license, a \$10,000 civil penalty per violation, and assessment of costs, against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public or any condition that does or might adversely affect his ability to safely and skillfully practice medicine; ORS 677.190(13) gross or repeated acts of negligence; and ORS 677.190(17) willful violation of any Board rule, specifically OAR 847-001-0024(2) Compliance, or Board order.

3.

Licensee is a board-certified orthopedic surgeon practicing in Hermiston, Oregon.

Licensee's acts and conduct alleged to violate the Medical Practice Act are as follows:

3.1 Patient A, a 48-year-old male, first presented to Licensee with complaints of left shoulder pain on March 20, 2014. Patient A had a history of morbid obesity, insulin dependent diabetes mellitus, tobacco abuse, peripheral vascular disease, and coronary bypass surgery.

Licensee conducted a focused orthopedic consultation and work-up. Licensee initially had Patient

1 A try activity modification with physical therapy. Licensee noted 55 degrees of external rotation,
2 good strength, and a lack of trauma. Licensee administered a steroid injection on April 30, 2014,
3 with no chart note addressing the risks for blood sugar management of an insulin-dependent
4 diabetic patient. On May 7, 2014, Licensee administered another steroid injection for carpal
5 tunnel issues. On March 2, 2015, Patient A reported to Licensee that he had recurrent left
6 shoulder pain after suffering a fall. A repeat MRI (magnetic resonance imaging) demonstrated no
7 residual or recurrent labial tear. Licensee did not order an X-ray, but did order an MRI
8 arthrogram, which showed a paucity of filling of the joint, which is most consistent with adhesive
9 capsulitis of the shoulder. Licensee erroneously noted that the intra-articular contrast filling the
10 subacromial-subdeltoid bursa implied a full-thickness rotator cuff tear. On April 23, 2015,
11 Licensee took Patient A to surgery. Examination of the left shoulder showed severe hypertrophic
12 synovitis and fraying of the labrum. The previous labial repair was seen to be intact and no
13 obvious tear of the rotator cuff was visualized from inside the joint. Licensee identified a small
14 rotator cuff tear and performed an open acromioplasty of the left shoulder with limited
15 debridement of the synovium and labrum. Licensee did not order a post-operative X-ray.
16 Licensee breached the standard of care in this case and exposed Patient A to the risk of harm by
17 failing to adequately assess Patient A's range of motion preoperatively; failing to perform a
18 functional evaluation; failing to assess Patient A's comorbidities, such as diabetes; failing to
19 obtain postoperative x-rays; and failing to recognize Patient A's high likelihood of severe
20 hypertrophic synovitis and fraying of the labrum preoperatively. Licensee's conduct violated ORS
21 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any
22 conduct or practice which does or might constitute a danger to the health or safety of a patient or
23 the public; and breached the standard of care, in violation of ORS 677.190(13) gross or repeated
24 acts of negligence.

25 3.2 The Board conducted a review of Licensee's care for Patients B – E, which
26 revealed a pattern of practice that breached the standard of care in Licensee's documentation and
27 delivery of orthopedic surgical care to include the following: failure to adequately assess range

1 of motion preoperatively; failure to adequately perform and document pre-operative functional
2 evaluations; failure to adequately address comorbidities such as diabetes; and failure to obtain
3 postoperative x-rays to assess surgical result. Each of these is considered a fundamental element
4 of orthopedic practice and these failures represent breaches of the standard of practice that put
5 patients in harm's way. Licensee's conduct violated ORS 677.190(1)(a) unprofessional or
6 dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice which does or
7 might constitute a danger to the health or safety of a patient or the public; and multiple breaches
8 of the standard of care, in violation of ORS 677.190(13) gross or repeated acts of negligence.

9 3.3 On July 12, 2018, the Board ordered that Licensee successfully complete an
10 evaluation at the Center for Personalized Education for Physicians in Colorado (CPEP) within 120
11 days from the date the Order was signed by the Board Chair; and to enroll within 30 days from the
12 date of the Order. Licensee failed to comply with this order within the time specified by the
13 Board. Instead, Licensee underwent an evaluation at the UC San Diego PACE Program. The
14 written evaluation report from PACE, dated August 7, 2018, concluded that Licensee
15 demonstrated average surgical skills with some significant deficiencies, specifically some below-
16 average technical skills and medical knowledge that was not up to date. Licensee subsequently
17 enrolled for the CPEP evaluation on December 19, 2018, and completed the evaluation on
18 February 28, 2019. The CPEP report found that Licensee performed well and demonstrated
19 minimal educational needs; however, CPEP's review of Licensee's health information revealed
20 conditions that could interfere with his performance of outpatient surgical procedures but would
21 not impede office practice and office procedures such as joint injections. A health condition that
22 could adversely affect Licensee's ability to safely and skillfully practice medicine constitutes
23 unprofessional or dishonorable conduct in accordance with ORS 677.190(1)(a), as defined by
24 ORS 677.188(4)(a) any condition that does or might adversely affect his ability to safely and
25 skillfully practice medicine. Licensee's failure to comply with the Board's Order for Evaluation
26 within the time specified violated ORS 677.190(17) willful violation of any Board rule,

27 ///

1 specifically OAR 847-001-0024(2) Compliance, or Board order, specifically the July 12, 2018,
2 order for evaluation.

3 4.

4 Licensee is entitled to a hearing as provided by the Administrative Procedures Act
5 (chapter 183), Oregon Revised Statutes. Licensee may be represented by counsel at the hearing.
6 If Licensee desires a hearing, the Board must receive Licensee's written request for hearing
7 within twenty-one (21) days of the mailing of this Notice to Licensee. Upon receipt of a request
8 for a hearing, the Board will notify Licensee of the time and place of the hearing.

9 5.

10 5.1 If Licensee requests a hearing, Licensee will be given information on the
11 procedures, right of representation, and other rights of parties relating to the conduct of the
12 hearing as required under ORS 183.413(2) before commencement of the hearing.

13 5.2 If Licensee proceeds to a hearing, the Board proposes to assess against Licensee
14 the Board's costs of this disciplinary process and action, including but not limited to all legal
15 costs from the Oregon Department of Justice, all hearing costs from the Office of Administrative
16 hearings, all costs associated with any expert or witness, all costs related to security and
17 transcriptionist services for the hearing, and administrative costs specific to this proceeding in an
18 amount not to exceed \$85,000.00, pursuant to ORS 677.205(2)(f).

19 6.

20 **NOTICE TO ACTIVE DUTY SERVICEMEMBERS:** Active Duty Servicemembers
21 have a right to stay these proceedings under the federal Servicemembers Civil Relief Act. For
22 more information contact the Oregon State Bar at 800-452-8260, the Oregon Military
23 Department at 503-584-3571 or the nearest United States Armed Forces Legal Assistance Office
24 through <http://legalassistance.law.af.mil>. The Oregon Military Department does not have a toll-
25 free telephone number:

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7.

Failure by Licensee to timely request a hearing or failure to appear at any hearing scheduled by the Board will constitute waiver of the right to a contested case hearing and will result in a default order by the Board, including the revocation of his medical license and assessment of such penalty and costs as the Board deems appropriate under ORS 677.205. If a default order is issued, the record of proceeding to date, including Licensee's file with the Board and any information on the subject of the contested case automatically becomes a part of the contested case record for the purpose of proving a prima facie case per ORS 183.417(4).

DATED this 16 day of June, 2020.

OREGON MEDICAL BOARD
State of Oregon


NICOLE KRISHNASWAMI, JD
EXECUTIVE DIRECTOR

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BEFORE THE
OREGON MEDICAL BOARD
STATE OF OREGON

In the Matter of

JERRY DEAN CRUM, MD
LICENSE NO. MD150347

}
}
}
}
} STIPULATED ORDER

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the State of Oregon. Jerry Dean Crum, MD (Licensee) is a licensed physician in the State of Oregon.

2.

On June 16, 2020, the Board issued a Complaint and Notice of Proposed Disciplinary Action (Notice) in which the Board proposed to take disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), which may include the revocation of license, a \$10,000 civil penalty per violation, and assessment of costs, against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public or any condition that does or might adversely affect his ability to safely and skillfully practice medicine; ORS 677.190(13) gross or repeated acts of negligence; and ORS 677.190(17) willful violation of any Board rule, specifically OAR 847-001-0024(2) Compliance, or Board order.

3.

Licensee and the Board desire to settle this matter by the entry of this Stipulated Order. Licensee understands that he has the right to a contested case hearing under the Administrative Procedures Act (Oregon Revised Statutes chapter 183), and fully and finally waives the right to a contested case hearing and any appeal therefrom by the signing of and entry of this Order in the Board's records. Licensee neither admits nor denies, but the Board finds that Licensee engaged

1 in conduct as described in the June 16, 2020, Notice, and that this conduct violated the Medical
2 Practice Act, to wit ORS 677.190(1)(a), as defined in ORS 677.188(4)(a); ORS 677.190(13); and
3 ORS 677.190(17), specifically OAR 847-001-0024(2). Licensee understands that this Order is a
4 public record and is a disciplinary action that is reportable to the National Practitioner Data Bank
5 and the Federation of State Medical Boards.

6 4.

7 Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order,
8 subject to the following terms:

9 4.1 Licensee must limit his orthopedics practice to an office-based, outpatient, non-
10 operative practice only.

11 4.2 Licensee must inform the Compliance Section of the Board of any and all practice
12 sites, as well as any changes in practice address(es), employment, or practice status within 10
13 business days. Additionally, Licensee must notify the Compliance Section of any changes in
14 contact information within 10 business days.

15 4.3 Licensee must obey all federal and Oregon state laws and regulations pertaining
16 to the practice of medicine.

17 4.4 Licensee stipulates and agrees that any violation of the terms of this Order shall
18 be grounds for further disciplinary action under ORS 677.190(17).

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1 4.5 Licensee stipulates and agrees that this Order becomes effective the date it is
2 signed by the Board Chair.

3 IT IS SO STIPULATED this 7th day of July, 2020

4
5 
6 JERRY DEAN CRUM, MD

7 IT IS SO ORDERED this 2nd day of October, 2020.

8 OREGON MEDICAL BOARD
9 State of Oregon
10 

11 KATHLEEN M. HARDER, MD
12 Board Chair
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License Verification Details

Subject to **Terms and Conditions**. This site is a primary source for verification of license credentials consistent with Joint Commission and NCQA standards.

Oregon Medical Board
1500 SW 1st Ave
Suite 620
Portland, OR 97201
Phone: (971) 673-2700



Information current as of 11/17/2020 02:18:40 PM

Crum, Jerry Dean, MD

MD License: MD150347

Originally Issued: 12/28/2009

Basis: NBME

Current Status: Active

Expedited Endorsement: No

Status Effective: 1/1/2020

Expires: 12/31/2021

Licensee Information

Gender: Male

Specialty : Orthopedic Surgery

Specialty is self-reported by the licensee. It does not necessarily indicate specialty board certification.

Supervising Physician Status : Not Approved

Languages : English, German

Practice Location(s)

Street	City, State Zip	County	Phone
236 E. Newport Ave.	Hermiston, OR 97838	Umatilla	541-289-7171

Education

School Name	Location	Degree Date	Degree Earned
UNIFORMED SERVS UNIV OF HLTH SCIS	BETHESDA, MARYLAND USA	05/22/1982	MD

Post-Graduate Training

	School Name	Location	From	To	Specialty
Internship	Letterman Army Medical Center	San Francisco, CA United States	07/1982	06/1983	
Residency	Letterman Army Medical Center	San Francisco, CA United States	07/1986	05/1988	Orthopedic Surgery
Residency	University of Utah SOM	Salt Lake City, UT United States	07/1992	06/1995	Orthopedic Surgery

The licensee may have completed additional education or training programs. Only those that have been verified with the primary source are shown.

Board Orders

Please note that Corrective Action Orders, Corrective Action Agreements, and Consent Agreements are not disciplinary and are removed from this website upon completion. However, these are public documents available through a license verification request.

Effective Date	End Date	Order Type
10/02/2020	Open	Stipulated Order

**Effective
Date**

End Date

Order Type

On October 2, 2020, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; gross or repeated acts of negligence; and willful violation of any Board rule. This Order limits Licensee's orthopedic practice to an office-based, outpatient, non-operative practice only.

06/16/2020

10/02/2020

Complaint and Notice

On June 16, 2020, the Board issued a Complaint and Notice of Proposed Disciplinary Action alleging violations of the Medical Practice Act (state law) regarding unprofessional or dishonorable conduct; gross or repeated acts of negligence; and willful violation of any Board rule.

Malpractice

Malpractice claim information is compiled by the Oregon Medical Board from claim reports it receives from primary insurers; public bodies required to defend, save harmless and indemnify an officer, employee or agent of the public; a self-insured entity; or a health maintenance organization. Claim reporting and disclosure requirements are governed by ORS 742.400.

The settlement of a medical malpractice claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the provider. Therefore, there may be no disciplinary action appearing for a licensee, even though there is a closed malpractice claim on file. A payment in the settlement of a medical malpractice action does not create a presumption that medical malpractice occurred. This database represents information from reporters to date. Please note: Not all reporters may have submitted claim information to the Board.

For malpractice claim information, [click here](#).