IN THE MATTER OF	*	**BEFORE THE**
NORA R. SUDARSAN, D.O.	*	**MARYLAND STATE BOARD**
Respondent	*	**OF PHYSICIANS**
LICENSE NUMBER: H0085147	*	**CASE NUMBER: 2225-0161B**

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CONSENT ORDER

On March 17, 2026, Disciplinary Panel B ("Panel B" or the "Panel") of the Maryland State Board of Physicians (the "Board") charged Nora R. Sudarsan, D.O. (the "Respondent"), License Number H0085147, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. §§ 14-101 *et seq.* (2021 Repl. Vol. & 2025 Supp.). Panel B charged the Respondent with violating the following provisions of the Act:

> **Health Occ. § 14-404. Denials, reprimands, probations, suspensions, and revocations – Grounds.**
>
> (a) *In general.* Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
> . . .
>
> (3) Is guilty of:
> . . .
>
> (ii) Unprofessional conduct in the practice of medicine; [and]
>
> (11) Willfully makes or files a false report or record in the practice of medicine[.]

On May 27, 2026, Panel B was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of this DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law, Order, Consent, and Acceptance.

FINDINGS OF FACT

Panel B makes the following findings of fact:

I. Background

1. At all relevant times hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent obtained her license to practice medicine in the State of Maryland on April 6, 2018, under license number H0085147. Her license is active through September 30, 2027, subject to renewal.

2. The Respondent is board-certified in Internal Medicine, Medical Oncology, and Hematology.

3. From approximately August 10, 2020, until January 14, 2025, the Respondent was employed as an attending physician at a hospital (the "Hospital") located in Montgomery County, Maryland.

II. Complaint

4. On or about January 31, 2025, the Board received a Mandated 10-Day Report[1] (the "Report") from the Hospital stating that the Respondent's employment was

[1] *See* Md. Code Ann., Health Occ. §§ 14-413, 14-414 (describing Mandated 10-Day Reports generally).

terminated[2] following an investigation conducted by the Hospital which determined that the Respondent documented and billed for patient care that she did not provide. Upon receipt of the Report, the Board initiated an investigation into the Respondent's conduct.

III. Board Investigation

5. As part of its investigation, the Board obtained relevant documentation, including the Patient's medical records from September 21, 2024 (the "Patient's Medical Record"), and conducted under-oath interviews with the Respondent and Hospital personnel including, but not limited to, the Hospital's Chief Medical Officer (the "CMO"),[3] a hospitalist (the "Hospitalist"),[4] and a compliance officer (the "Compliance Officer").[5] The Board's investigation confirmed that the Hospital's internal investigation determined that the Respondent documented and billed for treatment that she did not provide to a patient (the "Patient").

A. The Patient's Medical Records and Patient Encounter Discrepancy

6. The Patient's Medical Record states a service date/time that indicates that the Respondent treated the Patient on September 21, 2024 at 7:22 a.m. The Patient's Medical

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[2] According to the Respondent, her termination from the Hospital was later converted into a voluntary resignation.

[3] The CMO is responsible for ensuring that patients are receiving safe and quality care at the Hospital. She also works to support the physicians employed at the Hospital and ensures that they are compliant with the rules and regulations of the profession as well as the Hospital's policies.

[4] The Hospitalist manages in-patient services after patients have been admitted to the emergency room at the Hospital.

[5] The Compliance Officer provides support to the medical group for the Hospital by assisting with investigations, providing training, and other compliance-related matters.

Record was e-signed and dated by the Respondent on September 21, 2024 at 10:41 a.m.

7. On September 21, 2024, the Hospitalist requested that Respondent, acting as the on-call hematologist, conduct a hematology consultation for the Patient prior to the Patient's discharge. Upon review of the Respondent's notes in the Patient's Medical Record, which documented a physical examination by the Respondent and the Respondent's treatment recommendations, the Hospitalist informed the Patient that she would be discharged, as she had been evaluated by the hematologist. After the Patient and her spouse stated they had not seen the hematologist, the Hospitalist messaged the Respondent regarding the discrepancy. The Respondent advised him that she had seen the Patient earlier that morning. The Hospitalist later reported the incident to the Hospital's risk management team because he was concerned that the Respondent had not seen the Patient.

B. Hospital Internal Investigation

8. As part of the Hospital's internal investigation, the Compliance Officer worked with members from the Hospital's information technology ("IT") team to analyze the Respondent's EMR access of the Patient's Medical Record. Based on a review of the Hospital's internal software, IT determined that the only time the Respondent ever accessed the Patient's record in the EMR was on September 21, 2024 beginning on or around 10:13 a.m.[6]

[6] During her interview with Board staff, the Hospital's Chief Medical Officer stated that the Hospital's electronic medical record ("EMR") system documents the initial time a provider accesses the EMR. However, the EMR system also allows a provider to edit or alter the time of

9. The CMO also participated in the Hospital's investigation by reviewing Hospital surveillance footage and badge log records and speaking with the Respondent regarding her arrival at the Hospital. She identified the following discrepancies:

(i) The Respondent's Arrival at the Hospital

10. The Respondent stated that she came in through the main entrance around 7:00 a.m. on September 21, 2024, however, Hospital surveillance footage did not show the Respondent arriving at that time and Hospital security personnel confirmed that the main entrance did not open that day until 8:00 a.m.

11. When the CMO confronted the Respondent with this information, the Respondent then stated that she forgot her badge on that day and that she may have walked in behind someone else at the employee entrance. However, Hospital surveillance footage did not show the Respondent at the employee entrance or near any area of the Hospital where the Patient was located.

(ii) Hospital Badge Log

12. The badge log record revealed no evidence that the Respondent had used her badge in the Hospital at all on September 21, 2024.

C. Respondent's Response to the Complaint

During the Board's investigation, the Respondent submitted a written response to the Report and participated in an under-oath interview with Board staff. During the interview, the Respondent stated that she reviewed the Patient's chart on September 20, 2024, after

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service originally documented by the system on a patient's record. The EMR system will document both the original and the altered timestamps.

receiving a text from the Hospitalist requesting a hematology consultation for the Patient. In both her written response and interview, the Respondent maintained that she arrived at the Hospital around 7:00 a.m. on September 21, 2024, and that she likely walked through the door behind someone else if there was no evidence of her badge being used that day. She further maintained that her encounter with the Patient was brief because the Patient was drowsy and/or half asleep and that she completed her documentation at home.

CONCLUSIONS OF LAW

Based on the Findings of Fact, Panel B concludes that the Respondent: is guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii); and willfully made or filed a false report or record in the practice of medicine, in violation of Health Occ. § 14-404(a)(11).

ORDER

It is, thus, on the affirmative vote of a majority of the quorum of Panel B, hereby:

ORDERED that the Respondent is **REPRIMANDED**; and it is further

ORDERED that, within **SIX MONTHS**, the Respondent is required to take and successfully complete courses in **(1) ethics,** and **(2) medical recordkeeping**. The following terms apply:

(a) it is the Respondent's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the courses before the courses begin;

(b) the Respondent must provide documentation to the disciplinary panel that the Respondent successfully completed the courses;

(c) the courses may not be used to fulfill the continuing medical education credits required for license renewal; and

(d) the Respondent is responsible for the cost of the courses; and it is further

ORDERED that this Consent Order shall not be amended or modified, and future requests for modification will not be considered by the Board or a disciplinary panel; and it is further

ORDERED that, if the Respondent allegedly fails to comply with any term or condition imposed by this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If there is a genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings followed by an exceptions process before a disciplinary panel; and if there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before a disciplinary panel; and it is further

ORDERED that, after the appropriate hearing, if the disciplinary panel determines that the Respondent has failed to comply with any term or condition imposed by this Consent Order, the disciplinary panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend the Respondent's license with appropriate terms and conditions, or revoke the Respondent's license to practice medicine in Maryland. The disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine on the Respondent; and it is further

ORDERED that the Respondent is responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that this Consent Order goes into effect on the date the Consent Order is signed by the Executive Director of the Board or her designee. The Executive Director or her designee signs the Consent Order on behalf of the disciplinary panel which has imposed the terms and conditions of this Consent Order; and it is further

ORDERED that this Consent Order is a public document. *See* Md. Code Ann., Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. § 4-333(b)(6).

CONSENT

I, Nora R. Sudarsan, D.O., acknowledge that I have consulted with counsel before signing this Consent Order.

By this Consent, I agree to be bound by this Consent Order and all its terms and conditions and understand that the disciplinary panel will not entertain any request for amendments or modifications to any condition.

I assert that I am aware of my right to a formal evidentiary hearing, pursuant to Md. Code Ann., Health Occ. § 14-405 and Md. Code Ann., State Gov't §§ 10-201 *et seq.* concerning the pending charges. I waive this right and have elected to sign this Consent Order instead.

I acknowledge the validity and enforceability of this Consent Order as if entered after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my behalf, and to all other substantive and procedural protections as provided by law. I waive those procedural and substantive protections. I acknowledge the legal authority and the jurisdiction of the disciplinary panel to initiate these proceedings and to issue and enforce this Consent Order.

I voluntarily enter into and agree to comply with the terms and conditions set forth in the Consent Order as a resolution of the charges. I waive any right to contest the Findings of Fact and Conclusions of Law and Order set out in the Consent Order. I waive all rights to appeal this Consent Order.

I sign this Consent Order, without reservation, and fully understand the language and meaning of its terms.

6/14/26
Date

Signature on File
Nora R. Sudarsan, D.O.

NOTARY

STATE OF Maryland

CITY/COUNTY OF Howard

I HEREBY CERTIFY that on this 14th day of June 2026, before me, a Notary Public of the foregoing State and City/County, Nora R. Sudarsan, personally appeared and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

JAE SIN CHUNG
Notary Public - State of Maryland
Montgomery County
My Commission Expires Feb 28, 2028

Notary Public

My Commission expires: 02/28/2028

ACCEPTANCE

I, Christine A. Farrelly, sign this Consent Order on behalf of Panel B.

06/23/2026
Date

Signature on File
Christine A. Farrelly, Executive Director
Maryland State Board of Physicians