IN THE MATTER OF	*	**BEFORE THE**
DESMOND JOHNSON, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D27909	*	**Case Numbers: 2012-0774**

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ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE MEDICINE

The Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of **DESMOND JOHNSON, M.D. (the "Respondent") (D.O.B. 07/18/1950)** License Number D27909, to practice medicine in the State of Maryland. The Board takes such action pursuant to its authority under Md. State Gov't Code Ann. § 10-226(c)(2)(i)(2009 Repl. Vol. and 2011 Supp.) concluding that the public health, safety or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

Based on information received by, and made known to the Board, and the investigatory information obtained by, received by and made known to and available to the Board, including the instances described below, the Board has reason to believe that the following facts are true:[1]

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was initially licensed to practice medicine in the State of Maryland on June 1, 1982. His license is current and is scheduled to expire on September 30, 2014.

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[1] The statements regarding the Respondent's conduct are only intended to provide the Respondent with notice of the basis of the suspension. They are not intended as, and do not necessarily represent a completed description of the evidence, either documentary or testimonial, to be offered against the Respondent in this matter.

2. The Respondent is board-certified in internal medicine and rheumatology. He has no training in pain management.

3. At all times relevant hereto, the Respondent was employed as an independent contractor for Practice A in Laurel, Maryland.[2]

4. Prior to his employment at Practice A, the Respondent worked in occupational medicine for 25 years.

5. On May 1, 2012, the Board received a complaint from the mother ("the Complainant") of a patient ("Patient A") of the Respondent alleging the Respondent was prescribing narcotics to Patient A despite his alleged knowledge that Patient A was addicted to narcotics. The Complainant alleged that Patient A had track marks on her right arm.

6. Subsequently the Board initiated an investigation.

7. On or about June 20, 2012, the Board received a letter from the Division of Drug Control ("DDC") stating that a routine pharmacy inspection revealed concern regarding the Respondent's prescribing habits. The DDC provided printouts of the Respondent's prescriptions from January 1, 2012 through mid-May 2012 from several pharmacies, as well as copies of samples of the Respondent's prescriptions.

8. On or about July 10, 2012, the Board received information from a West Virginia pharmacist listing the Respondent as one of a number of physicians identified as "problem prescribers" by the West Virginia Board of Pharmacy.

9. On or about July 16, 2012, the Board received information from the Frederick County Police Department ("FCPD") regarding the death of a patient ("Patient B") on

[2] In order to maintain confidentiality, physician, patient and facility names will not be used in this document, but will be provided to the Respondent upon request.

May 5, 2012. According to the FCPD's investigation file, Patient B died of a prescription drug overdose and several pill bottles containing various prescriptions drugs were found at the scene. All of the medications were prescribed by the Respondent. The pill bottle closest to Patient B's body was for oxycodone 30 mg #112[3] and was filled the day before the patient's death. When the pill bottle was found it contained 42 pills. Patient B's death was caused by oxycodone intoxication.

10. According to the FCPD's incident/investigation report, a search of the hotel room where Patient B's body was found revealed the following medications prescribed by the Respondent:

a. oxycodone 30 mg IR #112, filled on May 4, 2012, 42 pills remaining;

b. oxycodone 15 mg #56, filled on May 4, 2012, 60 pills remaining;

c. carisprodol 350 mg #28[4], filled on May 4, 2012, 28 pills remaining;

d. lisinopril 20 mg #30[5], filled on May 4, 2012 with 30 pills remaining; and

e. naproxen 500 mg #60[6], filled on May 4, 2012 with 58 pills remaining.

11. On or about August 3, 2012, the Board issued a subpoena *duces tecum* for twelve patient records.

12. A member of the Board's staff sent 12 patient records ("Patients A, B, C, D, E, F, G, H, I, J, K, and L") to be reviewed by an expert in pain management (the "Expert").

13. The Expert concluded that based on his review of the 12 patient records, the public health, safety or welfare imperatively requires emergency action.

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[3] Oxycodone is a opioid medication and schedule II controlled dangerous substance ("CDS")
[4] Carisoprodol is a muscle relaxant and schedule IV CDS.
[5] Lisinopril is an ACE inhibitor used to treat high blood pressure.
[6] Naproxen (trade name: Naprosyn) is a non-steroidal anti-inflammatory (NSAID) drug.

14. On October 18, 2012, members of the Board's staff conducted an under oath interview of the Respondent.

15. The Respondent stated that Practice A does not accept insurance and that all of the patients pay $300 cash for their appointments.

16. The Respondent stated that a significant number of his patients commute an hour or hour-and-one-half to Practice A. He further stated that there are patients who come to Practice A for the wrong reasons and he does what he can "to weed out that particular type of patient from our practice as best as we can."

PATIENT-SPECIFIC FINDINGS

17. Set forth, *infra*, are the Expert's patient-specific findings. These summaries are not intended as, and do not represent, a complete description of the evidence with respect to the Respondent's conduct in this matter.

Patient A

18. Patient A, a female born in 1968, began seeing the Respondent in March 2012 with complaints of pain in her left hip and lower back. According to the Respondent's summary of care, Patient A's prior history included a motor vehicle accident ("MVA") in June 2011, a total left hip replacement sometime after the MVA, cervical spine multilevel Spondylosis, and neural foramen encroachment at C4-C5 and C5-6. Patient A was previously treated with narcotics for pain management by another physician.

19. At her initial visit, Patient A signed a Consent for Chronic Opoid [sic] Therapy, a Consent for Drug Screening, an agreement for Long-Term Controlled Substances Therapy for Chronic Pain, and a form agreeing not to obtain narcotics from another physician while under contract with Practice A. Patient A also signed a form

acknowledging that she will be drug tested at her next appointment[7] at a cost to her of $30.

20. The Respondent first saw Patient A on March 16, 2012, and monthly thereafter through August 2012. At each visit, Patient A filled out a monthly Patient Comfort Assessment Guide or a Pain Assessment Guide in which she rated the quality and location of her pain, as well as what made her pain better and worse.

21. In March 2012, the Respondent prescribed oxycodone 30 mg QID, methadone[8] 10 mg QID, and carisoprodol 350 mg.

22. In April 2012, the Respondent prescribed the same narcotics, but added oxycodone 15 mg q4-6h[9] and substituted Valium[10] 10 mg at bedtime for the carisoprodol.

23. In May, June and July 2012, the Respondent prescribed the same narcotics, and added carisoprodol in addition to Valium.

24. According to the Respondent's summary of care, just prior to Patient A's August 6, 2012 appointment, he received the complaint regarding Patient A. It was at that time, he states, that he learned of her alleged narcotic addiction. The Respondent stated that he checked her arms for needle marks and found none. However, the Respondent stated that he reduced Patient A's medications at that time. The Respondent discontinued methadone and oxycodone 15 mg and gave her a two-week course of her remaining medications (carisoprodol 350 mg, Valium 10 mg, oxycodone 30 mg) to minimize withdrawal symptoms.

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[7] Patient A signed this form on March 16, 2012, but she was not drug tested until August 2012.
[8] Methadone is an opioid pain reliever and a schedule II CDS.
[9] Every four to six hours.
[10] Valium is a benzodiazepine and schedule IV CDS.

25. The Respondent conducted a urine drug screen at the August 6, 2012, which returned appropriate results.

26. Patient A did not return to Practice A for her next scheduled appointment.

27. The Respondent failed to consider or document considering addiction or drug abuse in his differential diagnosis, assessment or plan of care.

28. The Respondent failed to perform or document performing a Clinical Opiate Withdrawal Scale ("COWS") assessment.

Patient B

29. Patient B, discussed *supra*, was a male born in 1983. He was a patient of another physician in Practice A, and was treated by the Respondent on one occasion, May 4, 2012. The Respondent reported complaints of neck and back pain from a previous injury.

30. An MRI dated April 3, 2008 revealed minimal disk bulging at C5-6 and C6-7.

31. On May 4, 2012, the Respondent conducted a limited physical examination. His documentation of the examination is sparse.

32. The Respondent continued Patient B on his previous prescriptions of carisoprodol 350 mg qhs[11], naproxen 500 mg BID[12], oxycodone 15 mg q12h[13] and Oxycodone 30 mg q6h[14].

33. Patient B died the following day from an oxycodone overdose.

Patient C

[11] The medical abbreviation qhs means "at bedtime".
[12] The medical abbreviation B.I.D. means "twice per day".
[13] The medical abbreviation q12h means "every 12 hours".
[14] The medical abbreviation q6 h means "every 6 hours".

34. Patient C, a female born in 1964, began seeing the Respondent in April 2012 with complaints of chronic back and thigh pain. Patient C had previously been a patient at Practice B but was discharged from the practice.

35. At her initial visit, Patient C signed a Consent for Chronic Opoid [sic] Therapy, a Consent for Drug Screening, an agreement for Long-Term Controlled Substances Therapy for Chronic Pain, and a form agreeing not to obtain narcotics from another physician while under contract with Practice A. Patient C also signed a form acknowledging that she will be drug tested at her next appointment[15] at a cost to her of $30.

36. At each monthly visit, Patient C filled out a Patient Comfort Assessment Guide or a Pain Assessment Form in which she rated the quality and location of her pain, as well as what made her pain better and worse.

37. The Respondent continued Patient C on her previous medications (oxycodone 30 mg q4-6h and methadone 10 mg q4-6h) with the addition of Naprosyn 500 mg Q.D.[16] and oxycodone 15 mg q4-6h.

38. The Respondent's record for Patient C lacks adequate documentation to justify treatment with narcotic analgesics. The Respondent indicated "stable refill rx" at each visit.

39. The Respondent failed to recommend or document recommending consultation with other specialists.

40. The Respondent failed to consider or document considering opioid misuse/abuse, addiction or diversion.

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[15] Patient C signed this form on March 16, 2012, but she was not drug tested until August 2012.
[16] The medical abbreviation Q.D. means "once a day".

Patient D

41. Patient D, a male born in 1961, began seeing the Respondent in March 2012 with complaints of low back pain. Patient D was an existing patient of Practice A since approximately June 2011. Patient D has a history of subacute bursting vertebral body fracture of L4, disc disease and facet disease resulting in moderate to severe spinal stenosis.

42. At each monthly visit, Patient D filled out a Patient Comfort Assessment Guide or a Pain Assessment Form in which he rated the quality and location of his pain, as well as what made his pain better and worse.

43. At Patient D's March 22, 2012 appointment, the Respondent prescribed Naproxen 500 mg B.I.D., oxycodone 30 mg q6h, Opana[17] 40 mg B.I.D. and carisoprodol 350 mg Q.D.

44. The Respondent discontinued Opana in April 2012 without explanation.

45. At Patient D's May, June, July and August 2012 appointments, the Respondent continued Patient D's prescriptions.[18]

46. The Respondent referred Patient D for physical therapy and surgical consultations but Patient D declined citing financial constraints. However, Patient D paid cash for his visits to the Respondent.

47. The Respondent's treatment plan for Patient D at each visit was "stable refill rx."

48. The Respondent failed to monitor or document monitoring Patient D for medication compliance by ordering a drug screen.

Patient E

[17] Opana (generic: oxymorphone) is a opioid analgesic similar to morphine and a schedule II CDS.
[18] The Respondent slightly decreased Patient D's prescription for Oxycodone by prescribing 120 pills rather than 140, although the dosage instructions remained "every 6 hours."

49. Patient E, a male born in 1977, began seeing the Respondent in March 2012 with complaints of low back and left knee pain. Patient E was an existing patient of Practice A since approximately June 2011. Patient E had a history of left anterior cruciate ligament (ACL) repair.

50. At each monthly visit, Patient E filled out a Patient Comfort Assessment Guide or a Pain Assessment Form in which he rated the quality and location of his pain, as well as what made his pain better and worse.

51. A cervical spine x-ray on December 18, 2007 was normal, and a lumbar spine x-ray on October 20, 2009 revealed no acute bony pathology and unchanged lumbar spondylosis. In addition, Patient E had an MRI of his left knee on February 12, 2012, which revealed small joint knee effusion.

52. Patient E first saw the Respondent on March 23, 2012. The Respondent continued Patient E's current medications (alprazolam[19] 1 mg Q.D., hydromorphone[20] 8 mg B.I.D. and oxycodone 30 mg q4-6h).

53. The Respondent continued Patient E on the same medication regimen in April, May and June 2012.

54. On May 18, 2012, the Respondent ordered an MRI of Patient E's lumbar spine but failed to document compliance and findings.

55. The Respondent's treatment plan for Patient E at each visit was "stable refill rx."

56. The Respondent's record for Patient E lacks adequate documentation to justify treatment with narcotic analgesics.

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[19] Alprazolam is a benzodiazepine and a schedule II CDS.
[20] Hydromorphone (trade name: Dilaudid) is an opioid analgesic and a schedule II CDS.

57. The Respondent failed to consider or document considering opioid misuse/abuse, addiction or diversion.

58. The Respondent failed to recommend or document recommending consultation with other specialists.

59. The Respondent failed to monitor or document monitoring Patient E for medication compliance by ordering a drug screen.

Patient F

60. Patient F, a male born in 1986, began seeing the Respondent in March 2012 with complaints of low back and head pain. Patient F was an existing patient of Practice A since approximately January 2011. Patient F had a history of a head injury, facial bone fractures and pulmonary embolism secondary to an assault in 2008.

61. At each monthly visit, Patient F filled out a Patient Comfort Assessment Guide or a Pain Assessment Form in which he rated the quality and location of his pain, as well as what made his pain better and worse.

62. On March 13, 2012, the Respondent continued Patient F on his usual medications (oxycodone 15 mg q6h and oxycodone 30 mg q4-6h) and added carisoprodol 350 mg Q.D.

63. The Respondent continued those same medications in May and June 2012.

64. On July 10, 2012, the Respondent ordered an MRI of Patient F's lumbar spine but failed to document compliance and findings.

65. The Respondent's treatment plan for Patient F at each visit was "stable refill rx."

66. The Respondent's record for Patient F lacks adequate documentation to justify treatment with narcotic analgesics.

67. The Respondent failed to recommend or document recommending consultation with other specialists.

68. The Respondent failed to consider or document considering opioid misuse/abuse, addiction or diversion, risks that are increased due to Patient F's history of head injury.

69. The Respondent failed to monitor or document monitoring Patient F for medication compliance by ordering a drug screen.

Patient G

70. Patient G, a male born in 1986, began seeing the Respondent in March 2012 with complaints of low back pain. Patient G was an existing patient of Practice A since approximately December 2011. Patient G had a history of spinal stenosis, disc protrusion, and laminectomy at L4-5 extending to L5-S1.

71. At each monthly visit, Patient G filled out a Patient Comfort Assessment Guide or a Pain Assessment Form in which he rated the quality and location of his pain, as well as what made his pain better and worse.

72. On March 12, 2012, at his first appointment with Patient G, the Respondent continued his previous medications (Naproxen 500 mg B.I.D., oxycodone 15 mg q6h).

73. The Respondent continued Patient G's prescriptions in April 2012, but increased the frequency of oxycodone so it could be taken every four-to-six hours.

74. On May 7, 2012, the Respondent prescribed carisoprodol 350 mg Q.D.

75. The Respondent continued Patient G's prescriptions in June 2012.

76. On July 2, 2012, the Respondent discontinued Naproxyn and prescribed Motrin 800 mg T.I.D[21]. He continued the same prescriptions at Patient G's next appointment on July 30, 2012

77. The Respondent's treatment plan for Patient G at each visit was "stable refill rx."

78. The Respondent's record for Patient G lacks adequate documentation to justify treatment with narcotic analgesics.

79. The Respondent failed to recommend or document recommending consultation with other specialists.

80. The Respondent failed to consider or document considering opioid misuse/abuse, addiction or diversion.

81. The Respondent failed to monitor or document monitoring Patient G for medication compliance by ordering a drug screen.

Patient H

82. Patient H, a male born in 1980, began seeing the Respondent in March 2012 with complaints of low back pain. Patient H was an existing patient of Practice A since approximately January 2012. Patient H had a history of traumatic back injury at work.

83. At each monthly visit, Patient H filled out a Patient Comfort Assessment Guide or a Pain Assessment Form in which he rated the quality and location of his pain, as well as what made his pain better and worse.

84. On March 21, 2012, at his first appointment with Patient H, the Respondent failed to document any evidence of radiculopathy but assessed Patient H as having low back

[21] The medical abbreviation T.I.D. means "three times daily."

pain with lumbar radiculopathy. The Respondent continued Patient H's previous medications of etodolac[22] 500 mg Q.D. and oxycodone 15 mg q6h.

85. On April 19, 2012, the Respondent changed Patient H's prescriptions to carisoprodol 350 mg qhs, Naprosyn 500 mg B.I.D., and doubled the oxycodone dosage to 30 mg q4-6h. The Respondent failed to document any justification for the increased oxycodone dosage.

86. On May 17, 2012, the Respondent doubled Patient H's daily dosage of carisoprodol to 350 mg q12h. He also added oxycodone 15 mg q4-6h, in addition to the existing oxycodone 30mg prescription and Naprosyn 500 mg. Patient H's reported pain level remained unchanged at 6/10. The Respondent failed to document any justification for the medication changes.

87. Also at the May appointment, the Respondent ordered an MRI of Patient H's cervical spine without contrast.

88. In July 2012, Patient H saw another physician who increased the Carisoprodol dosage to q6h and increased the number of Oxycodone pills, even though the dosage remained unchanged.

89. At his August 9, 2012 appointment, Patient H reported that his pain had improved to 5/10 from the previous month. However, the Respondent changed Patient H's medication by discontinuing oxycodone 15 mg q4-6h and replacing it with MS Contin[23] 15 mg BID. The Respondent also decreased the dosage of Carisoprodol 350 mg from QID to q12h, but increased the number of tablets from 40 to 56. The Respondent failed to document any justification for the medication changes.

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[22] Etodolac is an NSAID drug.
[23] MS Contin (generic: morphine) is an opioid analgesic and a schedule II CDS.

90. The Respondent failed to monitor or document monitoring Patient H for medication compliance by ordering a drug screen.

91. The Respondent failed to offer other treatment options to Patient H.

Patient I

92. Patient I, a female born in 1975, began seeing the Respondent in March 2012 with complaints of neck and low back pain. Patient I was an existing patient of Practice A since approximately February 2012.

93. Patient I first saw the Respondent on March 30, 2012. At that appointment, the Respondent continued her previous prescriptions of carisoprodol 350 mg qhs, oxycodone 30 mg q4-6h, and added oxycodone 15 mg q4-6h for breakthrough pain.

94. At the April 27, 2012 appointment, Patient I report her pain level as 7/10, which was the same as the previous month. The Respondent doubled Patient I's dosage of carisoprodol to 350 mg q12h and increased the number of oxycodone 15 mg tablets.

95. Patient I's next appointment was scheduled for May 25, 2012, but her file does not contain any record of additional visits.

96. The Respondent failed to monitor or document monitoring Patient I for medication compliance by ordering a drug screen.

97. The Respondent increased the dosages of narcotics without adequate justification.

98. The Respondent failed to address the risks of opioid misuse with Patient I.

99. The Respondent failed to sufficiently develop a plan of care for Patient I.

Patient J

100. Patient J, a male born in 1966, began seeing the Respondent in March 2012 with complaints of low back pain. Patient J was an existing patient of Practice A since approximately February 2012.

101. A September 2011 CT scan of Patient J's cervical spine revealed degenerative disease most prominent at C4-5, C5-6 and C6-7 levels. A CT scan of Patient J's lumbar spine revealed degenerative disease most prominent at L3-4, L4-5 and L5-S1. In addition, the CT scan of Patient J's lumbar spine revealed moderate central canal stenosis at L4-5.

102. Patient J filled out a Comfort Assessment Guide on February 2, 2012 and indicated that he has complete relief from pain with medication. He listed oxycodone 30 mg and fentanyl[24] patch 100 mg as the medications that provide relief. He did not list any other medications.

103. However, at Patient J's visits on March 29, 2012, April 26, 2012, May 23, 2012, June 20, 2012, July 18, 2012, Patient J indicated that his pain was 8/10 on the same medication.

104. Patient J first saw the Respondent on March 29, 2012. The Respondent continued Patient J on the same medications: carisoprodol 350 mg qhs, fentanyl TD 100 mcg/hr one every 72 hours, naproxen 500 mg BID, and oxycodone 30 mg q4-6 hr.

105. The Respondent saw Patient J for April 26, 2012, May 23, 2012, and June 20, 2012 and continued to prescribe the same medications.

106. The Respondent failed to perform or document performing adequate physical examinations of Patient J.

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[24] Fentanyl is a an opioid analgesic and a schedule II CDS.

107. The Respondent failed to monitor or document monitoring Patient J for medication compliance by ordering a drug screen.

108. The Respondent failed to discuss or document discussing alternative treatments to examine the cause of Patient J's pain.

109. The Respondent failed to sufficiently develop a plan of care for Patient J.

Patient K

110. Patient K, a male born in 1971, began seeing the Respondent in April 2012 with complaints of lower back pain. Patient K was an existing patient of Practice A since approximately June 2011. Patient K had a history of motor vehicle accident in 1998 and was status-post laminectomy from 2004.

111. On March 9, 2012, at Patient K's last appointment with his previous physician at Practice A, he reported that his pain level was 8/10. The physician prescribed Naprosyn 500 mg BID and oxycodone 30 mg q6h.

112. On April 6, 2012, at Patient K's first appointment with the Respondent, Patient K reported that his pain level was 6/10. Despite Patient K's reported improvement, the Respondent prescribed the same medications and added carisoprodol 350 mg qhs. The Respondent failed to document his justification for adding another medication to Patient K's regimen.

113. The Respondent failed to perform or document performing an adequate physical examination of Patient K. His documentation consists of circling pre-printed abbreviations (*i.e.*, No, Y, ab, is/not, n/a, etc.).

114. The Respondent failed to monitor or document monitoring Patient K for medication compliance by ordering a drug screen.

115. The Respondent failed to sufficiently develop a plan of care for Patient K.

Patient L

116. Patient L, a male born in 1972, began seeing the Respondent in March 2012 with complaints of low back pain. Patient L was an existing patient of Practice A since approximately June 2011.

117. The Respondent saw Patient L for the first time on March 20, 2012 and continued Patient L's existing prescriptions of carisoprodol 350mg qhs, Dilaudid 8 mg q6h, methadone 10 mg 3 tablets q12h.

118. In April 2012, the Respondent discontinued methadone and instead prescribed oxycodone 30 mg q4-6h.

119. In June 2012, the Respondent added Voltaren[25] 75 mg BID to Patient L's medication regimen. The Respondent also ordered an MRI of Patient L's lumbar spine, which revealed a left paramedian disk herniation at L4-5 with moderate left-sided intervertebral neural foramina stenosis and degenerative disk disease at L4-5 and L5-S1.

120. In August 2012, the Respondent discontinued Dilaudid and prescribed MS Contin 60 mg BID.

121. The Respondent failed to sufficiently develop a plan of care for Patient L.

122. The Respondent failed to assess or document assessing Patient L for opioid abuse, misuse or diversion.

CONCLUSIONS OF LAW

Based on the foregoing investigative facts, the Board concludes that the public health, safety or welfare imperatively requires emergency action in this case, pursuant

[25] Voltaren is an NSAID.

to Md. State Gov't Code Ann. § 10-226(c)(2)(i) and (ii)(2009 Repl. Vol. and 2011 Repl. Vol.).

ORDER

It is this 2nd day of **April 2013**, by a majority of the quorum of the Board:

ORDERED that pursuant to the authority vested by Md. State Gov't Code Ann. §10-226(c)(2), the Respondent's license to practice medicine in the State of Maryland be and hereby is **SUMMARILY SUSPENDED;** and be it further

ORDERED that a post-deprivation hearing on the Summary Suspension has been scheduled for **Wednesday, April 17, 2013 at 11:15 a.m.** at the Maryland Board of Physicians, 4201 Patterson Avenue, Baltimore, Maryland 21215; and be it further

ORDERED that at the conclusion of the **SUMMARY SUSPENSION** hearing held before the Board, the Respondent, if dissatisfied with the result of the hearing, may request within ten (10) days an evidentiary hearing, such hearing to be held within thirty (30) days of the request, before an Administrative Law Judge at the Office of Administrative Hearings, Administrative Law Building, 11101 Gilroy Road, Hunt Valley, Maryland 21031-1301; and be it further

ORDERED that on presentation of this Order, the Respondent **SHALL SURRENDER** to the Board the following items:

(1) His original Maryland License No.D27909; and

(2) His current renewal certificate;

ORDERED that a copy of this Order of Summary Suspension shall be filed with the Board in accordance with Md. Health Occ. Code Ann. § 14-407; and be it further

ORDERED that this is a Final Order of the Board and, as such, is a PUBLIC DOCUMENT pursuant to Md. State Govt. Code Ann., § 10-611 *et seq.*

April 2, 2013
DATE

Carole J. Catalfo, Executive Director
Maryland Board of Physicians