IN THE MATTER OF	*	BEFORE THE
SILVIU ZISCOVICI, M.D.	*	MARYLAND STATE BOARD
Respondent	*	OF PHYSICIANS
License Number: D47167	*	Board Case Numbers: 2010-0164, 2010-0263, 2010-0279, 2010-0382, 2010-0401

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FINAL DECISION AND ORDER OF REVOCATION

Procedural Findings

On December 1, 2010, pursuant to § 10-226(c)(2) of the State Government Article, Annotated Code of Maryland, the Maryland State Board of Physicians (the "Board") summarily suspended Respondent Silviu Ziscovici, M.D.'s (the "Respondent's") license to practice medicine in Maryland. On December 15, 2010, the Board charged the Respondent under the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §§ 14-101—14-702, with unprofessional conduct in the practice of medicine, Health Occ. § 14-404(a)(3)(ii); professional, physical, or mental incompetence, Health Occ. § 14-404(a)(4); and selling, prescribing, giving away, or administering drugs for illegal or illegitimate medical purposes, Health Occ. § 14-404(a)(27). On February 5, 2018, the matters were delegated to the Office of Administrative Hearings ("OAH") for issuance of a proposed decision.

On February 6, 2018, OAH mailed notice of the parties at their addresses of records stating that a Scheduling Conference was scheduled for Monday, March 5, 2018, at 9:30 a.m. at OAH in Hunt Valley, Maryland. By letter dated February 20, 2018, and received by OAH on February 27, 2018, the Respondent requested a postponement of the Scheduling Conference. He stated he was unable to attend due to treatment for medical conditions. The Respondent did not

provide documentation supporting the reason for his request. The Administrative Law Judge ("ALJ") denied the Respondent's request for postponement and advised him that he could participate by telephone.

On March 5, 2018, the ALJ convened the Scheduling Conference as scheduled. Administrative Prosecutors from the Office of the Attorney General appeared on behalf of the State. The ALJ telephoned the Respondent at 9:30 a.m. The Respondent did not answer the telephone. At 9:45 a.m., the ALJ again called the Respondent, and the Respondent again did not answer the telephone. The State moved for a default.

Under the OAH Rules of Procedure, "[i]f, after receiving proper notice, a party fails to attend or participate in a prehearing conference, hearing, or other stage of a proceeding, the judge may proceed in that party's absence or may, in accordance with the hearing authority delegated by the agency, issue a final or proposed default order against the defaulting party." COMAR 28.02.01.23A.

On March 12, 2018, the ALJ ruled, upon consideration of the record, that the Respondent had notice of the March 5, 2018, Scheduling Conference and failed to appear and participate in that stage of the proceedings. Accordingly, the ALJ proposed that the Respondent be found in default for the Respondent's cases before OAH. The ALJ further proposed that the Board find that the summary suspension was imperatively required, under State Gov't § 10-226(c)(2); the Allegations of Fact in the charges be adopted as fact; and the Respondent violated § 14-404(a)(3)(ii), (4), and (27) of the Health Occupations Article.

The ALJ's proposed default order, issued on March 12, 2018, notified the Respondent that, pursuant to COMAR 10.32.02.05B(1), he had 15 days to file exceptions with the Board. The ALJ mailed the proposed default order to the Respondent at his address of record.

In addition, on March 14, 2018, the Board sent a letter to the Respondent, addressed to the Respondent's address of record, notifying him that he had 15 days from the date of the ALJ's proposed decision, plus three days for mailing, to file written exceptions.

The Respondent did not file any exceptions to the ALJ's proposed default order of March 12, 2018.

FINDINGS OF FACT ON THE MERITS

Because Panel A concludes that the Respondent has defaulted, the following findings of fact are adopted from the Allegations of Fact set forth in the December 15, 2010, Charges Under the Maryland Medical Practice Act and the Investigative Findings from the December 1, 2010, Order for Summary Suspension of License to Practice Medicine and are deemed proven by the preponderance of evidence:

At all times relevant hereto, the Respondent was licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on April 11, 1995.

At all times relevant hereto, the Respondent maintained an office for the practice of medicine and pain management located at 1140 Rockville Pike, Suite 511, Rockville, Maryland 20852.

First Complaint (Case Number: 2010-0164)

On or about August 20, 2009, the Board received a referral from the Maryland Division of Drug Control (hereinafter the "DDC"), detailing concerns from several pharmacists regarding prescriptions written by the Respondent. Specifically, the DDC was contacted on April 3, 2009, by a pharmacist ("Pharmacist A") who noticed that several new patients presented prescriptions

written by the Respondent for large quantities of narcotic pain medication and Benzodiazepines.[1] Pharmacist A became suspicious because the patients "appeared to be drug abusers" and many paid cash for their prescriptions.

Five additional pharmacists contacted the DDC, all expressing concerns about the Respondent's prescribing practices, including but not limited to, the fact that Respondent's office was located in Rockville, Maryland, yet his patients traveled great distances to see him. The pharmacists noted that some patients lived as far away as Pennsylvania and Tennessee but chose to fill their prescriptions at pharmacies that were neither close to the Respondent's office nor close to their homes.

The DDC also reported that the Medical Director for a small pharmacy chain in Western Maryland became so concerned with the Respondent's prescribing practices that he instructed his stores not to fill nay prescriptions written by the Respondent.

On or about September 25, 2009, the Board received a supplemental referral from the DDC, regarding a complaint filed by another pharmacist ("Pharmacist B") concerning the Respondent's prescribing practices. Specifically, Pharmacist B opened his pharmacy on August 12, 2009. By September 24, 2009, approximately six weeks later, Pharmacist B had been presented with 230 Controlled Dangerous Substances ("CDS") prescriptions written by the Respondent, out of a total of 254[2] CDS prescriptions filled by his pharmacy during that period of time. Pharmacist B also randomly reviewed 52 Schedule II[3] CDS prescriptions written by the

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[1] Benzodiazepines are a family of tranquilizers commonly used to treat anxiety, insomnia and some seizure disorders. They care a risk of both physical and psychological dependence and/or addiction.

[2] Pharmacist B noted that the Respondent wrote 91% of all CDS prescriptions filled by his pharmacy during the relevant six-week period.

[3] Schedule II CDS have a high potential for abuse with potentially severe psychological and physical dependence.

Respondent and noted that thirty were for patients from Tennessee; two for patients from Kentucky; and one for a patient from West Virginia.

Second Complaint (Case Number: 2010-0263)

On or about September 29, 2009, the Board received a second complaint from an anonymous source, describing the prescribing practices of the Respondent. The second complaint alleged that the Respondent provided patients, ages 19 to 70, with narcotics, including but not limited to, OxyContin[4] and Roxicodone.[5] The complaint further alleged that the Respondent was treating 20 members of the same named family, many of whom were fabricating medical records in order to obtain prescriptions from the Respondent. For $300 in case, the Respondent would provide a narcotic prescription for "anyone . . . off the street . . ." as long as they stated that they were seen by the Respondent the month before, whether they had been previously treated by the Respondent or not. The complaint concluded by warning that "lives were being destroyed at very young ages because of this [doctor's] greed."

Third Complaint (Case Number: 2010-0279)

On or about October 5, 2009, the Board received a third compliant filed by a "very Concerned Mother and Grandmother," alleging that the Respondent was prescribing OxyContin and Roxicodone for patients with no documented surgery, prior magnetic resonance imaging ("MRI") or x-rays. The third complaint described an identical cash transaction of $300 in exchange for a narcotic prescription. It alleged similar concerns regarding very young patients, many of whom were from the same family, becoming addicted to narcotics prescribed by the Respondent, with little or no medical rationale or justification.

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[4] OxyContin is a brand name for the opioid narcotic analgesic, oxycodone, a Schedule II CDS, used to treat moderate to severe pain.

[5] Roxicodone, a Schedule II CDS, is a generic form of oxycodone, an opiate narcotic analgesic, typically used to treat moderate to severe pain.

Fourth Complaint (Case Number: 2010-0382)

On or about November 19, 2009, the Board received a fourth complaint from the mother of a 20-year-old patient of the Respondent's, alleging that her son had been hospitalized twice for OxyContin overdoses. She stated that the Respondent wrote prescriptions for 90 tablets of OxyContin 80 mg[6] and 90 tablets of Roxicodone 30 mg for both her son and his friends, with no medical justification. She expressed serious concern that "[s]omething needs to be done about this doctor before somebody's child dies" and further stated that at least one of the Respondent's patients had died in the prior six months.

Fifth Complaint (Case Number: 2010-0401)

On or about November 24, 2009, the Board received a fifth complaint from an anonymous complainant, referred by the DDC. The fifth complaint alleged that the Respondent was prescribing 80 mg OxyContin, Valium and Methadone, all at the same time, to patients 19 to 70 years of age. It also alleged that the Respondent stated that " . . . no one can stop him, that this is his [livelihood] [and] he will sue." The fifth complaint warned that "[the Respondent] needs to be stopped before someone dies."

DEA Investigation

On or about September 8, 2009, the United State Drug Enforcement Administration ("DEA") initiated a multi-agency investigation of the Respondent based on allegations that he was orchestrating the transport of patients from approximately thirteen different states to his medical office in Rockville, Maryland, purportedly for the treatment of pain. The Respondent would issue CDS prescriptions to these patients based on falsely presented illnesses and

[6] OxyContin 80 mg, the second highest unit dosage available, is intended for use only in opioid-tolerant patients. The Physicians' Desk Reference ("PDR") contains the warning that this dosage may cause fatal respiratory distress in patients not previously exposed to opioids.

conditions for cash payments of $250-$500. In some cases, the Respondent filed insurance claims for services for which he had already been paid in cash.

The DEA's investigation revealed that 15 of the Respondent's patients had died from ingesting lethal amounts of controlled narcotics. Of the 15 drug overdose deaths, eight occurred in Maryland, six in Tennessee and one in Pennsylvania.

On or about March 2, 2010, DEA and other federal agents executed a federal search and seizure warrant on the Respondent's residence and medical office. During the execution, the DEA seized approximately 4300 patient records, $6,282 in U.S. currency, multiple computers, hard drives, electronic devices, financial documents and appointment books from the Respondent's residence and medical office.

On or about March 18, 2010, DEA and other federal agents executed a second search and seizure warrant on three safe deposit boxes belonging to the Respondent, which contained $145,966 in U.S. currency, and rare collectible coins and jewelry appraised at $65,880.90.

Based upon an interview with Respondent's office manager and a projected financial analysis by the National Documentation Intelligence Center, the DEA estimated that the Respondent saw 4,628 patients in 2009 alone, at an average charge of $300-$400 per visit, resulting in a projected annual income between $1,388,400 and $1,851,200.

Between July 17, 2009 and October 15, 2009, the DEA received seven complaints against the Respondent, filed by pharmacists, the DDC, and family members of patients, including the mother of one of the Respondent's patients, whose son had recently died as a result of a drug overdose.

As part of its investigation, DEA investigators interviewed two confidential informants in Frederick, Maryland. The first informant disclosed information about a drug dealer in Frederick

County who sent his associates to the Respondent posing as patients for the purpose of obtaining CDS prescriptions for later diversion. The drug dealer reportedly paid directly to the Respondent fees for his associates' office visits.

The second informant disclosed information about a patient of the Respondent's, who, with the Respondent's full knowledge, sent other patients with fabricated MRI reports to the Respondent for the purpose of obtaining CDS prescriptions.

The DEA investigators also interviewed nurse practitioners employed by the Respondent, who revealed, among other things, that the Respondent:

a. Saw 30-40 patients per day;
b. Charged patients $300-$500 per visit;
c. Saw groups of patients from Tennessee, and some patients from West Virginia and Pennsylvania;
d. Directed patients to particular pharmacies to fill their prescriptions;
e. Often provided narcotic prescriptions without prior medical records or proper examinations;
f. Saw multiple patients at the same time; and
g. Continued to prescribe narcotics to patients with visible "track marks" and positive drug tests for illicit substances.

During their investigation, DEA investigators interviewed many of the Respondent's patients, former patients and family members/friends of patients who had obtained prescriptions from the Respondent. These interviews revealed that:

a. The Respondent provided large quantities of CDS to patients with little or no supporting medical history and/or records;

b. The Respondent failed to conduct proper medical examinations prior to providing narcotic prescriptions;

c. The Respondent wrote prescriptions for patients who exhibited clear signs of drug abuse, including patients with visible "track marks" and patients who tested positive for illicit drug use;

d. The Respondent saw multiple patients in his office at the same time, providing narcotic prescriptions to each, in the presence of other patients;

e. The Respondent was aware that patients were being transported across state lines in order to obtain prescriptions for CDS;

f. One patient who transported other patients from Tennessee to the Respondent's office received payment from him in the form of narcotics, food stamps, handguns and rifles;

g. Patients have died from lethal ingestion of CDS prescribed by the Respondent;

h. The Respondent provided prescriptions for CDS to patients who he knew were illegally distributing narcotics for financial gain; and

i. The Respondent prescribed lethal combinations of Methadone, Xanax, Morphine, OxyContin, and other CDS.

On or about December 2, 2009, the DEA conducted a drug survey dating back to June 1, 2006, of prescriptions written by the Respondent and filled by pharmacies in Virginia. Although the Respondent's office is in Rockville, Maryland, thousands of the Respondent's prescriptions were filled all throughout the State of Virginia.

In one example, a patient filled 159 prescriptions at pharmacies in 10 cities in Virginia, including Woodbridge, Falls Church, Sterling, Fairfax, Chantilly, Leesburg, Centreville,

Manassas, Springfield and Ashburn. This patient used three different addresses in order to obtain these potentially lethal combinations of CDS prescribed by the Respondent, including Oxycodone, Xanax,[7] Dexedrine,[8] and Adderall.[9]

DEA Order for Immediate Suspension of Registration

Based on its investigation, the DEA took emergency action against the Respondent on or about September 15, 2010, pending his right to a hearing, by executing an Order to Show Cause and Immediate Suspension of Registration ("ISO") thereby immediately suspending the Respondent's ability to prescribe Schedule II to V CDS under his DEA Certificate of Registration and authorizing DEA agents to take into possession, the Respondent's Certificate of Registration, all unused prescription forms, and all controlled substances in the Respondent's possession.

The DEA found that the Respondent had prescribed controlled substances without "legitimate medical purposes and/or outside the usual course of professional practice in violation of Federal and state law" and that his "continued registration during the pendency of these proceedings would constitute an imminent danger to the public health and safety because of the substantial likelihood that [the Respondent] will continue to divert controlled substances to potential abusers and other unauthorized persons who will then divert these controlled substances to other unauthorized users."

The ISO stated:

> a. Between August 2009 and October 2009, Montgomery County Police Department detectives acting in an undercover capacity

[7] Xanax is a Schedule III benzodiazepine, typically used to treat anxiety/depression.
[8] Dexedrine is a Schedule II CDS, typically used to treat the symptoms of Attention Deficit Hyperactivity Disorder ("ADHD").
[9] Adderall is a trade name psychostimulant typically used to treat ADHD and narcolepsy. It is a Schedule II CDS due to its significant abuse and addiction potential.

made three visits to [the Respondent's] office, posing as patients seeking controlled substances. At each visit [the Respondent] issued prescriptions for schedule II and IV controlled substances to the undercover detectives without performing even a cursory, medical examination, without taking a medical history and without a legitimate medical purpose.

b. Since at least August 2009, [the Respondent has] repeatedly prescribed controlled substances to patients under the following circumstances that indicated the individuals were diverting or abusing controlled substances: (i) urinalysis results that were positive for illicit drugs, positive for controlled substances not prescribed or negative for controlled substances that were prescribed; (ii) travelling extraordinary long distances to see [the Respondent], (iii) requesting refill prescriptions before the previous prescription should have been consumed; and (iv) exhibiting or admitting behavior indicative of addiction to or abuse of controlled substances.

Montgomery County Police – Undercover Drug Buys

On or about August 27, 2009, two undercover detectives from the Tactical narcotics unit for the Montgomery County Police Department ("Detectives A and B") entered the Respondent's practice located at 11400 Rockville Pike, Suite 511, Rockville MD 20852. Detective A posed as a new patient under an alias, and sought to obtain prescriptions for OxyContin 80 mg, Roxycontin 30 mg, and Xanax from the Respondent. Detective A claimed that he had suffered from knee pain dating back to youth basketball and back pain following an automobile accident three years earlier, in December 2006. Detective A did not have any prior medical records with him during the visit.

When the Respondent saw Detective A, he merely asked a couple cursory questions, such as what was wrong with Detective A and which disk was damaged. The Respondent failed to conduct an appropriate evaluation, failed to obtain a detailed medical history and never

performed a physical examination. At one point, Detective A told the Respondent that he used to be on OxyContin 80 mg, Roxycontin 30 mg and Xanax.

The Respondent then, without making an appropriate assessment and formulating a clear treatment plan, provided Detective A with prescriptions for:

a. OxyContin 80 mg (60 tablets);
b. Roxycontin 30 mg (120 tablets);
c. Xanax 2 mg (30 tablets); and
d. 60 tablets of an unidentified medication, 50 mg.

At the Respondent's request, Detective A paid $300 in cash, which the Respondent placed in his front pocket. Detective A was then given a follow-up appointment for September 24, 2009, approximately 28 days later. No receipt was ever provided.

While waiting in the lobby, Detective B initiated conversations with other patients. Detective B spoke with another patient who told him that the Respondent was "a quack" and would give patients whatever they asked for. Detective B also learned that the street value for one pill of OxyContin 80 mg was $60.00 and that "everyone in the room was here for the same thing" and that it was easy to get oxy[contin] from this doctor and how they hope[d] that no one finds out about him."

On September 21, 2009, two different undercover detectives ("Detectives C and D") from the Montgomery County Police Department conducted a similar undercover investigation of the Respondent's prescribing practices. Detective C posed as a new patient under an alias and sought to obtain prescriptions for OxyContin 80 mg., Adderall 30 mg., and Xanax from the Respondent.

During this meeting with Detective C, the Respondent failed to conduct an appropriate evaluation, failed to obtain a detailed medical history and never performed a physical examination. The Respondent merely asked a few cursory questions about the cause and severity of Detective C's alleged pain, at which time Detective C responded that he hurt his back

two years prior in an automobile accident; needed Adderall to treat ADHD and used Xanax for depression. The Respondent then issued narcotic prescriptions to Detective C without making an appropriate assessment and formulating a clear treatment plan.

For $300 in cash, the Respondent provided Detective C with prescriptions for:

a. OxyContin 80 mg (60 tablets);
b. Adderall 30 mg (30 tablets);
c. Xanax 1 mg (90 tablets); and
d. Diclofenac ER 100 mg.

Detective C was asked to sign a statement indicating that the medication would be used to treat his back pain and that he would not sell the medications to others. Detective C was given a follow-up appointment for October 19, 2009, approximately 28 days later. No receipt was ever provided.

While Detective D waited in the lobby for Detective C to return, he initiated conversations with other patients. In one conversation, a patient told Detective D that typically OxyContin 80 mg sold for $60 per tablet, but that tablets sold to "rich kids" at a local Western Maryland college were sold for $100 per pill because the students' parents paid for everything.

On October 19, 2009, Detective C returned to the Respondent's office for his scheduled follow-up visit. He noted that the mood in the waiting room was tense, and that patients were discussing the Respondent's new requirement of drug urinalysis that they presumed was related to a pending Justice Department investigation of the Respondent's practice.

When Detective C saw the Respondent, he asked for Detective C's prior medical records. Detective C responded that he had previously sent the records to the Respondent by Federal Express, at which time the Respondent stated that if he did not have Detective C's records by the next visit Detective C would no longer be his patient. The Respondent then asked for $300 in cash, which Detective C provided in pre-marked bills. Without any evaluation, physical

examination, assessment or plan of treatment, the Respondent handed Detective C prescriptions for OxyContin 80 mg (60 tablets), Xanax 1 mg (90 tablets) and Adderall 30 mg (30 tablets). Detective C also received a new appointment of November 17, 2009, and an order for urinalysis.

Summary of Expert Opinion

In furtherance of its investigation, the Board sought the opinion of a physician with a subspecialty certification in Pain Medicine (the "Expert") to review pertinent documents and provide an expert opinion regarding the Respondent's professional competence and conduct as well as the propriety of his prescribing practices.

After review, the Expert concluded that the Respondent participated in ongoing unprofessional conduct in the practice of medicine as a result of gross lack of professional competence and a clear disregard for the standards of care in practicing pain medicine.

The Expert also opined that the Respondent was not professionally competent to practice medicine because he failed to develop appropriate assessments or plans of care in treating his patients, particularly young patients with contact to drug culture. He unequivocally found that "[t]he Respondent's medical decision making process was grossly incompetent."

Finally, the Expert concluded that the Respondent prescribed drugs for illegitimate medical purposes. The Expert found that the Respondent, rather than providing medical services, sold narcotic prescriptions for cash.

In support of his opinions, the Expert noted numerous deficiencies in the Respondent's prescribing practices, which included, but were not limited to, the following:

a. The Respondent prescribed excessive amounts of controlled substances without legitimate reasons, harming patients with underlying addiction issues,

even young patients, exposed to a "drug culture." He also did not recognize or act on common drug related aberrant behaviors.

b. Respondent's clear disregard for the appropriate practice of pain medicine, led to several overdoses and patient deaths. Two unrelated patients were pronounced dead on the same date, July 10, 2010, both as a result of CDS intoxication.

c. The Respondent consistently prescribed high-dose opioid medications in conjunction with Benzodiazepines in the absence of medical necessity and/or therapeutic rationale for such treatment.

d. The Respondent did not obtain or integrate historical information, physical exam findings, or results of testing, in order to develop a plan of care that considered the risks and benefits of prescribing high dose CDS. He further did not adequately search for clues as to the patient's complaints, motivation or compliance, and is some instances, ignored evidence suggesting that patients were selling or diverting CDS prescribed by the Respondent.

e. Overall, the Respondent's medical records were grossly incomplete, were devoid of a documented physical exam, failed to document medical diagnoses or rationale for treatment, were unsigned and lacked any meaningful documentation whatsoever.

f. In rare instances, the Respondent ordered imaging studies, but failed to ascertain or document the results and/or failed to integrate the information obtained into a treatment plan.

g. Inconsistencies between the actual gender of the patient and gender descriptors in the patient chart suggested that the Respondent generically documented patient records without developing treatment plans.

CONCLUSIONS OF LAW

Panel A adopts the ALJ's proposed finding of default against the Respondent, under COMAR 28.02.01.23A, for his failure to attend or participate in the Office of Administrative Hearings' Scheduling Conference, which was scheduled for March 5, 2018. Panel A thus finds the Respondent in default. *See* State Gov't § 10-210(4). Based upon the findings of fact, Panel A concludes that the Respondent is guilty of unprofessional conduct in the practice of medicine, *see* Health Occ. § 14-404(a)(3)(ii); is professionally, physically, or mentally incompetent, *see* Health Occ. § 14-404(a)(4); and sold, prescribed, gave away, or administered drugs for illegal or illegitimate purposes, *see* Health Occ. § 14-404(a)(27). Also based upon the findings of fact, Panel A concludes, under section 10-226(c) of the State Government Article and COMAR 10.32.02.05, that the Respondent presents a substantial likelihood of risk of serious harm to the public health, safety, or welfare, imperatively requiring the summary suspension of his license to practice medicine in Maryland.

Sanction

The Respondent used his medical license to provide prescriptions for CDS without legitimate medical justification. He did so primarily for financial gain. In doing so he jeopardized the health and safety of the public and caused actual harm in certain instances. The revocation of the Respondent's Maryland medical license is thus warranted.

ORDER

It is, on the affirmative vote of a majority of the quorum of Board Disciplinary Panel A, hereby

ORDERED that Silviu Ziscovici, M.D.'s license to practice medicine in Maryland (License No. D47167) is **REVOKED;** and it is further

ORDERED that the Order for Summary Suspension of License to Practice Medicine, issued on December 1, 2010, against Dr. Ziscovici's license is terminated as moot as a result of the revocation of his license; and it is further

ORDERED that this is a public document, pursuant to Md. Code Ann., Gen. Prov. § 4-333(b)(6) and Health Occ. § 1-607.

June 1, 2018
Date

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

NOTICE OF RIGHT TO APPEAL

Pursuant to § 14-408(a) of the Health Occupations Article, Dr. Ziscovici has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review must be filed within 30 days from the date this Final Decision and Order was sent to the Respondent. The petition for judicial review must be made as directed in the Maryland Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222, and Maryland Rules 7-201 *et seq.*

If Dr. Ziscovici petitions for judicial review, the Board is a party and should be served with the court's process. In addition, Dr. Ziscovici should send a copy of his petition for judicial review to the Board's counsel, David Wagner, Assistant Attorney General, Office of the

Attorney General, 300 W. Preston Street, Suite 302, Baltimore, Maryland 21201. The administrative prosecutor is not involved in the circuit court process and does not need to be served or copied on pleadings filed in circuit court.