March 11, 2015 Minutes

South Dakota Board of Medical & Osteopathic Examiners – Public Board Meeting

Board Members Present:	Kevin Bjordahl, MD; Ms. Deb Bowman; Walter Carlson, MD; Mary Carpenter, MD; David Erickson, MD; Laurie Landeen, MD; Brent Lindbloom, DO; Mr. David Lust
Board Members Absent:	Jeffrey Murray, MD
Board Staff Present:	Margaret Hansen, PA-C; Mr. Tyler Klatt; Ms. Misty Rallis; Ms. Jane Phalen
Counsel Present:	Steven Blair, Board counsel William Golden, Staff counsel Roxanne Giedd

Dr. Mary Carpenter, President of the Board, called the public meeting to order at 9:00 am. Roll was called, a quorum was established. Dr. Carpenter welcomed Mr. David Lust as the newly appointed public member to the Board, and congratulated Dr. Walter Carlson, Dr. Brent Lindbloom and Dr. Jeffrey Murray on their re-appointment to the Board.

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS
PUBLIC HEARING ON PROPOSED ADMINISTRATIVE RULES
9:00 am

The purpose of the meeting was to conduct a public hearing on the proposed rules of the Board numbered: 20:78:07; 20:47:08; 20:78:05:09; 20:78:05:10; 20:63:04; 20:82 01; 20:82:02; 20:82:03; 20:83:01; 20:83:02; 20:83:03; 20:64:05; 20:52:02; 20:66:02; and 20:70:03.

Hearing Officer: Steven Blair, South Dakota Office of the Attorney General, Pierre South Dakota

Members of the Board in Attendance: Kevin Bjordahl, MD; Ms. Deb Bowman; Walter Carlson, MD; Mary Carpenter, MD; David Erickson, MD; Laurie Landeen, MD; Brent Lindbloom, DO; Mr. David Lust

Members of the Board Absent: Jeffrey Murray, MD

Others in Attendance: Margaret Hansen, William Golden, Roxanne Giedd, Tyler Klatt, Misty Rallis, Jane Phalen, Mark East, SDSMA; Jonathan Ellis, Argus Leader; Dr. Lars Aanning; Dayna Semchenko, PA;

Public Notices: Notice of this public hearing was published in the Rapid City Journal, Rapid City, South Dakota; Aberdeen News, Aberdeen, South Dakota; Argus Leader, Sioux Falls, South Dakota; and notice was available electronically on the State of South Dakota Administrative Rules website “Rules.SD.Gov” and the South Dakota Board of Medical and Osteopathic Examiners website “sdbmoe.gov”.

Call to Order: The hearing officer, Steven Blair, called the public hearing to order at 9:00 am. Roll was called resulting in a quorum. The first order of business was in regard to proposed rule ARSD 20:47:07 to add section “01” and “02” intended to provide recommendations for best practices for prescribers to follow when prescribing opioids and documenting the treatment of pain with opioids.

Mr. Blair informed the Board that written testimony opposing ARSD 20:47:07:01, and 02 had been received from Dr. Stephen Eckrich, Dr. Steven Giuseffi, Dr. Mike Elliott, Mr. Mary Milroy, and Dr. Michael Puumala. Discussion was held that this proposed rule should clarify the definition of “pain” as “chronic pain”, and should provide recommendations to prescribers regarding expectations for treating chronic pain with opioids. There being no further discussion, a motion by Dr. Carpenter to table ARSD 20:47:07 in order to continue working on this proposed rule was duly seconded and unanimously approved.

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The hearing examiner then opened the hearing to accept all written testimony into the record. Mr. Tyler Klatt presented four (4) letters and seventeen (17) electronic messages which were received by the executive secretary of the Board prior to the posting deadline. These letters and messages were received from the following: Dr. Mary Milroy, President, South Dakota State Medical Association (Sioux Falls); Dr. James Madara, American Medical Association (letter provided by Dr. Mary Milroy); Dr. Mike Elliott, Senior Vice President Medical Affairs/CMO, Avera McKennan Hospital and University Health Center (Sioux Falls); Dr. Henry Travers (Sioux Falls); Dr. Michael Puumala (Sioux Falls); Dr. Stephen Eckrich (Rapid City); Dr. Steven Giuseffi (Rapid City); Dr. Thomas Benzoni (Urbandale, Iowa); Carinna Fehlman (Ashton, SD); Diane Marshall (Sioux Falls); Donna Riley (Rapid City); Elizabeth Phillips (Rapid City); Georgia Larson (Sioux Falls); Helen Nichols (Rapid City); Hope Witte (Hot Springs); Kibbi Conti (Rapid City); Kim Hepper (Spearfish); Lisa Stark (Sioux Falls); Michele Sturdevant (Sioux Falls); Rene Brand (Rapid City); Shelly Brandenburger (Brookings).

The hearing officer then called for any additional written testimony. Mr. Klatt presented two (2) electronic messages from April Sorensen (Faulkton) and Debra Brakke (Pierre). These comments were received by the executive secretary after the posting deadline. With the receipt of the electronic messages the written testimony portion of the rules hearing was concluded.

The hearing examiner introduced each proposed rule and opened the hearing for oral and written testimony.

ARSD 20:47:08:01,02,03 – Physicians: establish a code of ethics. There was no supporting or opposing oral testimony. Supporting written testimony was received from Dr. Mary Milroy. A motion by Dr. Erickson to approve ARSD 20:47:08:01, 02, and 03 was duly seconded and unanimously approved.

ARSD 20:78:09,10 - Board member: conflict of interest. There was no supporting or opposing written testimony. Dr. Lars Aanning (Yankton) presented opposing oral testimony. Dr. Aanning strongly recommended that the Board adopt a more transparent way of identifying Board members on its website. He presented an exhibit showing that the Minnesota Board of Medical Practice website provides a picture of each Board member, a biography listing each Board member's education, employment, all committee and board appointments, all business and advocacy memberships, and provide the dates of the Board member's current term. Dr. Aanning recommended that the South Dakota Board of Medical and Osteopathic Examiners provide this same information in a similar format on its website for the public's information. Ms. Giedd informed the Board members that these particular conflict of interest rules are being adopted by a number of different boards to provide the Board members with some guidance in a situation when a conflict of interest does or does not exist. The ultimate goal is to provide notification to parties that appear before the Board of the possibility that there might be a potential conflict. It would then be up to the parties to decide whether a conflict exists, and whether or not the parties wish to object to a Board member's participation. A motion by Dr. Lindbloom to approve ARSD 20:47:09, and 10 was duly seconded and unanimously approved.

ARSD 20:63:04 – Athletic Trainers: establish a code ethics. There was no supporting or opposing written testimony. There was no supporting or opposing oral testimony. A motion by Dr. Landeen to approve ARSD 20:63:04 was duly seconded and unanimously approved.

ARSD 20:82:01,02,03 – Genetic Counselors: definitions, licensure requirements and establish a code of ethics. There was no supporting or opposing written testimony. There was no supporting or opposing oral testimony. A motion by Ms. Bowman to approve ARSD 20:82:01,02, and 03 was duly seconded and unanimously approved.

ARSD 20:83:01,02,03 – Licensed Nutritionists and Dietitians: definitions, licensure requirements, and establish a code of ethics. Supporting written testimony was received from Georgia Larson, Hope Witte, Lisa Stark, Diane Marshall, Rene Brand, Michele Sturdevant, Kim Hepper, Kibbe Conti, Carinna Fehlman, Elizabeth Phillips, Helen Nichols, Donna Riley, Rebecca Dorsett, Stella Watson, Doug Brakke and April Sorenson. Additional written testimony was received from Shelly Brandenburger who asked that the Board consider the inclusion of the Academy of Nutrition and Dietetics (AND) Code of Ethics into the proposed rule. Mr. Klatt explained that due to a name change from the American Dietetic Association to the Academy of Nutrition and Dietetics (AND) there has been some confusion about the citation and reference in the

proposed rule; however, it is the same code of ethics regardless of the name change. Ms. Hansen informed the Board that all parties who submitted comments would receive a response from the Board staff with information and explanations about the results of the rules hearing. A motion by Dr. Landeen to approve ARSD 20:83:01,02, and 03 was duly seconded and unanimously approved.

ARSD 20:64:05 – Occupational Therapists: establish a code of ethics. There was no supporting or opposing written testimony. There was no supporting or opposing oral testimony. A motion by Ms. Bowman to approve ARSD 20:64:05 was duly seconded and unanimously approved.

ARSD 20:52:02 – Physician Assistants: establish a code of ethics. There was no supporting or opposing oral testimony. There was no supporting written testimony. There was opposing written testimony from Dr. Thomas Benzoni and Dr. Henry Travers. The Board members identified several public comments that had merit and needed to be incorporated into the rule. The hearing examiner continued the hearing on ARSD 20:52:02 to allow the staff to make the identified changes to ARSD 20:52:02, and the Board would then consider the amended rule at the end of the rules hearing.

ARSD 20:70:03 – Respiratory Care Practitioners: establish a code of ethics. There was no supporting or opposing oral testimony. There was no supporting or opposing written testimony. A motion by Dr. Erickson to approve ARSD 20:66:02 was duly seconded and unanimously approved.

ARSD 20:66:02 - Physical Therapists: establish a code of ethics. There was no supporting or opposing oral testimony. There was no supporting written testimony. There was opposing testimony from Dr. Henry Travers and this was presented to the Board. After review, Mr. Golden explained that the physical therapists advisory committee recommended their national organization's version of the code of ethics with the accompanying annotations including their language, guidance, and core values which are referenced in the rule. After discussion regarding Dr. Traver's suggestions, Dr. Landeen moved to approve ARSD 20:66:02 as written, and to reply to Dr. Travers thanking him for his suggestions, and explaining the rationale and reasoning for the Board approving the rule as originally written. The motion was duly seconded and unanimously approved.

The hearing officer then called for return to discussion regarding 20:52:02 which was amended by staff at the instruction of the Board. The following changes were proposed to ARSD 20:52:02: 1) Nondiscrimination section: "Physician assistants ~~must~~ should not discriminate against classes or categories of patients in the delivery of needed health care"; 2) Initiation and Discontinuation of Care section: "If the patient decides to terminate the relationship, they are entitled to ~~access appropriate information contained within~~ a copy of their medical record"; 3) Reproductive Decision Making section: Physician Assistant Dayna Semchenko was present and provided testimony that physician assistants do not have concerns with this section of the proposed rule being referred to as "reproductive decision-making" as this language is directly from the AAPAs Code of Ethics. The Board then reviewed the changes as follows: "When the PA's personal values conflict with providing full disclosure or providing certain services, the PA need not become involved in that aspect of the patient's care~~. By referring the~~, but must refer the patient to a qualified provider ~~who is willing~~ to discuss and facilitate all treatment options. ~~the PA fulfills their ethical obligation to ensure the patient's access to all legal options".~~ There being no further discussion, Mr. Lust moved to amend the rules as proposed by staff. The motion was duly seconded and unanimously approved. Ms. Bowman moved to approve 20:52:02 as amended, and this motion was duly seconded and unanimously approved.

At 11:00 am, there being no further questions or comments from the Board members, Dr. Carlson moved that the public hearing for the proposed administrative rules 20:47:08; 20:78:05:09; 20:78:05:10; 20:63:04; 20:82 01; 20:82:02; 20:82:03; 20:83:01; 20:83:02; 20:83:03; 20:64:05; 20:52:02; 20:66:02; and 20:70:03 be concluded. The motion was duly seconded and unanimously approved.

Anyone wishing to obtain a copy of the minutes of the Public Hearing, a copy of the above referenced electronic communications or the letters, or a notice of Board meetings may call (605) 367-7781, email to SDBMOE@state.sd.us, or write to the South Dakota Board of Medical and Osteopathic Examiners, 101 N. Main Ave., Suite 301, Sioux Falls, South Dakota, 57104.

Dr. Carpenter called the regular public Board meeting to order at 11:00 am.

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The staff presented a petition to vacate the Declaratory Ruling ARSD 44:20:04:0:1 “Universal Precautions” which was adopted September 21, 1994. The Department of Health required all health professionals to comply with the universal precautions of the CDC pursuant to ARSD 44:20:04:01. The ruling was then repealed in December 2004. There was no supporting or opposing written or oral testimony. A motion to approve the petition to vacate Declaratory Ruling: ARSD 44:20:04:0: “Universal Precautions” was ratified by the Board (Bjordahl/unanimous).

The executive director provided an update on Senate Bill 63 announcing that the Interstate Medical Licensure Compact was passed by the South Dakota legislature, and that the bill will be signed by Governor Daugaard on March 30, 2015.

Maria Eining and Amanda McKnelly, Midwest Health Management Services (HPAP), met with the Board. Ms. Eining presented the financial report for information purposes. She then explained that their utilization continues to increase and she is seeing more voluntary and early interventions by professionals without Board mandated participation. The last item presented was that the contract with the Board is automatically renewable for a period of up to seven years unless any of the parties request changes. Midwest Health and the South Dakota Board of Nursing have not requested changes. The Board of Medicine had no changes to the contract and it was automatically renewed. The Board then requested that Ms. Eining need only appear in person at the Board meetings in September and March, and that she may just provide her report for the other Board meetings. They requested that her report provide additional information including a breakdown of the numbers and professions of the parties using HPAP, whether they are using the program for addiction, depression, or both, and how many use the program for behavioral health.

A motion to approve the minutes from the December 4, 2014, meeting was ratified by the Board (Carlson/unanimous).

The executive director presented the executive summary and the financial report which was accepted for information.

A motion to approve the new licenses, permits, certificates, and registrations issued from December 1, 2014, through February 28, 2015, was ratified by the Board (Carlson/unanimous).

The Board directed the staff to prepare and present white papers and reports at the June 11th Board meeting on the following topics: Board Certification requirements in other states, other state requirements for malpractice and malpractice insurance, physician continuing education requirements in other states, felony convictions and effect on licensure, Fishman book, and national standards for Board funds.

A motion to enter executive session at 11:45 am was ratified by the Board (Lindbloom/unanimous).

The public meeting resumed at 1:00 pm.

Advisory Committee Business:

The Board reviewed a slate of nominees for appointments and re-appointments as listed below:

New Committee member nominations:

Daniel Wagner, AT – new member of the Athletic Trainer Advisory Committee to fill the vacancy left by Josh Ellis, AT

Justin Thurman, PA – new member of the Physician Assistant Advisory Committee to fill the vacancy left by Dan Palmer, PA

Committee member nominations for re-appointment:

Mary Beth Zwart, AT – Athletic Trainer Advisory Committee – 2nd term

Robert Brockevelt, PT – Physical Therapy Advisory Committee – 2nd term

A motion to approve the slate of nominations for advisory committee appointments and re-appointments was ratified by the Board (Landeen/unanimous).

Dr. Carlson provided two articles regarding expansion of roles of certified nurse practitioners and advanced practice nurses in Michigan for information purposes.

Confidential Physician Hearings (Closed Session pursuant to SDCL 36-4-31.5 unless privilege is waived by physician). Board members assigned to a case do not deliberate or vote in that case (ARSD 27:78:05:05)

The physicians did not waive privilege so the Board entered a closed session pursuant to SDCL 36-4-31.5 *Evidence in cancellation, revocation, suspension, or limitation proceedings confidential. Testimony of a witness or documentary evidence of any kind on cancellation, revocation, suspension, or limitation proceedings are not subject to discovery or disclosure under chapter 15-6 or any other provision of law, and are not admissible as evidence in any action of any kind in any court or arbitration forum, except as hereinafter provided. No person in attendance at any hearing of the Board of Examiners considering cancellation, revocation, suspension, or limitation of a license, resident license, or certificate issued by it may be required to testify as to what transpired at such meeting. The prohibition relating to discovery of evidence does not apply to deny a physician access to or use of information upon which a decision regarding the physician's staff privileges was based. The prohibition relating to discovery of evidence does not apply to any person or the person's counsel in the defense of an action against the person's access to the materials covered under this section.* ***Source:*** *SL 1985, ch 297, § 21; SL 2009, ch 178, § 13; SL 2013, ch 172, § 14.*

Dr. James H. Oury (applicant for medical license). Dr. Oury appeared before the Board with his attorney Mr. Patrick Ginsbach. A motion by Mr. Lust to amend the proposed recommendations of the administrative hearing judge: Finding of Fact #1: issue the reprimand; Finding of Fact #2: modified to require Dr. Oury to complete a fitness to practice evaluation at an entity approved in advance by the Board within 6 months (September 11, 2015), release the findings of the evaluation to the Board, and appear before the Board if he wishes to request consideration for issuance of a conditioned license which would include Finding of Fact #3 that he could only practice under supervision of a licensed and practicing South Dakota licensed physician, and he must refrain from performing surgical procedures for a period of one year, or until the supervising physician deems that the supervision is no longer necessary, or in the alternative, deny the issuance of the license if the requirements are not fulfilled prior to September 11, 2015. The motion was approved by unanimous vote. The assigned Board member, Dr. Carlson, did not participate in the discussion, deliberation, or vote.

Dr. Christiana M. Lietzke (applicant for medical license). Dr. Lietzke did not appear before the Board. A motion to accept the administrative hearing judge's recommendation failed due to lack of a second. A motion by Mr. Lust to amend the proposed recommendation of the administrative hearing judge: Finding of Fact #8: modified to set the time frame of 6 months for Dr. Lietzke to complete a fitness to practice evaluation at an entity approved in advance by the Board within 6 months (September 11, 2015), release the findings of the evaluation to the Board, and appear before the Board if she wishes to request consideration for issuance of a conditioned license. The motion was approved by unanimous vote. The assigned Board member, Dr. Landeen, did not participate in the discussion, deliberation, or vote.

Public Hearings: Board members assigned to a case do not deliberate or vote in that case (ARSD 27:78:05:05)

David R. Starner (applicant for reinstatement and renewal of paramedic license). Mr. Starner did not appear before the Board. Mr. Starner's attorney, Mr. David Kroon, emailed the objections to the administrative judge's Findings of Fact and Conclusions of Law the day before the Board meeting at 4:30 pm. The objections were printed and provided to the Board members prior to discussion. A motion to accept the Findings of Fact, Conclusions of Law, and Recommendation of the administrative judge to deny the reinstatement and renewal of the paramedic license was approved (Erickson/unanimous). The assigned Board member, Dr. Carlson, did not participate in the discussion, deliberation, or vote.

The Executive Director Report was presented and included the following information: Monthly statistical reports for December 2014, January and February 2015; the Article about the Interstate Medical Licensure Compact that was published in SDSMA's *South Dakota Medicine*; the FSMB Strategic Planning Special Committee review for state board comment, Ms. Hansen will be a faculty presenter for the FSMB Annual Meeting will be in Ft. Worth, Texas, April 23 to 26, 2015, a reminder that the election of Board officers will be held at the June Board meeting and information on contested case process, administrative hearings and Board member case assignments.

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A motion to enter executive session pursuant to SDCL 1-25-2(1) and (3) to consult with legal counsel and discuss personnel issues was ratified by the Board (Lindbloom/unanimous). The meeting adjourned at 3:35 pm.

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March 11, 2015 Minutes

South Dakota Board of Medical & Osteopathic Examiners – Public Board Meeting

Board Members Present:	Kevin Bjordahl, MD; Ms. Deb Bowman; Walter Carlson, MD; Mary Carpenter, MD; David Erickson, MD; Laurie Landeen, MD; Brent Lindbloom, DO; Mr. David Lust
Board Members Absent:	Jeffrey Murray, MD
Board Staff Present:	Margaret Hansen, PA-C; Mr. Tyler Klatt; Ms. Misty Rallis; Ms. Jane Phalen
Counsel Present:	Steven Blair, Board counsel William Golden, Staff counsel Roxanne Giedd

Dr. Mary Carpenter, President of the Board, called the public meeting to order at 9:00 am. Roll was called, a quorum was established. Dr. Carpenter welcomed Mr. David Lust as the newly appointed public member to the Board, and congratulated Dr. Walter Carlson, Dr. Brent Lindbloom and Dr. Jeffrey Murray on their re-appointment to the Board.

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS
PUBLIC HEARING ON PROPOSED ADMINISTRATIVE RULES
9:00 am

The purpose of the meeting was to conduct a public hearing on the proposed rules of the Board numbered: 20:78:07; 20:47:08; 20:78:05:09; 20:78:05:10; 20:63:04; 20:82 01; 20:82:02; 20:82:03; 20:83:01; 20:83:02; 20:83:03; 20:64:05; 20:52:02; 20:66:02; and 20:70:03.

Hearing Officer: Steven Blair, South Dakota Office of the Attorney General, Pierre South Dakota

Members of the Board in Attendance: Kevin Bjordahl, MD; Ms. Deb Bowman; Walter Carlson, MD; Mary Carpenter, MD; David Erickson, MD; Laurie Landeen, MD; Brent Lindbloom, DO; Mr. David Lust

Members of the Board Absent: Jeffrey Murray, MD

Others in Attendance: Margaret Hansen, William Golden, Roxanne Giedd, Tyler Klatt, Misty Rallis, Jane Phalen, Mark East, SDSMA; Jonathan Ellis, Argus Leader; Dr. Lars Aanning; Dayna Semchenko, PA;

Public Notices: Notice of this public hearing was published in the Rapid City Journal, Rapid City, South Dakota; Aberdeen News, Aberdeen, South Dakota; Argus Leader, Sioux Falls, South Dakota; and notice was available electronically on the State of South Dakota Administrative Rules website “Rules.SD.Gov” and the South Dakota Board of Medical and Osteopathic Examiners website “sdbmoe.gov”.

Call to Order: The hearing officer, Steven Blair, called the public hearing to order at 9:00 am. Roll was called resulting in a quorum. The first order of business was in regard to proposed rule ARSD 20:47:07 to add section “01” and “02” intended to provide recommendations for best practices for prescribers to follow when prescribing opioids and documenting the treatment of pain with opioids.

Mr. Blair informed the Board that written testimony opposing ARSD 20:47:07:01, and 02 had been received from Dr. Stephen Eckrich, Dr. Steven Giuseffi, Dr. Mike Elliott, Dr. Mary Milroy, and Dr. Michael Puumala. Discussion was held that this proposed rule should clarify the definition of “pain” as “chronic pain”, and should provide recommendations to prescribers regarding expectations for treating chronic pain with opioids. There being no further discussion, a motion by Dr. Carpenter to table ARSD 20:47:07 in order to continue working on this proposed rule was duly seconded and unanimously approved.

The hearing examiner then opened the hearing to accept all written testimony into the record. Mr. Tyler Klatt presented four (4) letters and seventeen (17) electronic messages which were received by the executive secretary of the Board prior to the posting deadline. These letters and messages were received from the following: Dr. Mary Milroy, President, South Dakota State Medical Association (Sioux Falls); Dr. James Madara, American Medical Association (letter provided by Dr. Mary Milroy); Dr. Mike Elliott, Senior Vice President Medical Affairs/CMO, Avera McKennan Hospital and University Health Center (Sioux Falls); Dr. Henry Travers (Sioux Falls); Dr. Michael Puumala (Sioux Falls); Dr. Stephen Eckrich (Rapid City); Dr. Steven Giuseffi (Rapid City); Dr. Thomas Benzoni (Urbandale, Iowa); Carinna Fehlman (Ashton, SD); Diane Marshall (Sioux Falls); Donna Riley (Rapid City); Elizabeth Phillips (Rapid City); Georgia Larson (Sioux Falls); Helen Nichols (Rapid City); Hope Witte (Hot Springs); Kibbi Conti (Rapid City); Kim Hepper (Spearfish); Lisa Stark (Sioux Falls); Michele Sturdevant (Sioux Falls); Rene Brand (Rapid City); Shelly Brandenburger (Brookings).

The hearing officer then called for any additional written testimony. Mr. Klatt presented two (2) electronic messages from April Sorensen (Faulkton) and Debra Brakke (Pierre). These comments were received by the executive secretary after the posting deadline. With the receipt of the electronic messages the written testimony portion of the rules hearing was concluded.

The hearing examiner introduced each proposed rule and opened the hearing for oral and written testimony.

ARSD 20:47:08:01,02,03 – Physicians: establish a code of ethics. There was no supporting or opposing oral testimony. Supporting written testimony was received from Dr. Mary Milroy. A motion by Dr. Erickson to approve ARSD 20:47:08:01, 02, and 03 was duly seconded and unanimously approved.

ARSD 20:78:09,10 - Board member: conflict of interest. There was no supporting or opposing written testimony. Dr. Lars Aanning (Yankton) presented opposing oral testimony. Dr. Aanning strongly recommended that the Board adopt a more transparent way of identifying Board members on its website. He presented an exhibit showing that the Minnesota Board of Medical Practice website provides a picture of each Board member, a biography listing each Board member's education, employment, all committee and board appointments, all business and advocacy memberships, and provides the dates of the Board member's current term. Dr. Aanning recommended that the South Dakota Board of Medical and Osteopathic Examiners provide this same information in a similar format on its website for the public's information. Ms. Giedd informed the Board members that these particular conflict of interest rules are being adopted by a number of different boards to provide the Board members with some guidance in a situation when a conflict of interest does or does not exist. The ultimate goal is to provide notification to parties that appear before the Board of the possibility that there might be a potential conflict. It would then be up to the parties to decide whether a conflict exists, and whether or not the parties wish to object to a Board member's participation. A motion by Dr. Lindbloom to approve ARSD 20:47:09, and 10 was duly seconded and unanimously approved.

ARSD 20:63:04 – Athletic Trainers: establish a code ethics. There was no supporting or opposing written testimony. There was no supporting or opposing oral testimony. A motion by Dr. Landeen to approve ARSD 20:63:04 was duly seconded and unanimously approved.

ARSD 20:82:01,02,03 – Genetic Counselors: definitions, licensure requirements and establish a code of ethics. There was no supporting or opposing written testimony. There was no supporting or opposing oral testimony. A motion by Ms. Bowman to approve ARSD 20:82:01,02, and 03 was duly seconded and unanimously approved.

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proposed rule; however, it is the same code of ethics regardless of the name change. Ms. Hansen informed the Board that all parties who submitted comments would receive a response from the Board staff with information and explanations about the results of the rules hearing. A motion by Dr. Landeen to approve ARSD 20:83:01,02, and 03 was duly seconded and unanimously approved.

ARSD 20:64:05 – Occupational Therapists: establish a code of ethics. There was no supporting or opposing written testimony. There was no supporting or opposing oral testimony. A motion by Ms. Bowman to approve ARSD 20:64:05 was duly seconded and unanimously approved.

ARSD 20:52:02 – Physician Assistants: establish a code of ethics. There was no supporting or opposing oral testimony. There was no supporting written testimony. There was opposing written testimony from Dr. Thomas Benzoni and Dr. Henry Travers. The Board members identified several public comments that had merit and needed to be incorporated into the rule. The hearing examiner continued the hearing on ARSD 20:52:02 to allow the staff to make the identified changes to ARSD 20:52:02, and the Board would then consider the amended rule at the end of the rules hearing.

ARSD 20:70:03 – Respiratory Care Practitioners: establish a code of ethics. There was no supporting or opposing oral testimony. There was no supporting or opposing written testimony. A motion by Dr. Erickson to approve ARSD 20:66:02 was duly seconded and unanimously approved.

ARSD 20:66:02 - Physical Therapists: establish a code of ethics. There was no supporting or opposing oral testimony. There was no supporting written testimony. There was opposing written testimony from Dr. Henry Travers and this was presented to the Board. After review, Mr. Golden explained that the physical therapists advisory committee recommended their national organization's version of the code of ethics with the accompanying annotations including their language, guidance, and core values which are referenced in the rule. After discussion regarding Dr. Traver's suggestions, Dr. Landeen moved to approve ARSD 20:66:02 as written, and to reply to Dr. Travers thanking him for his suggestions, and explaining the rationale and reasoning for the Board approving the rule as originally written. The motion was duly seconded and unanimously approved.
The hearing officer then called for return to discussion regarding 20:52:02 which was amended by staff at the instruction of the Board. The following changes were proposed to ARSD 20:52:02: 1) Nondiscrimination section: "Physician assistants ~~must~~ should not discriminate against classes or categories of patients in the delivery of needed health care"; 2) Initiation and Discontinuation of Care section: "If the patient decides to terminate the relationship, they are entitled to ~~access appropriate information contained within~~ a copy of their medical record"; 3) Reproductive Decision Making section: Physician Assistant Dayna Semchenko was present and provided testimony that physician assistants do not have concerns with this section of the proposed rule being referred to as "reproductive decision-making" as this language is directly from the AAPAs Code of Ethics. The Board then reviewed the changes as follows: "When the PA's personal values conflict with providing full disclosure or providing certain services, the PA need not become involved in that aspect of the patient's care~~. By referring the~~, but must refer the patient to a qualified provider ~~who is willing~~ to discuss and facilitate all treatment options. ~~the PA fulfills their ethical obligation to ensure the patient's access to all legal options".~~ There being no further discussion, Mr. Lust moved to amend the rules as proposed by staff. The motion was duly seconded and unanimously approved. Ms. Bowman moved to approve 20:52:02 as amended, and this motion was duly seconded and unanimously approved.

At 11:00 am, there being no further questions or comments from the Board members, Dr. Carlson moved that the public hearing for the proposed administrative rules 20:47:08; 20:78:05:09; 20:78:05:10; 20:63:04; 20:82 01; 20:82:02; 20:82:03; 20:83:01; 20:83:02; 20:83:03; 20:64:05; 20:52:02; 20:66:02; and 20:70:03 be concluded. The motion was duly seconded and unanimously approved.

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The staff presented a petition to vacate the Declaratory Ruling ARSD 44:20:04:0:1 “Universal Precautions” which was adopted September 21, 1994. The Department of Health required all health professionals to comply with the universal precautions of the CDC pursuant to ARSD 44:20:04:01. The ruling was then repealed in December 2004. There was no supporting or opposing written or oral testimony. A motion to approve the petition to vacate Declaratory Ruling: ARSD 44:20:04:0: “Universal Precautions” was ratified by the Board (Bjordahl/unanimous).

The executive director provided an update on Senate Bill 63 announcing that the Interstate Medical Licensure Compact was passed by the South Dakota legislature, and that the bill will be signed by Governor Daugaard on March 30, 2015.

Maria Eining and Amanda McKnelly, Midwest Health Management Services (HPAP), met with the Board. Ms. Eining presented the financial report for information purposes. She then explained that their utilization continues to increase and she is seeing more voluntary and early interventions by professionals without Board mandated participation. The last item presented was that the contract with the Board is automatically renewable for a period of up to seven years unless any of the parties request changes. Midwest Health and the South Dakota Board of Nursing have not requested changes. The Board of Medicine had no changes to the contract and it was automatically renewed. The Board then requested that Ms. Eining need only appear in person at the Board meetings in September and March, and that she may just provide her report for the other Board meetings. They requested that her report provide additional information including a breakdown of the numbers and professions of the parties using HPAP, whether they are using the program for addiction, depression, or both, and how many use the program for behavioral health.

A motion to approve the minutes from the December 4, 2014, meeting was ratified by the Board (Carlson/unanimous).

The executive director presented the executive summary and the financial report which was accepted for information.

A motion to approve the new licenses, permits, certificates, and registrations issued from December 1, 2014, through February 28, 2015, was ratified by the Board (Carlson/unanimous).

The Board directed the staff to prepare and present white papers and reports at the June 11th Board meeting on the following topics: Board Certification requirements in other states, other state requirements for malpractice and malpractice insurance, physician continuing education requirements in other states, felony convictions and effect on licensure, Fishman book, and national standards for Board funds.

A motion to enter executive session at 11:45 am was ratified by the Board (Lindbloom/unanimous).

The public meeting resumed at 1:00 pm.

Advisory Committee Business:

The Board reviewed a slate of nominees for appointments and re-appointments as listed below:

New Committee member nominations:

Daniel Wagner, AT – new member of the Athletic Trainer Advisory Committee to fill the vacancy left by Josh Ellis, AT

Justin Thurman, PA – new member of the Physician Assistant Advisory Committee to fill the vacancy left by Dan Palmer, PA

Committee member nominations for re-appointment:

Mary Beth Zwart, AT – Athletic Trainer Advisory Committee – 2nd term

Robert Brockevelt, PT – Physical Therapy Advisory Committee – 2nd term

A motion to approve the slate of nominations for advisory committee appointments and re-appointments was ratified by the Board (Landeen/unanimous).

Dr. Carlson provided two articles regarding expansion of roles of certified nurse practitioners and advanced practice nurses in Michigan for information purposes.

Confidential Physician Hearings (Closed Session pursuant to SDCL 36-4-31.5 unless privilege is waived by physician). Board members assigned to a case do not deliberate or vote in that case (ARSD 27:78:05:05)

The physicians did not waive privilege so the Board entered a closed session pursuant to SDCL 36-4-31.5 *Evidence in cancellation, revocation, suspension, or limitation proceedings confidential. Testimony of a witness or documentary evidence of any kind on cancellation, revocation, suspension, or limitation proceedings are not subject to discovery or disclosure under chapter 15-6 or any other provision of law, and are not admissible as evidence in any action of any kind in any court or arbitration forum, except as hereinafter provided. No person in attendance at any hearing of the Board of Examiners considering cancellation, revocation, suspension, or limitation of a license, resident license, or certificate issued by it may be required to testify as to what transpired at such meeting. The prohibition relating to discovery of evidence does not apply to deny a physician access to or use of information upon which a decision regarding the physician's staff privileges was based. The prohibition relating to discovery of evidence does not apply to any person or the person's counsel in the defense of an action against the person's access to the materials covered under this section.* ***Source:*** *SL 1985, ch 297, § 21; SL 2009, ch 178, § 13; SL 2013, ch 172, § 14.*

Dr. James H. Oury (applicant for medical license). Dr. Oury appeared before the Board with his attorney Mr. Patrick Ginsbach. A motion by Mr. Lust to amend the proposed recommendations of the administrative hearing judge: Finding of Fact #1: issue the reprimand; Finding of Fact #2: modified to require Dr. Oury to complete a fitness to practice evaluation at an entity approved in advance by the Board within 6 months (September 11, 2015), release the findings of the evaluation to the Board, and appear before the Board if he wishes to request consideration for issuance of a conditioned license which would include Finding of Fact #3 that he could only practice under supervision of a licensed and practicing South Dakota licensed physician, and he must refrain from performing surgical procedures for a period of one year, or until the supervising physician deems that the supervision is no longer necessary, or in the alternative, deny the issuance of the license if the requirements are not fulfilled prior to September 11, 2015. The motion was approved by unanimous vote. The assigned Board member, Dr. Carlson, did not participate in the discussion, deliberation, or vote.

Dr. Christiana M. Lietzke (applicant for medical license). Dr. Lietzke did not appear before the Board. A motion to accept the administrative hearing judge's recommendation failed due to lack of a second. A motion by Mr. Lust to amend the proposed recommendation of the administrative hearing judge: Finding of Fact #8: modified to set the time frame of 6 months for Dr. Lietzke to complete a fitness to practice evaluation at an entity approved in advance by the Board within 6 months (September 11, 2015), release the findings of the evaluation to the Board, and appear before the Board if she wishes to request consideration for issuance of a conditioned license. The motion was approved by unanimous vote. The assigned Board member, Dr. Landeen, did not participate in the discussion, deliberation, or vote.

Public Hearings: Board members assigned to a case do not deliberate or vote in that case (ARSD 27:78:05:05)

David R. Starner (applicant for reinstatement and renewal of paramedic license). Mr. Starner did not appear before the Board. Mr. Starner's attorney, Mr. David Kroon, emailed the objections to the administrative judge's Findings of Fact and Conclusions of Law the day before the Board meeting at 4:30 pm. The objections were printed and provided to the Board members prior to discussion. A motion to accept the Findings of Fact, Conclusions of Law, and Recommendation of the administrative judge to deny the reinstatement and renewal of the paramedic license was approved (Erickson/unanimous). The assigned Board member, Dr. Carlson, did not participate in the discussion, deliberation, or vote.

The Executive Director Report was presented and included the following information: Monthly statistical reports for December 2014, January and February 2015; the Article about the Interstate Medical Licensure Compact that was published in SDSMA's *South Dakota Medicine*; the FSMB Strategic Planning Special Committee review for state board comment, Ms. Hansen will be a faculty presenter for the FSMB Annual Meeting will be in Ft. Worth, Texas, April 23 to 26, 2015, a reminder that the election of Board officers will be held at the June Board meeting and information on contested case process, administrative hearings and Board member case assignments.

A motion to enter executive session pursuant to SDCL 1-25-2(1) and (3) to consult with legal counsel and discuss personnel issues was ratified by the Board (Lindbloom/unanimous). The meeting adjourned at 3:35 pm.

EXECUTIVE SUMMARY FINANCIAL REPORT

TO: THE BOARD OF MEDICAL AND OSTEOPATHIC EXMINERS
FROM: MARGARET B HANSEN
DATE: MAY 13, 2015

1. The Board has three different locations of cash on hand (page 2)

- Petty Cash
- Local Checking
- State Treasury Fund

		FY15	FY14	FY13
		04/30/2015	*06/30/2014*	*06/30/2013*
Total Cash		3,093,365	2,656,838	2,303,882

2. Upcoming Anticipated Expenses and Reserve Funds (page 3)

- Total anticipated expenses and reserve funds.

		FY15
Total Anticipated Expenses and Reserve Funds		2,237,338

3. Revenue (page 5)

- Total revenue for licensing, services, and other sources by line detail on the report.

		FY15	FY14	FY13
		04/30/2015	*06/30/2014*	*06/30/2013*
Total Revenue		1,192,072.35	1,256,516.60	1,246,698.72

4. Income Statement – review of expense variances (Pages 6 – 7)

		FY15	FY15	FY14	FY14
		Budgeted	*04/30/2015*	Budgeted	*06/30/2014*
4-A	5102090 – Unemployment Insurance	42	122	42	99
4-B	5203280 - Other Public Out-of-state • HPAP billing is now being processed here which was previously processed through Other Contractual Services	100	171	100	150
4-C	5203300 - Lodging Out-Of-State • Hotel expenses for out of state meetings or training attended	500	1,250	500	3,653
4-D	5204160 - Workshop Registration Fees • Training classes for staff and meeting attendance fees	2,000	2,634	2,000	3,280
4-E	5204180 - State Computer Services • BIT maintenance expenses	9,359	14,809	9,359	15,734
4-F	5204200 – Central Services • DOH office expenses for items completed on our behalf or related to our office	3,531	4,349	3,531	3,709
4-G	5204530 - Telecommunication Services • Board Member Laptop wireless • Background Reports e.g. NPDB	3,000	8,892	3,000	15,418

4-H	5205320 - Duplication – Private • Printed pages from leased printers	300	5,895	300	1142
4-I	5205350 – Postage • Postage fees on all items mailed	11,000	13,609	11,000	11,557

5. Income Statement – Total Expenses - (page 7)
Shows total expenses and budget comparison.

	FY15	FY15	FY14	FY14	FY13	FY13
	Budgeted	*04/30/2015*	Budgeted	*06/30/2014*	Budgeted	*06/30/2013*
Total Expenses	1,011,493	778,861	988,618	924,257	966,606	752,398

6. Income Statement - Net Income - (page 7)
Shows earnings measured by taking total revenue and minus expenses.

	FY15	FY15	FY14	FY14	FY13	FY13
	Budgeted	*04/30/2015*	Budgeted	*06/30/2014*	Budgeted	*06/30/2013*
Net Income	174,257	413,212	210,382	332,259	209,394	494,300

7. Other Contractual Services Breakdown by service description (page 8)

	FY15	FY14	FY13
	04/30/2015	06/30/2014	06/30/2013
Total Other Contractual Services	36,751	60,868	52,060

SDBMOE Financial Report

05/13/2015

for
07/01/14 - 04/30/2015

Page	Report Name
2	Balance Sheet (Cash Only)
3	Upcoming Anticipated Expenses and Reserve Funds
4	Revenue Summary
6	Income Statement
8	Other Contractual Services

SDBMOE
Balance Sheet (Cash Only)

Date Range: July 1, 2014 - April 30, 2015

		FY15	FY14	FY13	FY12	FY11	FY10
		04/30/2015	*06/30/2014*	*06/30/2013*	*06/30/2012*	*06/30/2011*	*06/30/2010*
	Cash						
	Petty Cash	100	100	100	100	100	100
	Local Checking	2,034	3,598	2,930	4,223	4,712	4,313
	State Treasury Fund	3,091,232	2,653,139	2,300,852	1,810,978	1,370,641	1,149,460
1.	**Total Cash**	**3,093,365**	**2,656,838**	**2,303,882**	**1,815,301**	**1,375,452**	**1,153,873**

SDBMOE
Upcoming Anticipated Expenses and Reserve Funds

	Expense Items:		Anticipated Amount:
	Operating Expense Budget (with Salaries and Benefits)	$	1,011,493
	Technology Update:		
	Update Database - rework and implantation	$	415,000
	Technical Support for Board Members Technology	$	12,000
	Training Expenses (outside of budgeted amount in Operating Expenses)		
	Investigator Training	$	2,345
	Licensing Staff Training and Professional Certification	$	3,000
	Attorney Training	$	2,500
	Policy Training	$	1,000
	Sending 4 Board Members to the annual FSMB Meeting	$	10,000
	HPAP yearly support costs - projections for this year	$	200,000
	Scanning paper files to an electronic format	$	10,000
	Lawsuit reserve fund (for 3 large cases)	$	370,000
	Compact Licensing Funding	$	200,000
2.	**Total Anticipated Expenses**	**$**	**2,237,338**

SDBMOE
Revenue by Item Summary

Date Range: July 1, 2014 - April 30, 2015

Type	07/01/14 - 04/30/15 Amount	07/01/13 - 04/30/14 Amount	07/01/12 - 06/31/13 Amount
Licenses			
Athletic Trainer Application	$ 2,500.00	$ 3,000.00	$ 3,300.00
Athletic Trainer Reinstatement	$ -	$ -	$ 50.00
Athletic Trainer Renewal	$ 1,600.00	$ 9,500.00	$ 8,850.00
Advanced EMT for Instate Graduate	$ 1,300.00	$ 850.00	$ 700.00
Advanced EMT for out of state Graduate	$ 225.00	$ 225.00	
Advanced EMT Renewal	$ 275.00	$ 800.00	$ 450.00
Advanced EMT Reinstatement	$ 50.00	$ -	$ -
ALS-I 85 Application for Instate Graduate	$ 50.00	$ -	$ 200.00
ALS-I 85 Application for Out of State Graduate	$ 150.00	$ 75.00	$ 150.00
ALS-I 85 Renewal	$ 1,400.00	$ 3,625.00	$ 4,875.00
ALS-I 99 Application for Instate Graduate	$ -	$ -	$ -
ALS-I 99 Application for Out of State graduate	$ -	$ -	$ -
ALS-I 99 Renewal	$ 50.00	$ 225.00	$ 275.00
ALS-I 99 Reinstatement	$ -	$ -	$ 50.00
ALS-I85 Reinstatement	$ 100.00	$ 450.00	$ 350.00
ALS-Paramedic Application for Instate graduate	$ 950.00	$ 1,850.00	$ 2,100.00
ALS-Paramedic Application for Out of State Graduate	$ 3,150.00	$ 5,250.00	$ 2,475.00
ALS-Paramedic Renewal	$ 4,950.00	$ 11,100.00	$ 11,475.00
ALS-Paramedic Reinstatement	$ 450.00	$ 600.00	$ 500.00
Genetic Counselor Temporary Application	$ 100.00	$ 200.00	$ 100.00
Genetic Counselor Application	$ 2,800.00	$ 1,600.00	$ 1,200.00
Genetic Counselor Renewal	$ 300.00	$ 1,900.00	$ 800.00
Licensed Nutritionist Application	$ 1,190.00	$ 1,750.00	$ 2,240.00
Licensed Nutritionist Renewal	$ 420.00	$ 10,395.00	$ 10,290.00
Temporary License Nutritionist Application	$ 250.00	$ 250.00	$ 650.00
Licensed Nutritionist Reinstatement	$ 300.00	$ -	$ 100.00
Locum Tenens Application	$ 2,350.00	$ 2,550.00	$ 4,000.00
MD/DO Application	$ 51,600.00	$ 74,600.00	$ 76,800.00
MD/DO Reinstatement	$ 7,800.00	$ 6,600.00	$ 6,200.00
MD/DO-Renewals	$ 745,200.00	$ 729,400.00	$ 700,200.00
Medical Assistant Application	$ 630.00	$ 1,000.00	$ 900.00
Medical Assistant Renewal	$ 20.00	$ 2,720.00	$ 15.00
Medical Assistant Reinstatement	$ 40.00	$ 300.00	$ 30.00
Medical Corp Application	$ 650.00	$ 550.00	$ 300.00
Medical Corp Reinstatement	$ 700.00	$ 1,000.00	$ 650.00
Medical Corp Renewal	$ 15,900.00	$ 15,900.00	$ 17,100.00
Occupational Therapist Application	$ 1,550.00	$ 1,950.00	$ 2,200.00
Occupational Therapist Reinstatement	$ 75.00	$ 50.00	$ 75.00
Occupational Therapy Assistant Application	$ 900.00	$ 850.00	$ 1,050.00
Occupational Therapist Renewal	$ 21,200.00	$ 22,000.00	$ 22,000.00
Occupational Therapy Assistant Reinstatement	$ -	$ -	$ 50.00
Occupational Therapy Assistant Renewal	$ 7,200.00	$ 7,150.00	$ 7,100.00
Occupational Therapist Limited Permit	$ 25.00	$ 125.00	$ 50.00
Occupational Therapy Assistant Limited License	$ -	$ 75.00	$ 50.00
Physical Therapist Application	$ 4,020.00	$ 3,900.00	$ 4,630.00
Physical Therapist Renewal	$ 44,700.00	$ 43,900.00	$ 42,650.00
Physical Therapist Reinstatement	$ 500.00	$ 150.00	$ 100.00
Physical Therapist Assistant Application	$ 1,800.00	$ 1,980.00	$ 1,800.00
Physical Therapist Assistant Renewal	$ 12,050.00	$ 12,050.00	$ 11,550.00
Physical Therapist Assistant Reinstatement	$ -	$ 50.00	$ 50.00
Physician Assistant Corporation Application	$ -	$ -	$ -
Physician Assistant Corporation Renewal	$ 200.00	$ 200.00	$ 100.00
Physician Assistant Corporation Reinstatement	$ -	$ -	$ -
Physician Assistant Application	$ 3,000.00	$ 4,425.00	$ 4,275.00
Physician Assistant Temporary Permit	$ 50.00	$ 50.00	$ 150.00
Physician Assistant Reinstatement	$ 25.00	$ 125.00	$ 200.00
Physician Assistant Renewal	$ 55,000.00	$ 52,900.00	$ 50,500.00
Resident Certificate Application		$ -	$ 650.00
Resident License Application	$ 2,500.00	$ 3,800.00	$ 6,650.00
Resident License Renewal	$ 1,200.00	$ 3,650.00	$ -
Respiratory Care Practitioner Application	$ 1,050.00	$ 3,225.00	$ 3,375.00
Respiratory Care Temporary Application	$ 520.00	$ 520.00	$ 520.00
Respiratory Care Practitioner Renewal	$ 26,940.00	$ 60.00	$ 27,540.00
Respiratory Care Practitioner Reinstatement	$ 95.00	$ 95.00	$ 95.00
NSF Check Board Fine		$ -	$ -
USMLE Testing		$ 3,150.00	$ -
Other Income	$ 100.00	$ -	$ -

SDBMOE
Revenue by Item Summary

Date Range: July 1, 2014 - April 30, 2015

		07/01/14 - 04/30/15 Amount	07/01/13 - 04/30/14 Amount	07/01/12 - 06/31/13 Amount
Total Licenses		**$ 1,032,150.00**	**$ 1,054,695.00**	**$ 1,044,785.00**
Other				
Interest Income		$ 24,236.35	$ 30,177.73	$ 37,093.72
Fines & Penalties		$ -	$ -	$ -
Total Services		**$ 24,236.35**	**$ 30,177.73**	**$ 37,093.72**
Services				
Information Request		$ 30.00	$ 30.00	$ 90.00
Online Verifications		$ 104,076.00	$ 118,256.00	$ 119,495.00
Written Verifications		$ 31,010.00	$ 47,940.00	$ 42,810.00
Duplicate License Card		$ 570.00	$ 1,020.00	$ 1,325.00
Candian Service Fee (Skype Fee Charge)		$ -	$ (2.13)	$ -
Mailing List			$ 4,400.00	$ 1,100.00
Total Services		**$ 135,686.00**	**$ 171,643.87**	**$ 164,820.00**
Total	**3.**	**$ 1,192,072.35**	**$ 1,256,516.60**	**$ 1,246,698.72**

SDBMOE
Income Statement

Date Range: July 1, 2014 to April 30, 2015

		FY15 Budgeted	FY15 04/30/2015	% of Budget FY15	FY14 Budgeted	FY14 06/30/2014	% of Budget FY14	FY13 Budgeted	FY13 06/30/2013
Ordinary Income/Expense									
Income									
	License Fee Revenue	1,010,000	1,032,150	102%	1,012,000	1,054,695	104%	985,500	1,044,785
	Fines and Penalties	0	0	0%	0	0	0%	0	0
	Sales and Service Revenue	150,750	135,686	90%	152,000	171,644	113%	135,500	164,820
Total Income		**1,160,750**	**1,167,836**	**101%**	**1,164,000**	**1,226,339**	**105%**	**1,121,000**	**1,209,605**
Gross Profit		**1,160,750**	**1,167,836**	101%	**1,164,000**	**1,226,339**	105%	**1,121,000**	**1,209,605**
07/01/13 - 02/28/14									
	5101000 - Employee Salaries	288,154	271,523	94%	277,412	308,612	111%	266,986	267,036
	5101030 - Board & Community Member Fees	3,275	1,620	49%	3,154	2,520	80%	3,037	2,640
	5102010 - OASI	26,392	19,670	75%	24,207	22,796	94%	21,959	19,952
	5102020 - Retirement	16,133	16,044	99%	16,133	18,472	114%	16,133	16,022
	5102060 - Health Insurance	60,790	53,528	88%	50,963	70,193	138%	44,323	51,857
	5102080 - Worker's Compensation	889	217	24%	889	216	24%	889	322
4-A	5102090 - Unemployment Insurance	42	122	291%	42	99	235%	42	200
	5201030 - Board Member Per Diem			0%		0	0%	275	0
	5203010 - Auto - State owned - Instate		54						1,653
	5203030 - Auto - Private - Low Rate		988			423			241
	5203030 - Auto - Private - High Rate	2,000	278	14%	2,000	1,412	71%	2,000	530
	5203040 - Air-State owned-Instate	16,000	7,372	46%	16,000	8,473	53%	16,000	11,858
	5203060 - Air-Commercial Carrier Instate		5,565			582			
	5203070 - Air Travel - Charter Flights	30,000		0%	30,000	3,750	13%	30,000	
	5203100 - Lodging In-State	2,000	323	16%	2,000	697	35%	2,000	747
	5203120 - Incidentals-Travel Instate	50	32	64%	50	56	112%	50	
	5203130 - Nonemployee Travel		415			8,827			
	5203140 - Taxable Meals		27			20			119
	5203150 - Non-taxable meals In-state	600	405	68%	600	353	59%	600	319
	5203260 - Air-Commercial Out-of-state	1,100	471	43%	1,100	1,795	163%	1,100	
4-B	5203280 - Other Public Out-of-state	100	171	171%	100	150	150%	100	
4-C	5203300 - Lodging Out-Of-State	500	1,250	250%	500	3,653	731%	500	
	5203320 - Incidentals - Out of State		25			50			
	5203350 - Out of State Meals		255			436			
	5204010 - Subscriptions	1,000	90	9%	1,000	270	27%	1,000	87
	5204020 - Membership Dues	6,000	5,336	89%	6,000	4,171	70%	6,000	4,728
	5204030 - Legal Document Fees					10			
	5204050 - Computer Consultant					70,980			46,410
	5204080 - Legal Counsel	198,000	48,777	25%	198,000	37,188	19%	198,000	105,488
	5204090 - Management Consultant		148,333			22,655			
	5204100 - Consultant Fees--Medical	13,500	250	2%	13,500	1,750	13%	13,500	1,875
	5204130 - Other Consulting	0	9,692		0	8,820		0	9,210

SDBMOE
Income Statement

Date Range: July 1, 2014 to April 30, 2015

		FY15 Budgeted	FY15 04/30/2015	% of Budget FY15	FY14 Budgeted	FY14 06/30/2014	% of Budget FY14	FY13 Budgeted	FY13 06/30/2013
4-D	5204160 - Workshop Registration Fees	2,000	2,634	132%	2,000	3,280	164%	2,000	948
4-E	5204180 - State Computer Services	9,359	14,809	158%	9,359	15,734	168%	6,503	15,420
	5204181 - BIT Development Costs		155			12			77
	5204190 - Private Computer Services								
4-F	5204200 - Central Services	3,531	4,349	123%	3,531	3,709	105%	3,531	5,095
	5204202 - Property Management		307			317			23
	5204203 - Purchasing Central Services		420			488			46
	5204204 - Records Management		112			131			77
	5204207 - Human Resource Services		3,211			3,454			3,304
	5204220 - Equipment Maintenance		1,670			35,201			11,442
	5204230 - Janitorial					0			
	5204250 - Cable TV (Office Internet)		760			695			792
	5204320 - Audit Services - Private	5,500			5,500	0		5,500	
	5204350 - Advertising - Magazines		2,750			2,750			2,750
	5204360 - Advertising Newspapers	500	1,255		500	207		500	
	5204400 - Advertising Internet	500	294	0%	500	0	0%	500	
	5204460 - Equipment Rental	2,000	800	40%	2,000	1,040	52%	2,000	2,256
	5204490 - Rents - Other					791			
	5204510 - Rents - Lease	83,000	68,382	82%	62,000	51,160	83%	62,000	61,980
4-G	5204530 - Telecommunication Services	3,000	8,892	296%	3,000	15,418	514%	3,000	15,191
	5204550 - Garbage and Sewer		1,034			1,610			1,017
	5204580 - Truck-Drayage & Freight		1,703			857			1,505
	5204590 - Professional Liability Insurance	20,000	2,394	12%	20,000	2,400	12%	20,000	1,504
	5204620 - Taxes and License Fees					995			
	5204730 - Maintenance Contract	1,000		0%	1,000	0	0%	1,000	0
	5204740 - Bank Charges	24,192		0%	24,192	78	0%	24,192	78
	5204960 - Other Contractual Services	151,986	36,751	24%	172,986	50,800	29%	172,986	52,060
	5205020 - Office Supplies	10,000	2,482	25%	10,000	1,912	19%	10,000	6,201
	5205290 - Flags		209						
	5205040 - Educational & Instructional Sup					275			16
	5205310 - State-Printing					0			
4-H	5205320 - Duplication - Private	300	5,985	1995%	300	1,142	381%	300	7,074
	5205340 - Supp. Public & Ref Material		185						178
4-I	5205350 - Postage	11,000	13,609	124%	11,000	11,557	105%	11,000	16,005
	5205390 - Food Stuffs	100		0%	100	280	280%	100	120
	5207121 - Building Improvement & Remodel					800			
	5207451 - Office Furniture & Fixtures		1,194			37,742			
	5207495 - Telephone Equipment	10,000	76	1%	10,000	13,138	131%	10,000	282
	5207531 - Household Appliances					875			
	5207675 - Audio Visual Equipment		4,217			61,152			
	5207791 - Police and Security Equipment					0			3,335
	5207901 - Computer Hardware (BIT)		5,175			3,468			881
	5207905 - Computer systems	6,000			6,000	0		6,000	
	5207960 - Computer Software					0			1,078
	5207961 - Computer Software (BIT)	1,000			1,000	1,089		1,000	
	5207980 - Depreciation Expense - Computer					0			
	5207965 - Software State Contract					0			
	5208080 - Prior Year Revenue Refund					0			0
	5208210 - Interest on Late Vendor Payment		215			275			371
Total Expense	**5.**	**1,011,493**	**778,861**	**77%**	**988,618**	**924,257**	**93%**	**966,606**	**752,398**
Net Ordinary Income		**149,257**	**388,975**	**261%**	**175,382**	**302,082**	**172%**	**154,394**	**457,207**
Other Income/Expense									
Other Income									
	4491000 - Interest Income	25,000	24,236	97%	35,000	30,178	86%	55,000	37,094
Total Other Income		**25,000**	**24,236**	**97%**	**35,000**	**30,178**	**86%**	**55,000**	**37,094**
Net Other Income		**25,000**	**24,236**	**97%**	**35,000**	**30,178**	**86%**	**55,000**	**37,094**
Net Income	**6.**	**174,257**	**413,212**	**237%**	**210,382**	**332,259**	**158%**	**209,394**	**494,300**

SDBMOE
Other Contractual Services

Date Range: July 1, 2014 - April 30, 2015

	Description	FY15 04/30/2015	FY14 06/30/2014	FY13 06/30/2013
	Other Contractual Services			
	Health Practitioners Assistance - HPAP	$ -	$ 28,295	$ 7,405
	SDBON - CNP, CNM Co-regulation	$ -	$ -	$ -
	Investigator Contractor	$ -	$ -	$ -
	Investigations Expenses	$ 4,625	$ 1,521	$ 4,408
	Temporary Employment Services	$ -	$ -	$ 896
	Other State Verifications	$ -	$ -	$ -
	Shredding	$ -	$ -	$ 78
	Goods and Services	$ -	$ -	$ -
	Background Reports	$ -	$ -	$ 6,085
	BD member Expenses	$ 441	$ 172	$ -
	Board Meeting Audio	$ -	$ -	$ 535
	Other	$ 31,684	$ 30,881	$ 32,654
7.	**Total Other Contractual Services**	**$ 36,751**	**$ 60,868**	**$ 52,060**

New licenses, permits, certificates and registrations
March 1, 2015 through May 31, 2015

Advanced EMT: 10

Athletic Trainer: 3

Dietitian/Nutritionist: 7

EMT Student Status: 27

EMT I/85: 1

Genetic Counselors: 6

Genetic Counselor Temporary: 1

Medical Assistants: 17

Medical Corporations: 2

Medical License (MD/DO): 80

Nutritionist Temporary Permit: 5

Occupational Therapists: 9

Occupational Therapist Temporary Permit: 0

Occupational Therapy Assistants: 4

Occupational Therapy Assistants Temporary Permit: 0

Paramedics: 18

Physical Therapist Assistants: 7

Physical Therapists: 42

Physician Assistants: 5

Physician Assistant Temporary: 0

Physician Locum Tenens (60-Day Certificates): 14

Resident License: 2

Respiratory Care Practitioners: 5

Respiratory Care Practitioners Temporary Permit: 3

Total: 268

Advanced EMT License Total 7

License Number	Name	Address	Specialty	Issue Date
1905	Sara Lee Booth	PO Box 101, Hill City, SD 57745-0101		12/29/2014
1915	Slade Shannon Swedlund	PO Box 578, Hill City, SD 57745		2/12/2015
1904	Cesareo Davis Meza	184 Top O Hill Court, Hill City, SD 57745		12/23/2014
1903	Lori Elayne Balciunas	616 Clay Street, Custer, SD 57730		12/23/2014
1901	Brooke Marie Mabey	3512 Westview Drive, Spearfish, SD 57783		12/18/2014
1912	Julie Ann Martin	19122 Mockingbird Lane, Belle Fourche, SD 57717		2/10/2015
1918	Vince Paul Devlin	208 East 8th , Dell Rapids, SD 57022		2/24/2015

Athletic Trainer License Total 7

License Number	Name	Address	Specialty	Issue Date
0480	Katie Dee Willmott	1024 Delaware Avenue, Platt, SD 57369		2/9/2015
0474	Matthew Michael Stern	16212 S 120th Street, Springfield, NE 68059		12/2/2014
0479	Paige Katharina Mehling	180 S Circle Drive, Huron, SD 57350		1/5/2015
0476	Katie Marie Kimmich	908 S Thompson Ave., Sioux Falls, SD 57103		12/17/2014
0478	Mary Elizabeth Johnson	601 E. 69th Street Apt 227, Sioux Falls, SD 57108		1/5/2015
0477	Marcus Lee Moberg	71308 310th Street, Clinton, MN 56225		12/22/2014
0475	Michael Lee Smith	1101 W 22nd Street Unit 284, Sioux Falls, SD 57105		12/8/2014

Dietician/Nutritionist License Total 3

License Number	Name	Address	Specialty	Issue Date
0507	Patricia Ann Price	1009 Southland Lane, Apt 302, Brookings, SD 57006		12/17/2014
0509	Megan Nicole Olesen	1327 W 23rd Avenue Apt. 320, Mitchell, SD 57301		1/23/2015
0508	Jessica Ann VanOverschelde	2607 McLeod Drive East, West Fargo, ND 58078		12/24/2014

EMT Student Status Total 40

License Number	Name	Address	Specialty	Issue Date
3597	Lea Ann Krog-Tatro	2008 Colorado Drive, Sturgis, SD 57785		12/29/2014
3605	Denise Michelle Brown	48133 188th Street, Brandt, SD 57218		1/16/2015
3600	Lisa Renee Lundberg	812 Golf View Drive, Clear Lake, SD 57226		1/9/2015
3616	Jacob Steven Sandgren	34818 Oasis Road, Lindstrom, MN 55045		2/18/2015
3620	Kelli Melissa Grimlie	106 9th Ave North, Clear Lake, SD 57226		2/19/2015
3606	Billie Jo Gauger	18350 SD Hwy 15, Clear Lake, SD 57226		1/20/2015
3596	Melissa Jean Swedlund	1948 Davenport, Sturgis, SD 57785		12/29/2014
3603	Lisa Lynn Pederson	103 9th Ave N, Clear Lake, SD 57726		1/15/2015
3610	Jeffrey John Hauck	420 29th Street NW, Watertown, SD 57201		2/5/2015
3615	Michael Lawrence Sackmann	708 1st St NW, Watertown, SD 57201		2/12/2015
3609	Ayla Jene Dixon	116 17th Avenue, brookings, SD 57006		2/4/2015
3613	Taner Robert Reister	1200 2nd Ave SW #17, Watertown, SD 57201		2/10/2015
3612	Morgan Nicole Bartz	12020 463rd Avenue, Sisseton, SD 57262		2/6/2015
3627	Paul Scott Nelson	300 1st Ave NE Apt 130, Watertown, SD 57201		2/25/2015
3629	Theodore John Bueltel	3909 200th Ave, Minneota, MN 56264		2/25/2015
3618	Joe John Denison	19726 455th Ave, Arlington, SD 57212		2/18/2015
3595	Katie Adele O'Bryan	2007 Colorado Drive, Sturgis, SD 57785		12/29/2014
3604	Brenda Lee Schake	705 8TH ST. W., CLEAR LAKE, SD 57226		1/15/2015
3601	Erik Jon Eversman	713 5th Ave S., Clear Lake, SD 57226		1/13/2015
3598	Darin Michael Sinner	1825 Tanbury Lane, Brookings, SD 57006		1/5/2015
3623	Alexa Lynn Wallace	1019 Garfield Ave, Sheldon, IA 51201		2/23/2015

3602	Joni Adele Kanable	415 3rd Street West, Clear Lake, SD 57226		1/15/2015
3625	Matthew Carroll Gruchow	4521 E Ashbury Place, Apt. 102, Sioux Falls, SD 57110		2/24/2015
3608	Konard Otto Hauffe	1026 6th Ave, Brookings, SD 57006		1/28/2015
3624	Gage Tyler Whitted	45073 164th Street, Watertown, SD 57201		2/23/2015
3617	Tiffany Ann Davis	505 8th St., Springfield, SD 57062		2/18/2015
3626	Morgan Jaysen Bendt	46245 174th Street, Watertown, SD 57201		2/25/2015
3611	Nathan Ryan Becker	1951 42nd Street SW, Watertown, SD 57201		2/6/2015
3614	Trevor John Allen	405 E 13th NE Apt 201, Watertown, SD 57201		2/11/2015
3621	Rita Faye Sattler	820 E 12th Ave, Webster, SD 57274		2/20/2015
3622	Candyce Sue Michlitsch	620 E 2nd Street, Webster, SD 57274		2/20/2015
3594	Afton Elizabeth Leichtnam	5334 Williams St. , Rapid City, SD 57703		12/29/2014
3607	Sheila Joy Monnier	19061 479th Avenue, Brandt, SD 57218		1/20/2015
3599	Rachel Rene Sirignano	2128 Elm Ave, Rapid City, SD 57701		1/6/2015
3591	Samantha Jo Bartels	1921 Ellen Street Apt 5, Sturgis, SD 57785		12/5/2014
3592	Kaleb A Zook	1905 Heather Court, Sturgis, SD 57785		12/9/2014
3592	Kaleb A Zook	1905 Heather Court, Sturgis, SD 57785		12/9/2014
3593	Kingsley Arden Swanson	3820 jackson Blvd., Rapid City, SD 57702		12/15/2014
3619	Rachel Marie Wintle	5430 Bay Meadows Rd., Omaha, NE 68127		2/18/2015
3628	Meagan Elizabeth Einrem	311 8th Street, Springfield, SD 57078		2/25/2015

EMT-I/85 License Total 1

License Number	Name	Address	Specialty	Issue Date
1913	Clarence Duane Gilstad	214 Center Avenue South, Ashley, ND 58413		2/12/2015

Genetic Counselor License Total 4

License Number	Name	Address	Specialty	Issue Date
0035	Nicole Marie Mattila	3043 Wedge Court, Green Bay, WI 54313		12/23/2014
0034	Kristen Marie Rauch	29526 Lyndon Street, Livonia, MI 48154		12/15/2014
0033	Andrea Elizabeth Ramirez	3046 South Fork Drive, Corpus Christi, TX 78414		12/8/2014
0036	Rawan Isam Awwad	1015 Henrietta Street, Birmingham, MI 48009		2/9/2015

Medical Assistant Registration Total 17

License Number	Name	Address	Specialty	Issue Date
1162	Justin William Hagedorn	6145 Sunrise Lake Drive, Fort Worth, TX 76179		12/15/2014
1159	Jada Marie Keenan	4704 W. St. James Drive #12, Sioux Falls, SD 57106		12/8/2014
1163	Loni Skye Johnson	3841 N Gemini Drive, Sioux Falls, SD 57107		12/22/2014
1167	Mary Margaret Benson	7705 W Boulder Creek Place #11, Sioux Falls, SD 57106		1/29/2015
1170	Ashley Marie Barrie	405 4th St. SE, Watertown, SD 57201		2/24/2015
1172	Wendy Jane Rogers	20779 Monte Carlo Road, Lead, SD 57754		2/26/2015
1171	Ashleigh JeAnne Schmidt	24447 475th Avenue, Dell Rapids, SD 57022		2/25/2015
1161	Kristina Jade Huber	525 Morgan Lane #13, Tea, SD 57064		12/20/2014
1165	Kammi Jo Flemming	8709 E. Fiddlewood Drive, Sioux Falls, SD 57110		1/2/2015
1166	Nicole Ann Eichacker	44157 248th Street, Salem, SD 57058		1/21/2015
1164	Mindy Marie Ruble	3001 Hale Street, Sioux City, IA 51103		12/23/2014
1157	Danielle Kristin Kuehl	42 Stewart Avenue, Sioux City, IA 51105		12/5/2014
1156	Joan Holter	404 S Main Street, Hills, MN 56138		12/3/2014
1160	Mary Lisa Feiner	639 Streeter Drive Apt. 205, North Sioux City, SD 57049		12/8/2014
1158	Jenna Rae Walsh	16 Terra Alta Court, Sioux City, IA 51104		12/5/2014
1169	Priscilla Stanisljevic	2940 E Minnesota Street Apt #304, Rapid City, SD 57703		2/9/2015
1168	Courtney Kae Lorraine Linke	416 N Broadway, Watertown, SD 57201		2/9/2015

Medical Corporation Registration Total 4

License Number	Name	Address	Specialty	Issue Date
0572	Robert J Sage, MD, PC	2820 Mt. Rushmore Road, Rapid City, SD 57701	Dermatology	12/11/2014
0573	Nauman Nisar, P.C.	425 Bay Hill Circle, Dakota Dunes, SD 57049	Pathology	12/29/2014
574	Cosmetic and Plastic Surgery Specialists, P.C.	201 South Lloyd Street, Suite W230, Aberdeen, SD 57401	Plastic Surgery	1/29/2015
0575	Surgical Solutions, PLLC	904 Quincy Street, Rapid City, SD 57701	Surgery (General)	2/23/2015

Medical License (MD/DO) Total 61

License Number	Name	Address	Specialty	Issue Date
9417	Timothy Sebastian Fisher, MD	570 Aptos Creek Rd, PO Box 302 Aptos, CA 95003	Radiology	1/26/2015
9421	Kara Lee Underwood, MD	5125 Martin Road, Duluth, MN 55811	Family Medicine/General Practice	1/28/2015
9441	Kristin Jones Tarbet, MD	2800 3rd St , Rapid City, SD 57701-7374	Ophthalmology	2/19/2015
9388	Jena Auerbach, DO	7519 N 14th Avenue, Phoenix, AZ 85021	Pathology	12/9/2014
9415	Walter Lee Chesshir, MD	1833 Windermere Way, Brookings, SD 57006	Family Medicine/General Practice	1/21/2015
9390	Gregory Antoni Szych, DO	140 Torrey Pines Dr., Jackson, TN 38305	Gastroenterology	12/15/2014
9420	Robert Wayne King, MD	19939 State Hwy 49, Lawton, OK 73507	Emergency Medicine	1/27/2015
9427	Back Ki Hong, MD: Waiver	808 Cole Street, San Francisco, CA 94117	Anesthesiology	2/4/2015
9408	Ji Yoon Yoon, MD	301 Las Colinas Blvd. West Apt #358, Irving, TX 75039	Pathology	1/6/2015
9407	Wei Tian, MD	716 Orleans Drive, Southlake , TX 76092	Pathology	1/6/2015
9422	Natasha Adelle Telesford, MD: Waiver	451 Prospect Street, South Orange, NJ 07079	Internal Medicine (General)	1/29/2015
9411	Elizabeth Mary Tucker, DO	300 South Byron Boulevard, Chamberlain, SD 57325	Surgery (General)	1/14/2015
9397	Adebola Olufemi Adesanya, MD	1801 Cottonwood Valley Circle South, Irving, TX 75038	Anesthesiology	12/18/2014
9444	Sanjiv Vinayak Prabhu, MD	3843 W. Fitch Avenue, Lincolnwood, IL 60712-1011	Pathology	2/25/2015
9418	Melissa Maniscalco Bowers, DO	13443 Sienna Meadows Lane, Rapid City, SD 57702	Pediatrics (General)	1/27/2015
9404	Justin Nilsson Duke, MD	337 Richmar Drive, Birmingham, AL 35213	Orthopedic Surgery	12/30/2014
9426	Douglas Ryan Porter, MD	336 22nd Ave North, Nashville, TN 37203	Neurology	2/3/2015
9419	Daniel Edward Laurie, MD	1 City Drive, Ste. 570, St Louis, MO 63141	Internal Medicine (General)	1/27/2015

9443	Richard Lee Davis, MD	8707 GA Hwy 17, Bowersville, GA 30516	Orthopedic Surgery	2/20/2015
9430	Timothy Blake Ebbitt, MD	1221 Nicollet Mall, Ste. 600 Minneapolis, MN 55403	Radiology	2/10/2015
9495	Norma Therese Walks, MD	1601 Kniss Avenue, Luverne, MN 56156	Surgery (General)	12/17/2014
9442	Goutham Kolli, MD	6511 S Santa Rosa Pl, Sioux Falls, SD 57108	Internal Medicine (General)	2/20/2015
9400	Barbara Jane Blasko, MD	3671 Genista Place, Fallbrook, CA 92028	Emergency Medicine	12/19/2014
9406	Lisa Ella Thompson, MD	181 Malcolm X Blvd., Unit 2 New York, NY 10026	Emergency Medicine	12/30/2014
9386	Garrett Thomas Desman, MD	214 N 11th Street #6L, Brooklyn, NY 11211	Pathology	12/4/2014
9412	Massimo Asolati, MD: Waiver	1170 E. Amherst Avenue, Englewood, CO 80113	Surgery (General)	1/16/2015
9402	Alicia Velean Lee, MD	3116 Robert Drive, Richardson, TX 75082	Family Medicine/General Practice	12/19/2014
9436	Alon Jerome Vainer, MD	540 Telford Place, Atlanta, GA 30342	Nephrology	2/12/2015
9391	Russell Michael Bruney, MD	6505 N Stone Ridge Drive, Quincy, IL 62305	Radiology	12/16/2014
9437	Sorin Vainer, MD	687 Royer Place, Atlanta, GA 30342	Nephrology	2/12/2015
9434	Aaron Clementi Baker, MD	914 High Meadow Lane SW, Rochester, MN 55902	Vascular Surgery	2/11/2015
9431	Animesh Rathore, MD	3137 Avalon Cove Court NW, Rochester, MN 55901	Vascular Surgery	2/10/2015
9433	Syed Mohiuddin Peeran, MD	101 Civic Center Drive, Apt. 218, Rochester, MN 55906	Vascular Surgery	2/10/2015
9385	Inam Ur Rahman, MD	50 South Beretania Street, Suite C210 A1, Honolulu, HI 96813	Internal Medicine (General)	12/2/2014
9394	Aaron Gregory Potnick, MD	420 Woodhaven Place, West Sacramento, CA 95605	Radiology	12/16/2014
9387	Sita Paudel, MD	1308 Plum Tree Trail, Apt D, Hoover, AL 35226	Pediatrics Subspecialties	12/5/2014
9424	Greg Anthony Vigna, MD	994 Calle Abierta, Santa Barbara, CA 93111	Physical Med. & Rehab.	1/30/2015
9399	Dennis Jackson Rinehart, MD	10666 First Timberlane Drive, Northfield, MN 55057	Radiology	12/18/2014
9428	Glenn Andrew Tuckman, MD	6416 Shamel Drive, Indianapolis, IN 46278	Radiology	2/9/2015

9425	Kenneth Lee Gibbs, MD	9250 S. Tropical Trail, Merrit Island, FL 32952	Cardiology	2/2/2015
9429	Stephanie Kay Dahl, MD	517 Arrowwood Drive, Horace, ND 58047	Obstetrics and Gynecology	2/9/2015
9423	David Bruce Bettis, MD	502 Old Saybrook Drive, Boise, ID 83706	Pediatrics Subspecialties	1/29/2015
9409	Michael H. Song, MD	343 Elm Street, Suite 202, Reno, NV 89503	Neurological Surgery	1/13/2015
9496	James Thomas Barber, DO	2207 Eaglesmoor Lane, Enola, PA 17025	Obstetrics and Gynecology	12/17/2014
9445	Kiran Poudel, MD	3150 Ashton Brooke Drive, Apt #2, Beavercreek, OH 45431	Internal Medicine (General)	2/26/2015
9393	Jeffrey David Kleinman, MD	34640 Lakeview Drive, Solon, OH 44139	Radiology	12/16/2014
9410	Venkata Satish Iduru, MD	638 Knipp Road, Houston, TX 77024	Gastroenterology	1/13/2015
9389	Jehanzeb Khan, MD	217 Evergreen Garden Drive, Elizabethtown, KY 42701	Radiology	12/15/2014
9405	William Brendan Hayes, MD	4617 Briarhaven Road, Fort Worth, TX 76109	Anesthesiology	12/30/2014
9413	Osmund Ugochukwu Agbo, MD	17722 Rough River Court, Humble, TX 77346	Internal Medicine (General)	1/16/2015
9398	Mark Nelson Beard, MD	48052 260th Street, Brandon, SD 57005	Family Medicine/General Practice	12/18/2014
9435	Salah Georges Keyrouz, MD	2350 Maybrook Lane, Saint Louis, MO 63122	Neurology	2/12/2015
9401	Jo Anne Burkhalter, MD	1218 560th Street, Cherokee, IA 51012	Dermatology	12/19/2014
9438	Brooke Denise Renard, MD	213 North James Street, Silverton, OR 97381	Obstetrics and Gynecology	2/13/2015
9392	Aaron Douglas Dykstra, MD	7220 S Highway 16, Rapid City, SD 57702	Orthopedic Surgery	12/16/2014
9403	Emmett Terrance McEleney, MD	7220 S Highway 16, Rapid City, SD 57702	Orthopedic Surgery	12/19/2014
9416	William John Mohr, MD	640 Jackson Street, Mail Stop 11105C St Paul, MN 55101	Surgery (General)	1/21/2015
9414	Faisal Abdulah Khasawneh, MD	1 Cityplace Drive, Suite 570 St. Louis, MO 63141	Internal Medicine (General)	1/21/2015
9440	Christopher Richard Sidden, MD	3620 Pelham Road, #149 Greenville, SC 29615	Radiology	2/18/2015
9439	Valerie Anne Jones, MD	2668 Bayonne Street, Sullivan's Island, SC 29482	Physical Med. & Rehab.	2/18/2015

9432	John Athanasios Kazianis, MD	1 Cityplace Drive, Ste. 570 Saint Louis, MO 63141	Internal Medicine (General)	2/10/2015

Occupational Therapist License Total 14

License Number	Name	Address	Specialty	Issue Date
0945	Jamie Marie Lien	2410 Sunrise Ridge Circle #207, Brookings, SD 57006		2/5/2015
0944	Erin Michelle Schnabel	25 Edgewater Lane, Dakota Dunes, SD 57049		2/4/2015
0954	Ashley Kay Hoyme	180 30th Avenue, Hills, MN 56138		2/24/2015
0943	Kaylee Elizabeth Williamson	2612 Sunrise Court, Brandon, SD 57005		1/29/2015
0955	Kayla Mary Grutz	3500 Court Street, Sioux City, IA 51104		2/27/2015
0939	Erika Lorene Cornella	5117 Winterset Drive, Rapid City, SD 57702		12/23/2014
0949	Jill Emily Jacobs	100 Little Rock Ave, Marshall, MN 56258		2/9/2015
0950	Amanda Louise Rolfes	1724 S 1st Street, Aberdeen, SD 57401		2/12/2015
0947	Veronica Voss Iverson	8515 Nemo Road, Rapid City, SD 57702		2/5/2015
0951	Nikki Lynn Novak	2014 Beach Drive, Fort Pierre, SD 57532		2/12/2015
0953	Carrie Elizabeth Menke	109 N Dakota Street, Vermillion, SD 57069		2/18/2015
0952	Sara Ann Kaltenbach	2904 Sunrise Court, Brandon, SD 57005		2/12/2015
0946	Blane Terrance Sharkey	336 N 14th Street, Spearfish, SD 57783		2/5/2015
0948	Rachel Ann Blake	46362 295th St., Centerville, SD 57014		2/9/2015

Occupational Therapist Temporary Permit Total 1

License Number	Name	Address	Specialty	Issue Date
942	Kaylee Elizabeth Williamson	2612 Sunrise Court, Brandon, SD 57005		1/28/2015

Occupational Therapy Assistant License Total 3

License Number	Name	Address	Specialty	Issue Date
325A	Whitney Rose German	7601 W Legacy Street, Sioux Falls, SD 57106		2/9/2015
326A	Ashley Faye Muller	839 6th SW, Pipestone, MN 56164		2/12/2015
324A	Jacklyn Adair Taffe	423 West 3rd Street, PO Box 386 Graceville, MN 56240		12/17/2014

Paramedic License Total 16

License Number	Name	Address	Specialty	Issue Date
1919	Randy Webert	PO Box 1060, Yankton, SD 57078-1060		2/26/2015
1906	Kevin Ray Schlosser	4704 W. Antelope Drive, Sioux Falls, SD 57107		1/5/2015
1908	Daniel Simon Ell	3703 Nickerson Avenue, Bismarck, ND 58503		1/20/2015
1917	Nathan Dale Holthusen	402 N Spruce Street, Ogallala, NE 69153		2/18/2015
1902	Brock Jeffrey Soderberg	503 Oak Street, Wakefield, NE 68784		12/22/2014
1909	Matthew Ryan Callahan	1212 Lincoln Street, Vermillion, SD 57069		1/20/2015
1916	Riley Bro Beckstead	820 W 58th Street, Casper, WY 82601		2/18/2015
1896	Tate Olowan Locust	Po Box 165, Pine Ridge, SD 57770		12/3/2014
1900	Sarah Elizabeth Stewart	1010 Alta Vista Drive, Rapid City, SD 57701		12/15/2014
1899	Holli Ann Stirling	46704 265th St, Sioux Falls, SD 57107		12/11/2014
1907	Bridget Joanna McCormick	15710 County Road 32, Ovid, CO 80744		1/16/2015
1898	Kelly Allen Dollinger	4613 Hitchcock Drive, Bismarck, ND 58503		12/10/2014
1911	Brittany Nicole Oliver	310 N Derby Lane #103, North Sioux City, SD 57049		2/6/2015
1897	Stephen Alan McElmurry	1421 Ridgewood Drive, Fergus Falls, MN 56537		12/5/2014
1910	Burton Paul Hayden	1103 Rocking T Drive, Gillette, WY 82718		1/22/2015
1914	Lance Truels Iversen	PO Box 441, Murdo, SD 57559		2/12/2015

Physical Therapist Assistant Certificate Total 7

License Number	Name	Address	Specialty	Issue Date
0418	Katie Elizabeth Zach	2215 Glenwood Ave, Papillion, NE 68046		2/24/2015
0417	April Elaine Soderquist	48444 292nd Street, Hudson, SD 57034		2/3/2015
0416	Isaac Thomas Bigelow	408 N. Oak Ridge Road, Brandon, SD 57005		1/22/2015
0414	Dillon Lee Jensen	1251 HWY 20, Jackson, NE 68743		12/5/2014
0415	Sally Teresa Vickery	2514 Canterbury Road, Sergeant Bluff, IA 51054		1/8/2015
0420	Elia Mya Lexine	106 North 20th St., Fort Pierce, FL 34950		2/26/2015
0419	April Suzanne Harper	637 Kensington Ave., Salt Lake City, UT 84105		2/25/2015

Physical Therapist License Total 9

License Number	Name	Address	Specialty	Issue Date
1804	Patricia Kaydi Cassidy	623 Dakota Drive, Rapid City, SD 57702		1/29/2015
1807	Jenna Rae McNeely	3738 Gardner Barclay Road, Farmdale, OH 44417		2/4/2015
1806	Mark Allen Kaufman	3615 Adams Road, Oak Brook, IL 60523		2/2/2015
1805	Brandon Michael Ness	2008 Parkway Drive, Manhatten, KS 66502		2/2/2015
1802	Toni Marie Lais	755 Dugdale Avenue, Worthington, MN 56187		1/16/2015
1799	Erin Marie DeRoos	PO Box 322, Crofton, NE 68730		12/16/2014
1801	Megan Anne Snoozy	831 Brookside Drive, Jefferson, SD 57038		1/1/2015
1800	Kelley Lanette London	213 Woodburn Drive, Hampton, VA 23664		12/17/2014
1803	Rochelle Briones De Jesus	616 Banner Avenue, Basement Brooklyn, NY 11235		1/21/2015

Physician Assistant License Total 8

License Number	Name	Address	Specialty	Issue Date
0965	Holly Jo Savenko	506 NW 1st Street, Linton, ND 58552		12/11/2014
0969	Michael Scot Fleck	819 Durant Place NE #8, Atlanta, GA 30308		1/20/2015
0968	Deborah Michelle Adams	2333 Pulmosa Drive, Grimesland, NC 27837		1/5/2015
0967	James William Kearns	814 Spring Run Road, Winterville, NC 28590		1/5/2015
0970	Susan Carol Zwiaska	6437 Seminole Lane, Rapid City, SD 57702		1/28/2015
0971	Abby Marie Gietzen	350 28th Ave SE, Watertown, SD 57201		2/17/2015
0972	Jason Ryan Hennessey	19813 Emiline Street, Gretna, NE 68028		2/25/2015
0966	Angharad Supe Lyon	69 Foothill Blvd., Pocatello, ID 83204		12/16/2014

Physician Locum Tenens Total 13

License Number	Name	Address	Specialty	Issue Date
1471	Back Ki Hong, MD	808 Cole Street, San Francisco, CA 94117	Anesthesiology	12/5/2014
1478	Shaunak Vijay Rana, MD	4071 Gresham Street, San Diego, CA 92109	Nephrology	2/9/2015
1473	Justin Nilsson Duke, MD	337 Richmar Drive, Birmingham, AL 35213	Orthopedic Surgery	1/1/2015
1474	John Joseph Loffarelli, DO	18857 N 71st Lane, Glendale, AZ 85308	Internal Medicine (General)	12/19/2014
1469	Greg Anthony Vigna, MD	994 Calle Abierta, Santa Barbara, CA 93111	Physical Med. & Rehab.	12/5/2014
1467	Kenneth Lee Gibbs, MD	9250 S. Tropical Trail, Merrit Island, FL 32952	Cardiology	12/7/2014
1465	James Thomas Barber, DO	2207 Eaglesmoor Lane, Enola, PA 17025	Obstetrics and Gynecology	1/22/2015
1475	Kiran Poudel, MD	3150 Ashton Brooke Drive, Apt #2, Beavercreek, OH 45431	Internal Medicine (General)	12/28/2014
1468	Eugene Walper Lowe, MD	1733 Wycliffe Street, Bedford, VA 24523	Surgery (General)	12/22/2014
1472	Ronald Joseph Ruszkowski, MD	210 William Way, Williamsburg, VA 23185	Hematology & Oncology	12/20/2014
1476	Kip Cardell Newell, DO	2223 S 117th Circle, Omaha, NE 68144	Other Specialties	1/1/2015
1477	Osmund Ugochukwu Agbo, MD	17722 Rough River Court, Humble, TX 77346	Internal Medicine (General)	1/8/2015
1470	Salah Georges Keyrouz, MD	2350 Maybrook Lane, Saint Louis, MO 63122	Neurology	12/28/2014

Resident License Total 2

License Number	Name	Address	Specialty	Issue Date
0216	Rachael Joan Schultz	2601 S Nicollet Street, Sioux City, IA 55106	Family Medicine/General Practice	1/22/2015
0217	Sunnah Hope Widger Maki Doesken	2501 Pierce Street, Sioux City, IA 55104	Family Medicine/General Practice	2/19/2015

Respiratory Care Practitioner License Total 5

License Number	Name	Address	Specialty	Issue Date
1027	Kim Tutt	2520 Tower Road, Room 208 Rapid City, SD 57701		1/8/2015
1032	John Christian Olsen	2321 Huntland Hills Road, Cookeville, TN 38506		2/18/2015
1031	Michael Anthony Hernandez	35027 Ave C, Yucaipa, CA 92399		2/10/2015
1029	Sylest Sierra Ford	3901 Hartwell Road, Fayetteville, NC 28304		1/27/2015
1030	Barbara Elaine Randol	8500 E Willow Ridge Place, Sioux Falls, SD 57110		2/6/2015

Respiratory Care Practitioner Temporary Permit Total 2

License Number	Name	Address	Specialty	Issue Date
1028	Hannah Marie Stromseth	2720 South Summit Avenue, Sioux Falls, SD 57105		1/16/2015
1026	Tana Marie Lockner	2847 Nugget Gulch Drive, Rapid City, SD 57702		12/3/2014

Advanced Life Support Committee met on May 11, 2015

1. Discussed the EMS-DOH Stakeholders meetings—plan to wait for the conclusion of these meetings to before exploring any statute or rule issues
2. As a result of SB 14 passing, the committee will be reviewing a draft of rules for first responders to possess and administer opioid antagonists

Athletic Trainer Committee met on May 6, 2015

1. Discussed the disparity between the scope of practice in statute and what is taught in educational programs now
2. The committee will work on an administrative rule aimed at bringing the educational competencies and skills up to date

Nutrition and Dietetics Committee met on May 13, 2015

1. The committee had previously worked on a rule regarding therapeutic diets. Because the rule was not under the rulemaking authority of the Board, advice was given to have the state nutrition and dietetic association contact the Department of Health regarding the next steps to change the rule
2. The continuing education rules were reviewed and will be sent to the state nutrition and dietetic association for comment and input
3. Reviewed a question from a licensee regarding the temporary permit process

Genetic Counselor Committee met on May 6, 2015

1. The committee discussed the need for changes to statute
    a. There have been changes to the names of the groups that accredit programs

Occupational Therapy Committee met on May 14, 2015

1. The committee has finished their review of their administrative rules article and will be sending their recommendations to the South Dakota Occupational Therapy Association for their review and input

Physical Therapy Committee met on May 13, 2015

1. Discussed the interstate compact that the Federation of State Boards of Physical Therapy is currently working on
2. Continued discussion on the continuing education rule. The SD Physical Therapy Association will be holding meetings over the summer to gather input.
    a. In September, the SD Physical Therapy Association president will meet with the committee to go over their recommendation and to draft a recommendation for the board

Respiratory Therapy Committee met on May 12, 2015

1. Reviewed the continuing education audit letter that will be sent to licensees.
2. Discussed the auditing process.
3. Discussed the supervising relationship between physicians and respiratory therapists

Physician Assistant Committee met on May 21, 2015

1. Reviewed the introduction materials for the new member Justin Thurman
2. Reviewed a question on physician assistants supervising estheticians
3. Discussed the recommended opioid prescribing rule

Continuing Medical Education Requirements and Board Certifications Required for License Renewal

Only six boards[1] (Colorado Medical Board, Medical Licensing Board of Indiana, Montana Board of Medical Examiners, Hawaii Medical Board (DO), New York State Board of Medicine, and South Dakota Board of Medical and Osteopathic Examiners) do not require any type of continuing medical education or board certification for license renewal.

Boards that do require continuing education or board certification

- 13 boards require reporting of continuing medical education or board certification on a different schedule than license renewal
- 5 do not count board certification

States that accept certificates or awards as continuing medical education

- 33 accept American Medical Association Physician's Recognition Award
- 23 accept American Osteopathic Association
- 32 accept American Board of Medical Specialties
- 13 accept from state medical societies
- 8 accept from national specialty societies
- 37 accept graduate medical education

Geographic comparison

State	**CME Requirement**		**Certificate/Award accepted**
North Dakota	60	3 years	Yes: AMA PRA; ABMS
Minnesota	75	3 years	Yes: AMA PRA; ABMS
Iowa	40	2 years	Yes: AMA PRA; ABMS
Nebraska	50	2 years	Yes: AMA PRA; AOA; GME
Wyoming	60	3 years	Yes: AMA PRA; AOA; ABMS; GME
Montana	None		

AMA PRA – American Medical Association Physician's Recognition Award; **ABMS** – American Board of Medical Specialties; **AOA** – American Osteopathic Association; **GME** – graduate medical education

[1] American Medical Association. (2014). State Medical Licensure Requirements and Statistics 2014. Chicago: American Medical Association.

Medical Malpractice Insurance Requirements for Medical Licensure

Currently, seven state boards require medical malpractice insurance as a requirement for licensure.[1] These boards include the Colorado Medical Board, Connecticut Medical Examining Board, Kansas State Board of Healing Arts, Massachusetts Board of Registration in Medicine, New Jersey State Board of Medical Examiners, Rhode Island Board of Medical Licensure and Discipline, and Wisconsin Medical Examining Board.

The required amount of insurance coverage varied among these boards. On a per incident basis, the required amount ranged from $100,000 to $1,000,000. On an annual basis, the required amount ranged from $300,000 to $3,000,000. Table 1 shows the amounts required per incident and annually in the states that require malpractice insurance.

Table 1

State	Per Incident	Annually
Colorado[2]	$1,000,000	$3,000,000
Connecticut[3]	$500,000	$1,500,000
Kansas[4]	$200,000	$600,000
Massachusetts[5]	$100,000	$300,000
New Jersey[6]	$1,000,000	$3,000,000
Rhode Island[7]	$100,000	$300,000
Wisconsin[8]	$1,000,000	$3,000,000

According to the National Conference of State Legislators, 35 jurisdictions have a limit or cap on the amount of total damages that a provider may have to pay. [9] At least seven of these states require malpractice insurance to be eligible under a medical malpractice act. However, malpractice insurance is not a requirement for licensure.

In South Dakota there is no medical malpractice act; however, statute does limit the amount of damages for medical malpractice to $500,000.[10]

[1] American Medical Association. (2015). State laws mandating minimum levels of professional liability insurance.
[2] Colo. Rev. Stat. §13-64-301
[3] Conn. Gen. Stat. §20-11B
[4] Kan. Stat. §40-3401
[5] 243 CMR 2.07
[6] N.J. Rev. Stat. §45:9-19.17
[7] R.I. Gen. L §42-14.1-2
[8] Wis. Stat. §655.23
[9] http://www.ncsl.org/research/financial-services-and-commerce/medical-liability-medical-malpractice-laws.aspx
[10] SDCL §21-3-11

Variations

- Florida allows physicians to maintain an escrow account, maintain malpractice insurance, or obtain an irrevocable letter of credit. [11]
- Missouri requires medical malpractice insurance for physicians and surgeons who are on staff at a hospital in a county with a population of more than 75,000 people.[12]
- Colorado does require malpractice insurance as noted above; however, this requirement does not apply to qualifying public employees.[13]

[11] Fla. Stat. §458.320
[12] Mo. Rev. Stat. §383.500
[13] Colo. Rev. Stat. §13-64-301

CHAPTER 20:47:07

OPIOID STEWARDSHIP

20:47:07:01. Opioid stewardship defined

20:47:07:02. Stewardship of the prescription of opioids for the treatment of chronic pain.

20:47:07:03. Stewardship of medical records when prescribing opioids for the treatment chronic of pain

20:47:07:01. Opioid stewardship defined. "Opioid stewardship" means a process or procedure established in this Article as a guideline to physicians. Failure to comply with opioid stewardship established in this Article is not grounds for cancellation, revocation or suspension of a medical license. Failure to comply with opioid stewardship may be justified based on the circumstances of a particular case or on the applicable community standards. Compliance with opioid stewardship is a defense to a proceeding for cancellation, revocation or suspension of a medical license that is based upon medical treatment for which best practices have been established.

Source:

General Authority: SDCL 36-4-35.

Law Implemented: SDCL 36-4-28, 36-4-29, 36-4-30.

20:47:07:02.Stewardship for the prescribing of opioids for the treatment of chronic pain.

All patients have a level or risk of addiction to opioids prescribed for the treatment of pain which persists beyond the usual course of an acute disease or healing of an injury, or chronic pain, that can only be estimated initially, with the estimate modified over time as more information is obtained concerning the efficacy of the treatment and the patient's on-going or increasing risk of addiction. The stewardship for the prescription of opioids for the treatment of chronic pain follow this process and procedure:

1. A medical diagnosis is made with an appropriate differential*;*

2. A complete patient assessment, including assessment of the risk for substance use disorders, is performed. The state prescription drug monitoring program should be consulted to determine whether the patient is receiving prescriptions from any other physicians;

3. A proposed treatment plan that includes disclosure of the level or risk of addition and alternative treatment methods, is discussed with the patient and written informed consent from the patient is obtained;

4. A written treatment agreement, signed by both the physician and the patient, is established that sets forth the expectations and obligations of the patient and the treating physician;

5. An appropriate trial of opioid therapy, with or without adjunctive medications, is initiated. During this trial period, the efficacy of the opioid therapy is tested to determine whether the treatment goals can be met in terms of reduction of chronic

pain and restoration of function;

6. The written treatment plan is revised as necessary based upon the results of the trial of opioid therapy and discussed with the patient. The revised written treatment plan sets forth the expectations and obligations of the patient and the treating physician, and signed by both.

7. Regular assessments of chronic pain and function are conducted, initially every month, and after treatment goals are being met, a minimum of every 6 months, which include:

    a. a full reassessment of the patient's pain score and level of function;

    b. evaluation of the patient in terms of the "5 A's": Analgesia, Activity, Adverse Effects, Aberrant Behaviors, and Affect;

    c. review of the pain diagnosis and any comorbid conditions, including substance use disorders;

    d. Adjustment of the treatment regimen based upon the entire reassessment.

8. If treatment goals of reduction of chronic pain and restoration of function are not met, the physician shall adjust the opioid dose, substitute a different opioid, add an adjunctive therapy, or discontinue the use of opioids and select an alternative approach to chronic pain management.

9. In no cases should a physician continue to prescribe opioids at the same level or in the same manner, with no alternative therapies being explored, when a patient's

treatment goals are not being met.

General Authority: SDCL 36-4-35.

Law Implemented: SDCL 36-4-28, 36-4-29, 36-4-30.

Source: Federation of State Medical Boards Model Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain; Federation of State Medical Boards Model Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office.

20:47:07:03. Stewardship for medical records when prescribing controlled substances for the treatment of chronic pain. The stewardship for medical records when a physician prescribes opioids for the treatment of chronic pain includes each of the following listed items.

1. Copies of the signed informed consent and treatment agreement required by ARSD 20:47:07:02(3), (4) and (6);
2. The patient's medical history;
3. The results of all physical examinations and all laboratory tests;
4. The results of all risk assessments, including results of any screening instruments used;
5. A description of the treatments provided, including all medications prescribed or administered, with the date of prescription or administration, the name and type of the medication; and the dosage and quantity of medication prescribed or administered. The medical records must include all prescription orders for opioid analgesics and other controlled substances, whether written or telephoned;
6. Instructions to the patient, including discussions of risks and benefits with the patient and any significant others, and written instructions for the use of all medications;
7. Results of ongoing assessments of patient progress or lack of progress in terms of chronic pain management and functional improvement;
8. Notes on evaluations by and consultations with specialists;
9. Any other information used to support the initiation, continuation, revision, or termination of treatment and the steps taken in response to any aberrant medication

use behaviors;

10. Medical records of past hospitalizations or treatments by other providers, to the extent obtained by the physician;

11. Authorization for release of information to other treatment providers;

12. Name, address and telephone number of the patient's pharmacy.

General Authority: SDCL 36-4-35.

Law Implemented: SDCL 36-4-29, 36-4-30.

Source: Federation of State Medical Boards Model Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain; Federation of State Medical Boards Model Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office.

Resolution 15-4

Federation of State Medical Boards
House of Delegates Meeting
April 25, 2015

Subject: Revision of FSMB Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain

Introduced by: Washington State Medical Quality Assurance Commission

Approved: January 2015

Whereas, The FSMB adopted a Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain in 2013; and

Whereas, Recent studies have provided important new information on the use of opioids for pain, necessitating a revision to the Model Policy to make it aligned with the current science, as follows:

1. New studies do not support a "no ceiling on dose" principle. Language in the Model Policy suggesting otherwise should be removed:
   a. "Physicians will not be sanctioned solely for prescribing opioid analgesics or the dose (mg/mcg) prescribed for legitimate medical purposes;" and
   b. "The Board will judge the validity of the physician's treatment of a patient on the basis of available documentation, rather than solely on the quantity and duration of medication administered;" and

2. A recent study by the Agency for Healthcare Quality and Research finds a lack of long-term data on the effectiveness of opioids for chronic pain; and

3. Recent studies demonstrate the impact of escalating doses, the relationship of higher doses with overdose events, and that escalating doses do not have an impact on improving health outcomes; and

4. A study published in the New England Journal of Medicine in January 2015 found a national decrease in abuse of prescription opioid medications between 2011 and 2013 and called for further changes in public health policy; and

5. The Model Policy should be expanded to address how opioids are used for acute and sub-acute pain episodes to prevent chronic use that is not evidence-based. There is new evidence that the use of opioids in the acute and sub-acute pain period may be associated with adverse impact, particularly on the initiation and potentiation of disability, particularly in working-age people; and

6. The Model Policy emphasizes the importance of co-morbid substance abuse and mental health disorders, but needs stronger warnings on the increased risk of overdose and addiction. This is particularly true for the synergistic effect of respiratory depression regarding concomitant use of benzodiazepines and sedative-hypnotics. For example, benzodiazepines were involved in 31% of opioid analgesic poisoning deaths in 2011; and

7. The Model Policy needs greater guidance and specificity on tapering opioids. New data suggest that opioids are frequently continued in patients who have experienced an overdose event, and these patients may experience a subsequent overdose event or death; and

8. The Model Policy should give more attention to addiction. Current evidence suggests that addiction may be more common than previously appreciated. In addition, the current definitions of substance abuse disorder may be very different for persons prescribed opioids for chronic pain than it is for street users; and

9. The Centers for Disease Control and Prevention will be producing updated guidelines for opioid use in 2015. This guidance should be included in the updated FSMB Model Policy; and

10. In 2014, the latest edition of *Safe and Responsible Opioid Prescribing* by Dr. Scott Fishman was issued. The Model Policy should reflect the latest guidance for safe and effective opioid prescribing provided by Dr. Fishman (2014 edition); and

11. Language in the Model Policy is not consistent with language of at least six state medical boards who have revised their policies or rules in the last two years;

Therefore, be it hereby

Resolved, That the Federation of State Medical Boards will establish a workgroup to review the current science and revise the Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain.

Actions by the FSMB House of Delegates
April 25, 2015

1. The agenda for the April 25, 2015 House of Delegates meeting was **APPROVED**.

2. The minutes of the April 26, 2014 House of Delegates meeting were **APPROVED**.

3. The seven rules for conducting the 2015 business meeting of the House of Delegates as presented in the report of the Rules Committee were **ADOPTED**.

4. The FY 2016 budget was **ADOPTED**.

5. Elections

Chair-elect:	**Arthur S. Hengerer, MD (2015-2016)**
Treasurer:	**Ralph C. Loomis, MD (2015-2018)**
Directors:	**Claudette E. Dalton, MD (2015-2018)** **Jerry G. Landau, JD (2015-2018)** **Gregory B. Snyder, MD (2015-2018)** **Stephen E. Heretick, JD (2015-2017)** **Mark A. Eggen, MD (2015-2016)**

Nominating Committee:

Mohammed A. Arsiwala, MD (2015-2017)
James F. Griffin, DO (2015-2017)
Kelli M. Johnson, MBA (2015-2017)

6. Resolution 15-1; Consistency in the Format of Electronic Medical Records (EMRs) to Enhance Readability and Usability submitted by the Texas Medical Board:

   Resolved; that the Federation of State Medical Boards (FSMB) create a committee to consider recommended guidelines on electronic medical records (EMRs) that will provide an understandable, longitudinal, patient centric view of EMR data that will allow medical professionals to care for individual patients over time and for Medical Boards to oversee the process.

AND

Resolution 15-2; Task Force to Study Access by Regulatory Boards to Electronic Medical Records (EMRs) submitted by the Minnesota Board of Medical Practice:

Resolved; that the Federation of State Medical Boards (FSMB) will establish a task force to review the format of an electronic medical record; and be it further

Resolved; that the FSMB task force will evaluate how information is entered into an electronic record and how information is compiled and released from an electronic format; and be it further

Resolved; that the FSMB task force will evaluate the feasibility of regulatory boards being allowed direct access to electronic medical records for the purpose of reviewing and downloading information necessary to a board process.

were combined and **REFERRED TO THE BOARD OF DIRECTORS FOR STUDY AND REPORT BACK TO THE HOUSE OF DELEGATES.**

7. Resolution 15-3; Developing Model Language in Board Actions and Coordinating with ABMS on the Effects of Board Actions on Specialty Board Certification submitted by the Washington Medical Quality Assurance Commission was **REFERRED TO THE BOARD OF DIRECTORS FOR STUDY AND REPORT BACK TO THE HOUSE OF DELEGATES**:

   Resolved; that the Federation of State Medical Boards (FSMB) will establish a workgroup to develop model language in board actions and to coordinate with the American Board of Medical Specialties (ABMS) to better understand the types of actions and language that will affect board certification and to promote consistent outcomes among the state medical boards and the ABMS.

8. **A SUBSTITUTE RESOLUTION** in lieu of Resolution 15-4; Revision of *FSMB Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain* submitted by the Washington Medical Quality Assurance Commission was **ADOPTED**:

   Resolved; that the Federation of State Medical Boards will establish a workgroup, comprised of state medical and osteopathic boards and other key stakeholders, such as the American Medical Association (AMA), American Osteopathic Association (AOA), specialty societies and state medical associations, to review the current science and revise the *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain.*

9. **A SUBSTITUTE RESOLUTION** in lieu of Resolution 15-5; Best Practices in the Use of Social Media by Medical and Osteopathic Boards submitted by the North Carolina Medical Board was **ADOPTED**:

   Resolved; that at its 2016 Annual Meeting, the Federation of State Medical Boards (FSMB) shall present information on current uses of social media by regulatory agencies and collect and disseminate information on best practices for regulatory agencies to follow in using social media and other forms of communication to publicize Board news and information, including public disciplinary actions.

10. The policy document contained in BRD RPT 15-3; *Elements of a State Medical and Osteopathic Board – 5th Edition* was **ADOPTED**.

11. The policy document contained in BRD RPT 15-4; *Essentials of a State Medical and Osteopathic Practice Act – 14th Edition* was **ADOPTED**.

12. The proposed FSMB 2015-2020 Strategic Plan contained in BRD RPT 15-5; Report of the Special Committee on Strategic Positioning was **ADOPTED** and the remainder of the report filed.

Opiate Analgesics for Chronic Non-Cancer Pain

Recommendations from the Committee on Pain Management and Prescription Drug Abuse

South Dakota State Medical Association

June 1, 2015

DRAFT

Executive Summary

When used appropriately, opiate[*] analgesics can be important tools for relieving moderate to severe pain arising from a wide range of conditions, disease states, and medical procedures. These drugs, however, may also be misused and abused, and overprescribing of opiate pain relievers can result in multiple adverse health outcomes, including fatal overdoses. In recent years there has been a shift in thinking among many pain specialists about the use of Opiates for chronic non-cancer pain, and legislative efforts to more closely regulate the prescription of opiates are underway in many states, including South Dakota.

Since professional opinions on this topic have evolved, the South Dakota State Medical Association's Committee on Pain Management and Prescription Drug Abuse has reviewed current literature and existing clinical guidelines in order to articulate an up-to-date set of consensus views for chronic pain management with analgesics. This paper summarizes those findings and provides South Dakota prescribers with clear, evidence-based guidance about the appropriate prescription of opiate analgesics. Although the practices described in these guidelines are intended to apply broadly, they are not intended to establish a "standard of care," Physicians must exercise their own best medical judgment when providing treatment, taking all relevant circumstances into account, including the potential for abuse, diversion and risk for addiction.

The key points of these recommendations include:

- *With respect to chronic pain management, maintenance of clinical and functional goals is key, and the incorporation of opiates should only be used when safer options have been deemed less effective.*
- *Opiate analgesics are widely accepted as appropriate and effective for alleviating moderate-to-severe acute pain, pain associated with cancer, and persistent end-of-life pain.*
- *The use of opiates for chronic non-cancer pain is more problematic, and current research on the benefits and/or safety of opiates for this indication is either weak or inadequate.*

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[*] The literature sometimes uses the terms "opiate" and "opioids" interchangeably. As used in this paper, the term "opiates" is intended to include, as applicable, the term "opioids."

- *Opiates should be used for chronic non-cancer pain only when safer options have been deemed ineffective, and continued treatment should be based on maintenance of clinical and functional goals.*
- *Patients should utilize only one provider for the management of chronic pain.*
- *Risks increase with dose. High doses of opiates (> 100 morphine-equivalents/day) have been shown to be associated with higher risks for overdose and death and such use should be carefully assessed and monitored.*
- *Extended-release/long-acting opiates should not be used to treat acute pain.*
- *Taking other substances/drugs with opiates (e.g., alcohol) or having certain conditions (e.g., sleep apnea, mental illness) increase risk.*
- *Opiates should be used only as prescribed, should be stored securely, and when a course of treatment is altered, discontinued or stopped, any unused opiates should be disposed of properly.*

In addition to these clinical practice recommendations, the Committee came to a consensus on a number of other issues related to responsible opiate prescribing:

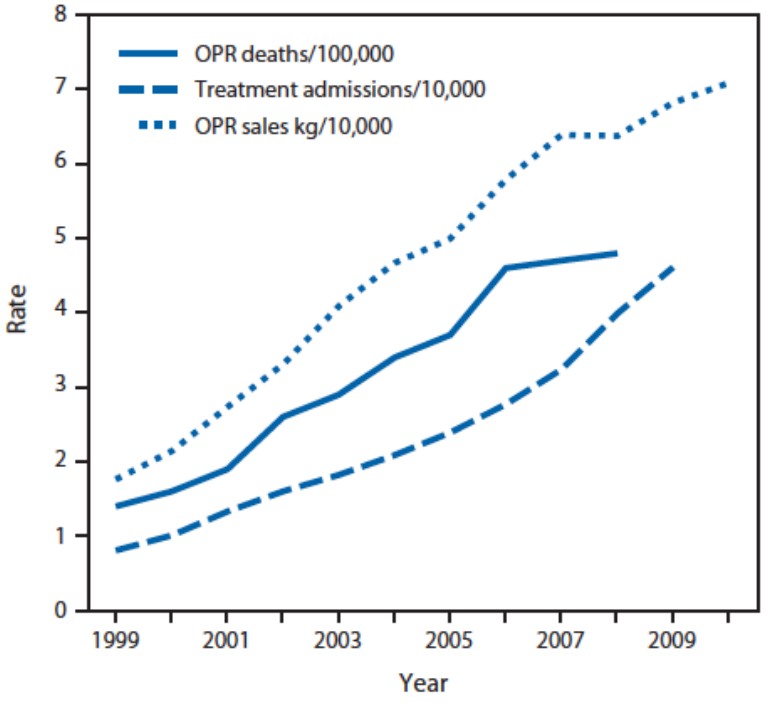
- *Expand and strengthen South Dakota's Prescription Drug Monitoring Program (PDMP) to facilitate rapid, accurate patient risk assessment to help improve patient care coordination, and to prevent diversion and/or "doctor shopping."*
- *Create new incentives for continuing medical education for opiate prescribers. Such education should be targeted to specific clinical practice needs, e.g. acute pain = emergency, surgery; long-acting/extended-release = pain management, etc.*
- *Create more safe medication disposal sites and promote their use.*
- *Expand patient education about the safe storage and use of opiates and other controlled substances to reduce the diversion of these medications for illicit use.*
- *Increase access to patients and caregivers for home and community use of the opiate-antidote naloxone (Narcan) to reduce morbidity and mortality related to opiate and heroin overdose.*

Scope of the problem

The use of opiate analgesics has risen dramatically in the past 20 years across the United States, including South Dakota. Between 1999 and 2010, the use of opiates quadrupled.[10] Much of this increase has been for the treatment of pain beyond moderate-to-severe acute pain or intractable end-of-life pain. In the past two decades, opiates have become widely-prescribed for chronic non-cancer conditions, such as back pain, osteoarthritis, fibromyalgia, and headache,[11] despite an evidence base that is much weaker than has been generally appreciated by many physicians until recently.[12]

As the number of opiate prescriptions has risen, so, too, has the rates of opiate abuse, addiction, and diversion for non-medical use. The current level of prescription opiate abuse has been described as an "epidemic" by the Centers for Disease Control and Prevention.[10]

Figure 1. Rates* of opiate analgesic overdose death, treatment admissions, and kilograms sold in the United States, 1999-2010[10]



* Age-adjusted rates per 100,000 population for OPR deaths, crude rates per 10,000 population for OPR abuse treatment admissions, and crude rates per 10,000 population for kilograms of OPR sold.

Despite a 104% increase in opiate analgesic prescriptions in the U.S. (from 43.8 million in 2000 to 89.2 million in 2010) *no improvements in disability rates or health status measures* of opiate users has been demonstrated.[13]

Physicians must balance an awareness of the ongoing problems of opiate over-prescription and abuse with the equally compelling need to relieve their patients' pain. Pain remains the most common reason people seek health care.[14] In fact, the incidence of chronic pain in the U.S. is estimated to be greater than that of diabetes, heart disease, and cancer combined.[15,16] Inadequately treating pain can lead to a wide range of adverse consequences (in addition to causing needless suffering) including diminished quality of life, and a higher risk for anxiety or depression.[17] Pain is also a major cause of work absenteeism, underemployment, and unemployment.[14]

Pain must be treated, but many types of pain treatments exist. Opiate analgesics may—or may not—be the right choice, particularly for those suffering from chronic non-cancer pain. Opiates do not address all of the physical and psychosocial dimensions of chronic pain, and they pose a wide range of potential adverse effects, including challenging side effects and the risk of abuse, addiction, and death.

Key concepts in pain medicine

Acute and chronic pain. Traditionally, pain has been classified by its duration. In this perspective, "acute" pain is relatively short-duration (lasting for only a matter of days or, at most, a few weeks), arises from obvious tissue injury, and usually fades with healing.[11] "Chronic" pain, in contrast, lasts longer than would be anticipated for the usual course of a given condition. The International Association for the Study of Pain defines this as pain lasting 3 months or longer.[18] These pain labels, however, provide no information about the biological nature of the pain itself, which is often critically important for optimal treatment.

Nociceptive and neuropathic pain. Pain can also be classified on the basis of its pathophysiology. Nociceptive pain is caused by the activation of nociceptors (pain receptors), and is generally, though not always, short-lived, and associated with the presence of an underlying medical condition. This is "normal" pain: a physiological response to an injurious stimulus.

Neuropathic pain, on the other hand, results either from an injury to the nervous system or from inadequately-treated nociceptive pain. It is an abnormal response to a stimulus caused by abnormal neuronal firing in the absence of active tissue damage. It may be continuous or episodic and varies widely in how it is perceived. Neuropathic pain is complex and can be difficult to diagnose and to manage because available treatment options are limited.

A key aspect of both nociceptive and neuropathic pain is the phenomenon of sensitization, which is a state of hyperexcitability in either peripheral nociceptors or neurons in the central nervous system. Sensitization may lead to either hyperalgesia (heightened pain from a stimulus that normally provokes pain) or allodynia (pain from a stimulus that is *not* normally painful).[19] Sensitization may arise from intense, repeated, or prolonged stimulation of nociceptors, or from the influence of compounds released by the body in response to tissue damage or inflammation.[20] Many patients—particularly those with chronic pain—experience pain that has both nociceptive and neuropathic components, which complicates assessment and treatment.

Differentiating between nociceptive and neuropathic pain is critical because the two respond differently to pain treatments. Neuropathic pain, for example, typically responds poorly to both opiate analgesics and non-steroidal anti-inflammatory (NSAID) agents.[21] Other classes of medications, such as anti-epileptics, antidepressants, or local anesthetics, may provide more effective relief for neuropathic pain.[22]

Cancer pain. Pain associated with cancer is sometimes given a separate classification, although it is not distinct, from a pathophysiological perspective. Cancer-related pain includes pain caused by the disease itself and/or painful diagnostic or therapeutic procedures. The treatment of cancer-related pain may be influenced by the life expectancy of the patient, by co-morbidities, and by the fact that such pain may be of exceptional severity and duration.

Chronic non-cancer pain. A focus of recent attention by the public, legislators, and physicians has been chronic pain that is *not* associated with cancer. Such pain may be caused by many kinds of conditions or disease states such as musculoskeletal injury, lower back trauma, dysfunctional healing from a wound or surgery, and persistent pain arising from autoimmune system disorders. With chronic non-cancer pain, the severity of pain experienced by a patient may not correspond well – or at all – to identifiable levels of tissue damage.

Dependence and addiction. Related to the nomenclature of pain itself are continuing confusions, by the public, but also in the medical community, about terms used to describe the effects of drugs on the brain and on behavior. To help clarify and standardize understanding, the American Society of Addiction Medicine (ASAM), the American Academy of Pain Medicine (AAPM), and the American Pain Society (APS) have recommended the following definitions:[23]

- *Physical Dependence.* A state of adaptation that often includes tolerance and is manifested by a drug class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, and/or administration of an antagonist. In brief, physical dependence is a physiological/automatic response of the body caused by the lack of or stoppage of treatment.
- *Addiction.* A primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving. In brief, addiction is a short-circuiting of the reward system of the brain – instead of having a job, a family, religion, friends, exercise, and/or a hobby to feel good, "addicts" decide to dispense those in favor of drugs.

Of note, opiate withdrawal is not dangerous and is usually preventable with a slow tapering down of the dosage/intake levels.

Managing chronic non-cancer pain in primary care

Many pharmacologic and non-pharmacologic approaches to treating painful conditions are available to primary care physicians. These options should be employed by using the following general principles:

- Identify and treat the source of the chronic pain, if possible, although treatment can begin before the source of the chronic pain is determined
- Select the most clinically appropriate approach to chronic pain management. This generally means using non-pharmacologic approaches as much as possible and/or trying medications with the least severe potential side effects first, and at the lowest effective doses

- Establish a function-based management plan if treatment is expected to be long-term

In treating chronic pain, clinicians can avail themselves of five basic modalities of chronic pain-management:

1. Cognitive-behavioral approaches
2. Rehabilitative approaches
3. Complementary and alternative therapies
4. Interventional approaches
5. Pharmacotherapy

These options can be used alone or in combinations to maximize pain control and functional gains. Only one of these options involves medications, and opiates are only one of many types of medications with potential analgesic utility. Which options are used in a given patient depends on the type of pain, the duration and severity of pain, patient preferences, co-occurring disease states or illnesses, patient life expectancy, cost, and the local availability of the treatment option. Multidisciplinary treatment needs to be patient-specific and based on the physical ailments of the individual.

Cognitive-behavioral approaches

Psychological therapies of all kinds may be a key element in managing chronic non-cancer pain. Cognitive therapy techniques may help patients monitor and evaluate negative or inaccurate thoughts and beliefs about their pain. For example, some patients engage in an exaggeration of their condition called “catastrophizing” or they may have an overly passive attitude toward their recovery which leads them to inappropriately expect a physician to “fix” their pain with little or no work or responsibility on their part. Individual, group, or family psychotherapy may be extremely helpful for addressing this and other psychological issues, depending on the specific needs of a patient. In general, psychological interventions may be best-suited for patients who express interest in such approaches, who feel anxious or fearful about their condition, or whose personal relationships are suffering as a result of chronic or recurrent pain. Unfortunately, the use of psychological approaches to pain management can be hampered by such barriers as provider time constraints, unsupportive reimbursement policies, lack of access to skilled and trained providers, or a lack of

awareness on the part of patients and/or physicians about the utility of such approaches for improving pain relief and overall functioning.

Rehabilitative approaches

In addition to relieving pain, a range of rehabilitative therapies can improve physical function, alter physiological responses to pain, and help reduce fear and anxiety. Treatments used in physical rehabilitation include exercises to improve strength, endurance, and flexibility, gait and posture training, stretching, and education about ergonomics and body mechanics. Exercise programs that incorporate Tai Chi, swimming, yoga, or core-training work may also be useful. Other noninvasive physical treatments for pain include thermotherapy (application of heat), cryotherapy (application of cold), counter-irritation, and electroanalgesia (e.g., transcutaneous electrical stimulation). Other types of rehabilitative therapies, such as occupational and social therapies, may be valuable for selected patients.

Complementary and alternative therapies

Complementary and alternative therapies (CAT) of various types are used by many patients in pain, both at home and in comprehensive pain clinics, hospitals, or other facilities. These therapies seek to reduce pain, induce relaxation, and enhance a sense of control over the pain or the underlying disease. Meditation, acupuncture, relaxation, imagery, biofeedback, and hypnosis are some of the therapies shown to be potentially helpful to some patients. CAT therapies can be combined with other pain treatment modalities and generally have few, if any, risks or attendant adverse effects. Such therapies can be an important and effective component of an integrated program of pain management.

Interventional approaches

Although beyond the scope of these guidelines, a wide range of surgical and other interventional approaches to patient-specific pain management exist, including: trigger point injections; epidural injections; facet blocks; spinal cord stimulators; laminectomy; spinal fusion; and deep brain implants. Treatments need to be patient-specific and based on the physical ailments of the individual.

Non-opiate analgesics

NSAIDs and Acetaminophen

Non-steroidal anti-inflammatory drugs (NSAIDs), which include aspirin and other salicylic acid derivatives, and acetaminophen are used in the management of both acute and chronic pain such as that arising from injury, arthritis, dental procedures, swelling, or surgical procedures. Although they are weaker analgesics than opiates, acetaminophen and NSAIDs do not produce tolerance, physical dependence, or addiction. Acetaminophen and NSAIDs are also frequently added to an opiate regimen for their opiate-sparing effect. Since non-opiates and opiates relieve pain via different mechanisms, combination therapy can provide improved relief with fewer side effects.

These agents are not without risk, however. Adverse effects of NSAIDs include gastrointestinal problems (e.g., stomach upset, ulcers, perforation, bleeding, liver dysfunction), bleeding (i.e., antiplatelet effects), kidney dysfunction, hypersensitivity reactions and cardiovascular concerns, particularly in the elderly.[24] The threshold dose for acetaminophen liver toxicity has not been established; however, the SDSMA recommends that the total adult daily dose should not exceed 3,000 mg. in patients without liver disease (although the ceiling may be lower for older adults).[25]

In 2014, new FDA rules went into effect that set a maximum limit of 325 mg of acetaminophen in prescription combination products (e.g. hydrocodone and acetaminophen) in an attempt to limit liver damage and other ill effects from the use of these products.[32]

Topical agents

Topical capsaicin and salicylates can both be effective for short term pain relief and generally have fewer side effects than oral analgesics, but their long term efficacy is not well studied.[26,27] Topical NSAIDs and lidocaine have been reported to be effective for short term relief of superficial pain with minimal side effects, although both are more expensive than topical capsaicin and salicylates. None of the topical agents are useful for non-superficial pain.

Antidepressants

Pain and depression are compounding – improving patient mood and/or controlling pain has a positive impact on the other. Some antidepressants, particularly tricyclics, SSRIs, and SNRIs, exhibit analgesic properties and may be particularly useful for treating neuropathic pain. Their analgesic actions do not depend on antidepressant activity, and antidepressants are equally effective in patients with and without depression.[28] While analgesia may occur at lower doses and sooner than antidepressant activity, maximum efficacy may require high antidepressant doses and trial duration.

Anticonvulsants

Antiepileptic drugs (AEDs) are increasingly used for treating neuropathic pain because they can reduce membrane excitability and suppress abnormal discharges in pathologically altered neurons.[29] The exact mechanism of action for their analgesic effects, however, is unclear. It does not appear to be specifically related to their antiepileptic activity. Other drugs that suppress seizures (e.g., barbiturates) do not relieve pain, and some AEDs with effective antiepileptic activity do not necessarily have good analgesic activity.[22]

Opiates for chronic non-cancer pain

The utility of opiate analgesics for treating chronic non-cancer pain is being increasingly questioned and a broad consensus is developing that these agents are not, in fact, suited for many patients with this type of pain. Clinical guidelines for the use of opiates in chronic non-cancer pain have evolved in recent years to stress the risks of opiates and strengthen procedures that prescribers should use to reduce the risk of addiction and misuse.[30,31,32]

Little evidence supports the assertion that long-term use of opiates provides clinically significant pain relief or improves quality of life or functioning.[33] The Agency for Healthcare Research and Quality (AHRQ), for example, recently found *no studies* that compare opiate therapy with either a placebo or a non-opiate treatment for long-term (>1 year) pain management.[34] A Cochrane review of opiates for long-term treatment of non-cancer pain found that many patients discontinue long-term opiate therapy (especially oral opiates) due to adverse events or insufficient pain relief.[33]

A large – and growing – body of evidence, on the other hand, demonstrates that opiates pose significant risks for adverse effects, abuse, addiction, and accidental overdose leading to death from respiratory depression.

Estimating the risk that patients face of becoming addicted to opiate analgesics is difficult because rigorous, long-term studies of these risks in patients without co-existing substance-use disorders have not been conducted.[5] A few surveys conducted in community practice settings, however, estimate rates of prescription opiate abuse of between 4% to 26%.[35,36,37,38] Risk rises with higher doses and longer durations.[39]

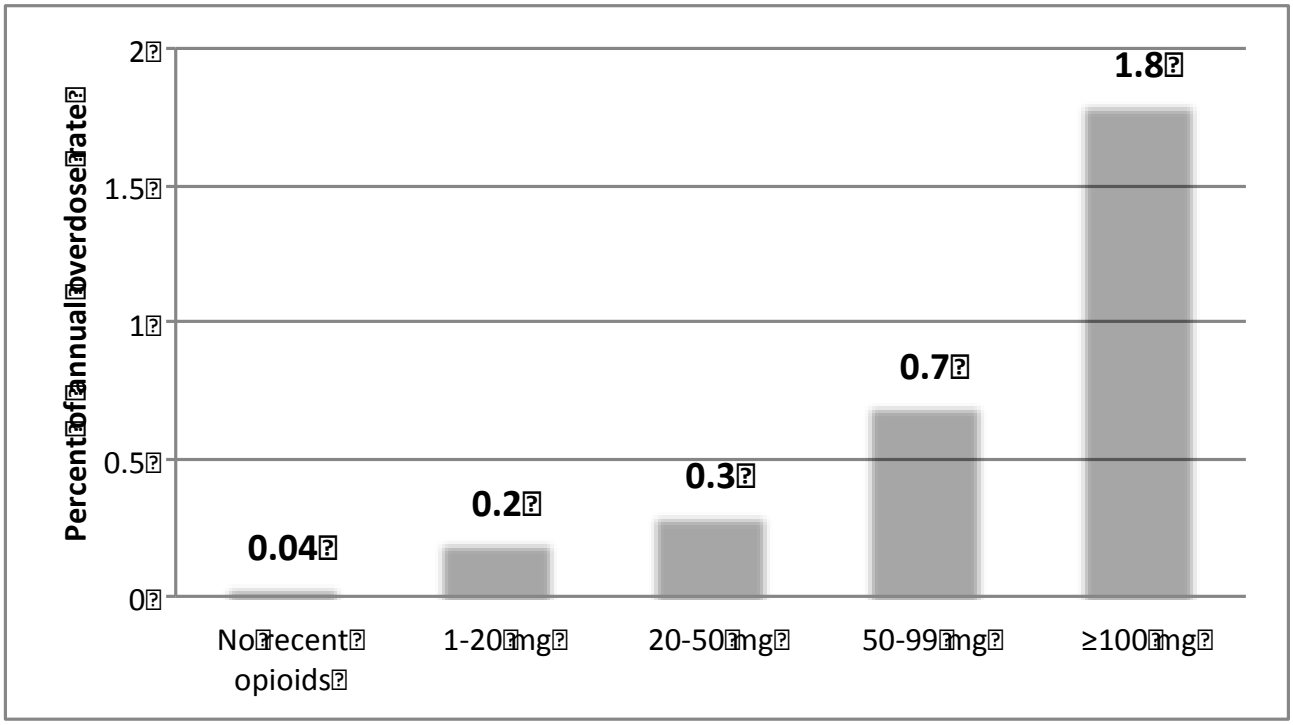
A 2011 study of a random sample of 705 patients undergoing long-term opiate therapy for non-cancer pain found a lifetime prevalence rate of DSM-5-defined opiate-use disorder of 35%.[40] The variability in such results probably reflects differences in opiate treatment duration, the short-term nature of most studies, and disparate study populations and measures used to assess abuse or addiction. Nonetheless, the levels of risk suggested by these studies are significant enough to warrant extreme caution in the prescription of any opiate for a chronic pain condition.

Caution is also required because a significant portion of patients can be expected not to use an opiate medication as prescribed. Fleming et al., conducted in-depth interviews with 801 patients receiving long-term opiate therapy and found the following:[36]

- 39% of patients increased their dose without direction from a health care provider
- 26% engaged in purposeful over-sedation
- 20% drank alcohol concurrent with opiate use
- 18% used opiates for purposes other than pain relief
- 12% hoarded their pain medications
- 8% obtained extra opiates from other doctors

The risk of overdose with opiate analgesics is significant and, as with risk of abuse/dependence, rises with both dose and duration.[41]

Figure 2. Percent of annual overdose rates rises with daily opiate dose[41]



In addition to the risks for misuse, addiction, and overdose, opiates can exert a wide range of uncomfortable or harmful adverse effects, the most common of which are neurologic (somnolence, dizziness), endocrine (hypogonadism), gastrointestinal (nausea, vomiting, and constipation), sexual (erectile dysfunction), and cutaneous (pruritus). In randomized trials of opiates, 50%-80% of patients report a side effect, and about 25% withdraw due to an adverse event.[33,42,43]

Although less common, there is also a dose-dependent increase in risk of fractures in opiate users compared to non-users, with risk highest in the period following initiation, particularly for short-acting opiates.[44,45]

An area of potential concern is the possibility that chronic opiate use may have immunosuppressive effects. Evidence from cell cultures and animal models is suggestive, and this is an area requiring further investigation.[46] Dublin et al., in a population-based case-control study, found a significantly higher risk of pneumonia in immunocompetent older adults who were prescribed opiates.[47] The risk was particularly high for adults taking long-acting opiates.[47]

Guidelines for responsible opiate prescribing

Given the limited evidence and risks, prescribing opiates for long-term non-cancer chronic pain should be carefully evaluated and only initiated in certain situations. For example, an opiate may be appropriate for chronic pain in certain limited circumstances, such as: when the pain is severe and refractory to other treatments; when it adversely impacts function or quality of life; and when the potential therapeutic benefits outweigh, or are likely to outweigh, potential harms.[11] In these cases, clinicians can take many steps to maximize the chances that the opiate will be effectively used with minimal risk to the patient and to society at large. This section reviews these steps in detail.

Patient selection and risk stratification

Prior to initiating opiate treatment for a chronic pain condition, clinicians should conduct a history, physical examination, appropriate testing, and an assessment of the patient's risk of substance abuse, misuse, or addiction.[11] A risk-benefit evaluation including a history, physical examination, and appropriate diagnostic testing, should be performed and documented both before a decision to treat is made, and on an ongoing basis if opiate treatment is begun.[11]

Patients or pain conditions unlikely to benefit from opiate therapy

Although the available evidence base is limited, professional guidelines suggest that the following patient characteristics and pain conditions are unlikely to benefit from opiate analgesics:[11]

- Poorly-defined pain conditions
- Daily headache
- Fibromyalgia
- A likely or diagnosed somatoform disorder
- Patients with unresolved workers compensation or legal issues related to pain or injury[†]

[†] Some evidence suggests that early treatment with opioids in this population may delay recovery and a return to work. Conflicts of motivation may also exist in patients on workers' compensation, such as if they don't want to return to an unsatisfying, difficult, or hazardous job.

Opiates must be used with extreme caution in patients with:[11]

- Pre-existing constipation, nausea, pulmonary disease, or cognitive impairment
- A history of drug or alcohol abuse

Pain assessment tools

Unidimensional pain scales (e.g., numeric or "faces") are seldom useful for guiding a decision to treat chronic pain because such pain is variable and scores from pain assessment tools are highly subjective. Multidimensional tools provide more information, such as the effects of pain on daily life. These tools can typically be administered in an office, examination room, or other clinical setting by either a physician or another health care professional, or they could be filled out by the patient, if appropriate. Examples of some multidimensional tools include:

- Initial Pain Assessment Tool[48]
- Brief Pain Inventory[49]
- McGill Pain Questionnaire (short-form available)[50]

Psychosocial evaluation

Because life stressors often underlie or co-exist with chronic pain and may warrant intervention, it is critical to assess the patient's psychosocial functioning. A thorough history should include questions about a patient's functioning at work and home, as well as how their pain might be affecting their significant relationships, sexual functioning, and recreational activities. Clinicians should be alert for signs of depression or anxiety (common in patients with chronic pain) as well as for suicidal thoughts since the risk of suicide is roughly double for patients with chronic pain.[51]

Instruments such as the Depression Anxiety & Positive Outlook Scale (available at: www.dapos.org), the Generalized Anxiety Disorder assessment (GAD-7, available at: http://www.patient.co.uk/doctor/generalised-anxiety-disorder-assessment-gad-7), and the Patient Health Questionnaire (www.phqscreeners.com) can facilitate a thorough psychosocial history. These are brief (i.e. > 5 min.) questionnaires filled out and scored by a clinician. The results can guide next steps, which may include pursuing a course of treatment, further questioning, use of additional short tools if a particular issue is uncovered (e.g., suicidality), or referral to a mental-

health professional if the patient has active psychological issues that are beyond a clinician's expertise.

Evaluating patients for risk of opiate dependence or abuse

Given the demonstrated risks of abuse and addiction associated with opiate analgesics, clinicians must assess patients for their potential vulnerability to these risks. Such assessment is not completely objective, and opinions differ about which patients should be more rigorously assessed. Some favor a "universal precautions" approach, in which all pain patients are considered to have some degree of vulnerability to abuse and addiction and, hence, all patients are given the same screenings and diagnostic procedures.[52] Some patient characteristics, however, do appear to be predictive of a potential for drug abuse, misuse, or other aberrant behaviors, particularly a personal or family history of alcohol or drug abuse.[11] Some studies also show that younger age and the presence of psychiatric conditions are associated with aberrant drug-related behaviors.[11]

Relatively brief, validated tools can help formalize assessment of a patient's risk of having a substance misuse problem (Table 1) and these should be considered for routine clinical use.[11] For more information on risk reduction strategies, a free online CME is available at: www.opioidprescribing.com. The use of a Prescription Drug Monitoring Program may also provide some helpful information about a patient's risk of dependence or abuse (see section on PDMPs on page 27).

Table 1. Tools for Patient Risk Assessment

Tool	Who Administers?	Length
Diagnosis, Intractability, Risk, Efficacy (DIRE)	Clinician	7 items
Opioid Risk Tool (ORT)	Clinician or patient self-report	5 yes/no questions
Screener and Opioid Assessment for Patients with Pain, Version 1 and Revised (SOAPP, and SOAPP-R)	Patient self-report	24 items

Function-based opiate management plans

A "medication agreement" or "management plan" can serve many useful functions, including patient education, clarification of expectations, and goal-setting, all of which may help a patient adhere to a regimen of opiate pain medication.[11] Additionally, routine screening should be considered by clinicians and medical systems for identification and brief intervention, if required. Of note, agreements should be written and signed by the provider and the patient, and should include the elements listed in Table 2.

Table 2: Components of an opiate medication agreement

Rationale (what you are treating and why)
Risks of the drug (side effects as well as risk of dependence, tolerance, addiction, misuse, and overdose; and risk of driving, working, etc., under the influence of the drug)
Treatment **goals** (pain level, function level)
Monitoring plan (how often to return for follow up)
Refill policy
Action plan for suspected **aberrant behavior** (may include urine drug screens to ensure the patient is not diverting the medication)
Conditions for **discontinuing** opiates (lack of efficacy, pain resolution, aberrant behavior)

In crafting a management plan, clinicians should avoid framing the agreement in terms of punishments for possible future misbehaviors or difficulties, and should take care to avoid using language that is stigmatizing, dominating, or pejorative. Since written agreements must be clearly understood by the patient, they should be written at the sixth- to seventh-grade level, and translated into the patient's language, if possible (in-person translators may also be used).[53] Time must be allowed for patients to ask questions, and for prescribers to ensure patients understand what they are being told. Some, or all, of these tasks may be handled by trained personnel (or staff members) rather than physicians. (A sample agreement is provided in Appendix I of this document.)

Clinicians should be aware that although the terms "agreement" or "plan" are more patient-friendly than the word "contract," from a legal standpoint, any written or oral agreement between a prescriber and a patient may be considered a binding "contract."[54]

Since pain itself cannot be measured objectively, opiate management plans should not be framed solely in terms of pain relief; functional goals are preferable. Chronic pain often impairs functioning in daily life, such as the ability to be physically active, mentally focused, and well-rested. Even relatively modest reductions in pain can allow for functional improvements.[55]

Framing treatment goals in terms of improved functioning allows prescribing decisions (or decisions to terminate treatment) to be based on objective data such as attendance at physical therapy appointments, sleeping in a bed instead of a chair, or walking a designated distance or number of steps. Another key benefit of a function-based opiate management plan is that the resulting data can help differentiate patients who are addicted to an opiate from patients who are not addicted but are nonetheless seeking an increased dose: addiction typically leads to *decreased* functioning, while effective pain relief typically improves functioning.[31]

Functional treatment goals should be realistic and tailored to each patient. Because patients with long-standing chronic pain are frequently physically deconditioned, progress in achieving functional goals can be slow or interrupted with "setbacks." It is better to set goals slightly too low than slightly too high. Raising goals after a patient has "succeeded" is preferable—and more motivational—than lowering goals after a patient has "failed."

Opioids for acute pain

Although the focus of this paper is on chronic non-cancer pain, opioids are widely used for acute pain as well, and a brief overview of recommended practice is appropriate here. Cautious use of opioids for moderate or severe acute pain may be considered for carefully-selected patients whose pain is not controlled with acetaminophen or NSAIDs, or for whom such medications are contraindicated. The opioid should be used at a minimum effective dose, and for a limited period of time, usually less than 2-3 days. Opioids should be used only as one part of a comprehensive pain care plan, and extended release opioids should be avoided in acute pain patients.[3]

Studies show that physicians routinely over-prescribe opioids for acute pain. For example, Rodgers et al., found that after outpatient orthopedic surgery, most patients were prescribed 30 pills of an opioid analgesic, although the mean patient consumption of those analgesics was only 10 pills.[4] Another study found that 72% of people who had been prescribed an opioid had leftover medication.[5] This guideline recommends that no more than a one-week supply be prescribed following surgery.

By definition, treatment of acute pain should not last longer than the time required for the healing or resolution of the trauma or condition. Hence, it is unlikely that opioids, or any other analgesic, will be needed beyond 90 days from initiation of treatment. Research shows that after 90 days of continuous opioid use, treatment is more likely to become life-long.[6,7,8,9] The 90-day mark, therefore, should be considered a "red flag" point at which use should be re-evaluated.

Informed consent

Informed consent is a fundamental part of any medical treatment plan, but it is critically important when considering long-term opiate therapy, given the potential risks involved. Four key questions clinicians may ask when obtaining informed consent in the context of opiate treatment are:[56]

1. Does the patient understand the various options for treatment?

2. Has the patient been informed of the potential benefits and risks associated with each of those options?

3. Is the patient free to choose among those options, and free from coercion by the health care professional, the patient's family, or others?

4. Does the patient have the capacity to communicate his or her preferences—verbally or in other ways (e.g., is the patient deaf or cognitively impaired)?

Documented informed consent may best be incorporated into an opiate management plan.

Initiating opiates

Before prescribing any opiate, clinicians may consider whether:

- Other treatment options have been exhausted
- The patient's physical and psychosocial condition has been fully assessed
- Level of opiate tolerance has been determined or estimated (see below)
- Informed consent has been obtained and a management plan is in place

Opiate selection, initial dosing, and titration must be individualized to the patient's health status, previous exposure to opiates, and treatment plan.[11] Patients who are opiate-naïve or have modest previous opiate exposure should be started at a low dose, generally of a short-acting opiate because these confer a lower risk of overdose, and titrated slowly upward to decrease the risk of opiate-related adverse effects.[11] If it is unclear whether a patient has recently been using opiates (either prescribed or non-prescribed), the clinician should assume that the patient is opiate-naïve (i.e., not tolerant) and proceed as just described. Some patients, such as frail older persons or those with comorbidities, may require an even more cautious therapy initiation.

The Special Case of Methadone

Methadone has some unique safety issues. It has a long and unpredictable half life and accounts for a higher proportion of accidental overdoses than any other opioid.[1] In addition, it prolongs the QTc interval, and increases the risk of fatal arrhythmias (*torsades de pointes*), especially in patients taking other QTc prolonging agents. The routine use of methadone for chronic pain in primary care should be avoided.

A decision to continue opiate therapy should be based on careful review of the trial outcomes. Outcomes to consider include:[31]

- Progress toward meeting functional goals
- Presence and nature of adverse effects
- Changes in the underlying pain condition
- Changes in medical or psychiatric comorbidities
- Degree of opiate tolerance in the patient
- Identification of aberrant behaviors, misuse, or diversion

Patient education

Whenever an opiate is prescribed, the patient should be thoroughly educated about the safe use, storage, and disposal of opiate medications. This can be done by a non-physician, if desired, and the key points can be included in patient/provider agreements or treatment plans. Safe use means following clinician instructions about dosing, reviewing and avoiding potentially dangerous drug interactions with other drugs, and assuring full understanding of how the medication should be consumed or, in some cases applied.

Safe storage means reminding patients that pain medications are sought after by many people, and, thus it is best if opiates are stored in a locked cabinet or other secure storage unit. If a locked unit is not available, patients should, at least, not keep opiates in a place that is obvious to, or easily accessed by others, since theft by friends, relatives, and guests is a known route by which opiates become diverted.[57] Storage areas should be cool, dry, and out of direct sunlight.

Proper disposal means getting rid of unused medications. Patients should:

- Follow any specific disposal instructions on the prescription drug labeling or patient information that accompanies the medication. Do not flush medicines down the sink or toilet unless this information specifically instructs to do so;
- Return medications to a pharmacy, health center, or other organization with a take-back program; or
- Mix the medication with an undesirable substance (e.g. coffee grounds or kitty litter) and putt it in the trash.

In 2014, the DEA loosened regulations to allow pharmacies, hospitals, clinics, and other authorized collectors to serve as drop-off sites for unused prescription drugs.

Opiate selection

Opiate analgesics are available in a wide range of formulations and routes of administration (i.e., oral, transdermal, transmucosal, rectal, intrathecal). Little evidence exists that specific analgesic formulations affect efficacy or addiction risk, so selection of agent should be based on the patient's pain complaint, lifestyle, and preferences.[58] Generally, if opiates are used at all, it is better to offer

short-acting opiates used on an as-needed basis. Extended-release (ER) or long-acting (LA) opiates produce a more steady state of analgesia without the cycling effect of pain relief and withdrawal associated with short-acting opiates, which may be helpful for certain patients.[59] With ER/LA agents, however, patients may end up using more drug than is actually needed, and physiological adaptations to the steady state may ultimately decrease analgesic efficacy.[60] In addition, ER/LA opiates pose a higher risk for being abused. Clinicians should warn patients that oral ER/LA opiates should not be broken, chewed, or crushed. Patches should not be cut or torn prior to use, since this may lead to rapid release of the opiate and could cause overdose or death. ER/LA agents should not be used to treat acute pain.

Prescribers should educate themselves about the general characteristics, toxicities, and drug interactions for ER/LA opiate products. [For detailed information on current ER/LA opiate analgesics, see the FDA Blueprint for Prescriber Education, available at: http://www.er-la-opioidrems.com].

Combination products join an opiate with a non-opiate analgesic, usually for use in patients with moderate pain. Using a combination product when dose escalation is required risks increasing adverse effects from the non-opiate co-analgesic, even if an increase of the opiate dose is appropriate. In such cases, using a pure opiate is preferable. Care, in particular, must be given to not exceed maximal daily doses of acetaminophen.

Periodic review and monitoring

If an opiate medication appears to be helpful (as determined by the functional goals outlined in the management plan) and therapy is continued, regular review and monitoring should be performed for the duration of treatment. Exactly what constitutes “regular” is determined by the needs and characteristics of each patient. A physical examination, for example, may or may not be required at each follow-up visit. Clinicians must evaluate progress against agreed-upon treatment goals for both pain relief and function, assess for physical and behavioral adverse effects, and confirm adherence to prescription regimens.

The intensity and frequency of monitoring is guided, in part, by the clinician’s assessment of the patient’s risk for abuse, diversion, or addiction. Tools and techniques similar or identical to those

used during an initial assessment of a patient's risk can be used to re-assess or monitor risk on an on-going basis.

Patients who may need more frequent or intense monitoring include:

- Those with a prior history of an addictive disorder, past substance abuse, or other aberrant use
- Those in an occupations demanding mental acuity
- Older adults
- Patients with an unstable or dysfunctional social environment
- Those with comorbid psychiatric or medical conditions
- Those who are taking other medications that may interact with an opiate

Caution about dose escalation

When treating chronic pain, dose escalation has not been proven to reduce pain or increase function, but it *can* increase risks.[61] Prescribing high-dose opiate therapy (≥120 mg morphine equivalents/day) may not be appropriate, and in such cases, referral to a provider with specialized skill or experience in dealing with high-risk patients may be prudent. A recent cohort study of 9,940 patients receiving opiate analgesics for chronic non-cancer pain found that patients receiving 100 mg or more per day had an 8.9-fold increase in overdose risk compared to patients receiving 1-20 mg. of opiates per day.[41] No randomized trials show long-term effectiveness of high opiate doses for chronic non-cancer pain. Many patients on high doses continue to have substantial pain and related dysfunction.[61] As noted earlier, higher doses of opiates are associated with increased risks for adverse events and side effects including overdose, fractures, hormonal changes, and increased pain sensitivity.

Table 3. 100 MED equivalents*

	Dose of Opiate
	42 mcg/hr fentanyl transdermal
	100 mg. hydrocodone
100 morphine equivalents =	25 mg. hydromorphone
	67 mg. oxycodone
	33 mg. oxymorphone

* This is not a chart for opiate conversion. See below regarding considerations for conversion or opiate rotation.

Urine drug screens

Urine drug testing is an imperfect science, but such testing can be a helpful component of responsible opiate prescribing. Drug testing should be conducted in a consensual manner as part of an agreed-upon opiate management plan and with the idea that such testing benefits both the patient and the provider. The potential benefits of urine drug testing include:

- Serving as a deterrent to inappropriate use
- Providing objective evidence of abstinence from drugs of abuse
- Monitoring compliance with the treatment plan

In primary care settings, unobserved urine collection is usually acceptable, however, clinicians should be aware of the many ways in which urine specimens can be adulterated. Specimens should be shaken to determine if soap products have been added, for example. The urine color should be noted on any documentation that accompanies the specimen for evaluation, since unusually colored urine could indicate adulteration. If possible, urine temperature and pH should be measured

immediately after collection.[62] (A guide for dealing with suspected adulteration of a urine sample or patients suspected of misusing a prescription is available to members of the SDSMA.)

Prescribers should be familiar with the metabolites associated with each opiate that may be detected in urine, since the appearance of a metabolite can be misleading. A patient prescribed codeine, for example, may test positive for morphine because morphine is a codeine metabolite. Similar misunderstandings may occur for patients prescribed hydrocodone who appear positive for hydromorphone or oxycodone and oxymorphone. In the event of an abnormal urine drug screen, prescribers should consider a differential diagnosis that includes: drug abuse or addiction; self-treatment of poorly-controlled pain; psychological issues; or diversion (which may be suggested by absence of prescribed opiates).[11]

Protecting against opiate-induced adverse events

The Veterans Administration/Department of Defense (VA/DoD) clinical practice guideline outlines a number of evidence-based strategies to reduce opiate-related adverse effects, summarized in Table 4.[63] Prophylaxsis for constipation, which is the most common opiate-induced adverse event, has been facilitated by the recent approval of methylnaltrexone (Relistor) subcutaneous administration and naloxegol (Movantik) oral administration for patients with chronic non-cancer pain.

Table 4: Recommendations for preventing or treating opiate-induced side effects[63]

Constipation	Methylnaltrexone or naloxegol Prophylactic mild peristaltic stimulant (e.g. bisacodyl or senna) If no bowel movement for 48 hours, increase dose of bowel stimulant If no bowel movement for 72 hours, perform rectal exam If not impacted, provide additional therapy (suppository, enema, magnesium citrate, etc.)
Nausea or vomiting	Consider prophylactic antiemetic therapy Add or increase non-opiate pain control agents (e.g. acetaminophen) If analgesia is satisfactory, decrease dose by 25% Treat based on cause
Sedation	Determine whether sedation is due to the opiate Eliminate nonessential CNS depressants (such as benzodiazepines) If analgesia is satisfactory, reduce dose by 10-15% Add or increase non-opiate or non-sedating adjuvant for additional pain relief (such as NSAID or acetaminophen)so the opiate can be reduced Add stimulant in the morning (such as caffeine)

	Change opiate
Pruritus	Consider treatment with antihistamines Change opiate
Hallucination or dysphoria	Evaluate underlying cause Eliminate nonessential CNS acting medications
Sexual dysfunction	Reduce dose Testosterone replacement therapy may be helpful (for men) Erection-enhancing medications (e.g., sildenafil)

The concurrent use of benzodiazepines and opiates is particularly problematic since these agents act synergistically to depress respiratory functioning.

Opiate rotation

Switching from one opiate to another may be needed for a variety of reasons: to better balance analgesia and side effects; lack of efficacy (often related to tolerance); bothersome or unacceptable side effects; need for dose increases that exceed recommended limits (e.g., dose limitations of co-compounded acetaminophen); or inability to absorb the medication in its present form.

Opiate rotation must be done cautiously because of the many pharmacokinetic and pharmacodynamic variables involved.[31] An equianalgesic chart should be used when changing from one opiate to another or from one route of administration to another. Such charts must be used carefully, however. A high degree of variation has been found across the various charts and online calculators, and may account for some overdoses and fatalities.[64] The optimal dose for a specific patient must be determined by careful titration and appropriate monitoring, and clinicians must remember that patients may exhibit incomplete cross-tolerance to different types of opiates because of differences in the receptors or receptor sub-types to which different opiates bind. Do not simultaneously switch both an agent *and* a route of administration or type of release (e.g., ER/LA)

Managing pain flare-ups

Pain is dynamic, and pain intensity may sometimes rise to the point that it is not controlled by a given steady-state dose. Providing patients either paper or electronic pain diaries can help them track such pain episodes and spot correlations between the flare-ups and variables in their lives. If specific triggers are identified, patients may be able to make changes that will reduce the prevalence of episodes without recourse to increased medication.[31]

Non-opiate methods of dealing with pain flare-ups (e.g., cold or warmth, massage, yoga, acupuncture, meditation, electrical stimulation) should be tried—or at least considered—before the dose of an opiate is increased. As with the management of the underlying chronic pain condition, clinicians should use an agreed-upon set of functional goals as a way to monitor, and if necessary, adjust, the use of as-needed opiate medications for pain flares.

Using Prescription Monitoring Programs

South Dakota's prescription drug monitoring program (PDMP) offers point-of-care access to pharmacy dispensing records of controlled substances from prescribers. From these, clinicians can quickly assess patterns of prescription drug use that can be helpful in confirming or refuting suspicions of aberrant behaviors. Information from the PDMP may also reveal that a patient is being prescribed medications whose combinations are contraindicated. By reviewing the PDMP each prescriber can identify other prescribers involved in the care of their patient. This can be especially useful for new patients to a practice on high dose opiates, with suspect or concerning behaviors.

Pharmacies and practitioners that dispense any Schedule II, III, or IV controlled substances in South Dakota, or to an address in South Dakota, must report such dispensing to the PDMP.

Addressing concerns about prescription activity

Suspicion that a patient is non-adherent to a prescription or is engaging in aberrant drug-related behaviors should prompt a thorough investigation of the situation, including an honest evaluation of the patient/provider relationship, which may be strained by such behaviors.[31] Possible reasons for non-adherence include:

- Inadequate pain relief
- Misunderstanding of the prescription
- Misunderstandings related to lack of fluency with English
- Attempts to "stretch" a medication to save money
- Cultural or familial pressure not to take a medication
- Stigma about taking a pain medication
- Patient fears about addiction

Listed below are some possible steps to take in response to concerns about a patient's prescription activity:

- Discuss the situation with the patient: express concern over the pattern of behavior; discuss how drug abuse begins; and emphasize its negative consequences on health, employment, finances, friends and family, etc.
- Clarify expectations (e.g., receiving controlled medications from only one prescriber, using only one pharmacy) and review existing patient/provider agreements
- Increase the intensity of patient monitoring (e.g., urine toxicology, pill counts and early refills) and establish limits on refills or lost medications

For persistent non-compliance, options include one or more of the following:

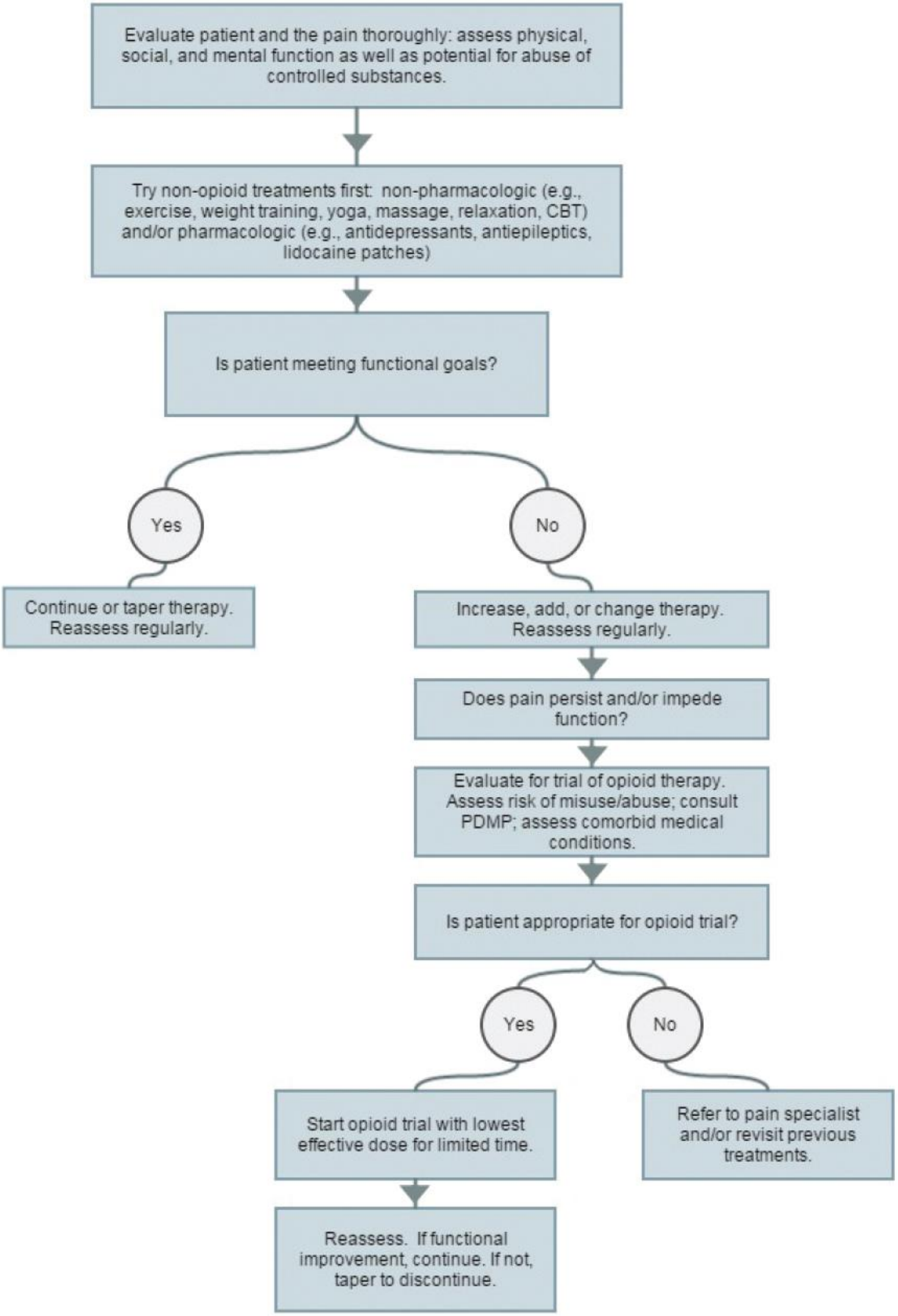
- Tapering drug therapy over several weeks to avoid withdrawal; consider incorporating non-opiate pain treatments.
- Referral to specialists, e.g., pain specialist, for evaluation of continued controlled substance prescribing
- Referral to an addiction management program

Patients with addictive disorders and/or complex chronic pain problems should maintain a relationship with a primary care provider, even if the management of the pain and/or addiction will be conducted by specialists. Providers are not required to take action that they believe to be contrary to the patient's best interests. If the provider believes that a crime has been committed, such as misrepresenting oneself to obtain controlled substance prescriptions, it is the right of the provider or staff to contact law enforcement and/or other providers. In criminal matters HIPAA restrictions generally do not apply. Legal input in difficult cases may be helpful. (A Legal Brief on Reporting Patient Drug Use or Diversion is available from the SDSMA and provides more detailed information on this topic.)

Roadmap for responsible opiate prescribing

The algorithm below summarizes the guidance presented in this section. It emphasizes the need to pursue non-opiate therapies first, to rigorously assess patients, and to work within a function-based paradigm of care.

Figure 3. Algorithm for pain management



Discontinuing opiate therapy

Discontinuation of an opiate may be necessary for a variety of reasons, including the healing of an injury or condition, an inability to achieve adequate analgesia, the lack of progress toward functional goals, the experience of intolerable side effects, or evidence of abuse, addiction or aberrant behaviors. If inappropriate use of a prescription medication is discovered, treatment must usually be suspended, although provisions should be in place for continuation of some kind of pain treatment and/or referral to other professionals or members of a pain management team.

Some clinicians may be willing and able to continue a regimen of opiate therapy even after the discovery of aberrant behavior, although this would require intensified monitoring, patient counseling, and careful documentation of all directives. This level of vigilance and risk management, however, may exceed the abilities and resources of primary care physicians. In such cases, referral to a provider with specialized skill or experience in dealing with high-risk patients may be prudent.

Stopping long-term opiate therapy is often more difficult than starting it.[65] For most patients, the opiate dose should be tapered by 20% to 50% of the current dose per week. The longer the patient has been on the drug, and the higher the initial dose, the slower should be the taper.[63]

Opiates and pregnancy

Current American Pain Society-American Academy of Pain Medicine (APS-AAPM) guidelines suggest that clinicians should avoid prescribing opiates during pregnancy unless the potential benefits outweigh risks.[11] Some data suggest an association between the use of long-term opiate therapy during pregnancy and adverse outcomes in newborns, including low birth weight and premature birth, though co-related maternal factors may play a role in these associations and causality is not certain.[11] Exposure to these medications has also been associated with birth defects in some studies. Opiate withdrawal can be expected in up to half of newborns of opiate-dependent mothers (neonatal abstinence syndrome).[11] If a mother is receiving long-term opiate therapy at or near the time of delivery, a professional experienced in the management of neonatal withdrawal

should be available – per ASAM, ACOG, AAP, neonatal abstinence can be effectively treated with no long-term, harmful effects on mom or baby.

Reducing the risk of overdose

Opiate overdose is reversible through the timely administration of the medication naloxone (trade name Narcan). Narcan is a prescription drug, but it is not a controlled substance and has no abuse potential. It is regularly carried by medical first responders and, as of July 1, 2015, such use became legal in South Dakota.

As an opiate antagonist, naloxone can quickly restore normal respiration to a person whose breathing has slowed or stopped as a result of heroin or prescription opiate overdose. As of 2010, programs that distribute naloxone to nonmedical personnel had reported more than 10,000 overdose reversals nationwide since 1996.[66] As of November 2014, 23 states have statutes that allow for "third-party" prescriptions of naloxone (i.e. the prescription can be written to friend, relative or person in a position to assist a person at risk of experiencing an opiate overdose). This kind of prescription has not yet been legalized In South Dakota.

Given the effectiveness of naloxone in overdose reversal, the Food and Drug Administration (FDA) has encouraged innovations in more user-friendly naloxone delivery systems such as auto-injectors, made particularly for lay use outside of health care settings. The FDA approved such an auto-injector in 2014.

Special populations

A full discussion of the many non-opiate pain treatment modalities, and how those modalities can be employed to manage pain across all disease states and conditions is beyond the scope of these guidelines, which focus primarily on the use of opiates. But a brief review of pain management recommendations in some common patient populations is warranted, since these often involve decisions about whether to use opiates and, if so, how they can most optimally be prescribed.

Emergency room patients

Pain is a frequent complaint of emergency room (ER) patients, and ER physicians are among the higher prescribers of opiates to patients ages 10-40.[67] ER physicians, however, face considerable challenges in determining a patient's appropriateness for opiate therapy. A medical history is often lacking, and the physician seldom knows the patient personally. Time constraints, as well, can preclude the kinds of careful assessment and evaluation recommended for responsible opiate prescribing. Because of this, current guidelines from the American College of Emergency Physicians include the following recommendations:[68]

- ER/LA opiate medications should *not* be prescribed for acute pain
- PDMPs should be used where available to help identify patients at high risk for opiate abuse or diversion
- Opiates should be reserved for more severe pain or pain that doesn't respond to other analgesics
- If opiates are indicated, the prescription should be for the lowest effective dose and for a limited duration (e.g., < 1 week).

Cancer pain

Pain is one of the most common symptoms of cancer, as well as being one of the most-feared cancer symptoms. Pain is experienced by about 30% of patients newly diagnosed with cancer, 30% - 50% of patients undergoing treatment, and 70% - 90% of patients with advanced disease.[16] Unrelieved pain adversely impacts motivation, mood, interactions with family and friends, and overall quality of life. Survival itself may be positively associated with adequate pain control.[69] Opiate pain medications are the mainstay of cancer pain management and a trial of opiate therapy should be administered to all cancer patients with moderate or severe pain, regardless of the known or suspected pain mechanism.[70]

ER/LA opiate formulations may optimize analgesia and lessen the inconvenience associated with the use of short-acting opiates. Patient-controlled analgesia with subcutaneous administration using an ambulatory infusion device may provide optimal patient control and effective analgesia.[71] The full range of adjuvant medications covered earlier should be considered for patients with cancer pain, with the caveat that such patients are often on already complicated pharmacological regimens,

which raises the risk of adverse reactions associated with polypharmacy. If cancer pain occurs in the context of a patient nearing the end of life, other treatment and care considerations may be appropriate. In these cases, patient integrated with a specialist in palliative care medicine may be advisable.

Pain at the end of life

Pain management at the end of life seeks to improve or maintain a patient's overall quality of life. This focus is important because sometimes a patient may have priorities that compete with, or supersede, the relief of pain. For some patients mental alertness sufficient to allow lucid interactions with loved ones may be more important than physical comfort. Optimal pain management, in such cases, may mean lower doses of an analgesic and the experience, by the patient, of higher levels of pain.

Since dying patients may be unconscious or only partially conscious, assessing their level of pain can be difficult. Nonverbal signs or cues must sometimes be used to determine if the patient is experiencing pain and to what degree an analgesic approach is effective. In general, even ambiguous signs of discomfort should usually be treated, although caution must be exercised in interpreting such signs.[72] Reports by family members or other people close to a patient should not be overlooked. In the Study to Understand Prognosis and Preference for Outcomes and Risks of Treatment (SUPPORT) , surrogates for patients who could not communicate verbally had a 73.5% accuracy rate in estimating presence or absence of the patient's pain.[73]

Opiates often are useful to providing effective analgesia at the end of life, and they are available in such a range of strengths, routes of administration, and duration of action that an effective pain regimen can be tailored to nearly each patient. No specific opiate is superior to another as first-line therapy. Rectal and transdermal routes of administration can be valuable at the end of life when the oral route is precluded because of reduced or absent consciousness, difficulty swallowing, or to reduce the chances of nausea and vomiting.[74] When selecting an opiate, clinicians should also consider cost, since expensive agents can place undue burden on patients and families.

Fear of inducing severe or even fatal respiratory depression may lead to clinician under-prescribing and reluctance by patients to take an opiate medication.[28] Despite this fear, studies have revealed no correlation between opiate dose, timing of opiate administration, and time of death in patients using

opiates in the context of terminal illness.[75] A consult with a specialist in palliative medicine in these situations may be advisable.

Older Adults

The prevalence of pain among community-dwelling older adults has been estimated between 25% and 50%.[76] The prevalence of pain in nursing homes is even higher. Unfortunately, managing pain in older adults is challenging due to: underreporting of symptoms; presence of multiple medical conditions; polypharmacy; declines in liver and kidney function; problems with communication, mobility, and safety; and cognitive and functional decline in general.

Acetaminophen is considered the drug of choice for mild-to-moderate pain in older adults because it lacks the gastrointestinal, bleeding, renal toxicities, and cognitive side-effects that have been observed with NSAIDs in older adults (although acetaminophen may pose a risk of liver damage). Opiates must be used with particular caution, and clinicians should "Start low, go slow" with initial doses and subsequent titration. Clinicians should consult the American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults for further information on the many medications that may not be recommended.[31]

The many challenges of pain management in older adults, only sketched here, suggest that early referral and/or consultation with geriatric specialists or pain specialists may be advisable.

Conclusions

The soaring use of opiate analgesics to treat chronic pain has led to escalating rates of opiate diversion, abuse, addiction, and overdose. The clinical evidence base supporting this use of opiates is much weaker than is often assumed, however, while the evidence for the many risks involved in long-term use of opiates is accumulating.

When used for severe acute pain in time- and dose-limited ways, or for the relief of cancer and end-of-life pain, opiates can be uniquely valuable and the risks of addiction and abuse are low. The benefits of using opiates outside of these realms, however, seldom outweigh their risks. These risks are amplified among older adults; those with impaired renal or hepatic function; individuals with

COPD, cardiopulmonary disorders, sleep apnea, or mental illness; and in patients who are likely to combine opiates with other respiratory depressants such as alcohol or benzodiazepines.

These guidelines have outlined an evidence-based strategy for identifying patients for whom the benefits of long-term opiate therapy might outweigh the risks. It is intended neither as an exhaustive review nor a standard of care. Rather, it summarizes established methods for appropriately prescribing opiate analgesics. Appropriate prescribing of opiates can be challenging, but it is not inherently different from the challenges physicians face when using any other treatment option that carries significant risks of harm. It is both feasible and necessary for clinicians to treat pain effectively while minimizing risk.

Resources

American Academy of Pain Medicine
www.painmed.org

Depression Anxiety & Positive Outlook Scale
www.dapos.org

Drug Enforcement Administration Diversion Control Program
www.DEAdiversion.usdoj.gov

FDA Blueprint for Prescriber Education
http://www.er-la-opioidrems.com

Generalized Anxiety Disorder assessment (GAD-7)
http://www.patient.co.uk/doctor/generalised-anxiety-disorder-assessment-gad-7

National Institute on Drug Abuse
Short and longer-form validate questionnaires
http://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf

The National Association of State Controlled Substances Authorities (NASCSA)
www.nascsa.org

Patient Health Questionnaire
www.phqscreeners.com

PainLaw.org
www.painlaw.org

Risk reduction strategies (free online CME)
www.opioidprescribing.com

University of Wisconsin Pain & Policy Studies Group
www.medsch.wisc.edu/painpolicy

Veterans Administration opioid clinical practice guidelines
http://www.healthquality.va.gov/guidelines/Pain/cot/

Appendix I: Sample Patient/Provider Agreement

[DIRECTIONS FOR USE – it is recommended that the provider create a pre-printed form with the provider's name inserted anywhere the words "your healthcare provider" are used; doing so should help avoid confusion and will otherwise make the form more user-friendly for both the patient and the provider.]

Opiate Pain Medication

Treatment Agreement and Informed Consent

Safe and effective treatment with opiate pain medications requires your understanding and your cooperation as is outlined below. Please read each item and check the box if you understand and agree to comply with the statement. If you do not understand the statement, or if you do not agree to it, please discuss the item with your healthcare provider.

Examples of opiate pain medications include, but are not limited to, Morphine, Hydrocodone, Oxycodone, Hydromorphone, Fentanyl and Methadone.

I the patient understand and agree as follows:

Agreement Basics.

☐ 1. Your routine opiate pain medications need to be prescribed only by **your healthcare provider, Dr._____,** or another healthcare provider that he/she may choose and name in writing. Do not ask for or accept opiate pain medications from other healthcare providers.

☐ 2. You may only get your opiate pain medications from one designated pharmacy. You have selected _____. Your pharmacy choice can be changed by notifying **your healthcare provider** in advance.

☐ 3. Do not take opiate pain medications at a larger dose or more often than has been prescribed. If I take too much pain medication or more often than prescribed, I understand that I could have complications and I could die. If I am not satisfied with my treatment, I am to call my **healthcare provider**.

☐ 4. Do not give or sell your opiate pain medications to anyone. Do not take opiate pain medications prescribed or otherwise obtained from any source except **your healthcare provider**. Do not take drugs from non-medical sources. Do not take illegal drugs.

☐ 5. You must give an honest and complete past medical history, including prior opiate treatment, current medications (including over-the-counter medications), current and past non-medical drug use, chemical dependency treatment, and psychiatric diagnoses and treatment. You should consent to communication among your current and past healthcare providers.

☐ 6. Inform any other healthcare provider who treats you that you have an Opiate Pain Medication Treatment Agreement with **your healthcare provider**.

☐ 7. Contact **your healthcare provider** before taking any outpatient opiate pain medication that may be prescribed by an emergency room or at hospital discharge. Contact **your healthcare provider** when you have been treated with opiate pain medications in an emergency room. This Agreement does not prevent you from being treated with opiate pain medications in an emergency room or when you have been admitted to a hospital.

☐ 8. You are required to undergo laboratory drug testing promptly when asked. This may include urine, blood or hair. This request may come at the start of treatment, randomly, or from time-to-time when requested by **your healthcare provider**.

☐ 9. Chronic pain treatment requires full and cooperative patient participation. Besides routine office visits, this may include physical therapy, counseling, and chemical dependency assessment. Frequent late arrivals, cancelling less than 24 hours before a scheduled appointment and/or not showing up for appointments is not acceptable.

☐ 10. You must accept and cooperate with **your healthcare provider's** prescription writing and renewal practices. This may include only receiving prescriptions at scheduled, in-person appointments.

☐ 11. Tell **your healthcare provider** if you are pregnant or may become pregnant.

☐ 12. The goal of opiate pain medication is to assist with pain control in order to allow for improved function and successful living. Relief of 100% of pain is usually not possible or necessary. Your healthcare provider may stop your opiate medication if your function does not improve.

Prescription and medication management safety.

☐ 13. Do not lose your prescription form. Immediately filling your prescription at your pharmacy of choice may be best. Do not lose or damage your pills.

☐ 14. Prescription form or pill loss may cause you to lose your access to opiate pain medications. Lost prescription forms or pills will not necessarily be replaced.

☐ 15. If your behavior causes **your healthcare provider** to become concerned about a chemical dependency problem, referral for a chemical dependency assessment may be made.

☐ 16. Keep your medications in a lock box. Do not give others access to your key or combination to your lock box. Take out a daily medication supply each day and keep it in your personal possession.

☐ 17. Do not handle your opiate pain medication by a sink or toilet. Only open your lock box after placing it on a table.

☐ 18. Some people do not tolerate opiates well and as a result may feel tired or not as alert as normal. Temporary periods of drowsiness may occur when drugs are new or when dose has been increased. In any event, there should be **no driving or operating powered machinery or equipment if there is any question of your ability to do so safely and alertly.** Discussion and agreement among you, a household or family member, and **your healthcare provider** is best.

☐ 19. Do not consume alcohol while taking opiate pain medications.

Opiate information.

☐ 20. Opiate medicine shouldn't be stopped suddenly. Another way of saying this is to say that routine use of opiates may cause physical dependence. Suddenly stopping opiates after prolonged routine use may cause a feeling of withdrawal over the course of several days or more. Opiate withdrawal is not dangerous, but it can be a miserable experience for some patients. Usually, it is preventable with a slow taper-down of the medication. Withdrawal symptoms can include increased pain, anxiety, sweating, yawning, difficulty sleeping, tearing, and loose stools.

☐ 21. Addiction is completely unrelated to physical dependence. Addiction, also called chemical dependency, is a short-circuit of the reward system of the brain. Instead of feeling good on account of family, career, religion, and recreation, people with chemical dependency substitute a drug for their reward. In a well-structured opiate prescribing program, the chance of developing a new chemical dependency problem is low.

☐ 22. Any of your healthcare providers can find out from the South Dakota Prescription Drug Monitoring Program (the "Program") about all opiate medications you fill at pharmacies in South Dakota and surrounding states. **Your healthcare provider** is obligated to report your prescriptions to the Program. Doctor shopping is a crime in South Dakota.

☐ 23. Routine opiate use may suppress the pituitary gland. This is most significant in men. An annual testosterone blood level test can monitor for this in men. Decreased testosterone can cause sweating, depression, decreased libido, and it can have an adverse effect on bone health. Tapering down or off opiates returns pituitary function to normal.

☐ 24. Opiates can aggravate sleep apnea.

☐ 25. Opiates do not damage organs. They do not cause stomach, liver, kidney, blood vessel, or nerve injury.

☐ 26. Opiates must be used cautiously if you have chronic obstructive lung disease. Opiates can cause respiratory depression if a large dose is given to someone whose body is inexperienced with opiates.

☐ 27. Nausea, itching and hives occur, and are more common at the beginning of treatment. Constipation is common with opiates, and must be managed on an ongoing basis. Dry mouth is occurs occasionally and is very bad for dental health. Difficulty initiating urination in men seems more common with morphine, and may be a reason to not use that drug.

☐ 28. What benefit opiates are providing to any individual remains under ongoing review. Establishing a correct dose at the beginning of treatment must be done by a slow taper-up. Determining what this is needed after a period of success is done by slow taper-down. High-dose opiates with poor pain control and functional result may be an indication for taper-down.

I the patient acknowledge and agree to the contents of this document and consent to treatment with opiate pain medication as proposed by **my healthcare provider.**

Patient Name: _____

Patient Signature: _____ Date_____

Doctor Name: _____

Doctor Signature: _____ Date_____

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Educational Program Proposal

Intent
In recognition of the fact Prescription Drug Monitoring Programs (PDMPs) and drug disposal programs alone will not eliminate the availability of drugs for abuse and diversion purposes, an educational program should be developed that will reduce the availability and ease at which prescription drugs may be obtained and ultimately will reduce the number of teens and adults in South Dakota who are addicted to and/or abusing prescription drugs.

Decreasing the abuse, diversion and addiction of prescription drugs may be achieved by providing information and education to prescribers and dispensers on appropriate prescribing patterns and patient management, drug diversion and abuse detection, and patient referral for treatment.

Strategies
Propose the development and delivery of a three-part educational campaign lasting 18-24 months. The campaign will focus on providing information and education to prescribers, dispensers and members of the health care community.

Part 1: Opioid Prescribing Series (6 Modules)
Program to be developed and offered online as an educational series. This course series to address opioid prescribing practices, monitoring opioid therapy and managing risk when prescribing opioids. Also, the opioid abuse epidemic to be examined in detail. All modules to be made available online as an enduring material.

Module 1: Prescribing Opioids for Chronic (non-Cancer) Pain
Learning Objectives:
After reading this material, a participant will be familiar with:

- The recommended steps to be taken prior to initiating long-term opioid therapy
- The recommended steps to be taken upon initiation of long-term opioid therapy
- Screening tools to assess the baseline risk of opioid addiction/abuse
- The Opioid Risk Tool
- The CAGE-AID Tool
- The Patient Health Questionnaire-9
- The monitoring of function and pain during opioid therapy
- The graded chronic pain scale
- The reasons to taper or discontinue opioid therapy

Module 2: Tapering Opioids, Opioid Therapy Agreements-Contracts and Drug Testing
Learning Objectives:
After reading this material, a participant will be familiar with:

- Factors that prolong the duration of an opioid taper
- Many of the common signs and symptoms of opioid withdrawal syndrome
- The factors that must be considered when tapering opioids
- The definition of drug potency
- The points that should be addressed in an opioid therapy agreement/contract
- The purpose of a urine drug test and what information can be obtained from a urine drug test
- When and how often urine drug tests should be performed
- Which drugs can be detected on urine toxicology screens
- The reasons why urine drug tests are under-utilized

Module 3: Urine Testing and Trends in Opioid Use, Misuse and Abuse
Learning Objectives:
After reading this material, a participant will be familiar with:

- The ability of urine immunoassay tests to detect THC, cocaine and alcohol
- The three acceptable ways to dispose of opioid medications
- Which unwanted medicines should be flushed down the drain according to the FDA and DEA
- The significant problems posed by not keeping controlled substances in locked/secure places
- "Take-back" programs
- The places that can accept controlled substances
- The definition of drug abuse
- The definition of drug tolerance
- The definition of drug addiction
- The definition of substance dependence
- The trends of opioid use in the U.S. since 2000
- The trends of opioid misuse/abuse in the U.S. since 2000
- The trends of opioid-related ER visits in the U.S. since 2000

Module: 4: The Opioid Abuse Epidemic and Commonly Abused Non-Opioid Prescription Drugs
Learning Objectives:
After reading this material, a participant will be familiar with:

- The rate at which the opioid abuse epidemic is growing
- The commonly abused non-opioid prescription drugs
- The various ways in which opioid abusers get the opioids
- How the opioid abuse rate in women compares to that of men
- How the opioid overdose death rate in women compares to that of men
- Which age group has the highest rate of opioid analgesic misuse and overdose deaths
- Which racial groups in the U.S. have the highest rates of medical and non-medical opioid use
- 1-800-662-HELP
- How prescription overdose rates in rural areas compare to those in urban areas
- Rates of prescription painkiller sales during the time period of 1999-2008 in the U.S.
- Rates of substance abuse treatment admissions during the time period of 1999-2008 in the U.S.
- Obtaining opioids from an online pharmacy
- What factors make some opioids more attractive to abuse than other opioids
- How opioid abusers alter the opioid pills and patches
- The terms "abuse-deterrent formulation" and "abuse-resistant formulation"
- The actions that a physician must take if he/she determines that a chronic pain patient becomes addicted to opioids
- The magnitude of the increase of the dispensing of opioids in the U.S. during the time period of 1997 to 2009

Module 5: Opioid Use in Special Populations, The Controlled Substances Act and Naloxone
Learning Objectives:
After reading the material, a participant will be familiar with:

- The number of pregnant women in the U.S. using opioids or dependent on opioids during the period of 2000-2009
- Neonatal abstinence syndrome (NAS)
- The incidence of NAS in the United States
- The number of drug and alcohol rehabilitation centers in each state and the number of drug and alcohol rehabilitation centers per capita for each state
- The term ultra-rapid metabolizers
- The potential consequences of administering codeine to an ultra-rapid metabolizer pediatric patient
- The potential consequences of administering codeine to an ultra-rapid metabolizer female patient who is breastfeeding
- The controlled substances act
- The schedule I drugs
- The schedule II drugs
- The schedule III drugs
- The schedule IV drugs
- The schedule V drugs
- Which healthcare providers can prescribe controlled substances
- Naloxone
- The potential side effects of naloxone
- The modes of administration of naloxone
- The dosage of naloxone
- The half-life of naloxone and the half-lives of the commonly abused opioids

Module 6: The Prescription Drug Abuse Plan, Prescription Drug Monitoring Programs and Risk Evaluation and Mitigation Strategy (REMS)
Learning Objectives:
After reading this material, a participant will be familiar with:

- The United States government document entitled "Epidemic: Responding to America's Prescription Drug Abuse Crisis"
- The extent of opioid pain management/risk management training presently being offered by healthcare professional schools
- The healthcare provider education programs outlined in the Prescription Drug Abuse Plan
- The intended goal of the Centers of Excellence in Pain Education
- Which medical educational institutions have been designated as Centers of Excellence in Pain Education
- The parent, youth and patient education programs outlined in the Prescription Drug Abuse Plan
- How the U.S. government proposes to enlist the medical research and development sector to help decrease the incidence of opioid abuse
- Prescription drug monitoring programs and the purpose that they serve
- The effect of prescription drug monitoring programs on the admission rate to substance abuse facilities
- The effect of prescription drug monitoring programs on the incidence of opioid abuse
- The effect of prescription drug monitoring programs on the practice of ER physicians
- Risk Evaluation and Mitigation Strategy (REMS)

Part 2: Resource Materials
Review, develop and distribute to prescribers and dispensers educational materials on the prevalence and dangers associated with prescription drug abuse and addiction, appropriate prescribing guidelines, and drug diversion and abuse detection, and treatment. Educational materials will be distributed via a special issue of *South Dakota Medicine*, and the proposed topics of this special issue include:

1. Commonly Abused Prescription Drugs and Nationwide Trends
2. Assessing Prescription Drug Abuse Within and Across South Dakota
3. Societal Impact of Prescription Drug Abuse: A Law Enforcement Perspective

4. Drugs, Brains and Behavior: The Science of Addiction
5. Screening for Prescription Drug Abuse and Diversion
6. Pain Management and Appropriate Prescribing Patterns
7. Opioid Use and Prescribing
8. Alternatives to Controlled Substances
9. The Principles of Drug Addiction Treatment
10. Treating Addiction to Prescription Opioids
11. Treating Addiction to CNS Depressants
12. Treating Addiction to Prescription Stimulants
13. Preventing Drug Abuse Among Children and Adolescents
14. The South Dakota Prescription Drug Monitoring Program

Part 3: Educational Workshops

Develop and conduct workshops at various locations throughout the state with educational programming to focus on the content of modules 1-6 outlined in Part 1. Emphasis given to the prevalence and dangers associated with prescription drug abuse and addiction; how to access and incorporate PDMP information into practice; appropriate prescribing protocols and guidelines; and the detection of prescription drug diversion and abuse, and referral for treatment.

Other Recommendations

1. Convene a group of stakeholders, to include the SD Department of Social Services, to discuss and develop ways to integrate treatment for substance abuse use disorders into health care and expand support for recovery.

2. Utilize members of the medical provider and law enforcement communities to develop and conduct media campaign aimed and teens and adults regarding the harmful effects of prescription drug abuse.

3. Convene a group of stakeholders, to include the SD Department of Health, as well as representatives of the law enforcement community, to discuss and develop ways to form and promote the utilization of drug "take back" programs.

Proposed Timeline:

1. Educational Modules/Workshops
    - June 2015 – August 2015 – Develop educational/program modules, identify and secure presenters, and prepare materials and apply for CME
    - September 2015 – February 2016 – Deliver modules, develop and post enduring materials
    - March 2016 – June 2016 – Conduct regional meetings, 1/month, locations – Aberdeen, Pierre, Rapid City and Sioux Falls

2. South Dakota Medicine
    - June 2015 – August 2016 – Develop, publish and distribute a special issue of South Dakota Medicine, dedicated to prescription drug abuse and addiction, patient management and appropriate prescribing guidelines, and drug diversion, abuse detection and treatment.

ARTICLE 20:47

PHYSICIANS AND SURGEONS

Chapter

20:47:01 Definitions, repealed.

20:47:02 Operation of board, transferred.

20:47:03 Licensure.

20:47:04 Inspections.

20:47:05 Declaratory rulings, transferred.

20:47:06 Fees.

20:47:07 Medical Record Standards.

20:47:08 Ethics

CHAPTER 20:47:07

MEDICAL RECORDS STANDARDS

20:47:07:01 Standards defined.

20:47:07:02 Standards for medical records when prescribing controlled substances for the treatment of pain

20:47:07:01. Standards defined. "Standards" means a process or procedure established in this article as a guideline to physicians. Failure to comply with standards established in this article is not grounds for cancellation, revocation or suspension of a medical license. Failure to comply with standards may be justified based on the circumstances of a particular case or on the applicable community standards. Compliance with standards is a defense to a proceeding for

cancellation, revocation or suspension of a medical license that is based upon record keeping for which standards have been established.

Source:

General Authority: SDCL 36-4-35.

Law Implemented: SDCL 36-4-28, 36-4-29, 36-4-30.

20:47:07:03~~2~~. ~~Best practices~~Standards for medical records when prescribing controlled substances for the treatment of pain. The ~~best practices~~standards for medical records when a physician prescribes controlled substances for the treatment of pain include each of the following listed items:

(1) Copies of the signed informed consent and any treatment agreement required by the physician~~ARSD 20:47:07:01(3), (4) and (6)~~;

(2) The patient's medical and psychosocial history;

(3) The results of all physical examinations and all laboratory tests;

(4) Confirmation that the appropriate ~~a~~ state ~~P~~prescription ~~D~~drug ~~M~~monitoring ~~P~~program ~~(if available)~~ has been accessed and~~,~~ the date of that access~~, and any details, if any, from a review of relevant patient records~~;

(5) The results of all risk assessments, including results of any screening instruments used;

(6) A description of the treatments provided, including all medications prescribed or administered, with the date of prescription or administration, the name and type of the medication~~;~~, and the dosage and quantity of medication prescribed or administered. The medical records must include all prescription orders for opioid analgesics and other controlled substances, whether written, ~~or~~ telephoned, faxed, or electronically transmitted;

(7) Instructions to the patient, including discussions with the patient and, if appropriate, significant others of~~:~~ the -risks and benefits of opioid analgesics, including the risks of addiction, overdose, and death; proper use and storage of medication; proper disposal of unused medications; the use of naloxone products to reverse overdose; ~~with the patient and any significant others, and written instructions for the use of all medications~~;

(8) Results of ongoing assessments, ~~(~~including, when appropriate, urine drug tests~~)~~, of patient progress or lack of progress in terms of pain management and functional improvement;

(9) Notes on any evaluations by and consultations with specialists ~~(if any)~~;

(10) Any other information used to support the initiation, continuation, revision, or termination of treatment;

(11) ~~and the~~ Any steps taken in response to ~~any~~ aberrant medication use by a patient and~~/or~~ aberrant behaviors related to a prescription for an opioid analgesic;

(12) Medical records of past hospitalizations or treatments by other providers, to the extent obtained by the physician;

(13) Authorization for release of information to other treatment providers; and

(14) Name, address, and telephone number of the patient's pharmacy.

Source:

General Authority: SDCL 36-4-35.

Law Implemented: SDCL 36-4-29, 36-4-30.

References: Federation of State Medical Boards Model Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain; Federation of State Medical Boards Model Policy on Data 2000 and Treatment of Opioid Addiction in the Medical Office.

Essentials of a State Medical and Osteopathic Practice Act

Approved by the House of Delegates of the Federation of State Medical Boards of the United States, Inc., as policy

April 2015

Introduction

As early as 1914, the Federation of State Medical Boards of the United States and its member boards recognized the need for what was to become *A Guide to the Essentials of a Modern Medical Practice Act*. First published in 1956, the stated purposes of the document have always been the same:

1. to serve as a guide to those states that may adopt new medical practice acts or may amend existing laws and
2. to encourage the development and use of consistent standards, language, definitions and tools by boards responsible for physician and physician assistant regulation.

Changes in medical education, in the practice of medicine and in the diverse responsibilities that face medical boards necessitate regular revision of medical practice acts. The *Essentials* has undergone numerous revisions in order to respond to these changes and to provide assistance to member boards in the evaluation and revision of their medical practice acts. The Federation urges member boards to consider including any recommendation contained in the *Essentials* in its medical practice act or under its rules.

The *Essentials* applies equally to practice acts that govern physicians who have acquired the M.D. or D.O. degree in the same statute or in separate statutes. The terms used herein should be interpreted throughout with this understanding.

Preamble

An essential is that element, quality or property that is indispensable in making a body, character or structure what it is. It constitutes the essence. The Federation of State Medical Boards of the United States believes that each of the 19 sections of this document express an essential of a modern medical practice act and that the recommendations in each section are basic to the realization of that essential.

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Table of Contents

Section I:	Statement of Purpose	3
Section II:	Definitions	3
Section III:	The State Medical Board	5
Section IV:	Examinations	7
Section V:	Requirements for Full Licensure	10
Section VI:	Graduates of Foreign Medical Schools	11
Section VII:	Licensure by Endorsement, Expedited Licensure by Endorsement, and Temporary and Special Licensure	12
Section VIII:	Limited Licensure for Physicians in Postgraduate Training	14
Section IX:	Disciplinary Action against Licensees	15
Section X:	Procedures for Enforcement and Disciplinary Action	20
Section Xl:	Impaired Physicians	21
Section XII:	Dyscompetent Physicians	22
Section XIII:	Compulsory Reporting and Investigation	24
Section XIV:	Protected Action and Communication	25
Section XV:	Unlawful Practice of Medicine: Violations and Penalties	27
Section XVI:	Periodic Renewal	27
Section XVII:	Physician Assistants	28
Section XVIII:	Rules and Regulations	29
Section XIX:	Funding and Fees	30

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Section I: Statement of Purpose

The medical practice act should be introduced by a statement of policy specifying the purpose of the act. This statement should include language expressing the following concepts:

A. The practice of medicine is a privilege granted by the people acting through their elected representatives.
B. In the interests of public health, safety and welfare, and to protect the public from the unprofessional, improper, incompetent, unlawful, fraudulent and/or deceptive practice of medicine, it is necessary for the government to provide laws and regulations to govern the granting and subsequent use of the privilege to practice medicine.
C. The primary responsibility and obligation of the state medical board is to act in the sovereign interests of the government by protecting the public through licensing, regulation and education as directed by the state government.

Section II: Definitions

A. Definitions: As used in this Act, the following terms shall have the following meanings:

"Assessment Program" means a formal system to examine or evaluate a physician's competence within the scope of the physician's practice.

"Competence" means possessing the requisite abilities and qualities (cognitive, non-cognitive and communicative) to perform effectively within the scope of the physician's practice while adhering to professional ethical standards.

"Dyscompetence" means failing to maintain acceptable standards of one or more areas of professional physician practice.

"Impairment" means a physician's inability to practice medicine with reasonable skill and safety due to:

1. mental, psychological or psychiatric illness, disease or deficit;
2. physical illness or condition, including, but not limited to, those illnesses or conditions that would adversely affect cognitive, motor or perceptive skills; or
3. habitual, excessive or illegal use or abuse of drugs defined by law as controlled substances, illegal drugs or alcohol or of other impairing substances.

"Incompetence" means lacking the requisite abilities and qualities (cognitive, non-cognitive, and communicative) to perform effectively in the scope of the physician's practice.

"Licensed physician" means a physician licensed to practice medicine in the jurisdiction.

"Physician assistant" means a skilled person who by training, scholarly achievements, submission of acceptable letters of recommendations and satisfaction of other requirements of the Board has been licensed for the provision of patient services under the supervision and direction of a licensed physician who is responsible for the performance of that person.

"Physician Assistant Council" means a council appointed by the Board or other means that reviews matters relating to physician assistants reports its findings to the Board and makes recommendations for action. The

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medical practice act should provide definitions of the practice of medicine as governed by the act as well as exceptions to the act. These provisions of the act should implement or be consistent with the following:

"Practice of medicine" means:

1. advertising, holding out to the public or representing in any manner that one is authorized to practice medicine in the jurisdiction;
2. offering or undertaking to prescribe, order, give or administer any drug or medicine for the use of any other person;
3. offering or undertaking to prevent or to diagnose, correct and/or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect or abnormal physical or mental condition of any person, including the management of pregnancy and parturition;
4. offering or undertaking to perform any surgical operation upon any person;
5. rendering a written or otherwise documented medical opinion concerning the diagnosis or treatment of a patient or the actual rendering of treatment to a patient within a state by a physician located outside the state as a result of transmission of individual patient data by electronic or other means from within a state to such physician or his or her agent;
6. rendering a determination of medical necessity or a decision affecting the diagnosis and/or treatment of a patient; and
7. using the designation Doctor, Doctor of Medicine, Doctor of Osteopathic Medicine/Doctor of Osteopathy, Physician, Surgeon, Physician and Surgeon, Dr., M.D., D.O. or any combination thereof in the conduct of any occupation or profession pertaining to the prevention, diagnosis or treatment of human disease or condition unless such a designation additionally contains the description of another branch of the healing arts for which one holds a valid license in the jurisdiction where the patient is located.

"Remediation" means the process whereby deficiencies in physician performance identified through an examination or assessment program are corrected, resulting in an acceptable state of physician competence.

"Supervising physician" means a licensed physician in good standing in the same jurisdiction as the physician assistant who the Board approved to supervise the services of a physician assistant, and who has in writing formally accepted the responsibility for such supervision.

B. The medical practice act shall not apply to:

1. students while engaged in training in a medical school approved or recognized by the state medical board, unless the Board licenses the student;
2. those providing service in cases of emergency where no fee or other consideration is contemplated, charged or received by the physician or anyone on behalf of the physician;
3. commissioned medical officers of the armed forces of the United States and medical officers of the United States Public Health Service or the Veterans Administration of the United States in the discharge of their official duties and/or within federally controlled facilities, provided that such persons who hold medical licenses in the jurisdiction should be subject to the provisions of the act and provided that all such persons should be fully licensed to practice medicine in one or more jurisdictions of the United States, further the military physician should be subject to the Military Health System Clinical Quality Assurance (CQA)

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Program 10 U.S.C.A. § 1094; Regulation DOD 6025.13-R;

4. those practicing dentistry, nursing, optometry, podiatry, psychology or any other of the healing arts in accord with and as provided by the laws of the jurisdiction;
5. those practicing the tenets of a religion or ministering religious based medical procedures or ministering to the sick or suffering by mental or spiritual means in accord with such tenets;
6. a person administering a lawful domestic or family remedy to a member of his or her own family;
7. those fully licensed to practice medicine in another jurisdiction of the United States who briefly render emergency medical treatment or briefly provide critical medical service at the specific lawful direction of a medical institution or federal agency that assumes full responsibility for that treatment or service and is approved by the state medical board~~.~~; and
8. a physician licensed in another state, territory or jurisdiction of the United States is exempted from the licensure requirements in (state) if the physician is employed or formally designated as the team physician by an athletic team visiting (state) for a specific sporting event and the physician limits the practice of medicine in (state) to medical treatment of the members, coaches and staff of the sports entity that employs (or has designated) the physician.

C. For the purpose of the medical practice act, the practice of medicine is determined to occur where the patient is located in order that the full resources of the state are available for the protection of that patient.

Section III: The State Medical Board

The medical practice act should provide for a separate state medical board, acting as a governmental agency, (referred to hereafter as the Board) to regulate the practice of medicine, including the licensure and discipline of physicians, in the jurisdiction. These provisions of the act should implement or be consistent with the following:

A. Whatever the professional regulatory structure established by the government of the jurisdiction, physicians should bear the primary responsibility for licensing and regulating the medical profession for the protection of the public, without abusing physicians in the discharge of that duty. Every Board should include both physician and public members. All Board members shall act to further the interest of the state, and not their personal interests.

B. Whatever the professional regulatory structure established by the government of the jurisdiction, the Board, within the context of the act and the requirements of due process, should have, at a minimum, the following powers and responsibilities:

1. Promulgate rules and regulations;
2. Select and/or administer licensing examination(s);
3. Develop and adopt policies and guidelines related to medical practice, other health care professions and regulation;
4. Evaluate medical education and training of applicants;
5. Evaluate or verify certification of medical and training programs to determine if these programs are appropriately preparing physicians for the practice of medicine;
6. Evaluate previous professional performance of applicants;
7. Issue or deny initial or endorsement licenses;

DRAFT

8. Maintain secure and complete records on individual licensees;
9. Provide the public with a profile of all licensed physicians;
10. Approve or deny applications for license renewal;
11. Develop and implement methods to identify physicians who are in violation of the medical practice act;
12. Develop and implement methods to identify and rehabilitate, if appropriate, physicians with an alcohol, drug and/or psychiatric illness;
13. Receive, review and investigate complaints including sua sponte complaints;
14. Review and investigate reports received from entities having information pertinent to the professional performance of licensees;
15. Review, investigate, and take appropriate action to enjoin reports received concerning the unlicensed practice of medicine;
16. Share investigative information at the early stages of a complaint investigation with other Boards;
17. Issue subpoenas, subpoenas duces tecum, administer oaths, receive testimony and conduct hearings;
18. Discipline licensees found in violation of the medical practice act;
19. Develop policies for disciplining or rehabilitating physicians that demonstrate inappropriate sexual behavior with patients or other professional boundaries violations;
20. Institute actions in its own name and enjoin violators of the medical practice act;
21. Acknowledge receipt of complaints or other adverse information to persons or entities reporting to the Board and to the physician, and inform them of the final disposition of the matters reported;
22. Develop and implement methods to identify dyscompetent physicians and physicians who fail to meet acceptable standards of care;
23. Develop or identify and implement methods to assess and improve physician practice;
24. Develop or identify and implement methods to ensure the ongoing competence of licensees;
25. Establish appropriate fees and charges to ensure active and effective pursuit of its legal responsibilities;
26. Develop and adopt its budget;
27. Develop educational programs to facilitate licensee awareness of provisions contained in the medical practice act and to facilitate public awareness of the role and function of state medical boards; and
28. Acquire real property or other capital for the administration and operation of the Board.

C. Members of the Board, whether appointed or elected, should serve staggered terms to ensure continuity. All appointments and elections should be confirmed through the legislative branch of the jurisdiction.

D. The length of terms on the Board should be set to permit development of effective skill and experience by members (e.g., three or four years). However, a limit should be set on consecutive terms of service (e.g., two or three).

E. Members of the Board should receive appropriate compensation for services and reimbursement for expenses at the State's current approved rate.

F. A member of the Board should be subject to removal only when he or she

1. ceases to be qualified;

DRAFT

2. is found guilty of a felony or an unlawful act involving moral turpitude by a court of competent jurisdiction;
3. is found guilty of malfeasance, misfeasance or nonfeasance in relation to his or her Board duties by a court of competent jurisdiction;
4. is found mentally incompetent by a court of competent jurisdiction;
5. fails to attend three successive Board meetings without just cause as determined by the Board or, if a new member, fails to attend a new members' training program without just cause as determined by the Board;
6. is disciplined for violations of the medical practice act; or
7. is found in violation of the conflict of interest/ethics law.

G. All physician members of the Board should hold full and unrestricted medical licenses in the jurisdiction, should be persons of recognized professional ability and integrity, and should have resided, practiced in the jurisdiction long enough to have become familiar with policies and practice in the jurisdiction (e.g., five years).

H. The Board should include public members who:
1. are not licensed physicians or providers of health care;
2. have no substantial personal or financial interests in the practice of medicine or with any organization regulated by the Board;
3. have no immediate familial relationships with individuals involved in the practice of medicine or any organization regulated by the Board;
4. are residents of the State; and
5. are individuals of recognized ability and integrity.

I. The Board should be authorized to appoint committees from its membership. To effectively perform its duties under the Act, the Board should also be authorized to hire, discipline and terminate staff, including an executive secretary or director. It should also be assigned adequate legal counsel by the office of the attorney general and/or be authorized to employ private counsel or its own full-time attorney.

J. The Board should conduct and new members should attend a training program designed to familiarize new members with their duties and the ethics of public service.

K. Travel, expenses and daily compensation should be paid for each Board member's attendance, in or out of state, for education or training purposes approved by the Board and directly related to Board duties.

L. Telephone or other telecommunication conference should be an acceptable form of Board meeting for the purpose of taking emergency action to enforce the medical practice act if the president alone or another officer and two Board members (if allowed by open meeting laws) believe the situation precludes another form of meeting. The Board should be authorized to establish procedures by which its committees may meet by telephone or other telecommunication conference system to take emergency action.

Section IV: Examinations

The medical practice act should provide for the Board's authority to approve an examination(s) of medical knowledge satisfactory to inform the Board's decision to issue a full, unrestricted license to practice medicine and surgery in the jurisdiction.

DRAFT

A. In order to ensure a high quality, valid and reliable examination of physician preparedness to practice medicine, the Board may delegate the responsibilities for examination development, administration, scoring and security to a third party or nationally recognized testing entity. Such an examination should be consistent with recognized national standards for professional testing such as those reflected in Standards for Educational and Psychological Testing.

B. No person should receive a license to practice medicine in the jurisdiction unless he or she has successfully completed all components of an examination(s) identified as satisfactory to the Board.

1. The currently administered USMLE Steps 1,2,3 or COMLEX-USA Levels 1,2,3; or
2. previously administered examinations such as the FLEX, NBME Parts or NBOME Parts; or
3. a combination of these examinations identified as acceptable by the Board.

C. The examination(s) approved by the Board shall be in the English language and designed to ascertain an individual's fitness for an unrestricted license to practice medicine and surgery.

D. The Board may stipulate the numeric score or performance level required for passing the examination(s) or accept the recommended minimum passing score as determined by the developers of the examination.

E. The Board should be authorized to limit the number of times an examination may be taken, to require applicants to pass all examinations within a specified period, and to specify further medical education required for applicants unable to do so.

~~B.~~F. In order to support periodic or mandated reviews of its approved examination(s), the Board should be provided with reasonable access by the third party or testing entity in order to review the examination design, format and content as well as performance data and relevant procedures for test administration, security, and scoring.

~~A. Medical Licensing Examination(s)~~

~~1. No person should receive a license to practice medicine in the jurisdiction unless he or she has passed an examination or examinations satisfactory to the Board.~~

~~2. The Board should approve the preparation and administration of an examination or examinations, in English, that it deems must be satisfactorily passed as part of its procedure for deter-mining an applicant's qualification for the practice of medicine.~~

~~3. Examinations should be scored in a way to ensure the anonymity of applicants.~~

~~4. The Board should stipulate the score required for passing the examination(s). The required passing score should be set before the administration of the examination(s).~~

~~5. The Board should be authorized to limit the number of times an examination may be taken, to require applicants to pass all examinations within a specified period, and to specify further medical education required for applicants unable to do so.~~

~~6. An applicant should pay all examination fees prior to the examination being administered and no later than a date set by the Board.~~

~~7. The Board may delegate to its agent or a third party examination agent the responsibilities of examination development and administration, including eliminating the need for the Board to sponsor or authorize an applicant for examination eligibility.~~

DRAFT

~~B. Examination Application~~

~~To apply for examination(s), an applicant should provide the Board or its agent and attest to the following information and documentation no later than a date set by the Board:~~

~~1. his or her full name and all aliases or other names ever used, current address, Social Security Number and date and place of birth;~~

~~2. a recent signed photograph and/or other documentation of identity;~~

~~3. name and location of medical school of graduation, degree earned and date of graduation or the medical school now being attended and current matriculated status;~~

~~4. a history of graduate medical education, including name and address of all programs and hospitals;~~

~~5. original of all documents and credentials or notarized photocopies or other verification of such documents and credentials acceptable to the Board or its agent and~~

~~6. any other information or documentation the Board or its agent determines necessary. C. Examination Security~~

~~1. Any individual found by the Board or its agent to have engaged in conduct that subverts or attempts to subvert the medical licensing examination process or the specialty board certification/recertification process, should, at the discretion of the Board, have his or her scores on the licensing examination withheld and/or declared invalid, be disqualified from the practice of medicine and/or be subject to the imposition of other appropriate sanctions. The Federation of State Medical Boards of the United States should be informed of all such actions.~~

~~2. Conduct that subverts or attempts to subvert the medical licensing examination process should include, but not be limited to:~~

~~a. conduct that violates the security of the examination materials, such as removing from the examination room any of the examination materials; reproducing or reconstructing any portion of the licensing examination; aiding by any means in the reproduction or reconstruction of any portion of the licensing examination; selling, distributing, buying, receiving or having unauthorized possession of any portion of a future, current or previously administered licensing examination; "hacking" or attempting to "hack" the electronic version of any examination or the files of the developing or administering entity through unauthorized access or entry;~~

~~b. conduct that violates the standard of test administration, such as communicating with any other examinee during the administration of the licensing examination; copying answers from another examinee or permitting one's answers to be copied by another examinee during the administration of the licensing examination; having in one's possession during the administration of the licensing examination any books, notes, written or printed materials or data of any kind, other than the examination distributed and/or~~

~~c. conduct that violates the credentialing process, such as falsifying or misrepresenting educational credentials or other information required for admission to the licensing examination, impersonating an examinee or having an impersonator take the licensing examination on one's behalf.~~

DRAFT

~~3. The Board or its agent should provide written notification to all applicants for medical licensure of the prohibitions on conduct that subverts or attempts to subvert the licensing examination process and of the sanctions imposed for such conduct. A copy of such notification attesting that he or she has read and understood the notification should be signed by the applicant and filed with his or her application.~~

Section V: Requirements for Full Licensure

The medical practice act should provide minimum requirements for full licensure for the independent practice of medicine that bear a reasonable relationship to the qualifications and fitness necessary for such practice. These provisions of the act should implement or be consistent with the following:

A. The applicant should provide the Board, or its agent, and attest to, or provide the means to obtain and verify the following information and documentation in a manner required by the Board:
   1. his or her full name and all aliases or other names ever used, current address, Social Security number and date and place of birth;
   2. a signed photograph not more than two (2) years old and, at the board's discretion, other documentation of identity;
   3. originals of all documents and credentials required by the Board, notarized photocopies or other verification acceptable to the Board of such documents and credentials;
   4. a list of all jurisdictions, United States or foreign, in which the applicant is licensed or has ever applied for licensure to practice medicine or is authorized or has ever applied for authorization to practice medicine, including all jurisdictions in which any license application or authorization has been withdrawn;
   5. a list of all jurisdictions, United States or foreign, in which the applicant has been denied licensure or authorization to practice medicine or as any other health care professional or has voluntarily surrendered a license or an authorization to practice medicine or as any other health care professional;
   6. a list of all sanctions, judgments, awards, settlements or convictions against the applicant in any jurisdiction, United States or foreign, that would constitute grounds for disciplinary action under the medical practice act or the Board's rules and regulations;
   7. a detailed educational history, including places, institutions, dates and program descriptions of all his or her education including all college, pre-professional, professional and professional postgraduate education;
   8. a detailed chronological life history, including places and dates of residence, employment and military service (United States or foreign) including periods of absence from the active practice of medicine;
   9. all Web sites associated with the applicant's practice and professional activities;
   10. a list and current status of all specialty certifications and the name of certifying organization; and
   11. any other information or documentation the Board determines necessary.

B. The applicant should possess the degree of Doctor of Medicine or Doctor of Osteopathic Medicine/Doctor of Osteopathy from a medical college or school located in the United States, its territories or possessions or Canada that was approved by the Board or by a private nonprofit accrediting body approved by the Board at the time the degree was conferred. No person who graduated from a medical school that was not approved at the time of graduation should be examined

DRAFT

for licensure or be licensed in the jurisdiction based on credentials or documentation from that school nor should such a person be licensed by endorsement.

C. Should the applicant graduate from a medical school in a foreign country, other than Canada, the applicant should meet all the requirements established by the Board to determine the applicant's fitness to practice medicine.

D. The applicant should have satisfactorily completed at least thirty-six (36) months of progressive postgraduate medical training ~~approved~~ accredited by the Board, the Accreditation Council for Graduate Medical Education (ACGME), or the American Osteopathic Association (AOA). ~~or by a private nonprofit accrediting body approved by the Board in an institution in the United States, its territories or possessions or Canada, which has been approved by the Board or by a private nonprofit accrediting body approved by the Board.~~

E. The applicant should have passed the USMLE Steps 1, 2, 3 or COMLEX Levels 1, 2, 3 or a predecessor examination (FLEX, NBME Parts, NBOME Parts) or a combination of these examinations identified as accredited by the Board. ~~The applicant should have passed medical licensing examination(s) satisfactory to the Board.~~

F. The applicant should have demonstrated a familiarity with the statutes and regulations of the jurisdiction relating to the practice of medicine and the appropriate use of controlled or dangerous substances.

G. The applicant should be physically, mentally and professionally capable of practicing medicine in a manner acceptable to the Board and should be required to submit to a physical, mental, professional competency or chemical dependency examination(s) or evaluation(s) if deemed necessary by the Board.

H. The applicant should not have been found guilty by a competent authority, United States or foreign, of any conduct that would constitute grounds for disciplinary action under the regulations of the Board or the act. The Board may be authorized, at its discretion, to modify this restriction for cause, but it should be directed to use such discretionary authority in a consistent manner.

I. If the applicant's license is denied or in accordance with Board policy, the applicant should be allowed a personal appearance before the Board or a representative thereof for interview, examination or review of credentials. At the discretion of the Board, the applicant should be required to present his or her original medical education credentials for inspection at the time of personal appearance.

J. The applicant should be held responsible for verifying to the satisfaction of the Board the validity of all credentials required for his or her medical licensure. The Board or its agent should ver~~i~~fy medical licensure credentials directly from primary sources, and utilize recognized national physician information services (e.g., the Federation of State Medical Boards' Board Action Data Bank and Credentials Verification Service, the files of the American Medical Association and the American Osteopathic Association, and other national data banks and information resources.)

K. The applicant should have paid all fees and have completed and attested to the accuracy of all application and information forms required by the Board before the Board's verification process begins. The Board should require the applicant to authorize the Board to investigate and/or verify any information provided to it on the licensure application.

L. Applicants should have satisfactorily passed a criminal background check.

Section VI: Graduates of Foreign Medical Schools

The medical practice act should provide minimum requirements, in addition to those otherwise established, for full licensure of applicants who are graduates of schools located outside the United States, its

DRAFT

territories or possessions, or Canada. These provisions of the act should implement or be consistent with the following:

A. Such applicants should possess the degree of Doctor of Medicine, Bachelor of Medicine or a Board-approved equivalent based on satisfactory completion of educational programs acceptable to the Board.
B. Such applicants should be eligible by virtue of their medical education, training and examination for unrestricted licensure or authorization to practice medicine in the country in which they received that education and training.
C. Such applicants should have passed an examination acceptable to the Board that adequately assesses the applicants' medical knowledge.
D. Such applicants should be certified by the Educational Commission for Foreign Medical Graduates or its Board-approved successor(s), or by an equivalent Board-approved entity.
E. Such applicants should have a demonstrated command of the English language satisfactory to the Board.
F. Such applicants should have satisfactorily completed at least thirty-six (36) months of progressive post-graduate medical training ~~approved~~ accredited by the Board, the Accreditation Council for Graduate Medical Education (ACGME), or the American Osteopathic Association (AOA). ~~or by a private nonprofit accrediting body approved by the Board in an institution in the United States, its territories or possessions or Canada approved by the Board or by a private nonprofit accrediting body approved by the Board.~~
G. All credentials, diplomas and other required documentation in a foreign language submitted to the Board by or on behalf of such applicants should be accompanied by certified English translations acceptable to the Board.
H. Such applicants should have satisfied all of the applicable requirements of the United States Immigration and Naturalization Service.

Section VII: Licensure by Endorsement, Expedited Licensure by Endorsement, and Temporary and Special Licensure

The medical practice act should provide for licensure by endorsement, expedited licensure by endorsement, and in certain clearly defined cases, for temporary and special licensure. These provisions of the act should implement or be consistent with the following:

A. Endorsement for Licensed Applicants:

The Board should be authorized, at its discretion, to issue a license by endorsement to an applicant who:

1. has complied with all current medical licensing requirements save that for examination administered by the Board;
2. has passed a medical licensing examination given in English by another state, the District of Columbia, a territory or possession of the United States or Canada, provided the Board determines that examination was equivalent to its own current examination, or an independent testing agent designated by the Board; and
3. has a valid current medical license in another state, the District of Columbia, a territory or

DRAFT

possession of the United States or Canada.

B. Expedited Licensure by Endorsement:

The Board should be authorized, at its discretion, to issue an expedited license by endorsement to an applicant who provides documentation of:

1. identity as required by the Board;
2. all jurisdictions in which the applicant holds a full and unrestricted license;
3. graduation from an approved medical school;
    a. Liaison Committee on Medical Education (LCME) or American Osteopathic Association (AOA) approved medical school;
    b. Fifth Pathway certificate; or
    c. Educational Commission for Foreign Medical Graduates (ECFMG) certificate
4. passing one or more of the following examinations acceptable for initial licensure within three attempts per step/level;
    a. United States Medical Licensing Examination (USMLE) Steps 1-3 or its predecessor examinations (National Board of Medical Examiners (NBME) I-III or the Federation Licensing Examination (FLEX).
    b. Examinations offered by the National Board of Osteopathic Medical Examiners (COMLEX-USA) Levels 1-3 or its predecessor examination(s).
    c. Medical Council of Canada Qualifying Examinations (MCCQE) or its predecessor examination(s) offered by the Licentiate Medical Council of Canada.
5. successful completion of the total examination sequence within seven (7) years, except when in combination with a Ph.D. program;
6. successful completion of three (3) years of progressive postgraduate training in a program accredited by the Accreditation Council on Graduate Medical Education (ACGME) or the AOA; and/or
7. certification or recertification by a medical specialty board recognized by the American Board of Medical Specialties (ABMS) or the AOA within the previous ten (10) years. Lifetime certificate holders who have not passed a written specialty recertification examination must demonstrate successful completion of the Special Purpose Examination (SPEX), Comprehensive Osteopathic Medical Variable Purpose Examination (COMVEX) or applicable recertification examination.

Boards should obtain supplemental documentation including, but not limited to:

1. Criminal background check;
2. Absence of current/pending investigations in any jurisdiction where licensed;
3. Verification of specialty board certification; and
4. Professional experience.

Physicians desiring an expedited process for licensure must utilize the Federation Credentials Verification Service (FCVS), or credentials verification meeting equivalent standards for verification of core credentials, including:

1. medical school diploma,

DRAFT

2. medical school transcript,
3. dean's certificate,
4. examination history,
5. disciplinary history,
6. identity (photograph and certified birth certificate or original passport),
7. ECFMG certificate, if applicable,
8. Fifth Pathway certificate, if applicable, and postgraduate training verification.

C. Temporary Licensure:

The Board should be authorized to establish regulations for issuance of a temporary medical license for the intervals between Board meetings. Such a license should:

1. be granted only to an applicant demonstrably qualified for a full and unrestricted medical license under the requirements set by the medical practice act and the regulations of the Board and
2. automatically terminate within a period specified by the Board.

D. Special Licensure:

The Board should be authorized to issue conditional, restricted, probationary, limited or otherwise circumscribed licenses as it determines necessary. ~~This provision should include the ability to issue a special purpose license to practice medicine across state lines~~. It is to the discretion of the state medical board to set the criteria for issuing special purpose licenses. This provision should include, but not be limited to, the ability to issue a special license for the following purposes:

1. to practice medicine across state lines;
2. to provide medical services to a traveling sports team, coaches and staff for the duration of the sports event;
3. to provide volunteer medical services to under-insured/uninsured patients;
4. to provide medical services to youth camp enrollees, counselors and staff for the duration of the youth camp; and
5. to engage in the limited practice of medicine in an institutional setting by a physician who is licensed in another jurisdiction in the United States.

Section VIII: Limited Licensure for Physicians in Postgraduate Training

The medical practice act should provide that all physicians in all postgraduate training in the state or jurisdiction who are not otherwise fully licensed to practice medicine should be licensed on a limited basis for educational purposes. These provisions of the act should implement or be consistent with the following:

A. To be eligible for limited licensure, the applicant should have completed all the requirements for full and unrestricted medical licensure except postgraduate training or specific examination requirements.
B. Issuance of a limited license specifically for postgraduate training shall occur only after the applicant demonstrates that he or she is accepted in a residency program. The application for limited licensure should be made directly to the Board in the jurisdiction where the applicant's postgraduate training is to take place.
C. The Board should establish by regulation restrictions for the limited license to assure that the holder

will practice only under appropriate supervision and within the confines of the program within which the resident is enrolled.

D. The limited license should be renewable annually and upon the written recommendation of the supervising institution, including a written evaluation of performance, until the Board regulations require the achievement of full and unrestricted medical licensure.

E. Program directors responsible for postgraduate training should be required annually to provide the Board a written report on the status of program participants having a limited license.

1. The report should inform the Board about program participants who have successfully completed the program, have departed from the program, have had unusual absences from the program, or have had problematic occurrences during the course of the program.
2. The report should include an explanation of any disciplinary action taken against a limited licensee for performance or behavioral reasons which, in the judgment of the program director, could be a threat to public health, safety and welfare; unapproved or unexplained absences from the program; resignations from the program or nonrenewal of the program contract; dismissals from the program for performance or behavioral reasons; and referrals to substance abuse pro-grams not approved by the Board.
3. Failure to submit the annual program director's report shall be considered a violation of the mandatory reporting provisions of the Medical Practice Act and shall be grounds to initiate such disciplinary action as the Board deems appropriate, including fines levied against the supervising institution and suspension of the program director's medical license.

F. The disciplinary provisions of the medical practice act should apply to the holders of the limited and postgraduate training license as if they held full and unrestricted medical licensure.

G. The issuance of a limited license should not be construed to imply that a full and unrestricted medical license would be issued at any future date.

Section IX: Disciplinary Action against Licensees

The medical practice act should provide for disciplinary and/or remedial action against licensees and the grounds on which such action may be taken. These provisions of the act should implement or be consistent with the following:

A. Range of Actions: A range of progressive disciplinary and remedial actions should be made available to the Board. These should include, but not be limited to, the following:

1. revocation of the medical license;
2. suspension of the medical license;
3. probation;
4. stipulations, limitations, restrictions, probation, and conditions relating to practice;
5. censure (including specific redress, if appropriate);
6. reprimand;
7. chastisement, letters of concern and advisory letters;
8. monetary redress to another party;
9. a period of free public or charity service, either medical or non-medical;
10. satisfactory completion of an educational, training and/or treatment program(s), or professional developmental plan;
11. levy fine; and

DRAFT

12. payment of administrative and disciplinary costs.

The Board should be authorized, at its discretion, to take disciplinary, non-disciplinary, public or non-public actions singly or in combination as the nature of the violation requires and to promote public protection.

B. Letter of Concern or Advisory Letter: The Board should be authorized to issue a confidential (if allowed by state law), non-reportable, non-disciplinary letter of concern or advisory letter to a licensee when evidence does not warrant formal discipline, but the Board has noted indications of possible errant conduct by the licensee that could lead to serious consequences and formal action if the conduct were to continue. In its letter of concern or advisory letter, the Board should also be authorized, at its discretion, to request clarifying information from the licensee.

C. Examination/Evaluation: The Board should be authorized, at its discretion, to require professional competency, physical, mental or chemical dependency examination(s) or evaluation(s) of any applicant or licensee, including withdrawal and laboratory examination of bodily fluids, tissues, hair, or nails.

D. Grounds for Action: The Board should be authorized to take disciplinary action for unprofessional or dishonorable conduct, which should be defined to mean, but not be limited to, the following:

1. fraud or misrepresentation in applying for or procuring a medical license or in connection with applying for or procuring periodic renewal of a medical license;
2. cheating on or attempting to subvert the medical licensing examination(s);
3. the commission or conviction or the entry of a guilty, nolo contendere plea, or deferred adjudication (without expungement) of:
    a. a misdemeanor whether or not related to the practice of medicine and any crime involving moral turpitude;
    b. or a felony, whether or not related to the practice of medicine. The Board shall revoke a licensee's license following conviction of a felony, unless a 2/3 majority vote of the board members present and voting determined by clear and convincing evidence that such licensee will not pose a threat to the public in such person's capacity as a licensee and that such person has been sufficiently rehabilitated to warrant the public trust;
4. conduct likely to deceive, defraud or harm the public;
5. disruptive behavior and/or interaction with physicians, hospital personnel, patients, family members or others that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient;
6. making a false or misleading statement regarding his or her skill or the efficacy or value of the medicine, treatment or remedy prescribed by him or her or at his or her direction in the treatment of any disease or other condition of the body or mind;
7. representing to a patient that an incurable condition, sickness, disease or injury can be cured;
8. willfully or negligently violating the confidentiality between physician and patient except as required by law;
9. professional incompetency as one or more instances involving failure to adhere to the applicable standard of care to a degree which constitutes ~~gross~~ negligence, as determined by the board;

DRAFT

~~professional incompetency by repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board;~~

10. being found mentally incompetent or of unsound mind by any court of competent jurisdiction;
11. being physically or mentally unable to engage in the practice of medicine with reasonable skill and safety;
12. practice or other behavior that demonstrates an incapacity or incompetence to practice medicine;
13. the use of any false, fraudulent or deceptive statement in any document connected with the practice of medicine;
14. giving false, fraudulent, or deceptive testimony while serving as an expert witness;
15. practicing medicine under a false or assumed name;
16. aiding or abetting the practice of medicine by an unlicensed, incompetent or impaired person;
17. allowing another person or organization to use his or her license to practice medicine;
18. commission of any act of sexual misconduct, including sexual contact with patient surrogates or key third parties, which exploits the physician-patient relationship in a sexual way;
19. habitual or excessive use or abuse of drugs, alcohol or other substances that impair ability;
20. failing or refusing to submit to an ~~body fluid~~ examination or any other examination that may detect the presence of alcohol or drugs upon Board order or any other form of impairment;
21. prescribing, selling, administering, distributing, diverting, ordering or giving any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug for other than medically accepted therapeutic purposes;
22. knowingly prescribing, selling, administering, distributing, ordering or giving to a habitual user or addict or any person previously drug dependent, any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug, except as otherwise permitted by law or in compliance with rules, regulations or guidelines for use of controlled substances and the management of pain as promulgated by the Board;
23. prescribing, selling, administering, distributing, ordering or giving any drug legally classified as a controlled substance or recognized as an addictive ~~or dangerous~~ drug to a family member or to himself or herself;
24. violating any state or federal law or regulation relating to controlled substances;
25. signing a blank, undated or predated prescription form;
26. obtaining any fee by fraud, deceit or misrepresentation;
27. employing abusive, illegal, deceptive or fraudulent billing practices;
28. directly or indirectly giving or receiving any fee, commission, rebate or other compensation for professional services not actually and personally rendered, though this prohibition should not preclude the legal functioning of lawful professional partnerships, corporations or associations;
29. disciplinary action of another state or federal jurisdiction against a license or other authorization to practice medicine or participate in a federal program (payment or treatment)

DRAFT

based upon acts or conduct by the licensee similar to acts or conduct that would constitute grounds for action as defined in this section, a certified copy of the record of the action taken by the other state or jurisdiction being conclusive evidence thereof;

30. failure to report to the Board any adverse action taken against oneself by another licensing jurisdiction (United States or foreign), by any peer review body, by any health care institution, by any professional or medical society or association, by any governmental agency, by any law enforcement agency or by any court for acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;
31. failure to report or cause a report to be made to the Board any physician upon whom a physician has evidence or information that appears to show that the physician is incompetent, guilty of negligence, guilty of a violation of this act, engaging in inappropriate relationships with patients, is mentally or physically unable to practice safely or has an alcohol or drug abuse problem;
32. failure of physician who is the chief executive officer, medical officer or medical staff to report to the Board any adverse action taken by a health care institution or peer review body, in addition to the reporting requirement in 31. (note: a report under ~~32~~ 31 may need to wait until the peer review and due process procedures are completed, but the report under ~~31~~ 30 must be reported immediately without waiting for the final action of the health care institution and applies to all physicians not just staff physicians);
33. failure to report to the Board surrender of a license limitation or other authorization to practice medicine in another state or jurisdiction, or surrender of membership on any medical staff or in any medical or professional association or society has surrendered the authority to utilize controlled substances issued by any state or federal agency, or has agreed to a limitation to or restriction of privileges at any medical care facility while under investigation by any of those authorities or bodies for acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;
34. any adverse judgment, award or settlement against the licensee resulting from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;
35. failure to report to the Board any adverse judgment, settlement or award arising from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;
36. failure to provide pertinent and necessary medical records to another physician or patient in a timely fashion when legally requested to do so by the subject patient or by a legally designated representative of the subject patient regardless of whether the patient owes a fee for services;
37. improper management of medical records, including failure to maintain timely, legible, accurate, and complete medical records and to comply with the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Part 160 and 164, of the Health Insurance Portability and Accountability Act of 1996.
38. failure to furnish the Board, its investigators or representatives, information legally requested by the Board or to fail to comply with a Board subpoena or order;
39. failure to cooperate with a lawful investigation conducted by the Board;
40. violation of any provision(s) of the medical practice act or the rules and regulations of

DRAFT

the Board or of an action, stipulation or agreement of the Board;

41. engaging in conduct calculated to or having the effect of bringing the medical profession into disrepute, including but not limited to, violation of any provision of a national code of ethics acknowledged by the Board;
42. failure to follow generally accepted infection control procedures;
43. failure to comply with any state statute or board regulation regarding a licensee's reporting responsibility for HIV, HVB (hepatitis B virus), sero-positive status or any other reportable condition (including child abuse and vulnerable adult abuse) or disease;
44. practicing medicine in another state or jurisdiction without appropriate licensure;
45. conduct which violates patient trust, exploits the physician-patient relationship or violates professional boundaries;
46. failure to offer appropriate procedures/studies, failure to protest inappropriate managed care denials, failure to provide necessary service or failure to refer to an appropriate provider within such actions are taken for the sole purpose of positively influencing the physician's or the plan's financial well--being;
47. providing treatment or consultation recommendations, including issuing a prescription via electronic or other means, unless the physician has obtained a history and physical evaluation of the patient adequate to establish diagnosis and identify underlying conditions and/or contraindications to the treatment recommended/provided;
48. violating a Board formal order, condition of probation, consent agreement or stipulation;
49. representing, claiming or causing the appearance that the physician possesses a particular medical specialty certification by a Board recognized certifying organization (ABMS, AOA) if not true;
50. failing to obtain adequate patient informed consent;
51. using experimental treatments without appropriate patient consent and adhering to all necessary and required guidelines and constraints;
52. any conduct that may be harmful to the patient or the public;
53. failing to divulge to the Board upon legal demand the means, method, procedure, modality or medicine used in the treatment of an ailment, condition or disease;
54. conduct likely to deceive, defraud or harm the public;
55. the use of any false, fraudulent or deceptive statement in any document connected with the practice of the healing arts including intentional falsifying or fraudulent altering of a patient or medical care facility record;
56. failure to keep written medical records which accurately describe the services rendered to the patient, including patient histories, pertinent findings, examination results and test results;
57. delegating professional responsibilities to a person when the licensee knows or has reason to know that such person is not qualified by training, experience, or license to perform them;
58. using experimental forms of therapy without proper informed patient consent, without conforming to generally accepted criteria or standard protocols, without keeping detailed legible records or without having periodic analysis of the study and results reviewed by a committee or peers; and
59. failing to properly supervise, direct or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation or practice protocols.

DRAFT

Section X: Procedures for Enforcement and Disciplinary Action

The medical practice act should provide for procedures that will permit the Board to take appropriate enforcement and disciplinary action when and as required, while assuring fairness and due process to licensees. These provisions of the act should implement or be consistent with the following:

A. Board Authority: The Board should be empowered to commence legal action to enforce the provisions of the medical practice act and to exercise full discretion and authority with respect to disciplinary actions. In the course of an investigation, the Board's authority should include the ability to issue subpoenas to licensees, health care organizations, complainants, patients and witnesses to produce documents or appear before the Board or staff to answer questions or be deposed. The Board should have the power to enforce its subpoenas, including disciplining a non-compliant licensee, and it is incumbent upon the subpoenaed party to seek a motion to quash the subpoena.

~~B. Separation of Functions: In the exercise of its power, the Board's investigative and judicial functions should be separated to assure fairness and the Board should be required to act in a consistent manner in the application of disciplinary and/or remedial sanction.~~

~~C.~~B. Administrative Procedures: The existing administrative procedures act or similar statute, in whole or in part, should either be applicable to or serve as the basis of the procedural provisions of the medical practice act. The procedural provisions should provide for Board investigation of complaints; notice of formal or informal charges or allegations to the licensee; a fair and impartial hearing for the licensee before the Board, an examining committee or hearing officer; an opportunity for representation of the licensee by counsel; the presentation of testimony, evidence and arguments; subpoena power and attendance of witnesses; a record of the proceedings; and judicial review by the courts in accordance with the standards established by the jurisdiction for such review. The Board should have subpoena authority to conduct comprehensive reviews of a licensee's patient and office records and administrative authority to access otherwise protected peer review records. The Board should not need the patients' consent to obtain copies of medical records, nor shall health care institutions' peer-review privilege bar the Board from obtaining copies of peer review information. Once in the Board's possession, the patient records and peer review records should have the same legal protection from disclosure as they have when in the possession of the licensee, the patient or the peer-review organization.

~~D.~~C. Standard of Proof: The Board should be authorized to use preponderance of the evidence as the standard of proof in its role as trier of fact for all levels of discipline.

~~E.~~D. Informal Conference: Should there be an open meeting law, an exemption to it should be authorized to permit the Board, at its discretion, to meet in informal conference with a licensee who seeks or agrees to such a conference. Disciplinary action taken against a licensee because of such an informal conference and agreed to in writing by the Board and the licensee should be binding and a matter of public record. However, license revocation and suspension should be held in open formal hearing, unless executive session is permitted by the State's open meetings law. The holding of an informal conference should not preclude an open formal hearing if the Board determines such is necessary.

~~F.~~E. Summary Suspension: The Board should be authorized to summarily suspend or restrict a license prior to a formal hearing when it believes such action is required to protect the public from an imminent threat to public health and safety. The Board should be permitted to summarily suspend or restrict a license by means of a vote con-ducted by telephone conference call or other electronic means if appropriate Board officials believe such prompt action is required. Proceedings for a formal

DRAFT

hearing should be instituted simultaneously with the summary suspension. The hearing should be set within a reasonable time of the date of the summary suspension. No court should be empowered to lift or otherwise interfere with such suspension while the Board proceeds in a timely fashion.

~~G.~~F. Cease and Desist Orders/Injunctions: The Board should be authorized to issue a cease-and-desist order and/or obtain an injunction to restrain any person or any corporation or association and its officers and directors from violating any provision of the medical practice act. Violation of an injunction should be punishable as contempt of court. No proof of actual damage to any person should be required for issuance of a cease-and-desist order and/or an injunction, nor should issuance of an injunction relieve those enjoined from criminal prosecution, civil action or administrative process for violation of the medical practice act.

~~H.~~G. Board Action Reports: All the Board's final disciplinary actions, non-administrative license withdrawals, and license denials, including related findings of fact and conclusions of law, should be matters of public record. The Board should report such actions and denials to the Board Action Data Bank of the Federation of State Medical Boards of the United States within 30 days of the action being taken, to any other data repository required by law and to the media. Voluntary surrender of and voluntary limitation(s) on the medical license of any person should also be matters of public record and should also be reported to the Federation of State Medical Boards of the United States and to any other data repository by law. The Board should have the authority to keep confidential practice limitations and restrictions due to physical impairment when the licensee has not violated any provision in the medical practice act.

~~I.~~H. Tolling Periods of License Suspension or Restriction: The Board should provide, in cases of license suspension or restriction, that any time during which the disciplined licensee practices in another jurisdiction without comparable restriction shall not be credited as part of the period of suspension or restriction.

~~J.~~I. The Board should have the authority, at its discretion, to share investigative and adjudicatory files with other state and territorial medical boards at any time during the investigational or adjudicative process.

Section XI: Impaired Physicians

The medical practice act should provide for the limitation, restriction, conditioning, suspension or revocation of the medical license of any licensee whose mental or physical ability to practice medicine with reasonable skill and safety is impaired.

The Board should have available to it a confidential impaired physician program approved by the Board and charged with the evaluation and treatment of licensees who are in need of rehabilitation. The Board may directly provide such programs or through a formalized contractual relationship with an independent entity whose program meets standards set by the Board. The Board shall have ~~authority over such program and~~ the ability to monitor or audit the program to ensure the program meets the requirements of the Board.

The Board should be authorized, at its discretion, to require a licensee or applicant to submit to a mental or physical examination, body fluid, nail, or hair follicle test, or a chemical addiction, abuse or dependency evaluation conducted by an independent evaluator designated or approved in advance by the Board. The results of the examination or evaluation should be admissible in any hearing before the Board or hearing officer, despite any claim of privilege under a contrary rule or statute. Every person who receives a license to practice medicine or who files an application for a license to practice medicine should be deemed to have given

DRAFT

consent to submit to mental or physical examination or a chemical addition, abuse or dependency evaluation, and to have waived all objections to the admissibility of the results in any hearing before the Board. If a licensee or applicant fails to submit to an examination or evaluation when properly directed to do so by the Board, the Board should be permitted to enter a final order upon proper notice, hearing and proof of refusal.

If the Board finds, after an evaluation, examination or hearing, that a licensee is mentally, ~~psychologically,~~ physically or chemically impaired, it should be authorized to take one or more of the following actions:

A. direct the licensee to submit to therapy, medical care, counseling or treatment acceptable to the Board and comply with monitoring to ensure compliance;
B. suspend, limit ~~or~~, restrict or place conditions on the licensee's medical license for the duration of the impairment and monitoring or treatment; and/or
~~A.~~C. revoke the licensee's medical license.

Any licensee or applicant who is prohibited from practicing medicine under this provision should be afforded at reasonable intervals an opportunity to demonstrate to the satisfaction of the Board that he or she can resume or begin the practice of medicine with reasonable skill and safety. A license should not be reinstated, however, without the payment of all applicable fees and the fulfillment of all requirements as if the applicant had not been prohibited from practicing medicine.

While all impaired licensees should be reported to the Board in accord with the mandatory reporting requirements of the medical practice act, unidentified and unreported impaired licensees should be encouraged to seek treatment. To this end, the Board should be authorized, at its discretion, to establish rules and regulations for the review and approval of a medically directed Physician Health Program (PHP). Those conducting a Board-approved PHP should be exempt from the mandatory reporting requirements relating to an impaired licensee who is participating satisfactorily in the program, or the Board should hold its report in confidence and without action, unless or until the impaired licensee ceases to participate satisfactorily in the program. The Board should require a PHP to report any impaired licensee whose participation is unsatisfactory to the Board as soon as that determination is made. Participation in an approved PHP should not protect an impaired licensee from Board action resulting from a report of his or her impairment from another source. The Board should be the final authority for approval of a PHP, should conduct a review of its approved program(s) on a regular basis and should be permitted to withdraw or deny its approval at its discretion. The PHP should be required to report to the Board information regarding any violation of the medical practice act by a PHP participant, other than the impairment, even if the violation is unrelated to the licensee's impairment.

Section XII: Dyscompetent and Incompetent Licensees

The medical practice act should provide for the restriction, conditioning, suspension, revocation or denial of the medical license of any licensee who the Board determines to be dyscompetent or incompetent. These provisions of the act should implement or be consistent with the following:

A. The Board should be authorized to develop and implement methods to identify dyscompetent or incompetent licensees and licensees who fail to provide the appropriate quality of care. The Board should also be authorized to develop and implement methods to assess and improve licensee practices.
B. The Board should have access to a Board-approved assessment program charged with assessing

DRAFT

licensees' clinical competency.

C. The Board should be authorized, at its discretion, to require a licensee or an applicant for licensure to undergo a physician competency evaluation conducted by a Board-designated independent evaluator at licensee's own expense. The results of the assessment should be admissible in any hearing before the Board or hearing officer, despite any claim of privilege under a contrary rule or statute. Every person who receives a license to practice medicine or who files an application for a license to practice medicine should be deemed to have given consent to submit to a physician competency evaluation, and to have waived all objections to the admissibility of the results in any hearing before the Board or hearing officer. If a licensee or applicant fails to submit to a competency assessment when properly directed to do so by the Board, the Board should be permitted to enter a final order upon proper notice, hearing and proof of refusal to submit to such an evaluation.

D. If the Board finds, after evaluation by the assessment program, that a licensee or applicant for licensure is unable to competently practice medicine, it should be authorized to take one or more of the following actions:

1. suspend, revoke or deny the licensee's medical license or application;
2. restrict or limit the licensee's practice to those areas of demonstrated competence and comply with monitoring to ensure compliance~~, and/or~~;
3. place conditions on the licensee's license; and/or,
4. ~~3.~~ direct the licensee to submit to a Board approved remediation program and comply with monitoring to ensure compliance to resolve any identified deficits in medical knowledge or clinical skills acceptable to the Board.

E. Any licensee or applicant for licensure who is prohibited from practicing medicine, or who has had restrictions or conditions placed upon his license, under ~~the pro- vision referenced in paragraph~~Subsection D of this section should be afforded, at reasonable intervals, an opportunity to demonstrate to the satisfaction of the Board that he or she can resume or begin the practice of medicine, or can practice without the restrictions or conditions, with reasonable skill and safety. A license should not be reinstated, however, without the payment of all applicable fees and the fulfillment of all requirements as if the applicant had not been previously prohibited.

F. The Board should be authorized to require the assessment program to provide to the Board a written report of the results of the assessment with recommendations for remediation of the identified deficiencies.

G. The Board should have access to Board approved remedial medical education programs for referral of licensees in need of remediation. Such programs shall incorporate and comply with standards set by the Board. During remediation, the program shall provide, at Board determined intervals, written reports to the Board on the licensee's progress. Upon completion of the remediation program, the program shall provide a written report to the Board addressing the remediation of the previously identified areas of deficiency. The Board should be authorized to mandate that the licensee undergo post-remediation assessment to identify areas of continued deficit. The licensee shall be responsible for all expenses incurred as part of the assessment and the remediation.

Section XIII: Compulsory Reporting and Investigation

The medical practice act should provide that certain persons and entities report to the Board any possible violation of the act or of the Board's rules and regulations by a licensee. These provisions of the act should implement or be consistent with the following:

DRAFT

A. Any person should be permitted to report to the Board in a manner prescribed by the Board, any information he or she believes indicates a medical licensee is or may be ~~medically incompetent~~dyscompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine.

B. The following should be required to report to the Board promptly and in writing any information that indicates a licensee is or may be ~~medically incompetent~~dyscompetent, guilty of unprofessional conduct or mentally or physically unable to engage safely in the practice of medicine; and any restriction, limitation, loss or denial of a licensees staff privileges or membership that involves patient care:

1. all licensees licensed under the act,
2. all licensed health care providers,
3. the state medical associations and its components,
4. all hospitals and other health care organizations in the state, to include hospitals, medical centers, ~~nursing homes,~~ long term care facilities, managed care organizations, ambulatory ~~surgi-centers~~ surgery centers, clinics, group practices, coroners, etc.,
5. all chiefs of staff, medical directors, department administrators, service directors, attending physicians, residency directors, etc.,
6. all liability insurance organizations,
7. all local medical/osteopathic societies,
~~5.~~8. all local professional societies,
~~6.~~9. all state agencies,
~~7.~~10. all law enforcement agencies in the state,
~~8.~~11. all courts in the state,
~~9.~~12. all federal agencies (e.g., DEA, FDA, and CMS),
~~10.~~13. all peer review bodies in the state, and
~~11.~~14. resident training program directors.

C. A licensee's voluntary resignation from the staff of a health care organization or voluntary limitation of his or her staff privileges at such an organization should be promptly reported to the Board by the organization if that action occurs while the licensee is under formal or informal investigation by the organization or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct or mental, physical, alcohol or drug impairment.

D. Malpractice insurance carriers, the licensee's attorney, a hospital, a group practice and the affected licensees should be required to file with the Board a report of each final judgment, settlement, arbitration award, or any form of payment by the licensee or on the licensee's behalf by any source upon any demand, claim or case alleging medical malpractice, battery, dyscompetence, incompetence or failure of informed consent. Licensees not covered by malpractice insurance carriers should be required to file the same information with the Board regarding themselves. All such reports should be made to the Board promptly (e.g., within 30 days).

E. The Board should be permitted to investigate any evidence that appears to show a licensee is or may be medically incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine.

F. Any person, institution, agency or organization who reports in good faith and not made in bad faith, a licensee pursuant to subsections (A) or (B) of this section should not be subject to civil damages or criminal prosecution for so reporting. A bad faith report is grounds for disciplinary action under the

DRAFT

medical practice act. There should be no monetary liability on the part of, and no cause of action for damages should arise against any person, institution, agency or organization for reporting in good faith.

G. To assure compliance with compulsory reporting requirements, specific civil penalties should be established for demonstrated failure to report (e.g., up to $10,000 per instance).

H. The Board should promptly acknowledge all reports received under this section. The Board should promptly notify persons or entities reporting under this section of the Board's final disposition of the matters reported.

Section XIV: Protected Action and Communication

The medical practice act should provide legal protection for the members of the Board and its staff and for those providing information to the Board in good faith. These provisions of the act should implement or be consistent with the following:

A. Qualified Immunity

1. There shall be no liability on the part of and no action for damages against any member of the board, or its agents or employees, or any member of an examining committee of physicians appointed or designated by the board, for any action undertaken or performed by such person within the scope of the duties, powers, and functions of the board or such examining committee as provided for in this Part when such person is acting in good faith and in the reasonable belief that the action taken by him is warranted.
2. No person, committee, association, organization, firm, or corporation providing information to the board in good faith and in the reasonable belief that such information is accurate and, whether as a witness or otherwise, shall be held, by reason of having provided such information, to be liable in damages under the law of the state or any political subdivision thereof.
3. In any suit brought against the board, its employees or agents, any member of an examining committee appointed by the board or any person, firm, or other entity providing information to the board, when any such defendant substantially prevails in such suit, the court shall, at the conclusion of the action, award to any such substantially prevailing party defendant against any such claimant the cost of the suit attributable to such claim, including a reasonable attorney's fee, if the claim was frivolous, unreasonable, without foundation, or in bad faith. For the purposes of this Section, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains an award for damages or permanent injunctive or declaratory relief.
4. There shall be no liability on the part of and no action for damages against any ~~nonprofit~~ corporation, foundation, or organization that enters into any agreement with the board related to the operation of any committee or program to identify, investigate, counsel, monitor, or assist any licensed physician who suffers or may suffer from alcohol or substance abuse or a physical or mental condition which could compromise such physician's fitness and ability to practice medicine with reasonable skill and safety to patients, for any investigation, action, report, recommendation, decision, or opinion undertaken, performed, or made in connection with or on behalf of such committee or program, in good faith and in the reasonable belief that such investigation, action, report, recommendation, decision, or opinion was warranted.

DRAFT

5. There shall be no liability on the part of and no action for damages against any person who serves as a director, trustee, officer, employee, consultant, or attorney for or who otherwise works for or is associated with any ~~nonprofit~~ corporation, foundation, or organization that enters into any agreement with the board related to the operation of any committee or program to identify, investigate, counsel, monitor, or assist any licensed physician who suffers or may suffer from alcohol or substance abuse or a physical or mental condition which could compromise such physician's fitness and ability to practice medicine with reasonable skill and safety to patients, for any investigation, action, report, recommendation, decision, or opinion undertaken, performed, or made in connection with or on behalf of such committee or program, in good faith and in the reasonable belief that such investigation, action, report, recommendation, decision, or opinion was warranted.
6. In any suit brought against any ~~nonprofit~~ corporation, foundation, organization, or person described in Subsection D or E of this Section, when any such defendant substantially prevails in the suit, the court shall, at the conclusion of the action, award to any substantially prevailing party defendant against any claimant the cost of the suit attributable to such claim, including reasonable attorney fees, if the claim was frivolous or brought without a reasonable good faith basis. For purposes of this Subsection, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains a judgment for damages, permanent injunction, or declaratory relief.

B. Indemnity and Defense

The state should defend a current or former member, officer, administrator, staff member, committee member, examiner, representative, agent, employee, consultant, witness, contractor or any other person serving or having served the Board against any claim or action arising out of the act, omission, proceeding, conduct or decision related to his or her duties undertaken or performed in good faith and within the scope of the function of the Board. The State should provide and pay for such defense and should pay any resulting judgment, compromise or settlement.

C. Protected Communication

1. Every communication made by or on behalf of any person, institution, agency or organization to the Board or to any person(s) designated by the Board relating to an investigation or the initiation of an investigation, whether by way of report, complaint or statement, should be privileged. No action or proceeding, civil or criminal, should be permitted against any person, institution, agency or organization that made such a communication in good faith.
2. The protections afforded in this provision should not be construed as prohibiting a respondent or his or her legal counsel from exercising the respondent's constitutional right of due process under the law.

Section XV: Unlawful Practice of Medicine: Violations and Penalties

The medical practice act should provide a definition of the unlawful practice of medicine and penalties for such unlawful practice. These provisions of the act should implement or be consistent with the following:

A. It should be unlawful for any person, corporation or association to perform any act constituting the practice of medicine as defined in the medical practice act without first obtaining a

medical license in accord with that act and the rules and regulations of the Board. Other licensed health care professionals may provide medical services within the scope of their authorizing license.

B. The Board should be authorized to issue a cease-and-desist order and/or obtain injunctive relief against the unlawful practice of medicine by any person, corporation or association.

C. It should be a felony crime for any person, corporation or association that performs any act constituting the practice of medicine as defined in the medical practice act, or causing or aiding and abetting such actions.

D. A physician located in another state practicing within the state by electronic or other means without a license (full, special purpose or otherwise) issued by the Board should be deemed guilty of a felonious offense.

Section XVI: Periodic Renewal

The medical practice act should provide for the periodic renewal of medical licenses to permit the Board to review the qualifications of licensees on a regular basis. These provisions of the act should implement or be consistent with the following:

A. At the time of periodic renewal, the Board should require the licensee to demonstrate to its satisfaction his or her continuing qualification for medical licensure. The Board should design the application for licensure renewal to require the licensee to update and/or add to the information in the Board's file relating to the licensee and his or her professional activity. It should also require the licensee to report to the Board the following information:

1. Any action taken for acts or conduct similar to acts or conduct described in the medical practice act as grounds for disciplinary action against a licensee by:
    a. any jurisdiction or authority (United States or foreign) that licenses or authorizes the practice of medicine or participation in a payment or practice program;
    b. any peer review body;
    c. any specialty certification board;
    d. any health care organization;
    e. any professional medical society or association;
    f. any law enforcement agency;
    g. any health insurance company;
    h. any malpractice insurance company;
    i. any court; and
    j. any governmental agency.
2. Any adverse judgment, settlement or award against the licensee or payment by or on behalf of the licensee arising from a professional liability demand, claim or case.
3. The licensee's voluntary surrender of or voluntary limitation on any license or authorization to practice medicine in any jurisdiction, including military, public health and foreign.
4. Any denial to the licensee of a license or authorization to practice medicine by any jurisdiction, including military, public health and foreign.
5. The licensee's voluntary resignation from the medical staff of any health care

DRAFT

organization or voluntary limitation of his or her staff privileges at such an organization if that action occurred while the licensee was under formal or informal investigation by the organization or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct or mental, physical, alcohol or drug impairment.

6. The licensee's voluntary resignation or withdrawal from a national, state or county medical society, association or organization if that action occurred while the licensee was under formal or informal investigation or review by that body for any reason related to possible medical incompetence, unprofessional conduct mental, physical, alcohol or drug impairment.
7. Whether the licensee has abused or has been addicted to or treated for addiction to alcohol or any chemical substance.
8. Whether the licensee has had any physical injury, impairment, condition, disease or mental or psychological illness that adversely affected or interrupted his or her practice of medicine.
9. The licensee's completion of continuing medical education or other forms of professional maintenance and/or evaluation, including specialty board certification or recertification, within the renewal period.

B. The Board should be authorized, at its discretion, to require continuing medical education for license renewal and to require documentation of that education. The Board should have the authority to audit, randomly or specifically, licensees for compliance.

C. The Board should require the licensee to apply for license renewal in a manner prescribed by the board and attest to the accuracy and truthfulness of the information submitted.

D. The Board should be directed to establish an effective system for reviewing renewal forms. It should also be authorized to initiate investigations and/or disciplinary proceedings based on information submitted by licensees for license renewal.

E. Failure to report fully and correctly should be grounds for disciplinary action by the Board.

Section XVII: Physician Assistants

The medical practice act should provide for the Board to license and regulate physician assistants. These provisions of the act should implement or be consistent with the following:

A. Administration: The Board should administer and enforce these provisions of the medical practice act with the advice and assistance of the Physician Assistant Council.

B. Physician Assistant Licensing

1. No person should perform or attempt to ~~perform~~ practice as a physician assistant without first obtaining a license from the Board and having a supervising physician.
2. An applicant for licensure as a physician assistant should complete all Board application forms and pay a nonrefundable fee. The forms should request the applicant provide their name and address and such additional information as the Board deems necessary. The Board may issue a license to a physician assistant applicant who fulfills all board requirements for licensure. However, a licensed physician assistant is prohibited from practicing until they have an agreement with a supervising physician(s).
3. Each licensed physician assistant should renew their license and file updated documentation stating their name and current address and any additional information as required by the Board. A fee set by the Board should accompany each renewal and filing of updated

documentation.

4. The Board may require written notification by the supervising physician and the physician assistant if the relationship is changed or severed for ~~any~~ a reason that would have an adverse effect for patient care. ~~The notification should include a detailed explanation of when and why the relationship changed and/or ended.~~
5. Persons not licensed by the Board who hold themselves out as physician assistants should be subject to penalties applicable to the unlicensed practice of medicine.

C. Rules and Regulations: The Board should be empowered to adopt and enforce rules and regulations for:

1. setting qualifications of education, skill and experience for the licensing of a person as a physician assistant and providing forms and procedures for licensure and for renewal; and
2. evaluating applicants for licensure as physician assistants ~~as to their skill, knowledge and experience in the field of medical care~~.

D. Disciplinary Actions: The Board should be empowered to deny, revoke or suspend any license, to limit or restrict the location of practice, to issue reprimands, to remove the authorization of a supervising physician and to limit or restrict the practice of a physician assistant upon grounds and according to procedures similar to those for such disciplinary actions against licensed physicians. Such actions should be reported to the Federation of State Medical Boards.

E. Duties and Scope of Practice: A physician assistant should be permitted to provide those medical services delegated to them by the supervising physician that are within their training and experience~~, form a usual component of the supervising physician's scope of practice, and are provided pursuant to the supervising physician's instructions~~.

F. Responsibility of Supervising Physician: Every physician supervising or employing a physician assistant ~~should practice in the medical areas in which the physician assistant is to perform and~~ should be legally responsible for the delegation of health care tasks, the performance and the acts and omissions of the physician assistant. Nothing in these provisions, however, should be construed to relieve the physician assistant of any responsibility for any of their own acts and omissions. No physician should have under their supervision more staff, physician assistant or otherwise than the physician can adequately supervise. In the event the supervising physician is absent, he or she must provide for appropriate supervision of the physician assistant by another licensed physician. Each and every relationship should adhere to all statutory requirements for licensure.

G. The Board should be authorized, at its discretion, to require evidence of satisfactory completion of continuing medical education for license renewal.

Section XVIII: Rules and Regulations

The medical practice act should authorize the Board to promulgate rules and regulations to facilitate the enforcement of the act. These provisions of the act should implement or be consistent with the following:

A. The Board should be authorized to adopt and enforce rules and regulations to carry out the provisions of the medical practice act and to fulfill its duties under the act.

B. The Board should adopt rules and regulations in accord with administrative procedures established in the jurisdiction.

Section XIX: Funding and Fees

DRAFT

The medical practice act should provide that Board fees be adequate to fund the Board's effective regulation of the practice of medicine under the act and that those fees paid by licensees be used only for purposes related to licensee licensure, discipline and Board administration. These provisions of the act should implement or be consistent with the following:

A. The Board should be fully supported by the revenues generated from its activities, including fees, charges and reimbursed costs, which the Board should deposit in an appropriate account, and the Board should also receive all interest earned on the deposit of such revenues. Such funds should be appropriated continuously. All fines levied by the Board may be deposited in the State General Fund, unless otherwise allowed by law. All administrative, investigative and adjudicatory costs recoupment should be deposited in the Board's account.
B. The Board should develop and adopt its own budget reflecting revenues, including the interest thereon, and costs associated with each health care field regulated. Revenues and interest thereon, from each health care field regulated should fully support Board regulation of that field. The budget should include allocations for establishment and maintenance of a reasonable reserve fund.
C. The Board should be authorized to set fees and charges pursuant to its proposed budget needs. Reasonable notice should be provided for all increases or decreases in fees and charges.
D. The Board should operate on the same fiscal year as the State.
E. A designated officer of the Board or employee, at the direction of the Board, should oversee the collection and disbursement of funds.
F. The State Auditor's Office (or the equivalent State office) should routinely audit the financial records of the Board and report to the Board and the Legislature.

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Federation of STATE MEDICAL BOARDS

Thirteenth Edition

Essentials of a State Medical and Osteopathic Practice Act

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(817) 868-4000
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Essentials of a State Medical and Osteopathic Practice Act

Thirteenth Edition

Introduction

As early as 1914, the Federation of State Medical Boards of the United States and its member boards recognized the need for what was to become *A Guide to the Essentials of a Modern Medical Practice Act*. First published in 1956, the stated purposes of the document have always been the same:

1. to serve as a guide to those states that may adopt new medical practice acts or may amend existing laws and

2. to encourage the development and use of consistent standards, language, definitions and tools by boards responsible for physician and physician assistant regulation.

Changes in medical education, in the practice of medicine and in the diverse responsibilities that face medical boards necessitate regular revision of medical practice acts. The *Essentials* has undergone numerous revisions in order to respond to these changes and to provide assistance to member boards in the evaluation and revision of their medical practice acts. The Federation urges member boards to consider including any recommendation contained in the *Essentials* in its medical practice act or under its rules.

The *Essentials* applies equally to practice acts that govern physicians who have acquired the M.D. or D.O. degree in the same statute or in separate statutes. The terms used herein should be interpreted throughout with this understanding.

Preamble

An essential is that element, quality or property that is indispensable in making a body, character or structure what it is. It constitutes the essence. The Federation of State Medical Boards of the United States believes that each of the 19 sections of this document express an essential of a modern medical practice act and that the recommendations in each section are basic to the realization of that essential.

Table of Contents

Section I:	Statement of Purpose	3
Section ll:	Definitions	3
Section lll:	The State Medical Board	5
Section IV:	Examinations	8
Section V:	Requirements for Full Licensure	10
Section VI:	Graduates of Foreign Medical Schools	12
Section VII:	Licensure by Endorsement, Expedited Licensure by Endorsement, and Temporary and Special Licensure	13
Section VIII:	Limited Licensure for Physicians in Postgraduate Training	15
Section IX:	Disciplinary Action against Licensees	16
Section X:	Procedures for Enforcement and Disciplinary Action	20
Section Xl:	Impaired Physicians	22
Section XII:	Dyscompetent Physicians	23
Section XIII:	Compulsory Reporting and Investigation	24
Section XIV:	Protected Action and Communication	25
Section XV:	Unlawful Practice of Medicine: Violations and Penalties	27
Section XVI:	Periodic Renewal	28
Section XVII:	Physician Assistants	29
Section XVIII:	Rules and Regulations	30
Section XIX:	Funding and Fees	31

Section I: Statement of Purpose

The medical practice act should be introduced by a statement of policy specifying the purpose of the act. This statement should include language expressing the following concepts:

A. The practice of medicine is a privilege granted by the people acting through their elected representatives.

B. In the interests of public health, safety and welfare, and to protect the public from the unprofessional, improper, incompetent, unlawful, fraudulent and/or deceptive practice of medicine, it is necessary for the government to provide laws and regulations to govern the granting and subsequent use of the privilege to practice medicine.

C. The primary responsibility and obligation of the state medical board is to act in the sovereign interests of the government by protecting the public through licensing, regulation and education as directed by the state government.

Section II: Definitions

A. Definitions: As used in this Act, the following terms shall have the following meanings:

"Assessment Program" means a formal system to examine or evaluate a physician's competence within the scope of the physician's practice.

"Competence" means possessing the requisite abilities and qualities (cognitive, non-cognitive and communicative) to perform effectively within the scope of the physician's practice while adhering to professional ethical standards.

"Dyscompetence" means failing to maintain acceptable standards of one or more areas of professional physician practice.

Impairment means a physician's inability to practice medicine with reasonable skill and safety due to:

1. mental, psychological or psychiatric illness, disease or deficit;
2. physical illness or condition, including, but not limited to, those illnesses or conditions that would adversely affect cognitive, motor or perceptive skills; or
3. habitual, excessive or illegal use or abuse of drugs defined by law as controlled substances, illegal drugs or alcohol or of other impairing substances.

"Incompetence" means lacking the requisite abilities and qualities (cognitive, non-cognitive, and communicative) to perform effectively in the scope of the physician's practice.

"Licensed physician" means a physician licensed to practice medicine in the jurisdiction.

"Physician assistant" means a skilled person who by training, scholarly achievements, submission of acceptable letters of recommendations and satisfaction of other requirements of the Board has been licensed for the provision of patient services under the supervision and direction of a licensed physician who is responsible for the performance of that person.

"Physician Assistant Council" means a council appointed by the Board or other means that reviews matters relating to physician assistants reports its findings to the Board and makes recommendations for action.

The medical practice act should provide definitions of the practice of medicine as governed by the act as well as exceptions to the act. These provisions of the act should implement or be consistent with the following:

"Practice of medicine means"

1. advertising, holding out to the public or representing in any manner that one is authorized to practice medicine in the jurisdiction;
2. offering or undertaking to prescribe, order, give or administer any drug or medicine for the use of any other person;
3. offering or undertaking to prevent or to diagnose, correct and/or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect or abnormal physical or mental condition of any person, including the management of pregnancy and parturition;
4. offering or undertaking to perform any surgical operation upon any person;
5. rendering a written or otherwise documented medical opinion concerning the diagnosis or treatment of a patient or the actual rendering of treatment to a patient within a state by a physician located outside the state as a result of transmission of individual patient data by electronic or other means from within a state to such physician or his or her agent;
6. rendering a determination of medical necessity or a decision affecting the diagnosis and/or treatment of a patient and
7. using the designation Doctor, Doctor of Medicine, Doctor of Osteopathic Medicine/Doctor of Osteopathy, Physician, Surgeon, Physician and Surgeon, Dr., M.D., D.O. or any combination thereof in the conduct of any occupation or profession pertaining to the prevention, diagnosis or treatment of human disease or condition unless such a designation additionally contains the description of another branch of the healing arts for which one holds a valid license in the jurisdiction.

"Remediation" means the process whereby deficiencies in physician performance identified through an examination or assessment program are corrected, resulting in an acceptable state of physician competence.

"Supervising physician" means a licensed physician in good standing in the same jurisdiction as the physician assistant who the Board approved to supervise the services of a physician assistant, and who has in writing formally accepted the responsibility for such supervision.

B. The medical practice act shall not apply to:

1. students while engaged in training in a medical school approved or recognized by the state medical board, unless the Board licenses the student;

2. those providing service in cases of emergency where no fee or other consideration is contemplated, charged or received by the physician or anyone on behalf of the physician;

3. commissioned medical officers of the armed forces of the United States and medical officers of the United States Public Health Service or the Veterans Administration of the United States in the discharge of their official duties and/or within federally controlled facilities, provided that such persons who hold medical licenses in the jurisdiction should be subject to the provisions

of the act and provided that all such persons should be fully licensed to practice medicine in one or more jurisdictions of the United States, further the military physician should be subject to the Military Health System Clinical Quality Assurance (CQA) Program 10 U.S.C.A. § 1094; Regulation DOD 6025.13-R;

4. those practicing dentistry, nursing, optometry, podiatry, psychology or any other of the healing arts in accord with and as provided by the laws of the jurisdiction;

5. those practicing the tenets of a religion or ministering religious based medical procedures or ministering to the sick or suffering by mental or spiritual means in accord with such tenets;

6. a person administering a lawful domestic or family remedy to a member of his or her own family and

7. those fully licensed to practice medicine in another jurisdiction of the United States who briefly render emergency medical treatment or briefly provide critical medical service at the specific lawful direction of a medical institution or federal agency that assumes full responsibility for that treatment or service and is approved by the state medical board.

C. For the purpose of the medical practice act, the practice of medicine is determined to occur where the patient is located in order that the full resources of the state are available for the protection of that patient.

Section III: The State Medical Board

The medical practice act should provide for a separate state medical board, acting as a governmental agency, (referred to hereafter as the Board) to regulate the practice of medicine, including the licensure and discipline of physicians, in the jurisdiction. These provisions of the act should implement or be consistent with the following:

A. Whatever the professional regulatory structure established by the government of the jurisdiction, physicians should bear the primary responsibility for licensing and regulating the medical profession for the protection of the public, without abusing physicians in the discharge of that duty. Every Board should include both physician and public members. All Board members shall act to further the interest of the state, and not their personal interests.

B. Whatever the professional regulatory structure established by the government of the jurisdiction, the Board, within the context of the act and the requirements of due process, should have, at a minimum, the following powers and responsibilities:

   1. Promulgate rules and regulations
   2. Select and/or administer licensing examination(s)
   3. Develop and adopt policies and guidelines related to medical practice, other health care professions and regulation
   4. Evaluate medical education and training of applicants
   5. Evaluate or verify certification of medical and training programs to determine if these programs are appropriately preparing physicians for the practice of medicine
   6. Evaluate previous professional performance of applicants
   7. Issue or deny initial or endorsement licenses
   8. Maintain secure and complete records on individual licensees

9. Provide the public with a profile of all licensed physicians
10. Approve or deny applications for license renewal
11. Develop and implement methods to identify physicians who are in violation of the medical practice act
12. Develop and implement methods to identify and rehabilitate, if appropriate, physicians with an alcohol, drug and/or psychiatric illness
13. Receive, review and investigate complaints including sua sponte complaints
14. Review and investigate reports received from entities having information pertinent to the professional performance of licensees
15. Review, investigate, and take appropriate action to enjoin reports received concerning the unlicensed practice of medicine
16. Share investigative information at the early stages of a complaint investigation with other Boards.
17. Issue subpoenas, subpoenas duces tecum, administer oaths, receive testimony and conduct hearings
18. Discipline licensees found in violation of the medical practice act
19. Develop policies for disciplining or rehabilitating physicians that demonstrate inappropriate sexual behavior with patients or other professional boundaries violations
20. Institute actions in its own name and enjoin violators of the medical practice act
21. Acknowledge receipt of complaints or other adverse information to persons or entities reporting to the Board and to the physician, and inform them of the final disposition of the matters reported
22. Develop and implement methods to identify dyscompetent physicians and physicians who fail to meet acceptable standards of care
23. Develop or identify and implement methods to assess and improve physician practice
24. Develop or identify and implement methods to ensure the ongoing competence of licensees
25. Establish appropriate fees and charges to ensure active and effective pursuit of its legal responsibilities
26. Develop and adopt its budget
27. Develop educational programs to facilitate licensee awareness of provisions contained in the medical practice act and to facilitate public awareness of the role and function of state medical boards and
28. Acquire real property or other capital for the administration and operation of the Board

C. Members of the Board, whether appointed or elected, should serve staggered terms to ensure continuity. All appointments and elections should be confirmed through the legislative branch of the jurisdiction.

D. The length of terms on the Board should be set to permit development of effective skill and experience by members (e.g., three or four years). However, a limit should be set on consecutive terms of service (e.g., two or three).

E. Members of the Board should receive appropriate compensation for services and reimbursement for expenses at the State's current approved rate.

F. A member of the Board should be subject to removal only when he or she

1. ceases to be qualified;

2. is found guilty of a felony or an unlawful act involving moral turpitude by a court of competent jurisdiction;
3. is found guilty of malfeasance, misfeasance or nonfeasance in relation to his or her Board duties by a court of competent jurisdiction;
4. is found mentally incompetent by a court of competent jurisdiction;
5. fails to attend three successive Board meetings without just cause as determined by the Board or, if a new member, fails to attend a new members' training program without just cause as determined by the Board;
6. is disciplined for violations of the medical practice act or
7. is found in violation of the conflict of interest/ethics law.

G. All physician members of the Board should hold full and unrestricted medical licenses in the jurisdiction, should be persons of recognized professional ability and integrity, and should have resided, practiced in the jurisdiction long enough to have become familiar with policies and practice in the jurisdiction (e.g., five years).

H. The Board should include public members who:

1. are not licensed physicians or providers of health care;
2. have no substantial personal or financial interests in the practice of medicine or with any organization regulated by the Board;
3. have no immediate familial relationships with individuals involved in the practice of medicine or any organization regulated by the Board;
4. are residents of the State; and
5. are individuals of recognized ability and integrity.

I. The Board should be authorized to appoint committees from its membership. To effectively perform its duties under the Act, the Board should also be authorized to hire, discipline and terminate staff, including an executive secretary or director. It should also (be assigned adequate legal counsel by the office of the attorney general and/or be authorized to employ private counsel or its own full-time attorney.)

J. The Board should conduct and new members should attend a training program designed to familiarize new members with their duties and the ethics of public service.

K. Travel, expenses and daily compensation should be paid for each Board member's attendance, in or out of state, for education or training purposes approved by the Board and directly related to Board duties.

L. Telephone or other telecommunication conference should be an acceptable form of Board meeting for the purpose of taking emergency action to enforce the medical practice act if the president alone or another officer and two Board members (if allowed by open meeting laws) believe the situation precludes another form of meeting. The Board should be authorized to establish procedures by which its committees may meet by telephone or other telecommunication conference system to take emergency action.

Section IV: Examinations

The medical practice act should provide for medical licensing examination(s), examination application, and examination security. These provisions of the act should implement or be consistent with the following:

A. Medical Licensing Examination(s)

1. No person should receive a license to practice medicine in the jurisdiction unless he or she has passed an examination or examinations satisfactory to the Board.
2. The Board should approve the preparation and administration of an examination or examinations, in English, that it deems must be satisfactorily passed as part of its procedure for deter-mining an applicant's qualification for the practice of medicine.
3. Examinations should be scored in a way to ensure the anonymity of applicants.
4. The Board should stipulate the score required for passing the examination(s). The required passing score should be set before the administration of the examination(s).
5. The Board should be authorized to limit the number of times an examination may be taken, to require applicants to pass all examinations within a specified period, and to specify further medical education required for applicants unable to do so.
6. An applicant should pay all examination fees prior to the examination being administered and no later than a date set by the Board.
7. The Board may delegate to its agent or a third party examination agent the responsibilities of examination development and administration, including eliminating the need for the Board to sponsor or authorize an applicant for examination eligibility.

B. Examination Application

To apply for examination(s), an applicant should provide the Board or its agent and attest to the following information and documentation no later than a date set by the Board:

1. his or her full name and all aliases or other names ever used, current address, Social Security Number and date and place of birth;
2. a recent signed photograph and/or other documentation of identity;
3. name and location of medical school of graduation, degree earned and date of graduation or the medical school now being attended and current matriculated status;
4. a history of graduate medical education, including name and address of all programs and hospitals;
5. original of all documents and credentials or notarized photocopies or other verification of such documents and credentials acceptable to the Board or its agent and
6. any other information or documentation the Board or its agent determines necessary.

C. Examination Security

1. Any individual found by the Board or its agent to have engaged in conduct that subverts or attempts to subvert the medical licensing examination process or the specialty board certification/recertification process, should, at the discretion of the Board, have his or her scores on the licensing examination withheld and/or declared invalid, be disqualified from the practice of medicine and/or be subject to the imposition of other appropriate sanctions. The Federation of State Medical Boards of the United States should be informed of all such actions.

2. Conduct that subverts or attempts to subvert the medical licensing examination process should include, but not be limited to:

   a. conduct that violates the security of the examination materials, such as removing from the examination room any of the examination materials; reproducing or reconstructing any portion of the licensing examination; aiding by any means in the reproduction or reconstruction of any portion of the licensing examination; selling, distributing, buying, receiving or having unauthorized possession of any portion of a future, current or previously administered licensing examination; "hacking" or attempting to "hack" the electronic version of any examination or the files of the developing or administering entity through unauthorized access or entry;
   b. conduct that violates the standard of test administration, such as communicating with any other examinee during the administration of the licensing examination; copying answers from another examinee or permitting one's answers to be copied by another examinee during the administration of the licensing examination; having in one's possession during the administration of the licensing examination any books, notes, written or printed materials or data of any kind, other than the examination distributed and/or
   c. conduct that violates the credentialing process, such as falsifying or misrepresenting educational credentials or other information required for admission to the licensing examination, impersonating an examinee or having an impersonator take the licensing examination on one's behalf.

3. The Board or its agent should provide written notification to all applicants for medical licensure of the prohibitions on conduct that subverts or attempts to subvert the licensing examination process and of the sanctions imposed for such conduct. A copy of such notification attesting that he or she has read and understood the notification should be signed by the applicant and filed with his or her application.

Section V: Requirements for Full Licensure

The medical practice act should provide minimum requirements for full licensure for the independent practice of medicine that bear a reasonable relationship to the qualifications and fitness necessary for such practice. These provisions of the act should implement or be consistent with the following:

A. The applicant should provide the Board, or its agent, and attest to, or provide the means to obtain and verify the following information and documentation in a manner required by the Board:

1. his or her full name and all aliases or other names ever used, current address, Social Security number and date and place of birth;

2. a signed photograph not more than two (2) years old and, at the board's discretion, other documentation of identity;

3. originals of all documents and credentials required by the Board, notarized photocopies or other verification acceptable to the Board of such documents and credentials;

4. a list of all jurisdictions, United States or foreign, in which the applicant is licensed or has ever applied for licensure to practice medicine or is authorized or has ever applied for authorization to practice medicine, including all jurisdictions in which any license application or authorization has been withdrawn;

5. a list of all jurisdictions, United States or foreign, in which the applicant has been denied licensure or authorization to practice medicine or as any other health care professional or has voluntarily surrendered a license or an authorization to practice medicine or as any other health care professional;

6. a list of all sanctions, judgments, awards, settlements or convictions against the applicant in any jurisdiction, United States or foreign, that would constitute grounds for disciplinary action under the medical practice act or the Board's rules and regulations;

7. a detailed educational history, including places, institutions, dates and program descriptions of all his or her education including all college, pre-professional, professional and professional postgraduate education;

8. a detailed chronological life history, including places and dates of residence, employment and military service (United States or foreign) including periods of absence from the active practice of medicine;

9. all Web sites associated with the applicant's practice and professional activities;

10. a list and current status of all specialty certifications and the name of certifying organization; and

11. any other information or documentation the Board determines necessary.

B. The applicant should possess the degree of Doctor of Medicine or Doctor of Osteopathic Medicine/Doctor of Osteopathy from a medical college or school located in the United States, its territories or possessions or Canada that was approved by the Board or by a private nonprofit accrediting body approved by the Board at the time the degree was conferred. No person who graduated from a medical school that was not approved at the time of graduation should be examined for licensure or be licensed in the jurisdiction based on credentials or documentation from that school nor should such a person be licensed by endorsement.

C. Should the applicant graduate from a medical school in a foreign country, other than Canada, the applicant should meet all the requirements established by the Board to determine the applicant's fitness to practice medicine.

D. The applicant should have satisfactorily completed at least thirty-six (36) months of progressive postgraduate medical training approved by the Board or by a private nonprofit accrediting body approved by the Board in an institution in the United States, its territories or possessions or Canada, which has been approved by the Board or by a private nonprofit accrediting body approved by the Board.

E. The applicant should have passed medical licensing examination(s) satisfactory to the Board.

F. The applicant should have demonstrated a familiarity with the statutes and regulations of the jurisdiction relating to the practice of medicine and the appropriate use of controlled or dangerous substances.

G. The applicant should be physically, mentally and professionally capable of practicing medicine in a manner acceptable to the Board and should be required to submit to a physical, mental, professional competency or chemical dependency examination(s) or evaluation(s) if deemed necessary by the Board.

H. The applicant should not have been found guilty by a competent authority, United States or foreign, of any conduct that would constitute grounds for disciplinary action under the regulations of the Board or the act. The Board may be authorized, at its discretion, to modify this restriction for cause, but it should be directed to use such discretionary authority in a consistent manner.

I. If the applicant's license is denied or in accordance with Board policy, the applicant should be allowed a personal appearance before the Board or a representative thereof for interview, examination or review of credentials. At the discretion of the Board, the applicant should be required to present his or her original medical education credentials for inspection at the time of personal appearance.

J. The applicant should be held responsible for verifying to the satisfaction of the Board the validity of all credentials required for his or her medical licensure. The Board or its agent should verify medical licensure credentials directly from primary sources, and utilize recognized national physician information services (e.g., the Federation of State Medical Boards' Board Action Data Bank and Credentials Verification Service, the files of the American Medical Association and the American Osteopathic Association, and other national data banks and information resources.)

K. The applicant should have paid all fees and have completed and attested to the accuracy of all application and information forms required by the Board before the Board's verification process begins. The Board should require the applicant to authorize the Board to investigate and/or verify any information provided to it on the licensure application.

L. Applicants should have satisfactorily passed a criminal background check.

Section VI: Graduates of Foreign Medical Schools

The medical practice act should provide minimum requirements, in addition to those otherwise established, for full licensure of applicants who are graduates of schools located outside the United States, its territories or possessions, or Canada. These provisions of the act should implement or be consistent with the following:

A. Such applicants should possess the degree of Doctor of Medicine, Bachelor of Medicine or a Board-approved equivalent based on satisfactory completion of educational programs acceptable to the Board.

B. Such applicants should be eligible by virtue of their medical education, training and examination for unrestricted licensure or authorization to practice medicine in the country in which they received that education and training.

C. Such applicants should have passed an examination acceptable to the Board that adequately assesses the applicants' medical knowledge.

D. Such applicants should be certified by the Educational Commission for Foreign Medical Graduates or its Board-approved successor(s), or by an equivalent Board-approved entity.

E. Such applicants should have a demonstrated command of the English language satisfactory to the Board.

F. Such applicants should have satisfactorily completed at least thirty-six (36) months of progressive post-graduate medical training approved by the Board or by a private nonprofit accrediting body approved by the Board in an institution in the United States, its territories or possessions or Canada approved by the Board or by a private nonprofit accrediting body approved by the Board.

G. All credentials, diplomas and other required documentation in a foreign language submitted to the Board by or on behalf of such applicants should be accompanied by certified English translations acceptable to the Board.

H. Such applicants should have satisfied all of the applicable requirements of the United States Immigration and Naturalization Service.

Section VII: Licensure by Endorsement, Expedited Licensure by Endorsement, and Temporary and Special Licensure

The medical practice act should provide for licensure by endorsement, expedited licensure by endorsement, and in certain clearly defined cases, for temporary and special licensure. These provisions of the act should implement or be consistent with the following:

A. Endorsement for Licensed Applicants: The Board should be authorized, at its discretion, to issue a license by endorsement to an applicant who:

1. has complied with all current medical licensing requirements save that for examination administered by the Board;

2. has passed a medical licensing examination given in English by another state, the District of Columbia, a territory or possession of the United States or Canada, provided the Board determines that examination was equivalent to its own current examination, or an independent testing agent designated by the Board; and

3. has a valid current medical license in another state, the District of Columbia, a territory or possession of the United States or Canada.

B. Expedited Licensure by Endorsement: The Board should be authorized, at its discretion, to issue an expedited license by endorsement to an applicant who provides documentation of:

1. identity as required by the Board;

2. all jurisdictions in which the applicant holds a full and unrestricted license;

3. graduation from an approved medical school;

   a. Liaison Committee on Medical Education (LCME) or American Osteopathic Association (AOA) approved medical school; or
   b. Fifth Pathway certificate or
   c. Educational Commission for Foreign Medical Graduates (ECFMG) certificate

4. passing one or more of the following examinations acceptable for initial licensure within three attempts per step/level

   a. United States Medical Licensing Examination (USMLE) Steps 1-3 or its predecessor examinations (National Board of Medical Examiners (NBME) I-III or the Federation Licensing Examination (FLEX).
   b. Examinations offered by the National Board of Osteopathic Medical Examiners (COMLEX-USA) Levels 1-3 or its predecessor examination(s).
   c. Medical Council of Canada Qualifying Examinations (MCCQE) or its predecessor examination(s) offered by the Licentiate Medical Council of Canada.

5. successful completion of the total examination sequence within seven (7) years, except when in combination with a Ph.D. program
6. successful completion of three (3) years of progressive postgraduate training in a program accredited by the Accreditation Council on Graduate Medical Education (ACGME) or the AOA and/or
7. certification or recertification by a medical specialty board recognized by the American Board of Medical Specialties (ABMS) or the AOA within the previous ten (10) years. Lifetime certificate holders who have not passed a written specialty recertification examination must demonstrate successful completion of the Special Purpose Examination (SPEX), Comprehensive Osteopathic Medical Variable Purpose Examination (COMVEX) or applicable recertification examination.
8. Boards should obtain supplemental documentation including, but not limited to:
    a. Criminal background check;
    b. Absence of current/pending investigations in any jurisdiction where licensed;
    c. Verification of specialty board certification and
    d. Professional experience.

Physicians desiring an expedited process for licensure must utilize the Federation Credentials Verification Service (FCVS), or credentials verification meeting equivalent standards for verification of core credentials, including:

1. medical school diploma,
2. medical school transcript,
3. dean's certificate,
4. examination history,
5. disciplinary history,
6. identity (photograph and certified birth certificate or original passport),
7. ECFMG certificate, if applicable,
8. Fifth Pathway certificate, if applicable and
9. postgraduate training verification.

C. Temporary Licensure: The Board should be authorized to establish regulations for issuance of a temporary medical license for the intervals between Board meetings. Such a license should:

1. be granted only to an applicant demonstrably qualified for a full and unrestricted medical license under the requirements set by the medical practice act and the regulations of the Board and
2. automatically terminate within a period specified by the Board.

D. Special Licensure: The Board should be authorized to issue conditional, restricted, probationary, limited or otherwise circumscribed licenses as it determines necessary. This provision should include the ability to issue a special purpose license to practice medicine across state lines.

Section VIII: Limited Licensure for Physicians in Postgraduate Training

The medical practice act should provide that all physicians in all postgraduate training in the state or jurisdiction who are not otherwise fully licensed to practice medicine should be licensed on a limited basis for educational purposes. These provisions of the act should implement or be consistent with the following:

A. To be eligible for limited licensure, the applicant should have completed all the requirements for full and unrestricted medical licensure except postgraduate training or specific examination requirements.

B. Issuance of a limited license specifically for postgraduate training shall occur only after the applicant demonstrates that he or she is accepted in a residency program. The application for limited licensure should be made directly to the Board in the jurisdiction where the applicant's postgraduate training is to take place.

C. The Board should establish by regulation restrictions for the limited license to assure that the holder will practice only under appropriate supervision and within the confines of the program within which the resident is enrolled.

D. The limited license should be renewable annually and upon the written recommendation of the supervising institution, including a written evaluation of performance, until the Board regulations require the achievement of full and unrestricted medical licensure.

E. Program directors responsible for postgraduate training should be required annually to provide the Board
a written report on the status of program participants having a limited license.

   1. The report should inform the Board about program participants who have successfully completed the program, have departed from the program, have had unusual absences from the program, or have had problematic occurrences during the course of the program.
   2. The report should include an explanation of any disciplinary action taken against a limited licensee for performance or behavioral reasons which, in the judgment of the program director, could be a threat to public health, safety and welfare; unapproved or unexplained absences from the program; resignations from the program or nonrenewal of the program contract; dismissals from the program for performance or behavioral reasons; and referrals to substance abuse pro-grams not approved by the Board.
   3. Failure to submit the annual program director's report shall be considered a violation of the mandatory reporting provisions of the Medical Practice Act and shall be grounds to initiate such disciplinary action as the Board deems appropriate, including fines levied against the supervising institution and suspension of the program director's medical license.

F. The disciplinary provisions of the medical practice act should apply to the holders of the limited license as if they held full and unrestricted medical licensure.

G. The issuance of a limited license should not be construed to imply that a full and unrestricted medical license would be issued at any future date

Section IX: Disciplinary Action against Licensees

The medical practice act should provide for disciplinary and/or remedial action against licensees and the grounds on which such action may be taken. These provisions of the act should implement or be consistent with the following:

A. Range of Actions: A range of progressive disciplinary and remedial actions should be made available to the Board. These should include, but not be limited to, the following:

   1. revocation of the medical license;
   2. suspension of the medical license;
   3. probation;
   4. stipulations, limitations, restrictions, probation, and conditions relating to practice;
   5. censure (including specific redress, if appropriate);
   6. reprimand;
   7. chastisement, letters of concern and advisory letters;
   8. monetary redress to another party;
   9. a period of free public or charity service, either medical or non-medical;
   10. satisfactory completion of an educational, training and/or treatment program(s), or professional developmental plan;
   11. levy fine and
   12. payment of administrative and disciplinary costs.

The Board should be authorized, at its discretion, to take disciplinary, non-disciplinary, public or non-public actions singly or in combination as the nature of the violation requires and to promote public protection.

B. Letter of Concern or Advisory Letter: The Board should be authorized to issue a confidential (if allowed by state law), non-reportable, non-disciplinary letter of concern or advisory letter to a licensee when evidence does not warrant formal discipline, the Board has noted indications of possible errant conduct by the licensee that could lead to serious consequences and formal action if the conduct were to continue. In its letter of concern or advisory letter, the Board should also be authorized, at its discretion, to request clarifying information from the licensee.

C. Examination/Evaluation: The Board should be authorized, at its discretion, to require professional competency, physical, mental or chemical dependency examination(s) or evaluation(s) of any applicant or licensee, including withdrawal and laboratory examination of bodily fluids.

D. Grounds for Action: The Board should be authorized to take disciplinary action for unprofessional or dishonorable conduct, which should be defined to mean, but not be limited to, the following:

   1. fraud or misrepresentation in applying for or procuring a medical license or in connection with applying for or procuring periodic renewal of a medical license;
   2. cheating on or attempting to subvert the medical licensing examination(s);

3. the commission or conviction or the entry of a guilty, nolo contendere plea, or deferred adjudication (without expungement) of a misdemeanor whether or not related to the practice of medicine and any crime involving moral turpitude or a felony, whether or not related to the practice of medicine. The Board shall revoke a licensee's license following conviction of a felony, unless a 2/3 majority vote of the board members present and voting determined by clear and convincing evidence that such licensee will not pose a threat to the public in such person's capacity as a licensee and that such person has been sufficiently rehabilitated to warrant the public trust;
4. conduct likely to deceive, defraud or harm the public;
5. disruptive behavior and/or interaction with physicians, hospital personnel, patients, family members or others that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient;
6. making a false or misleading statement regarding his or her skill or the efficacy or value of the medicine, treatment or remedy prescribed by him or her or at his or her direction in the treatment of any disease or other condition of the body or mind;
7. representing to a patient that an incurable condition, sickness, disease or injury can be cured;
8. willfully or negligently violating the confidentiality between physician and patient except as required by law;
9. professional incompetency as one or more instances involving failure to adhere to the applicable standard of care to a degree which constitutes gross negligence, as determined by the board;
10. professional incompetency by repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board;
11. being found mentally incompetent or of unsound mind by any court of competent jurisdiction;
12. being physically or mentally unable to engage in the practice of medicine with reasonable skill and safety;
13. practice or other behavior that demonstrates an incapacity or incompetence to practice medicine;
14. the use of any false, fraudulent or deceptive statement in any document connected with the practice of medicine;
15. giving false, fraudulent, or deceptive testimony while serving as an expert witness;
16. practicing medicine under a false or assumed name;
17. aiding or abetting the practice of medicine by an unlicensed, incompetent or impaired person;
18. allowing another person or organization to use his or her license to practice medicine;
19. commission of any act of sexual misconduct, including sexual contact with patient surrogates or key third parties, which exploits the physician-patient relationship in a sexual way;
20. habitual or excessive use or abuse of drugs, alcohol or other substances that impair ability;
21. failing or refusing to submit to a body fluid examination or any other examination that may detect the presence of alcohol or drugs upon Board order;
22. prescribing, selling, administering, distributing, ordering or giving any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug for other than medically accepted therapeutic purposes;
23. knowingly prescribing, selling, administering, distributing, ordering or giving to a habitual user or addict or any person previously drug dependent, any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug, except as otherwise permitted by law or in compliance with rules, regulations or guidelines for use of controlled substances and

the management of pain as promulgated by the Board;

24. prescribing, selling, administering, distributing, ordering or giving any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug to a family member or to himself or herself;
25. violating any state or federal law or regulation relating to controlled substances;
26. signing a blank, undated or predated prescription form;
27. obtaining any fee by fraud, deceit or misrepresentation;
28. employing abusive, illegal, deceptive or fraudulent billing practices;
29. directly or indirectly giving or receiving any fee, commission, rebate or other compensation for professional services not actually and personally rendered, though this prohibition should not preclude the legal functioning of lawful professional partnerships, corporations or associations;
30. disciplinary action of another state or federal jurisdiction against a license or other authorization to practice medicine or participate in a federal program (payment or treatment) based upon acts or conduct by the licensee similar to acts or conduct that would constitute grounds for action as defined in this section, a certified copy of the record of the action taken by the other state or jurisdiction being conclusive evidence thereof;
31. failure to report to the Board any adverse action taken against oneself by another licensing jurisdiction (United States or foreign), by any peer review body, by any health care institution, by any professional or medical society or association, by any governmental agency, by any law enforcement agency or by any court for acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;
32. failure to report or cause a report to be made to the Board any physician upon whom a physician has evidence or information that appears to show that the physician is incompetent, guilty of negligence, guilty of a violation of this act, engaging in inappropriate relationships with patients, is mentally or physically unable to practice safely or has an alcohol or drug abuse problem;
33. failure of physician who is the chief executive officer, medical officer or medical staff to report to the Board any adverse action taken by a health care institution or peer review body, in addition to the reporting requirement in 31. (note: a report under 32 may need to wait until the peer review and due process procedures are completed, but the report under 31 must be reported immediately without waiting for the final action of the health care institution and applies to all physicians not just staff physicians);
34. failure to report to the Board surrender of a license limitation or other authorization to practice medicine in another state or jurisdiction, or surrender of membership on any medical staff or in any medical or professional association or society has surrendered the authority to utilize controlled substances issued by any state or federal agency, or has agreed to a limitation to or restriction of privileges at any medical care facility while under investigation by any of those authorities or bodies for acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;
35. any adverse judgment, award or settlement against the licensee resulting from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;
36. failure to report to the Board any adverse judgment, settlement or award arising from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;

37. failure to provide pertinent and necessary medical records to another physician or patient in a timely fashion when legally requested to do so by the subject patient or by a legally designated representative of the subject patient regardless of whether the patient owes a fee for services;
38. improper management of medical records, including failure to maintain timely, legible, accurate, and complete medical records and to comply with the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Part 160 and 164, of the Health Insurance Portability and Accountability Act of 1996.
39. failure to furnish the Board, its investigators or representatives, information legally requested by the Board or to fail to comply with a Board subpoena or order;
40. failure to cooperate with a lawful investigation conducted by the Board;
41. violation of any provision(s) of the medical practice act or the rules and regulations of the Board or of an action, stipulation or agreement of the Board;
42. engaging in conduct calculated to or having the effect of bringing the medical profession into disrepute, including but not limited to, violation of any provision of a national code of ethics acknowledged by the Board;
43. failure to follow generally accepted infection control procedures;
44. failure to comply with any state statute or board regulation regarding a licensee's reporting responsibility for HIV, HVB (hepatitis B virus), sero-positive status or any other reportable condition (including child abuse and vulnerable adult abuse) or disease;
45. practicing medicine in another state or jurisdiction without appropriate licensure;
46. conduct which violates patient trust, exploits the physician-patient relationship or violates professional boundaries;
47. failure to offer appropriate procedures/studies, failure to protest inappropriate managed care denials, failure to provide necessary service or failure to refer to an appropriate provider within such actions are taken for the sole purpose of positively influencing the physician's or the plan's financial well being;
48. providing treatment or consultation recommendations, including issuing a prescription via electronic or other means, unless the physician has obtained a history and physical evaluation of the patient adequate to establish diagnosis and identify underlying conditions and/or contraindications to the treatment recommended/provided;
49. violating a Board formal order, condition of probation, consent agreement or stipulation;
50. representing, claiming or causing the appearance that the physician possesses a particular medical specialty certification by a Board recognized certifying organization (ABMS, AOA) if not true;
51. failing to obtain adequate patient informed consent;
52. using experimental treatments without appropriate patient consent and adhering to all necessary and required guidelines and constraints;
53. any conduct that may be harmful to the patient or the public;
54. failing to divulge to the Board upon legal demand the means, method, procedure, modality or medicine used in the treatment of an ailment, condition or disease;
55. conduct likely to deceive, defraud or harm the public;
56. the use of any false, fraudulent or deceptive statement in any document connected with the practice of the healing arts including intentional falsifying or fraudulent altering of a patient or medical care facility record;
57. failure to keep written medical records which accurately describe the services rendered to the patient, including patient histories, pertinent findings, examination results and test results;

58. delegating professional responsibilities to a person when the licensee knows or has reason to know that such person is not qualified by training, experience, or license to perform them;
59. using experimental forms of therapy without proper informed patient consent, without conforming to generally accepted criteria or standard protocols, without keeping detailed legible records or without having periodic analysis of the study and results reviewed by a committee or peers; and
60. failing to properly supervise, direct or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation or practice protocols.

Section X: Procedures for Enforcement and Disciplinary Action

The medical practice act should provide for procedures that will permit the Board to take appropriate enforcement and disciplinary action when and as required, while assuring fairness and due process to licensees. These provisions of the act should implement or be consistent with the following:

A. Board Authority: The Board should be empowered to commence legal action to enforce the provisions of the medical practice act and to exercise full discretion and authority with respect to disciplinary actions. In the course of an investigation, the Board's authority should include the ability to issue subpoenas to licensees, health care organizations, complainants, patients and witnesses to produce documents or appear before the Board or staff to answer questions or be deposed. The Board should have the power to enforce its subpoenas, including disciplining a non-compliant licensee, and it is incumbent upon the subpoenaed party to seek a motion to quash the subpoena.

B. Separation of Functions: In the exercise of its power, the Board's investigative and judicial functions should be separated to assure fairness and the Board should be required to act in a consistent manner in the application of disciplinary and/or remedial sanction.

C. Administrative Procedures: The existing administrative procedures act or similar statute, in whole or in part, should either be applicable to or serve as the basis of the procedural provisions of the medical practice act. The procedural provisions should provide for Board investigation of complaints; notice of formal or informal charges or allegations to the licensee; a fair and impartial hearing for the licensee before the Board, an examining committee or hearing officer; an opportunity for representation of the licensee by counsel; the presentation of testimony, evidence and arguments; subpoena power and attendance of witnesses; a record of the proceedings; and judicial review by the courts in accordance with the standards established by the jurisdiction for such review. The Board should have subpoena authority to conduct comprehensive reviews of a licensee's patient and office records and administrative authority to access otherwise protected peer review records. The Board should not need the patients' consent to obtain copies of medical records, nor shall health care institutions' peer-review privilege bar the Board from obtaining copies of peer review information. Once in the Board's possession, the patient records and peer review records should have the same legal protection from disclosure as they have when in the possession of the licensee, the patient or the peer-review organization.

D. Standard of Proof: The Board should be authorized to use preponderance of the evidence as the standard of proof in its role as trier of fact for all levels of discipline.

E. Informal Conference: Should there be an open meeting law, an exemption to it should be authorized to permit the Board, at its discretion, to meet in informal conference with a licensee who seeks or agrees to such a conference. Disciplinary action taken against a licensee because of such an informal conference and agreed to in writing by the Board and the licensee should be binding and a matter of public record. However, license revocation and suspension should be held in open formal hearing, unless executive session is permitted by the State's open meetings law. The holding of an informal conference should not preclude an open formal hearing if the Board determines such is necessary.

F. Summary Suspension: The Board should be authorized to summarily suspend a license prior to a formal hearing when it believes such action is required to protect the public from an imminent threat to public health and safety. The Board should be permitted to summarily suspend a license by means of a vote con-ducted by telephone conference call or other electronic means if appropriate Board officials believe such prompt action is required. Proceedings for a formal hearing should be instituted simultaneously with the summary suspension. The hearing should be set within a reasonable time of the date of the summary suspension. No court should be empowered to lift or otherwise interfere with such suspension while the Board proceeds in a timely fashion.

G. Cease and Desist Orders/Injunctions: The Board should be authorized to issue a cease-and-desist order and/or obtain an injunction to restrain any person or any corporation or association and its officers and directors from violating any provision of the medical practice act. Violation of an injunction should be punishable as contempt of court. No proof of actual damage to any person should be required for issuance of a cease-and-desist order and/or an injunction, nor should issuance of an injunction relieve those enjoined from criminal prosecution, civil action or administrative process for violation of the medical practice act.

H. Board Action Reports: All the Board's final disciplinary actions, non-administrative license withdrawals, and license denials, including related findings of fact and conclusions of law, should be matters of public record. The Board should report such actions and denials to the Board Action Data Bank of the Federation of State Medical Boards of the United States within 30 days of the action being taken, to any other data repository required by law and to the media. Voluntary surrender of and voluntary limitation(s) on the medical license of any person should also be matters of public record and should also be reported to the Federation of State Medical Boards of the United States and to any other data

repository by law. The Board should have the authority to keep confidential practice limitations and restrictions due to physical impairment when the licensee has not violated any provision in the medical practice act.

I. Tolling Periods of License Suspension or Restriction: The Board should provide, in cases of license suspension or restriction, that any time during which the disciplined licensee practices in another jurisdiction without comparable restriction shall not be credited as part of the period of suspension or restriction.

J. The Board should have the authority, at its discretion, to share investigative and adjudicatory files with other state and territorial medical boards at any time during the investigational or adjudicative process.

Section XI: Impaired Physicians

The medical practice act should provide for the limitation, restriction, suspension or revocation of the medical license of any licensee whose mental or physical ability to practice medicine with reasonable skill and safety is impaired.

The Board should have available to it a confidential impaired physician program approved by the Board and charged with the evaluation and treatment of licensees who are in need of rehabilitation. The Board may directly provide such programs or through a formalized contractual relation with an independent entity whose program meets standards set by the Board. The Board shall have authority over such program and the ability to monitor or audit the program to ensure the program meets the requirements of the Board.

The Board should be authorized, at its discretion, to require a licensee or applicant to submit to a mental or physical examination, body fluid or hair follicle test, or a chemical dependency evaluation conducted by an independent evaluator designated by the Board. The results of the examination or evaluation should be admissible in any hearing before the Board or hearing officer, despite any claim of privilege under a contrary rule or statute. Every person who receives a license to practice medicine or who files an application for a license to practice medicine should be deemed to have given consent to submit to mental or physical examination or a chemical dependency evaluation, and to have waived all objections to the admissibility of the results in any hearing before the Board. If a licensee or applicant fails to submit to an examination or evaluation when properly directed to do so by the Board, the Board should be permitted to enter a final order upon proper notice, hearing and proof of refusal.

If the Board finds, after an evaluation, examination or hearing, that a licensee is mentally, psychologically, physically or chemically impaired, it should be authorized to take one or more of the following actions:

1. direct the licensee to submit to therapy, medical care, counseling or treatment acceptable to the Board and comply with monitoring to ensure compliance
2. suspend, limit or restrict the licensee's medical license for the duration of the impairment and monitoring or treatment, and/or
3. revoke the licensee's medical license.

Any licensee or applicant who is prohibited from practicing medicine under this provision should be afforded at reasonable intervals an opportunity to demonstrate to the satisfaction of the Board that he or she can resume or begin

the practice of medicine with reasonable skill and safety. A license should not be reinstated, however, without the payment of all applicable fees and the fulfillment of all requirements as if the applicant had not been prohibited.

While all impaired licensees should be reported to the Board in accord with the mandatory reporting requirements of the medical practice act, unidentified and unreported impaired licensees should be encouraged to seek treatment. To this end, the Board should be authorized, at its discretion, to establish rules and regulations for the review and approval of a medically directed Physician Health Program (PHP). Those conducting a Board-approved PHP should be exempt from the mandatory reporting requirements relating to an impaired licensee who is participating satisfactorily in the program, or the Board should hold its report in confidence and without action, unless or until the impaired licensee ceases to participate satisfactorily in the program. The Board should require a PHP to report any impaired licensee whose participation is unsatisfactory to the Board as soon as that determination is made. Participation in an approved PHP should not protect an impaired licensee from Board action resulting from a report of his or her impairment from another source. The Board should be the final authority for approval of a PHP, should conduct a review of its approved program(s) on a regular basis and should be permitted to withdraw or deny its approval at its discretion. The PHP should be required to report to the Board information regarding any violation of the medical practice act by a PHP participant, other than the impairment, even if the violation is unrelated to the licensee's impairment.

Section XII: Dyscompetent and Incompetent Licensees

The medical practice act should provide for the restriction, suspension, revocation or denial of the medical license of any licensee who the Board determines to be dyscompetent or incompetent. These provisions of the act should implement or be consistent with the following:

A. The Board should be authorized to develop and implement methods to identify dyscompetent or incompetent licensees and licensees who fail to provide the appropriate quality of care. The Board should also be authorized to develop and implement methods to assess and improve licensee practices.

B. The Board should have access to a Board approved assessment program charged with assessing licensees' clinical competency.

C. The Board should be authorized, at its discretion, to require a licensee or an applicant for licensure to undergo a physician competency evaluation conducted by a Board designated independent evaluator at licensee's own expense. The results of the assessment should be admissible in any hearing before the Board or hearing officer, despite any claim of privilege under a contrary rule or statute. Every person who receives a license to practice medicine or who files an application for a license to practice medicine should be deemed to have given consent to submit to a physician competency evaluation, and to have waived all objections to the admissibility of the results in any hearing before the Board or hearing officer. If a licensee or applicant fails to submit to a competency assessment when properly directed to do so by the Board, the Board should be permitted to enter a final order upon proper notice, hearing and proof of refusal to submit to such an evaluation.

D. If the Board finds, after evaluation by the assessment program, that a licensee or applicant for licensure is unable to competently practice medicine, it should be authorized to take one or more of the following actions:

    1. suspend, revoke or deny the licensee's medical license or application;
    2. restrict or limit the licensee's practice to those areas of demonstrated competence and comply with monitoring to ensure compliance, and/or

3. direct the licensee to submit to a Board approved remediation program and comply with monitoring to ensure compliance to resolve any identified deficits in medical knowledge or clinical skills acceptable to the Board.

F. Any licensee or applicant for licensure who is prohibited from practicing medicine under the provision referenced in paragraph D should be afforded, at reasonable intervals, an opportunity to demonstrate to the satisfaction of the Board that he or she can resume or begin the practice of medicine with reasonable skill and safety. A license should not be reinstated, however, without the payment of all applicable fees and the fulfillment of all requirements as if the applicant had not been previously prohibited.

G. The Board should be authorized to require the assessment program to provide to the Board a written report of the results of the assessment with recommendations for remediation of the identified deficiencies.

H. The Board should have access to Board approved remedial medical education programs for referral of licensees in need of remediation. Such programs shall incorporate and comply with standards set by the Board. During remediation, the program shall provide, at Board determined intervals, written reports to the Board on the licensee's progress. Upon completion of the remediation program, the program shall provide a written report to the Board addressing the remediation of the previously identified areas of deficiency. The Board should be authorized to mandate that the licensee undergo post-remediation assessment to identify areas of continued deficit. The licensee shall be responsible for all expenses incurred as part of the assessment and the remediation.

Section XIII: Compulsory Reporting and Investigation

The medical practice act should provide that certain persons and entities report to the Board any possible violation of the act or of the Board's rules and regulations by a licensee. These provisions of the act should implement or be consistent with the following:

A. Any person should be permitted to report to the Board in a manner prescribed by the Board, any information he or she believes indicates a medical licensee is or may be medically incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine.

B. The following should be required to report to the Board promptly and in writing any information that indicates a licensee is or may be medically incompetent, guilty of unprofessional conduct or mentally or physically unable to engage safely in the practice of medicine; and any restriction, limitation, loss or denial of a licensees staff privileges or membership that involves patient care:

1. all licensees licensed under the act,
2. all licensed health care providers,
3. the state medical associations and its components,
4. all hospitals and other health care organizations in the state, to include hospitals, medical centers, managed care organizations, ambulatory surgi-centers, clinics, group practices, etc.,
5. all chiefs of staff, medical directors, department administrators, service directors, attending physicians, residency directors, etc.,
6. all state agencies,

7. all law enforcement agencies in the state,
8. all courts in the state,
9. all federal agencies (e.g., DEA, FDA, and CMS),
10. all peer review bodies in the state, and
11. resident training program directors.

C. A licensee's voluntary resignation from the staff of a health care organization or voluntary limitation of his or her staff privileges at such an organization should be promptly reported to the Board by the organization if that action occurs while the licensee is under formal or informal investigation by the organization or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct or mental, physical, alcohol or drug impairment.

D. Malpractice insurance carriers, the licensee's attorney, a hospital, a group practice and the affected licensees should be required to file with the Board a report of each final judgment, settlement, arbitration award, or any form of payment by the licensee or on the licensee's behalf by any source upon any demand, claim or case alleging medical malpractice, battery, dyscompetence, incompetence or failure of informed consent. Licensees not covered by malpractice insurance carriers should be required to file the same information with the Board regarding themselves. All such reports should be made to the Board promptly (e.g., within 30 days).

E. The Board should be permitted to investigate any evidence that appears to show a licensee is or may be medically incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine.

F. Any person, institution, agency or organization who reports in good faith and not made in bad faith, a licensee pursuant to subsections (A) or (B) of this section should not be subject to civil damages or criminal prosecution for so reporting. A bad faith report is grounds for disciplinary action under the medical practice act. There should be no monetary liability on the part of, and no cause of action for damages should arise against any person, institution, agency or organization for reporting in good faith.

G. To assure compliance with compulsory reporting requirements, specific civil penalties should be established for demonstrated failure to report (e.g., up to $10,000 per instance).

H. The Board should promptly acknowledge all reports received under this section. The Board should promptly notify persons or entities reporting under this section of the Board's final disposition of the matters reported.

Section XIV: Protected Action and Communication

The medical practice act should provide legal protection for the members of the Board and its staff and for those providing information to the Board in good faith. These provisions of the act should implement or be consistent with the following:

A. Qualified Immunity

1. There shall be no liability on the part of and no action for damages against any member of the board, or its agents or employees, or any member of an examining committee of physicians appointed or designated by the board, for any action undertaken or performed by such person within the scope of the duties, powers, and functions of the board or such examining committee as provided for in this Part when such person is

acting in good faith and in the reasonable belief that the action taken by him is warranted.

2. No person, committee, association, organization, firm, or corporation providing information to the board in good faith and in the reasonable belief that such information is accurate and, whether as a witness or otherwise, shall be held, by reason of having provided such information, to be liable in damages under the law of the state or any political subdivision thereof.

3. In any suit brought against the board, its employees or agents, any member of an examining committee appointed by the board or any person, firm, or other entity providing information to the board, when any such defendant substantially prevails in such suit, the court shall, at the conclusion of the action, award to any such substantially prevailing party defendant against any such claimant the cost of the suit attributable to such claim, including a reasonable attorney's fee, if the claim was frivolous, unreasonable, without foundation, or in bad faith. For the purposes of this Section, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains an award for damages or permanent injunctive or declaratory relief.

4. There shall be no liability on the part of and no action for damages against any nonprofit corporation, foundation, or organization that enters into any agreement with the board related to the operation of any committee or program to identify, investigate, counsel, monitor, or assist any licensed physician who suffers or may suffer from alcohol or substance abuse or a physical or mental condition which could compromise such physician's fitness and ability to practice medicine with reasonable skill and safety to patients, for any investigation, action, report, recommendation, decision, or opinion undertaken, performed, or made in connection with or on behalf of such committee or program, in good faith and in the reasonable belief that such investigation, action, report, recommendation, decision, or opinion was warranted.

5. There shall be no liability on the part of and no action for damages against any person who serves as a director, trustee, officer, employee, consultant, or attorney for or who otherwise works for or is associated with any nonprofit corporation, foundation, or organization that enters into any agreement with the board related to the operation of any committee or program to identify, investigate, counsel, monitor, or assist any licensed physician who suffers or may suffer from alcohol or substance abuse or a physical or mental condition which could compromise such physician's fitness and ability to practice medicine with reasonable skill and safety to patients, for any investigation, action, report, recommendation, decision, or opinion undertaken, performed, or made in connection with or on behalf of such committee or program, in good faith and in the reasonable belief that such investigation, action, report, recommendation, decision, or opinion was warranted.

6. In any suit brought against any nonprofit corporation, foundation, organization, or person described in Subsection D or E of this Section, when any such defendant substantially prevails in the suit, the court shall, at the conclusion of the action, award to any substantially prevailing party defendant against any claimant the cost of the suit attributable to such claim, including reasonable attorney fees, if the claim was frivolous or brought without a reasonable good faith basis. For purposes of this Subsection, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains a judgment for damages, permanent injunction, or declaratory relief.

B. Indemnity and Defense

The state should defend a current or former member, officer, administrator, staff member, committee member, examiner, representative, agent, employee, consultant, witness, contractor or any other person serving or having served the Board against any claim or action arising out of the act, omission, proceeding, conduct or decision related to his or her duties undertaken or performed in good faith and within the scope of the function of the Board. The State should provide and pay for such defense and should pay any resulting judgment, compromise or settlement.

C. Protected Communication

1. Every communication made by or on behalf of any person, institution, agency or organization to the Board or to any person(s) designated by the Board relating to an investigation or the initiation of an investigation, whether by way of report, complaint or statement, should be privileged. No action or proceeding, civil or criminal, should be permitted against any person, institution, agency or organization that made such a communication in good faith.

2. The protections afforded in this provision should not be construed as prohibiting a respondent or his or her legal counsel from exercising the respondent's constitutional right of due process under the law.

Section XV: Unlawful Practice of Medicine: Violations and Penalties

The medical practice act should provide a definition of the unlawful practice of medicine and penalties for such unlawful practice. These provisions of the act should implement or be consistent with the following:

A. It should be unlawful for any person, corporation or association to perform any act constituting the practice of medicine as defined in the medical practice act without first obtaining a medical license in accord with that act and the rules and regulations of the Board. Other licensed health care professionals may provide medical services within the scope of their authorizing license.

B. The Board should be authorized to issue a cease-and-desist order and/or obtain injunctive relief against the unlawful practice of medicine by any person, corporation or association.

C. It should be a felony crime for any person, corporation or association that performs any act constituting the practice of medicine as defined in the medical practice act, or causing or aiding and abetting such actions.

D. A physician located in another state practicing within the state by electronic or other means without a license (full, special purpose or otherwise) issued by the Board should be deemed guilty of a felonious offense.

Section XVI: Periodic Renewal

The medical practice act should provide for the periodic renewal of medical licenses to permit the Board to review the qualifications of licensees on a regular basis. These provisions of the act should implement or be consistent with the following:

A. At the time of periodic renewal, the Board should require the licensee to demonstrate to its satisfaction his or her continuing qualification for medical licensure. The Board should design the application for licensure renewal to require the licensee to update and/or add to the information in the Board's file relating to the licensee and his or her professional activity. It should also require the licensee to report to the Board the following information:

1. Any action taken for acts or conduct similar to acts or conduct described in the medical practice act as grounds for disciplinary action against a licensee by:

   - any jurisdiction or authority (United States or foreign) that licenses or authorizes the practice of medicine or participation in a payment or practice program;
   - any peer review body;
   - any specialty certification board;
   - any health care organization;
   - any professional medical society or association;
   - any law enforcement agency;
   - any health insurance company;
   - any malpractice insurance company;
   - any court, and
   - any governmental agency.

2. Any adverse judgment, settlement or award against the licensee or payment by or on behalf of the licensee arising from a professional liability demand, claim or case.

3. The licensee's voluntary surrender of or voluntary limitation on any license or authorization to practice medicine in any jurisdiction, including military, public health and foreign.

4. Any denial to the licensee of a license or authorization to practice medicine by any jurisdiction, including military, public health and foreign.

5. The licensee's voluntary resignation from the medical staff of any health care organization or voluntary limitation of his or her staff privileges at such an organization if that action occurred while the licensee was under formal or informal investigation by the organization or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct or mental, physical, alcohol or drug impairment.

6. The licensee's voluntary resignation or withdrawal from a national, state or county medical society, association or organization if that action occurred while the licensee was under formal or informal investigation or review by that body for any reason related to possible medical incompetence, unprofessional conduct mental, physical, alcohol or drug impairment.

7. Whether the licensee has abused or has been addicted to or treated for addiction to alcohol or any chemical substance.

8. Whether the licensee has had any physical injury, impairment, condition, disease or mental or psychological illness that adversely affected or interrupted his or her practice of medicine.

9. The licensee's completion of continuing medical education or other forms of professional maintenance and/or evaluation, including specialty board certification or recertification, within the renewal period.

B. The Board should be authorized, at its discretion, to require continuing medical education for license renewal and to require documentation of that education. The Board should have the authority to audit, randomly or specifically, licensees for compliance.

C. The Board should require the licensee to apply for license renewal in a manner prescribed by the board and attest to the accuracy and truthfulness of the information submitted.

D. The Board should be directed to establish an effective system for reviewing renewal forms. It should also be authorized to initiate investigations and/or disciplinary proceedings based on information submitted by licensees for license renewal.

E. Failure to report fully and correctly should be grounds for disciplinary action by the Board.

Section XVII: Physician Assistants

The medical practice act should provide for the Board to license and regulate physician assistants. These provisions of the act should implement or be consistent with the following:

A. Administration: The Board should administer and enforce these provisions of the medical practice act with the advice and assistance of the Physician Assistant Council.

B. Physician Assistant Licensing

1. No person should perform or attempt to perform as a physician assistant without first obtaining a license from the Board and having a supervising physician.
2. An applicant for licensure as a physician assistant should complete all Board application forms and pay a nonrefundable fee. The forms should request the applicant provide their name and address and such additional information as the Board deems necessary. The Board may issue a license to a physician assistant applicant who fulfills all board requirements for licensure. However, a licensed physician assistant is prohibited from practicing until they have an agreement with a supervising physician(s).
3. Each licensed physician assistant should renew their license and file updated documentation stating their name and current address and any additional information as required by the Board. A fee set by the Board should accompany each renewal and filing of updated documentation.
4. The Board may require written notification by the supervising physician and the physician assistant if the relationship is changed or severed for any reason. The notification should include a detailed explanation of when and why the relationship changed and/or ended.
5. Persons not licensed by the Board who hold themselves out as physician assistants should be subject to penalties applicable to the unlicensed practice of medicine.

C. Rules and Regulations: The Board should be empowered to adopt and enforce rules and regulations for:

1. setting qualifications of education, skill and experience for the licensing of a person as a physician assistant and providing forms and procedures for licensure and for renewal; and
2. evaluating applicants for licensure as physician assistants as to their skill, knowledge and experience in the field of medical care.

D. Disciplinary Actions: The Board should be empowered to deny, revoke or suspend any license, to limit or restrict the location of practice, to issue reprimands, to remove the authorization of a supervising physician and to limit or restrict the practice of a physician assistant upon grounds and according to procedures similar to those for such disciplinary actions against licensed physicians. Such actions should be reported to the Federation of State Medical Boards.

E. Duties and Scope of Practice: A physician assistant should be permitted to provide those medical services delegated to them by the supervising physician that are within their training and experience, form a usual component of the supervising physician's scope of practice, and are provided pursuant to the supervising physician's instructions.

F. Responsibility of Supervising Physician: Every physician supervising or employing a physician assistant should practice in the medical areas in which the physician assistant is to perform and should be legally responsible for the delegation of health care tasks, the performance and the acts and omissions of the physician assistant. Nothing in these provisions, however, should be construed to relieve the physician assistant of any responsibility for any of their own acts and omissions. No physician should have under their supervision more staff, physician assistant or otherwise than the physician can adequately supervise. In the event the supervising physician is absent, he or she must provide for appropriate supervision of the physician assistant by another licensed physician. Each and every relationship should adhere to all statutory requirements for licensure.

G. The Board should be authorized, at its discretion, to require evidence of satisfactory completion of continuing medical education for license renewal.

Section XVIII: Rules and Regulations

The medical practice act should authorize the Board to promulgate rules and regulations to facilitate the enforcement of the act. These provisions of the act should implement or be consistent with the following:

A. The Board should be authorized to adopt and enforce rules and regulations to carry out the provisions of the medical practice act and to fulfill its duties under the act.

B. The Board should adopt rules and regulations in accord with administrative procedures established in the jurisdiction.

Section XIX: Funding and Fees

The medical practice act should provide that Board fees be adequate to fund the Board's effective regulation of the practice of medicine under the act and that those fees paid by licensees be used only for purposes related to licensee licensure, discipline and Board administration. These provisions of the act should implement or be consistent with the following:

A. The Board should be fully supported by the revenues generated from its activities, including fees, charges and reimbursed costs, which the Board should deposit in an appropriate account, and the Board should also receive all interest earned on the deposit of such revenues. Such funds should be appropriated continuously. All fines levied by the Board may be deposited in the State General Fund, unless otherwise allowed by law. All administrative, investigative and adjudicatory costs recoupment should be deposited in the Board's account.

B. The Board should develop and adopt its own budget reflecting revenues, including the interest thereon, and costs associated with each health care field regulated. Revenues and interest thereon, from each health care field regulated should fully support Board regulation of that field. The budget should include allocations for establishment and maintenance of a reasonable reserve fund.

C. The Board should be authorized to set fees and charges pursuant to its proposed budget needs. Reasonable notice should be provided for all increases or decreases in fees and charges.

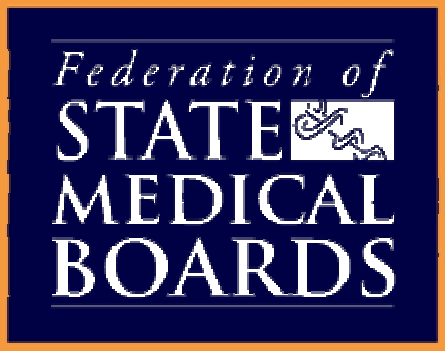
D. The Board should operate on the same fiscal year as the State.

E. A designated officer of the Board or employee, at the direction of the Board, should oversee the collection and disbursement of funds.

F. The State Auditor's Office (or the equivalent State office) should routinely audit the financial records of the Board and report to the Board and the Legislature.

The FSMB Mission . . .

FSMB leads by promoting excellence in medical practice, licensure, and regulation as the national resource and voice on behalf of state medical boards in their protection of the public.



Federation of State Medical Boards of the United States Inc.
400 Fuller Wiser Rd., Suite 300 Euless, TX 76039
(817) 868-4000 www.fsmb.org

BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

April 2015

By Margaret B. Hansen and Randi Sterling

LICENSING: Ensure only qualified professionals are licensed and allowed to practice.

Current/Past Events:

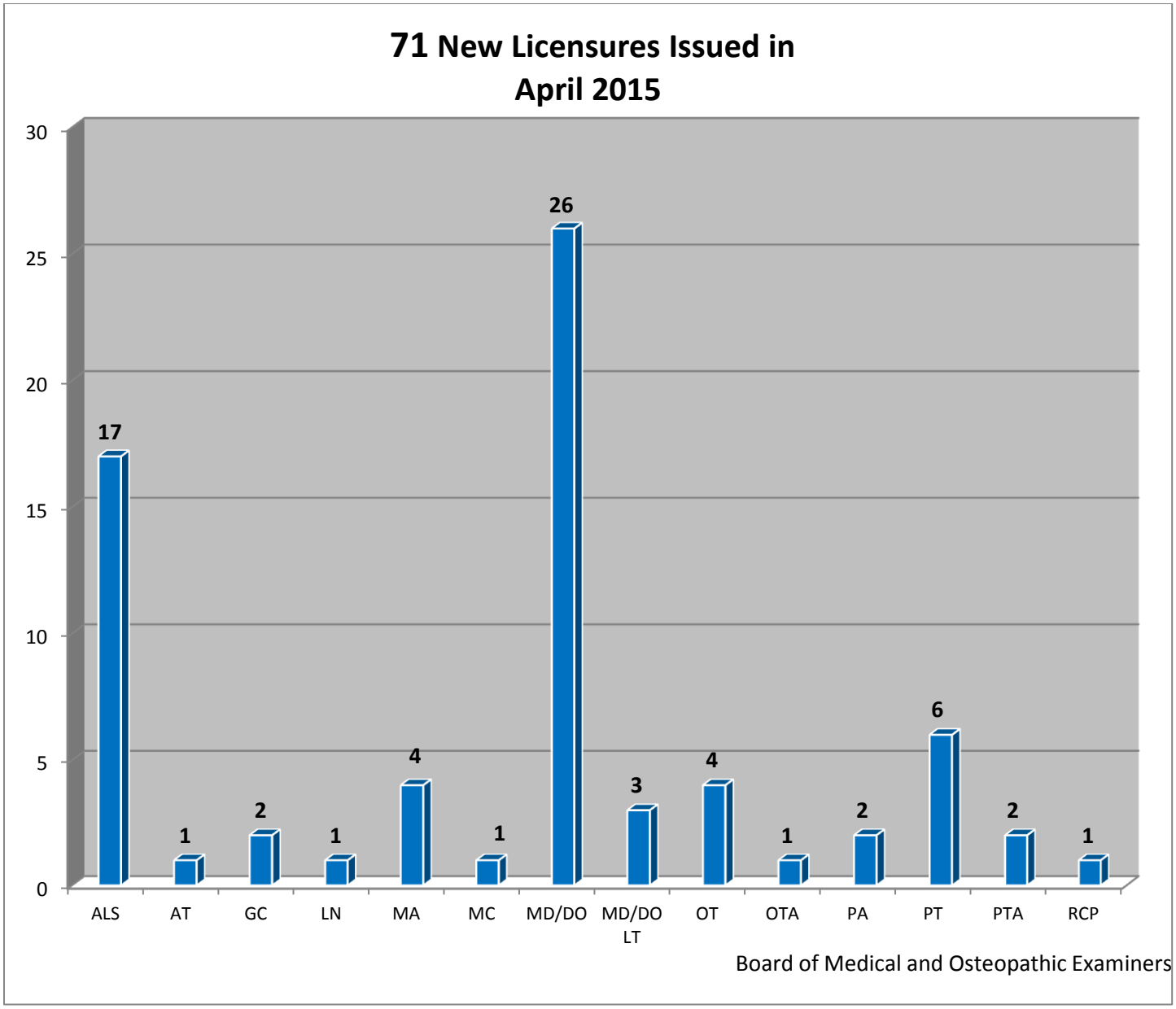
Ceremonial Signing for SB 63

BMOE representatives: Board Member Deb Bowman, President Mary Carpenter, Executive Director Margaret Hansen, CEO Scott Duke SDAHO, Susan Sporrer, DOH; SDSMA representatives: Dean Krogman and Justin Bell, Sen. Deb Soholt, Secretary of Health Kim Malsam-Rysdon, Rep. Scott Munsterman, and Sanford representative Nick Kotzea watch Governor Daugaard sign SB 63.

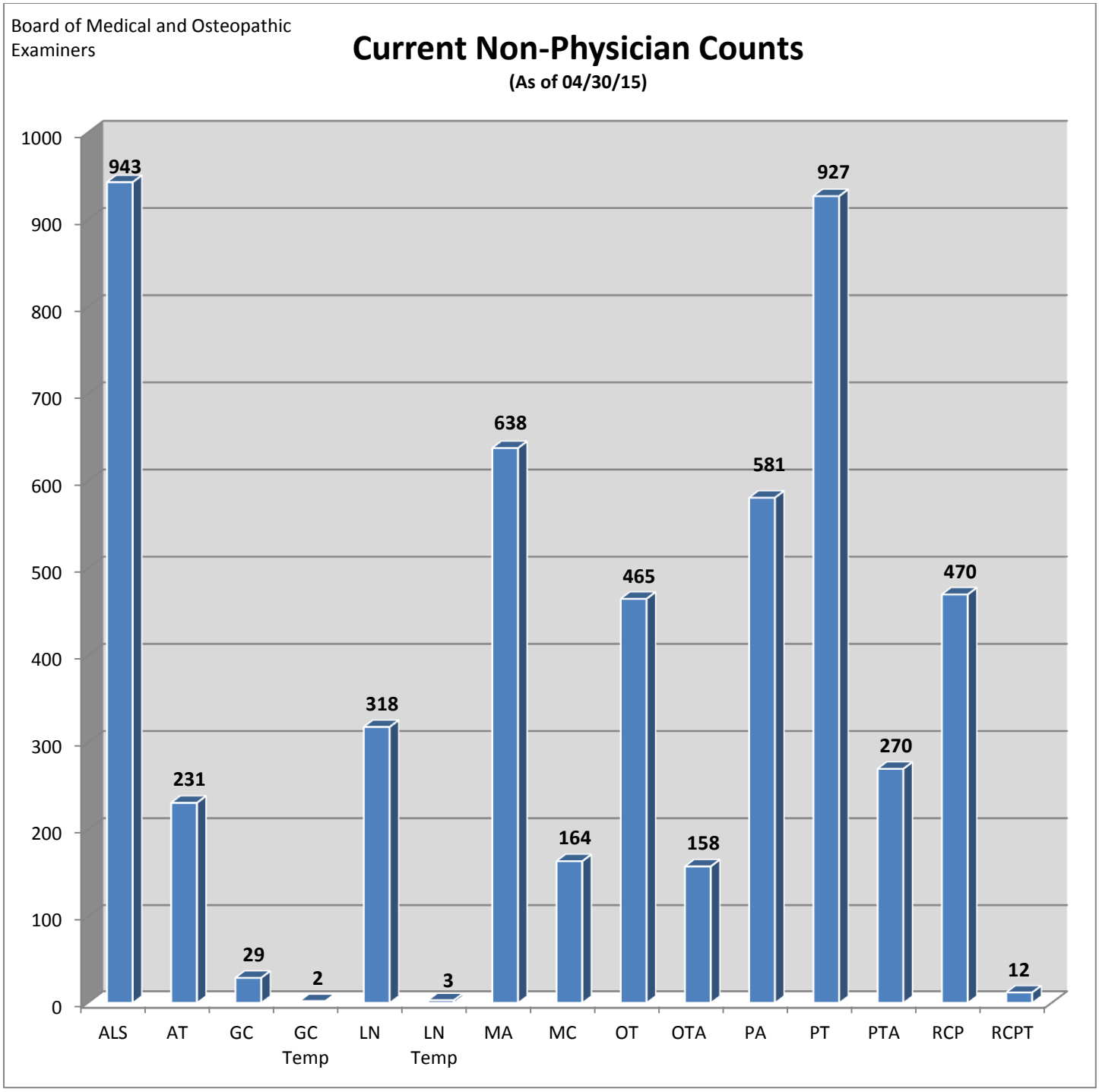
BMOE representatives: Board Member Deb Bowman, President Mary Carpenter, Executive Director Margaret Hansen, CEO Scott Duke SDAHO, Susan Sporrer, DOH; SDSMA representatives: Dean Krogman and Justin Bell, Sen. Deb Soholt, Secretary of Health Kim Malsam-Rysdon, Rep. Scott Munsterman, and Sanford representative Nick Kotzea with Governor Daugaard.

The physician license renewal period ended March 1, 2015 with 3718 medical licenses renewed.

Statistics



ALS – Advanced Life Support (EMT)
AT – Athletic Trainer
GC – Genetic Counselor
GCT – Genetic Counselor Temp
LN – Licensed Nutritionist/ Dietitian
MA – Medical Assistant
MC – Medical Corporation
MD/DO – Medical License
MD/DO LT – Physician Locums Tenens
MD/DO RL – Resident License
OT – Occupational Therapist
OTA – Occupational Therapist Assistant
PT – Physical Therapist
PTA – Physical Therapist Assistant
RCP – Respiratory Therapy



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LN – Licensed Nutritionist
MA – Medical Assistant
MC – Medical Corporation
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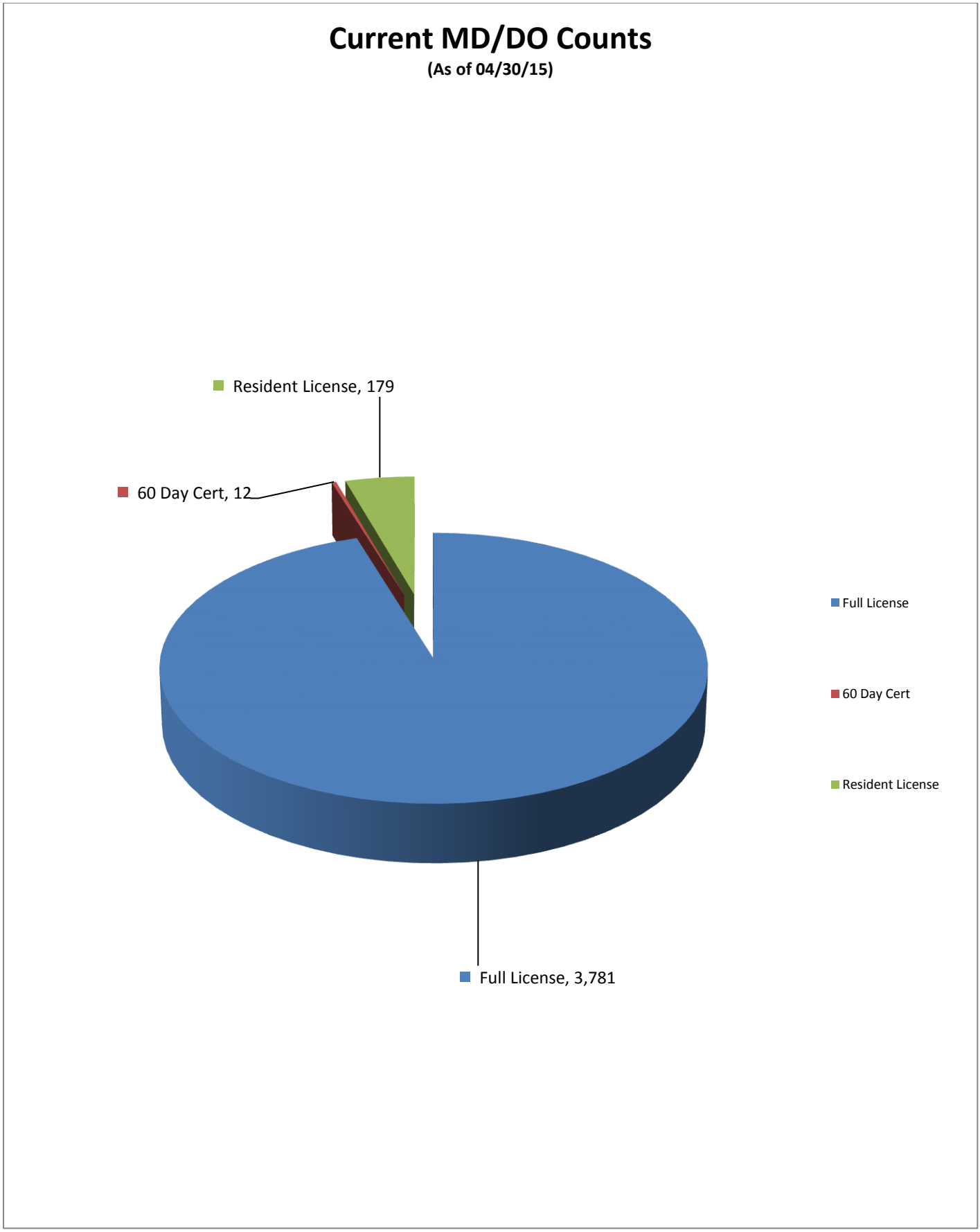
OTA – Occupational Therapy Assistant
PA – Physician Assistant
PT – Physical Therapist
PTA – Physical Therapist Assistant
RCP – Respirator Care Practitioner


Current MD/DO Counts
(As of 04/30/15)
Resident License, 179
60 Day Cert, 12
Full License, 3,781
Full License
60 Day Cert
Resident License

INVESTIGATIONS: Ensure complaints and issues are properly investigated and resolved.

Issues

Complaints:

Summary of new applications

1.) New Licenses were issued

a. 71 new licenses issued

b. 24 complex applications resolved or closed

Statistics

Investigations and Complaints
(As of 04/30/2015)

Category	New	On-going	Resolved
Complex Applications	32	69	24
Complaints/ Investigations	21	47	17
Competency (Malpractice cases)	0	336	0

Reinstatement and Renewal Applications
(As of 04/30/2015)

Category	New	On-going	Completed
Reinstatement and Renewal Applications	7	19	8

OUTREACH: Make life easier for our customers.

Education

The Executive Director and Board staff continues to meet and do outreach to the medical school, residency programs, healthcare recruiters, clinic managers, health system administrators, state regulatory boards and associations as well as with the SDBMOE licensees.

Outreach Efforts:

Outreach Activities

(Totals reflect activities from first to last day of month)

Activity	Organization	# Participants	Topic Covered
Training	Academic Program (Residency) Directors & Coordinators. Healthcare Systems Recruiter. Board & Advisory Members	120	Licensing discussion
Phone/General Email	Licensees/ Applicants	3002	General questions
In-Office Assistance	Licensees/ Applicants	50	Renewal and general questions

Upcoming Events:

- **2015 Meeting Dates**
  - June 11, September 10 and December 3
- **2016 Meeting Dates**
  - March 3 & 4, June 2, September 8 and December 1

BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

March 2015

By Margaret B. Hansen and Randi Sterling

LICENSING: Ensure only qualified professionals are licensed and allowed to practice.

Current/Past Events:

Ceremonial Signing for SB 63

BMOE representatives: Board Member Deb Bowman, President Mary Carpenter, Executive Director Margaret Hansen, CEO Scott Duke SDAHO, Susan Sporrer, DOH; SDSMA representatives: Dean Krogman and Justin Bell, Sen. Deb Soholt, Secretary of Health Kim Malsam-Rysdon, Rep. Scott Munsterman, and Sanford representative Nick Kotzea watch Governor Daugaard sign SB 63.

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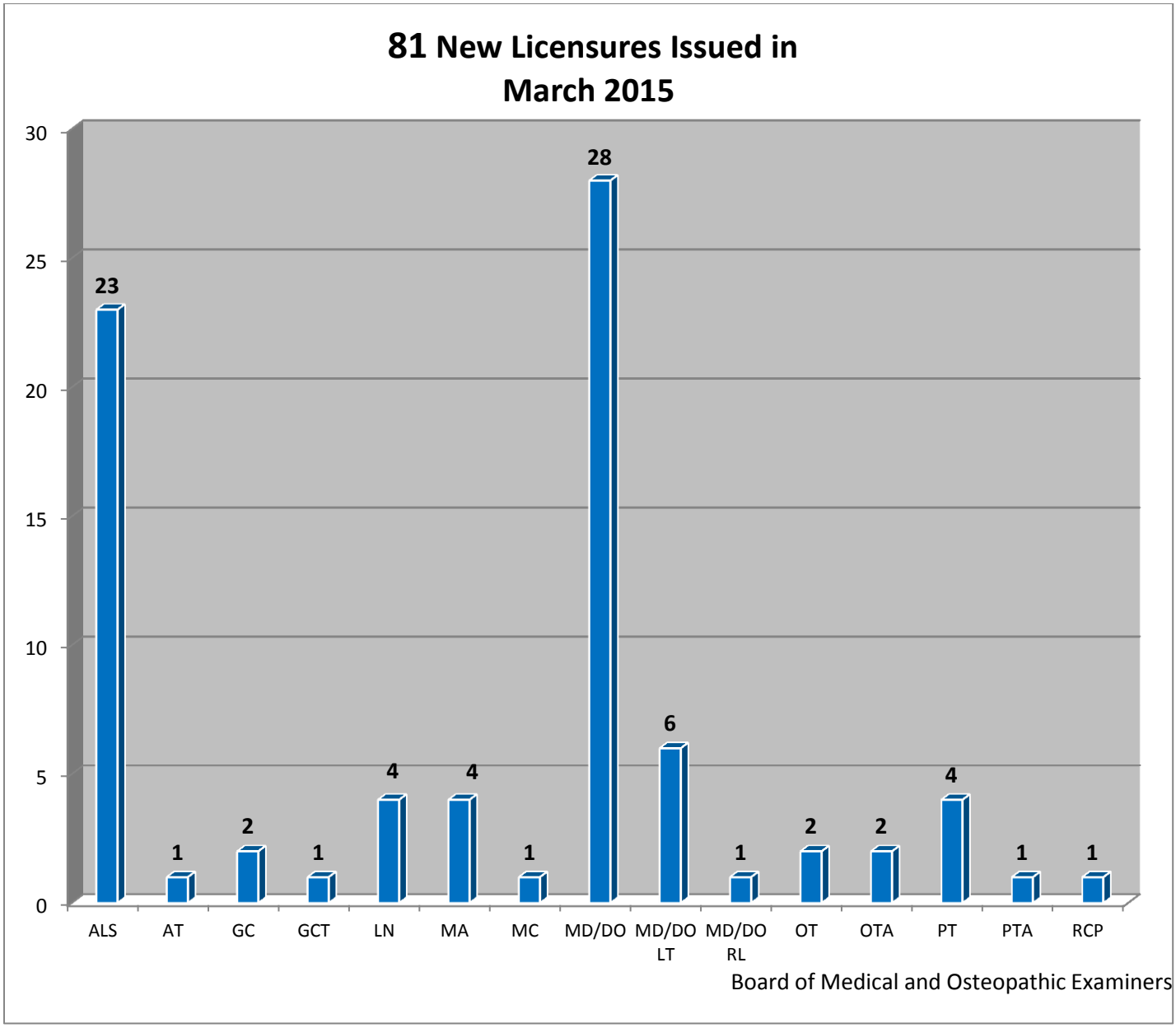
The physician license renewal period ended March 1, 2015 with 3718 medical licenses renewed.

Statistics



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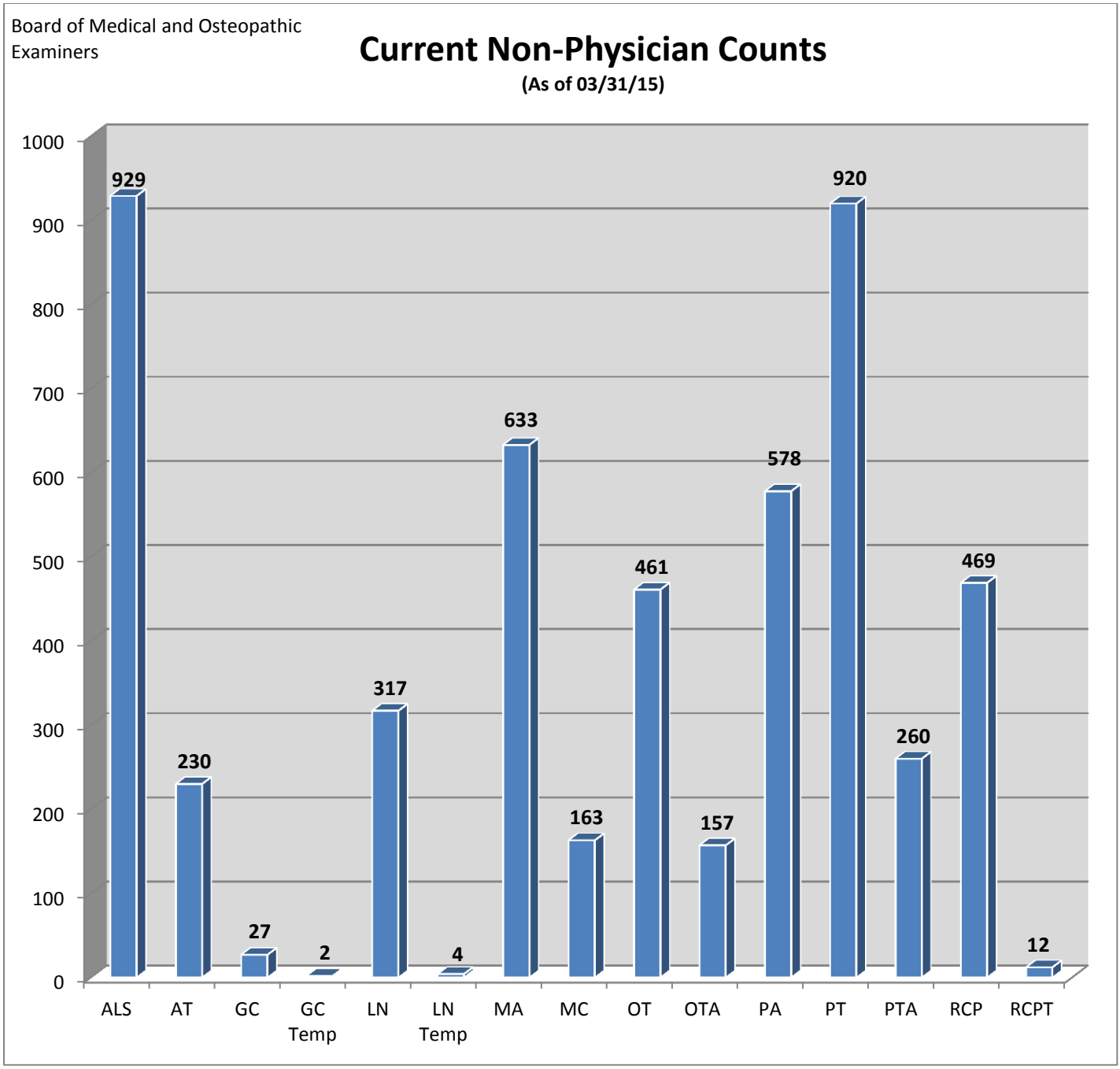

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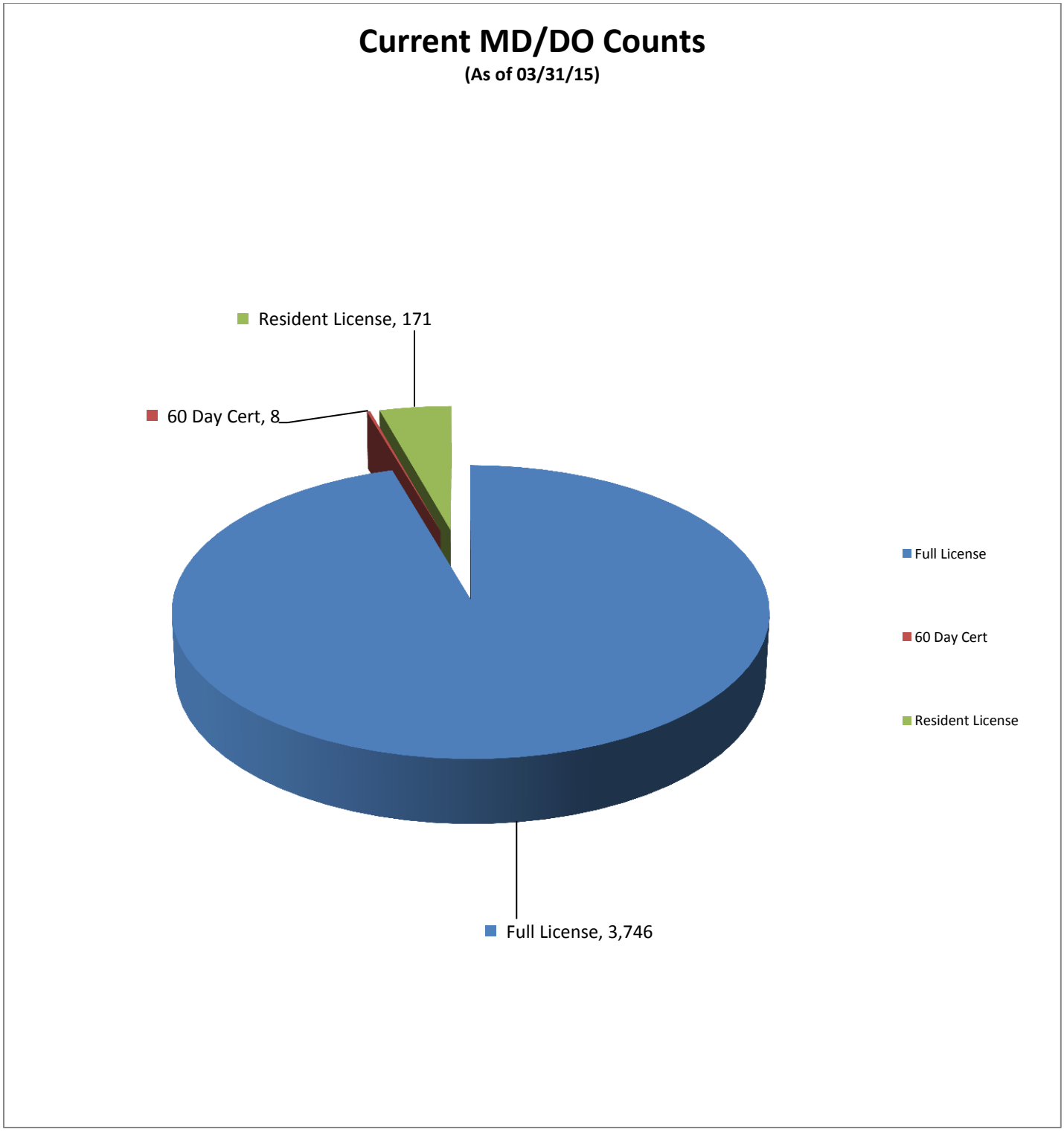
Current MD/DO Counts
(As of 03/31/15)
Resident License, 171
60 Day Cert, 8
Full License, 3,746
Full License
60 Day Cert
Resident License

INVESTIGATIONS: Ensure complaints and issues are properly investigated and resolved.

Issues

Complaints:

Summary of new applications

1.) New Licenses were issued

a. 81 new licenses issued

b. 22 complex applications resolved or closed

Statistics

Investigations and Complaints
(As of 03/31/2015)

Category	New	On-going	Resolved
Complex Applications	26	61	22
Complaints/ Investigations	31	30	25
Competency (Malpractice cases)	0	291	0

Reinstatement and Renewal Applications
(As of 3/31/2015)

Category	New	On-going	Completed
Reinstatement and Renewal Applications	12	17	8

OUTREACH: Make life easier for our customers.

Education

The Executive Director and Board staff continues to meet and do outreach to the medical school, residency programs, healthcare recruiters, clinic managers, health system administrators, state regulatory boards and associations as well as with the SDBMOE licensees.

Outreach Efforts:

Outreach Activities

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Upcoming Events:

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SDBMOE Board News

By Margaret B. Hansen, PA-C, MPAS, Executive Director,
South Dakota Board of Medical and Osteopathic Examiners

Interstate Medical Licensure Compact Bill Passes the South Dakota Legislature

The Interstate Medical Licensure Compact

- Is an expedited additional and voluntary pathway for medical licensure for physicians interested in practicing in multiple states
- Is a way for states to preserve and exercise their authority to license and regulate the practice of professions while addressing shared interests and concerns
- Does not change the definition of or the practice scope for physicians in the South Dakota Medical Practice Act

The traditional medical licensure pathway remains intact with no changes in requirements or how physicians are allowed to practice

Support for the Interstate Medical Licensure Compact in South Dakota

- AARP South Dakota
- Avera Health
- Governor's Primary Care Task Force Oversight Committee
- Regional Health
- Sanford Health
- South Dakota Association of Healthcare Organizations
- South Dakota Board of Medical and Osteopathic Examiners
- South Dakota Department of Health
- South Dakota State Medical Association

SDBMOE member Deb Bowman, SDBMOE President Mary Carpenter, MD, SDBMOE Executive Director Margaret Hansen, SDAHO CEO Scott Duke, Susan Sporrer of the South Dakota Department of Health; SDSMA lobbyists Dean Krogman and Justin Bell, Sen. Deb Soholt, Secretary of Health Kim Malsam-Rysdon, Rep. Scott Munsterman, Nick Kotzea of Sanford Health with Gov. Dennis Daugaard after signing SB 63.

SDBMOE Board News is a monthly bulletin from the South Dakota Board of Medical and Osteopathic Examiners. For more information, contact the Board at SDBMOE@state.sd.us or write to SDBMOE, 101 N. Main Avenue, Suite 301, Sioux Falls, SD 57104.

Current Board Members

Keith H. Berge, M.D.

Policy & Planning Committee Member
Dept. of Anesthesiology
Mayo Clinic, MB2-505C
200 First Street SW
Rochester, MN 55905
Fax: 507-255-2939

Dr. Berge, of Rochester, is a board certified consultant in anesthesiology at Mayo Clinic. He also serves as an assistant professor of anesthesiology in the College of Medicine, Mayo Clinic. Berge received his Bachelor of Science degree in microbiology from the University of Minnesota and his doctor of medicine degree from the Mayo Medical School. Dr. Berge is a member of the American Medical Association, American Society of Anesthesiologists, Minnesota Medical Association, and the Minnesota Society of Anesthesiologists.

Current Board term: June 03, 2013 through January 04, 2016
Congressional District: One

Mark A. Eggen, M.D. (President)

B-515 Mayo Building 294
420 Delaware Street SE
Minneapolis, MN 55455
Fax: 612-617-2166

Dr. Eggen practices as an anesthesiologist with University of Minnesota Physicians. He is a diplomat of the American Board of Anesthesiologists and is a licensed physician in Minnesota and California.

Dr. Eggen earned his doctor of medicine degree from the University of Minnesota, Minneapolis, MN and completed his anesthesiology residency at Stanford University. He is a past president and member of the Minnesota Society of Anesthesiologists and a member of the American Society of Anesthesiologist. Dr. Eggen is also a member of the Minnesota Medical Association serving on its Policy Council.

Dr. Eggen serves nationally as a fellow of the Federation of State Medical Boards (FSMB), the American Board of Medical Specialties (ABMS) and the American Board of Anesthesiologists (ABA).

Current Board term: June 03, 2013 through January 02, 2017
Congressional District: Four

V. John Ella, J.D.

Policy & Planning Committee Chair
Jackson Lewis, LLP
225 South Sixth Street, Suite 3850
Minneapolis, MN 55402
Fax: 612-341-0609

Mr. Ella of Robbinsdale is an attorney of counsel to the Jackson Lewis law firm in Minneapolis, a position he has held since 2007. Previously, he was an attorney and shareholder with the Mansfield, Tanick and Cohen law firm in Minneapolis, an attorney with Western Minnesota Legal Services in Willmar, and also served as a judicial law clerk. Mr. Ella earned his law degree cum laude from the University of Minnesota Law School, and his Bachelor of Arts degree from Tufts University in Boston, Massachusetts. He is a member of numerous law-related committees, and has served his community as a member of the Robbinsdale Human Rights Commission.

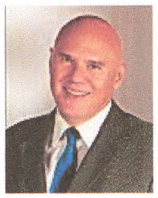
Current Board term: June 24, 2014 through January 01, 2018
Congressional District: Five

Sarah L. Evenson, J.D., M.B.A.

Licensure Committee Member
Minnesota Board of Medical Practice
2829 University Avenue SE, #500
Minneapolis, MN 55414-3246
Fax: 612-617-2166

Ms. Evenson, of Maple Grove, is an attorney with expertise in personal injury, estate planning, business and real estate law. She earned her Juris Doctor degree from Hamline University School of Law in St. Paul, Master of Business Administration (MBA) degree from the University of St. Thomas Graduate School of Business in Minneapolis, and Bachelor of Science degrees in Accounting and Business Finance from the University of Wisconsin - River Falls. Ms. Evenson currently serves as the Communications Director for the Association of Legal Administrators of Minnesota. She has also servced on many other boards including the Wright-Hennepin Cooperative Electric Association Board of Directors from 2008 to 2011.

Current Board term: July 1, 2012 through January 4, 2016
Congressional District: Three



Dr. Eduardo T. Fernandes

Policy & Planning Committee Member
Department of Urology, Suite 112-D
Veterans Hospital
One Veterans Drive
Minneapolis, MN 55417
Bus: 612-467-3460

Dr. Fernandes is an urologist who currently serves as Chief of Urology at the Minneapolis Veterans Hospital since 2001 and Associate Director of Surgical Services and Specialty Care since 2012. He is an Associated Professor of Urology at the University of Minnesota, having served as Acting Chairman of Urology from 2006 to 2009. He completed his Urology residency at the University of Minnesota, and had previous training in Pediatric Surgery at LeBonheur Children's Hospital, Memphis, Tennessee and Pediatric Urology at the University of Minnesota.

Current Board term: June 24, 2014 through January 01, 2018
Congressional District: Three (At large)

Rebecca J. Hafner-Fogarty, M.D., M.B.A.

Licensure Committee Chair
Minnesota Board of Medical Practice
2829 University Avenue SE, #500
Minneapolis, MN 55414-3246
Fax: 612-617-2166

Dr. Hafner-Fogarty is a primary care physician executive who currently serves as Chief Medical Officer of Zipnosis, and as a consultant to several other Minnesota healthcare companies. She also maintains an active clinical practice. Dr. Hafner-Fogarty completed her undergraduate degree at the College of St. Benedict, her medical degree at the University of North Dakota, and an MBA in healthcare administration from the University of St. Thomas. Dr. Hafner-Fogarty previously served on the Board of Medical Practice from 1998-2003 and 2004-2010, serving as Board president in 2009. She has also been active at the national level. Dr. Hafner-Fogarty helped to found the Women's Caucus at the Federation of State Medical Boards, served on the Program Committee, and currently serves on the Editorial Board of the Journal of Medical Regulation (the official journal of the FSMB) and the Board of Directors of the FSMB Foundation.

Current Board Term: June 30, 2012 through January 04, 2016
Congressional District: Six

Subbarao Inampudi, M.B., B.S., FACR (Vice President)

Complaint Review Committee Member
Minnesota Board of Medical Practice
2829 University Avenue SE, Suite 500
Minneapolis, MN 55414-3246
Fax: 612-617-2166

Dr. Inampudi is an active, practicing, interventional radiologist, a Fellow with the American College of Radiology, and the immediate past president of the Minnesota Radiological Society. Besides being the founding physician chair of Abbott Northwestern Hospital's (ANW) clinical council, he has served as President of his 65+member group-Consulting Radiologists, Ltd.; President of ANW medical staff; and, a member of the ANW Board of Trustees. He is presently a member of the Board of Allina Hospitals and Clinics; and chair of the Allina Board's Quality Committee and a member of the Physician Governance Committee. He earned his medical degree from Sri Venkateswara University, Tirupati, India and completed his fellowship and residency at The Mount Sinai Hospital in New York city, New York.

Current Board term: June 03, 2013 through January 02, 2017
Congressional District: Three

Irshad H. Jafri, M.B., B.S., FACP

Complaint Review Committee Member
HealthPartners Specialty Center
Gastroenterology and Hepatology
435 Phalen Blvd., 3rd Floor
St. Paul, MN 55101
Fax: 651-254-8656

Dr. Jafri is a gastroenterologist, practicing in Minnesota since 1997. He is currently the Department Head of Gastroenterology and Hepatology at Regions Hospital and the HealthPartners Medical Group. He is also Assistant Professor of Medicine in the Department of Medicine, at the University of Minnesota Medical School. Dr. Jafri did his Internal Medicine residency at Hennnepin County Medical Center, then went on to do a fellowship in Gastroenterology at the University of Massachusetts Medical Center, in Worcester, Massachusetts. He is currently a member of the American College of Gastroenterology, American Gastroenterology Association, American Society of Gastrointestinal Endoscopy and the Minnesota Medical Association.

Current Board Term: October 15, 2012 through January 05, 2015
Congressional District: Two

Kelli Johnson, M.B.A.

Complaint Review Committee Member
SHADAC/University of MN
2221 University Ave., SE, #345
Minneapolis, MN 55414
Fax: 612-624-1493

Ms. Johnson of St. Paul is a senior research fellow at the State Health Access Data Assistance Center at the University of Minnesota School of Public Health. Previously, she held positions with Allina Health Systems, the Minnesota Department of Health, the Minnesota House of Representatives, and the office of U.S. Senator David Durenberger. Ms. Johnson is currently a doctoral candidate in organizational leadership, policy and development - evaluation studies at the University of Minnesota. She earned her Master of Business Administration degree from the University of St. Thomas in St. Paul, and her Bachelor of Arts degree from St. Olaf College in Northfield. Ms. Johnson has served on a number of non-profit boards and currently chairs the board of Hearth Connection.

Current Board term: June 24, 2014 through January 01, 2018
Congressional District: Four

Gerald T. Kaplan, M.A., L.P.

Complaint Review Committee Member
2712 Fremont Avenue South
Minneapolis, MN 55408-1122
Fax: 612-874-8885

Mr. Kaplan has been a licensed psychologist since 1977. He is the Executive Director of Alpha Human Services and Alpha Service Industries, sister agencies that provide inpatient and outpatient sex offender management and treatment.

Mr. Kaplan was previously a member of the Board of Medical Practice from 2000 to 2004 and was a member of the Board's 1995 Consultation Group on Physician Sexual Misconduct. Mr. Kaplan serves nationally as a fellow of the Federation of State Medical Boards and is a member of the Federation's Ethics and Professionalism Committee.

Mr. Kaplan was a member of the Board of Psychology from 1992 to 2000, including two years as the Board Chair. He also currently serves as a Board member on the Board on Judicial Standards.

Current Board term: March 29, 2011 through January 05, 2015
Congressional District: Three

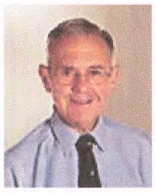
Patricia J. Lindholm, M.D., FAAFP

Licensure Committee Member
Lake Region Healthcare Clinic Services
615 South Mill Street
Fergus Falls, MN 56537
Fax: 218-739-5501

Dr. Lindholm received her medical degree from the George Washington University in Washington, D.C. She received a B.A. degree in chemistry from Bryn Mawr College in Pennsylvania. She practices family medicine. After serving 4 years at a community health center in Ohio, she has practiced in Fergus Falls since 1990.

Dr. Lindholm is a past president of the Minnesota Academy of Family Physicians and has served on a national commission for the American Academy of Family Physicians. She is also a past president of the Minnesota Medical Association. She has previous served on the Board of Directors of Midwest Medical Insurance Company (now the MMIC Group), Minnesota Community Measurement, Lake Region Hospital and the Fergus Falls Medical Group. She currently has clinical faculty appointments at the University of Minnesota Medical School and the University of North Dakota Medical School. She is currently Chair of the Outpatient Services Committee of Lake Region Healthcare.

Current Board term: October 30, 2013 through January 04, 2016
Congressional District: Seven



Charles F. Moldow, M.D. (Secretary)

Licensure Committee Member
Primary Care Center,
University of Minnesota
Clinic 3A, Mail Code: MMC-88
Phillips-Wangensteen Building, 516 Delaware Street SE
Minneapolis, MN 55455
Bus: 612-624-9499

SUNY Downstate Medical School, MD. NYU Bellevue Hospital training in Internal Medicine and Hematology. University of Minnesota Medical School 1972 to present. Professor in Department of Medicine. VA Medical Center, Head of Department

of Medicine 1982-1994, Chief of Staff 1994-1998. University of Minnesota Senior Medical School Associate Dean for Research 1988-2010. Currently physician in the Primary Care Clinic, University of Minnesota.

Current Board term: June 30, 2012 through January 4, 2016.
Congressional District: Five

Allen G. Rasmussen, M.A.

Policy & Planning Committee Member
Rainy River Community College
1501 Highway 71
International Falls, MN 56649
Fax: 218-285-2239

Mr. Rasmussen is President Emeritus of Rainy River Community College and a retired Superintendent of Schools in International Falls, Minnesota.

He earned a Bachelor of Science degree from Bemidji State University, a Master of Arts degree from the University of Northern Colorado and numerous graduate credits from the University of Minnesota, Twin Cities and Duluth campuses.

Mr. Rasmussen previously served on the Minnesota Board of Medical Practice from 2002 to 2010, as Secretary in 2009 and Vice Chair in 2010. He currently is serving his second term on the Minnesota Board of Dentistry as Secretary. He is Chair of the Health Professionals Services Program (HPSP) Program Committee.

He also serves his community as Chair of the Koochiching Economic Development Authority, Secretary of the Northeast Minnesota Workforce Investment Board, Treasurer of the Arrowhead Regional Development Commission, Board member of the Northern Minnesota Region and Vice Chair of the Northland Chapter of the American Red Cross.

Current Board term: September 29, 2014 through January 1, 2018.
Congressional District: Eight

Maria K. Statton, M.D., Ph.D.

Complaint Review Committee Chair
Sanford Health
1233 34th Street NW
Bemidji, MN 56601
Fax: 612-617-2166

Dr. Statton is from Bemidji and practices Family Medicine at Sanford Health of Northern Minnesota. She obtained her undergraduate degree from Bemidji State University and her medical degree and Ph.D from the University of North Dakota.

Dr. Statton has previously served on the Board of directors for the Upper Mississippi Mental Health Center and the Family Advocacy Center of Northern Minnesota. She is a member of the American Academy of Family Practice as well as the Minnesota Medical Association.

Current Board Term: June 03, 2013 through January 02, 2017
Congressional District: Eight

Jon V. Thomas, M.D., M.B.A.

Licensure Committee Member
Ear, Nose and Throat SpecialtyCare of MN, PA
347 North Smith Ave., Suite 602
St. Paul, MN 55102
Fax: 651-297-6597

Dr. Thomas of Vadnais Heights is an Otolaryngologist and Chief Operating Officer of Ear, Nose, and Throat SpecialtyCare of Minnesota, PA. He is also Chief of Staff - elect and a member of the Senior Management Team at United Hospital in St. Paul, where he previously served as Secretary/Treasurer of the Medical Staff and Chair of the By-laws Committee. Previously, he was a doctor and partner with Head and Neck Physicians and Surgeons Clinic, and a Clinical Assistant Professor in the Department of Family Practice and Community Health with the University of Minnesota Medical School. Dr. Thomas earned his Doctor of Medicine degree from Mayo Medical School in Rochester, his Master of Business Administration degree from the University of St. Thomas in St. Paul, and his Bachelor of Science degree from Carleton College in Northfield. He serves on the Board of Directors of the Federation of State Medical Boards, and is a member of its Governance Committee.

Current Board Term: June 24, 2014 through January 01, 2018
Congressional District: Four (At large)

Joseph R. Willett, D.O., FACOI

Complaint Review Committee Chair
Affiliated Community Medical Centers
1521 Carlson Street
Marshall, MN 56258
Fax: 507-532-1905

Dr. Willett is an Internal Medicine physician with Affiliated Community Medical Center in Marshall. Dr. Willett previously served on the Minnesota Board of Medical Practice from 1996 to 2003.

Current Board term: March 29, 2011 through January 05, 2015
Congressional District: Seven

These drafted biographies are for your review. Please indicate if there are any additions or revisions you would like to make.

Kevin L. Bjordahl, MD
City: Milbank
Term Ends: 10/30/2015
Specialty: Family Medicine
Certification: American Board of Family Medicine
Work Address: 803 E Milbank Avenue Milbank, South Dakota 57252
Professional Background: Dr. Bjordahl has served the communities of Webster from 1985 to 1995 and Milbank from 1995 to the present as a Board Certified Family Physician. He also serves as a Clinical Professor for the department of Family Medicine for the Sanford School of Medicine at the University of South Dakota. Dr. Bjordahl received his Doctor of Medicine degree from the University of South Dakota in 1982 and completed his residency training at the Siouxland Medical Education Foundation.

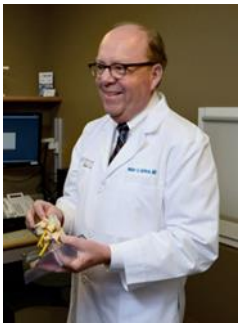
Deb K. Bowman

City: Pierre

Term Ends: 10/30/2016

Work Address:

Professional Background: Until her retirement in April 2014, Deb Bowman served in key leadership positions in South Dakota state government for 22 years under 5 different governors. Prior to joining state government Deb served for 14 years as the CEO of ECCO, Inc., a private non-profit organization serving individuals with developmental disabilities. She was also employed as a manager of government affairs for US West and started her career as a middle school English teacher. Throughout her career Bowman has received numerous awards and recognitions for her passionate leadership for some of society's most vulnerable citizens including individuals with disabilities, the elderly, children, and low-income families. In addition to being an advocate for South Dakota's most vulnerable citizens, Deb is also a passionate advocate for organ donation. She received a kidney transplant in 2000; her youngest daughter was her donor.



Walter O. Carlson, MD, MBA; Vice President

City: Sioux Falls

Term Ends: 10/30/2017

Specialty: Orthopedics, Pediatric Orthopedics

Certification: American Board of Orthopedic Surgery

Work Address: 810 E 23rd Street Sioux Falls, South Dakota 57117

Professional Background: Dr. Carlson has served the greater Sioux Falls community during his nearly 30 years as a Board Certified Orthopedic Surgeon and partner at Orthopedic Institute. He also serves as a Clinical Professor for the Sanford Medical School at the University of South Dakota. Dr. Carlson received his Doctor of Medicine degree from the University of Minnesota in 1977 and completed his residency training at the Mayo School of Medicine. He is affiliated with Avera McKennan Hospital, Sanford University Center and Sioux Falls Specialty Hospital, is consulting staff with LifeScape in Sioux Falls, Osceola Community Hospital in Sibley, IA, and Huron Regional Medical Center, Huron, and is courtesy staff at Brooking Hospital, Brooking. He has been active in many professional and community organizations including the South Dakota State Medical Association, the American Medical Association, the American Academy of Orthopedic Surgeons, the American Academy of Cerebral Palsy and Developmental Medicine, Texas Scottish Rite Hospital for Crippled Children Alumni Association, the Sioux Falls Chamber of Commerce, the Boy Scouts, Rotary International, the Sioux Falls United Way, the Washington Pavilion, the South Dakota Symphony, the South Dakota State Art Museum, and the First Dakota National Bank.

Mary S. Carpenter, MD; President

City: Winner

Term Ends: 10/30/2016

Specialty: Family Medicine

Certification: American Academy of Family Medicine (Fellow)

Work Address: Box 769, Winner, SD 57580

Professional Background: Dr. Carpenter spent 28 years as a Family Practice physician serving the Winner and Burke communities. She continues to serve South Dakota as the medical director for Medicaid and Corrections Health, and as a medical consultant for the Department of Health. Dr. Carpenter has been tasked by the Governor to provide her expertise on the Infant Mortality Task Force.

David K. Erickson, MD
City: Sioux Falls
Term Ends: 10/30/2015
Specialty: Family Medicine
Certification: American Board of Family Medicine
Work Address: 3900 W Avera Dr Sioux Falls, South Dakota 57108

Professional Background: Executive Vice President & Chief Medical Officer for the Avera Health Systems. Dr. Erickson received his Doctor of Medicine degree from the University of South Dakota in 1983. After completing his Internship at the University of Colorado Health Sciences Center in Denver, Colorado in 1984 and his Residency at the Fort Collins Family Practice Program in Fort Collins, CO. in 1986, he engaged in full time clinical practice at the Dell Rapids Medical Clinic for 14 years. Dr. Erickson is a member of the American Academy of Family Physicians, South Dakota State Medical Society, and 7th District Medical Society. He holds a Specialty Certification as Diplomat of the National Board of Medical Examiners and Diplomat of the American Board of Family Practice. He joined Avera Health in 2000. Dr. Erickson is a member of the St. Mary's Catholic Church and is involved in a number of other community organizations.

Laurie B. Landeen, MD
City: Sioux Falls
Term Ends: 10/30/2016
Specialty: Obstetrics & Gynecology
Certification: American Board of Obstetrics and Gynecology
Work Address: 1500 W 22nd Street, Suite 301 Sioux Falls, SD 57105
Dr. Landeen is a Board Certified Obstetrician and Gynecologist. She received her Doctor of Medicine degree from Georgetown University in 1988 and completed her residency training at the University of Minnesota.

Brent J. Lindbloom, DO; Secretary
City: Pierre
Term Ends: 10/30/2017
Specialty: Obstetrics & Gynecology
Certification: American Board of Obstetrics and Gynecology
Work Address: 100 MAC Lane Pierre, South Dakota 57501
Professional Background: Dr. Lindbloom, a Board Certified Obstetrician and Gynecologist, is a fellow with the American College of Obstetricians and Gynecologists. Since 1989, he has been providing medical services to the Pierre community. Dr. Lindbloom received his Doctor of Osteopathic Medicine degree from Des Moines University in 1985 and completed his residency training at the University of South Dakota.

David E. Lust, JD

City: Rapid City

Term Ends: 10/31/2018

Work Address: 506 Sixth Street PO Box 8045 Rapid City, SD 57709

Professional Background:

David is a partner in the law firm of Gunderson, Palmer, Nelson & Ashmore, LLP, and specializes in commercial transactions, commercial litigation and real property matters. He joined the firm in 1999 after a two-year clerkship with a US District Court Judge. He earned a BA degree from Dartmouth College and his JD degree from the University of South Dakota School of Law. David is actively engaged in the Rapid City community where he has served on numerous boards. In addition, he served in the South Dakota House of Representatives for eight years – four years as House Majority Leader.

Jeffrey A. Murray, MD

City: Sioux Falls

Term Ends: 10/30/2017

Specialty: Gastroenterology

Certification: American Board of Internal Medicine

Work Address: 1205 S Grange Avenue, Suite 104 Sioux Falls, SD 57105

Professional Background: Dr. Murray practices with Sanford Clinic Gastroenterology and is Board Certified in both Internal Medicine and Gastroenterology. He also is a Clinical Associate Professor for the Department of Internal Medicine at Sanford School of Medicine at the University of South Dakota and Vice-Chair of the Department of Internal Medicine with the Sanford Medical Staff. Dr. Murray received his Doctor of Medicine degree from the University of South Dakota in 1982 and completed his residency training at the University of Iowa.

MEET THE BOARD STAFF

BMOE staff with Secretary of Health Malsam-Rysdon (left to right): Tyler Klatt, Lisa Andersen, Margaret Hansen, Kim Malsam-Rysdon, Michele Knorr, Randi Sterling, Misty Rallis, Elise Ellenz, (Jane Phalen, absent).

Staff Biographies

Lisa Andersen

Lisa Andersen is the Receptionist who answers phones, greets clients, processes incoming mail, sends Employment Verifications, checks over documents and other secretarial duties as well as carries out special projects as assigned. Lisa enjoys spending time with her children and dogs, gardening, sewing, walks and home improvement projects.

Elise Ellenz

Elise Ellenz, Licensing Specialist reviews submitted applications and creates checklists for applicants, communicates with and monitors applicant progress throughout the licensing process, issues licenses, creates and maintains online accounts.

Elise was born and raised in Sioux Falls, SD. She graduated from O'Gorman High School in 2004 and went on to graduate from Minnesota State University in Mankato, MN in 2008 majoring in Marketing and minors in Business Administration and Consumer Behavior. Prior to working as a Licensing Specialist, Elise worked as a Loan Assistant for Dacotah Bank for 5 years. Elise is married to her husband Matt. They stay busy raising their 2 children Andrew (3 years) and Erica (2 years). Elise likes to do activities with her family such as going to the zoo, taking walks, and traveling.

Tyler Klatt

Tyler Klatt is the Management Analyst for the Board of Medical and Osteopathic Examiners. Mr. Klatt oversees eight medical professional advisory groups and assists these groups with policy and regulatory

issues. Mr. Klatt also assists the Board with research, policy issues, and rule making. Tyler grew up in Watertown, South Dakota and attended the University of South Dakota where he earned his Bachelor of Arts in Political Science and his Master of Public Administration degrees. Tyler's hobbies include playing golf, softball, and movies.

Michele Knorr

Michele Knorr, Licensing Specialist processes applications from the Online Account Request through to the Issuing of the license. She assists applicants, third parties and the public with questions and concerns throughout the application process. Michele processes all License Verifications to be sent to other state boards. She monitors Advanced Life Support Student Status applicants and send bi-weekly progress reports to Program Directors. Michele's hobbies include: music, wine, travel, shopping, movies, sewing, needlepoint, and poetry.

Jane Phalen, Board Operations

Jane has worked for the Board since September 1993. She is responsible for preparing the agendas and meeting materials, and coordinating the quarterly Board meetings. She attends the meetings and prepares the summary minutes within 24 hours of the meeting as well as drafting the regular minutes and preparing post-meeting correspondence. She drafts and prepares disciplinary documents and ensures that the parties have appropriate notice and due process. She manages the disciplinary documents, updates the dockets, schedules contested case hearings, drafts and sends notices of hearing and other correspondence. Jane is also responsible for submitting all the national, state, and local reports and notifications about the disciplinary action. She assists board staff and the staff attorney in drafting and editing letters, documents, briefs, petitions, reports and other correspondence, and she assists board staff with renewal applications, supervision requirements, phone calls, email correspondence, and other administrative functions as needed. Jane spends her free time being "grandma" to her granddaughter, Evie, and is eagerly awaiting the arrival of her grandson October 1st.

Randi Sterling

Randi Sterling is the Head Licensing and Business Specialist. She handles the complex licensing applications, updates the website as needed, and processes the Board's financial items (reports, reconciles transactions, sends received invoices to Pierre for processing and prepares deposits as needed).

Randi was born and raised in Pierre, SD, graduating high school from T.F. Riggs High School in 2000. She moved to Sioux Falls in August of 2000, where she attended Southeast Tech for Financial Services and took accounting classes with Globe University. Randi has 2 daughters; ages 4 and 14 that are her major focus outside of work. She has been with her significant other, Keith, for 11 years this September. They enjoy staying active by playing sports and spending as much family time together as possible. They also are in the process of restoring a 1971 Pontiac Lemans.

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
101 N MAIN AVE, SUITE 301
SIOUX FALLS, SD 57104
SDBMOE@STATE.SD.US
P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV

Via Federal Express

April 15, 2015

Colin Jay Boone
3409 51st #414
Sioux Falls, SD 57106

Dear Mr. Boone:

In regard to the contested case hearing that was held on February 6, 2015, enclosed please find a copy of the administrative hearing judge's proposed Findings of Fact, Conclusions of Law, and Recommendation in your contested case.

These proposed Findings of Fact, Conclusions of Law and Recommendation will be presented to the South Dakota Board of Medical and Osteopathic Examiners at the next Board meeting scheduled on Thursday, June 11, 2015.

Also enclosed please find a Notice of Hearing which will provide you with the time and location of the Board meeting. You have the right to attend this meeting if you wish to do so, and to have an attorney of your own choosing accompany you to the meeting if you so desire; however, this is not a requirement.

If you plan to attend the Board meeting please notify William H. Golden, Board attorney, at 605-201-8588 prior to May 1, 2015.

Sincerely,

Jane Phalen

Jane Phalen
SD Medical Board Staff

Enclosure: Proposed Findings of Fact, Conclusions of Law and Recommendation
Notice of Hearing for June 11, 2015

cc: William H. Golden, esq.
Office of the South Dakota Attorney General
Assistant Attorney General/Civil Litigation Division
Counsel to the South Dakota Board of Medical and Osteopathic Examiners
(605) 201-8588

THE BOARD OF MEDICAL AND
OSTEOPATHIC EXAMINERS OF THE
STATE OF SOUTH DAKOTA

FILE COPY

IN THE MATTER OF:	)	NO. 14-189
	)	
COLIN JAY BOONE	)	FINDINGS OF FACT
APPLICANT/EMT STUDENT STATUS	)	AND
	)	CONCLUSIONS OF LAW
Respondent.	)	
	)	

This matter having been heard pursuant to SDCL 36-4B-6, 31, SDCL 1-26 and South Dakota's Administrative Rules (ARSD) 20:78:04 and 05. Respondent, Colin Jay Boone, submitted an application for Advanced Life Support Personnel Student Status. Respondent's address as reported to the Board is 3409 51st St. #414, Sioux Falls 57106.

After investigation, a recommendation was made pursuant to ARSD 20:78:04:04 for the BMOE to deny his application for student status. Respondent contested this recommendation. Pursuant to ARSD 20:78:05:04, the Secretary scheduled a contested case hearing with a hearing examiner. The hearing was conducted on February 6, 2015, and Mr. Boone received timely notice pursuant to SDCL 1-26 and ARSD 20:78:05:04.

FINDINGS OF FACT

1. Mr. Boone submitted an application for a South Dakota Advanced Life Support Personnel Student Status on September 22 2014.
2. Mr. Boone was placed under investigation due to the federal charges and for investigation of his moral character.
3. On December 17, 2013, Mr. Boone was indicted for Unreasonable Use of Force under Title 18, United States Code, and Section 242. While acting under the color of law as a police officer with the Des Moines Police Department he kicked O.P.H, willfully depriving him of his rights, secured and protected by the

3. On December 17, 2013, Mr. Boone was indicted for "Unreasonable Use of Force" under Title 18, United States Code, and Section 242. While acting under the color of law as a police officer with the Des Moines Police Department he kicked O.P.H, willfully depriving him of his rights, secured and protected by the Constitution and Laws of the United States for freedom from the use of unreasonable force by a law enforcement officer.
4. BMOE staff requested copies of any and all police reports and court documents regarding the reported incident, and requested a detailed response from Mr. Boone. Mr. Boone failed to provide the requested information.

CONCLUSIONS OF LAW

1. Any Conclusion of Law deemed to be a Finding of Fact or vice versa shall be appropriately incorporated into the Findings of Fact or Conclusions of Law as the case may be;
2. The BMOE has subject matter jurisdiction over the parties in this matter under SDCL 36-4B.
3. The allegations contained in the staff Petition are supported by clear and convincing evidence. Colin Jay Boone has the burden to show good moral character; however, he has failed to provide information and evidence as requested by the Board. SDCL 36-4B-6 and 36-4B-31. See In the Matter of Brett Jarman 2015 S.D 8
4. Colin Jay Boone's application is not complete due to his failure to supply the requested information, and he has exceeded the time allowed by rule to complete his application.

5. Timely notice has been provided to Colin Jay Boone for all hearings pursuant to SDCL 1-26 and ARSD 20:78:05:04.

RECOMMENDATION

It is the recommendation of the hearing examiner that Colin Jay Boone's application for advanced life support student status be denied.

Dated this 9th day of April, 2015.

By: _____
Paul Henry

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

* *

IN THE MATTER OF THE
SOUTH DAKOTA BOARD OF
MEDICAL & OSTEOPATHIC
EXAMINERS:
DENIAL OF
APPLICATION FOR ADVANCED
LIFE SUPPORT STUDENT STATUS
RE: COLIN JAY BOONE

NOTICE OF HEARING

* *

Please take notice that a contested case hearing has been scheduled before the South Dakota Board of Medical and Osteopathic Examiners in the above captioned matter. The hearing will take place on Thursday, June 11, 2015, in the Board Conference Room, 101 N. Main Ave., Suite 215, Sioux Falls, SD.

Dated this 15th day of April, 2015.

William H. Golden, esq.
Assistant Attorney General/Civil Litigation Division
317 N. Main Ave.
Sioux Falls, SD 57104
Attorney for the South Dakota Board of Medical and Osteopathic Examiners
(605) 201-8588

From: (605) 367-7781
Margaret Hansen
SDBMOE
101 N. Main Ave., Suite 301

Sioux Falls, SD 57104

Origin ID: FSDA

FedEx Express

J151215022303uv

Ship Date: 15APR15
ActWgt: 1.0 LB
CAD: 5282744/INET3610

Delivery Address Bar Code

Ref #
Invoice #
PO #
Dept #

SHIP TO: (515) 240-7286 BILL SENDER

Colin Jay Boone

3409 51st #414

SIOUX FALLS, SD 57106

TRK# 0201 **7733 7333 2447**

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SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

* *

IN THE MATTER OF THE APPLICATION FOR STUDENT STATUS SUBMITTED TO THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS	NOTICE OF HEARING IN CONTESTED CASE

RE: COLIN J. BOONE

* *

Please take notice that a contested case hearing has been scheduled before an Administrative Law Judge of the Office of Hearing Examiners in the above captioned matter. The hearing will take place on Friday, February 6, 2015, in the Board Room, Suite 303, 101 N. Main Ave., Sioux Falls, SD, beginning at 9:00 am.

Dated this 18th day of December, 2014.

William H. Golden, esq.
Assistant Attorney General/Civil Litigation Division
317 N. Main Ave.
Sioux Falls, SD 57104
Attorney for the South Dakota Board of Medical and Osteopathic Examiners
(605) 201-8588

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
101 N MAIN AVE, SUITE 301
SIOUX FALLS, SD 57104
SDBMOE@STATE.SD.US
P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV

Via electronic and regular mail

December 22, 2014

Colin J. Boone
3409 51st #414
Sioux Falls, SD 57106
booneemt@gmail.com

Dear Mr. Boone:

Enclosed please find the Petition in the matter of the recommendation for the denial of your application for Student Status.

The Notice of Hearing was provided to you earlier this month.

Please direct any questions to the Board Counsel, William H. Golden, at 605-201-8588.

Sincerely,

Jane Phalen
SD Medical Board Staff

Enclosure

cc: William H. Golden, esq.
State of South Dakota Office of Attorney General
Assistant Attorney General/Civil Litigation Division

THE BOARD OF MEDICAL AND
OSTEOPATHIC EXAMINERS OF THE
STATE OF SOUTH DAKOTA

IN THE MATTER OF:	)	NO. 14-189
	)	
COLIN JAY BOONE APPLICANT/EMT STUDENT STATUS	))	PETITION FOR BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS
	)	
Respondent.	)	
	)	

COMES NOW, the Executive Secretary of the South Dakota Board of Medical and Osteopathic Examiners ("Secretary") and files this Petition pursuant to SDCL 36-4B-6, 31, SDCL 1-26 and South Dakota's Administrative Rules (ARSD) 20:78:04 and 05. Respondent, Colin Jay Boone, submitted an application for Advanced Life Support Student Status. Respondent's address as reported to the Board is 3409 51st St. #414 Sioux Falls 57106.

After investigation, a recommendation was made pursuant to ARSD 20:78:04:04 for the BMOE to deny his application for student status. Respondent has contested this recommendation. The Secretary, pursuant to ARSD 20:78:04 and ARSD 20:78:05, therefore files this Petition for a contested case hearing.

A. TIME, PLACE AND NATURE OF HEARING

Hearing. A contested case hearing on this licensure action shall be heard by a Hearing Examiner pursuant to ARSD 20:78:05:04. The hearing shall begin at 9:00 pm on Friday, February 6, 2014, in the BMOE Conference Room, 101 North Main Avenue, Suite 215, Sioux Falls, South Dakota 57104.

Answer. Respondent may file an Answer within twenty (20) days of the date he is served with this Petition. An Answer, if filed, should specifically admit, deny, or otherwise answer all allegations contained in sections C and D of this Petition. The Answer and any other pleading must be filed with the Board at the following address: BMOE, 101 North Main Avenue, Suite 301, Sioux Falls, South Dakota 57104.

Presiding Officer. The Hearing Examiner will preside over the hearing and make a recommended decision consisting of proposed Findings of Fact, Conclusions of Law, and an Order, to the Board. ARSD 20:78:05:06. The Board will read the record, transcript of the contested case proceeding, and all exhibits, and make its decision thereon at a BMOE meeting following the contested case hearing. The Board may request that the parties appear to present oral argument and objections to the Hearing Examiner's recommended decision. ARSD 20:78:05:06.

Hearing Procedures. The procedural rules governing the conduct of the hearing are found at SDCL chs. 36-4B and 1-26, and ARSD chs. 20:78:05. The contested case proceeding is an adversarial proceeding. At the hearing, you have the right to be present, to appear personally, and/or to be represented by legal counsel at your own expense. You will be allowed the opportunity to respond to the allegations of the Petition, to produce evidence on your behalf, to present witnesses, to cross-examine witnesses, and to examine and respond to any documents introduced at hearing. These and other due process rights will be forfeited if they are not exercised at the hearing.

The hearing is open to the public.

Any decision of the BMOE based on the contested case proceeding may be appealed to the circuit court and the State Supreme Court as provided by law.

Pre-hearing Conferences and Continuances. Any party may request a pre-hearing conference to discuss evidentiary issues related to hearing, or may request a continuance, by filing a motion for a prehearing conference with the BMOE at the address above.

Prosecution. Counsel for the Secretary is responsible for representing the public interest (the State) in this proceeding. Counsel for the Secretary is: William H. Golden, Assistant Attorney General, South Dakota Attorney General's Office, 101 North Main Avenue, Suite 301, Sioux Falls, South Dakota 57104. Copies of all pleadings filed in this matter must be provided to Counsel for the Secretary at this address.

Communications. You may not contact Board members in any manner, including by phone, letter, in person, or by e-mail about this Petition. BMOE members may only receive information about the case when all parties have notice and an opportunity to participate, such as at the hearing or in pleadings you file with the BMOE office and serve upon all parties in this case. *See* SDCL 1-26-26.

B. LEGAL AUTHORITY AND JURISDICTION

Jurisdiction. The BMOE has jurisdiction in this matter pursuant to SDCL 36-4B.

Legal Authority. If any of the allegations against you are founded, the BMOE has authority to take disciplinary action against you under SDCL 36-4B-6, 31 and 36-4-30, and ARSD 20:78:04 and 05.

Default. If you fail to appear at the hearing, the Board may enter a default decision or proceed with the hearing and render a decision in your absence, in accordance with SDCL 1-26.

C. SECTIONS OF STATUTES AND RULES INVOLVED

Count I

Mr. Boone is subject to review under SDCL 36-4B-6 for failing to prove good moral character when he submitted his application on September 22, 2014, and disclosed that he was charged with a civil rights violation due to an incident that occurred while he was working for the Des Moines Police Department.

D. FACTUAL CIRCUMSTANCES

1. Mr. Boone submitted an application for a South Dakota Advanced Life Support Student Status on September 22 2014.
2. Mr. Boone was placed under investigation due to the federal charges and for investigation of his moral character.
3. On December 17, 2013, Mr. Boone was indicted for Unreasonable Use of Force under Title 18, United States Code, Section 242. While acting under the color of law as a police officer with the Des Moines Police Department he kicked O.P.H, willfully depriving him of his rights which are secured and

protected by the Constitution and Laws of the United States for freedom from the use of unreasonable force by a law enforcement officer.

4. BMOE staff requested copies of any and all police reports and court documents regarding the reported incident, and requested a detailed response from Mr. Boone. Mr. Boone failed to provide the requested information.

5. It is hereby requested that Mr. Boone's application be denied for unprofessional conduct in this matter and his failure to prove good moral character.

E. SETTLEMENT

This matter may be resolved by settlement agreement. The procedural rules governing the Board's settlement process are found at ARSD 20:78:04:04. If you are interested in pursuing settlement of this matter, please contact William Golden, Assistant Attorney General, at (605) 201-8588.

Signed pursuant to Article 20:78:05:02: Margaret B. Hansen Date: 12/22/2014

Margaret B. Hansen
Executive Director
South Dakota Board of Medical
and Osteopathic Examiners

Copies to: William Golden
Assistant Attorney General
South Dakota Attorney General's Office
317 N. Main
Sioux Falls, SD 57104

Colin J. Boone
3409 51st #414
Sioux Falls, SD 57106

THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

****

Re: COLIN JAY BOONE
DENIAL OF APPLICATION
FOR ADVANCED
LIFE SUPPORT
STUDENT STATUS

FINAL ORDER

****

The above-entitled matter having come before the South Dakota Board of Medical and Osteopathic Examiners ("Board"), and the Board having been fully advised in the premises thereof; and

The documents relating to this matter will be provided to other state licensing authorities upon their request.

NOW; THEREFORE, the Board hereby:

APPROVES the Findings of Fact, Conclusions of Law and Recommendation for the Denial of the Application for Advanced Life Support Student Status, and this Final Order, and directs that these are public records of the Board and the State of South Dakota and shall be published on the Board's website and reported to the national data banks and any other entity deemed appropriate by the Board and in compliance with State and Federal law.

By:_____Date:_____
South Dakota Board of Medical and Osteopathic Examiners

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

* *

IN THE MATTER OF THE
SOUTH DAKOTA BOARD OF
MEDICAL & OSTEOPATHIC
EXAMINERS:
DENIAL OF
APPLICATION FOR ADVANCED
LIFE SUPPORT STUDENT STATUS
RE: COLIN JAY BOONE

NOTICE OF HEARING

* *

Please take notice that a contested case hearing has been scheduled before the South Dakota Board of Medical and Osteopathic Examiners in the above captioned matter. The hearing will take place on Thursday, June 11, 2015, in the Board Conference Room, 101 N. Main Ave., Suite 215, Sioux Falls, SD.

Dated this 15th day of April, 2015.

William H. Golden, esq.
Assistant Attorney General/Civil Litigation Division
317 N. Main Ave.
Sioux Falls, SD 57104
Attorney for the South Dakota Board of Medical and Osteopathic Examiners
(605) 201-8588

THE BOARD OF MEDICAL AND
OSTEOPATHIC EXAMINERS OF THE
STATE OF SOUTH DAKOTA

IN THE MATTER OF:	)	NO. 14-189
	)	
COLIN JAY BOONE	)	FINDINGS OF FACT
APPLICANT/EMT STUDENT STATUS	)	AND
	)	CONCLUSIONS OF LAW
Respondent.	)	
	)	

This matter having been heard pursuant to SDCL 36-4B-6, 31, SDCL 1-26 and South Dakota's Administrative Rules (ARSD) 20:78:04 and 05. Respondent, Colin Jay Boone, submitted an application for Advanced Life Support Personnel Student Status. Respondent's address as reported to the Board is 3409 51st St. #414, Sioux Falls, South Dakota 57106.

After investigation, a recommendation was made pursuant to ARSD 20:78:04:04 for the BMOE to deny his application for student status. Respondent contested this recommendation. Pursuant to ARSD 20:78:05:04, the Secretary scheduled a contested case hearing with a hearing examiner. The hearing was conducted on February 6, 2015, and Mr. Boone received timely notice pursuant to SDCL 1-26 and ARSD 20:78:05:04.

FINDINGS OF FACT

1. Mr. Boone submitted an application for a South Dakota Advanced Life Support Personnel Student Status on September 22 2014.
2. Mr. Boone was placed under investigation due to federal charges pending against him, and for investigation of his moral character.

3. On December 17, 2013, Mr. Boone was indicted for "Unreasonable Use of Force" under Title 18, United States Code, and Section 242. While acting under the color of law as a police officer with the Des Moines Police Department he kicked O.P.H, willfully depriving him of his rights, secured and protected by the Constitution and Laws of the United States for freedom from the use of unreasonable force by a law enforcement officer.
4. BMOE staff requested copies of any and all police reports and court documents regarding the reported incident, and requested a detailed response from Mr. Boone. Mr. Boone failed to provide the requested information.

CONCLUSIONS OF LAW

1. Any Conclusion of Law deemed to be a Finding of Fact or vice versa shall be appropriately incorporated into the Findings of Fact or Conclusions of Law as the case may be;
2. The BMOE has subject matter jurisdiction over the parties in this matter under SDCL 36-4B.
3. The allegations contained in the staff Petition are supported by clear and convincing evidence. Colin Jay Boone has the burden to show good moral character; however, he has failed to provide information and evidence as requested by the Board. SDCL 36-4B-6 and 36-4B-31. See In the Matter of Brett Jarman 2015 S.D 8
4. Colin Jay Boone's application is not complete due to his failure to supply the requested information, and he has exceeded the time allowed by rule to complete his application.

5. Timely notice has been provided to Colin Jay Boone for all hearings pursuant to SDCL 1-26 and ARSD 20:78:05:04.

RECOMMENDATION

It is the recommendation of the hearing examiner that Colin Jay Boone's application for advanced life support student status be denied.

Dated this 9th day of April, 2015.

By: _____
Paul Henry

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

* *

IN THE MATTER OF THE SOUTH DAKOTA BOARD OF MEDICAL & OSTEOPATHIC EXAMINERS: DENIAL OF APPLICATION FOR ADVANCED LIFE SUPPORT STUDENT STATUS
RE: COLIN JAY BOONE

NOTICE OF HEARING

* *

Please take notice that a contested case hearing has been scheduled before the South Dakota Board of Medical and Osteopathic Examiners in the above captioned matter. The hearing will take place on Thursday, June 11, 2015, in the Board Conference Room, 101 N. Main Ave., Suite 215, Sioux Falls, SD.

Dated this 15th day of April, 2015.

William H. Golden, esq.
Assistant Attorney General/Civil Litigation Division
317 N. Main Ave.
Sioux Falls, SD 57104
Attorney for the South Dakota Board of Medical and Osteopathic Examiners
(605) 201-8588

STATE OF SOUTH DAKOTA
DEPARTMENT OF HEALTH
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

STATE OF SOUTH DAKOTA)
: SS
COUNTY OF MINNEHAHA)

SUBPOENA

DUCES TECUM

TO: Colin Jay Boone
3409 51st #414
Sioux Falls, SD 57106

In the matter of: In Re: Colin Boone, Docket #14-189

GREETINGS

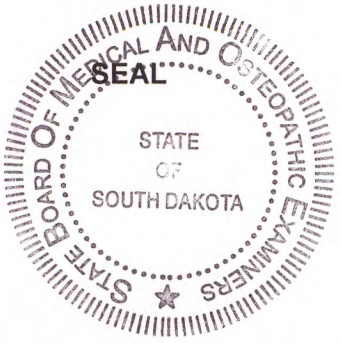
YOU ARE HEREBY COMMANDED to be and appear at the office of the South Dakota Board of Medical and Osteopathic Examiners, 101 N. Main Ave., Suite 301, Sioux Falls, SD, 57104, at 10:00AM on January 5, 2015, then and there to give testimony on the part of the South Dakota Board of Medical and Osteopathic Examiners, in the matter noted above which is an administrative proceeding pending before the South Dakota Board of Medical and Osteopathic Examiners.

You are further commanded to produce for examination at the time, date and place stated above, the following:

Any and all police reports, videos and records of disciplinary action you were subject to as a police officer and any and all documentation on the current federal charges

In lieu of your appearance as above stated, you may, on or before 10:00AM on January 5, 2015, mail or otherwise deliver to the undersigned legible copies of the documents and items you are commanded to produce in response to this subpoena. If such documents and items are produced in advance of the date and time set for your appearance, your appearance will not be required.

WITNESS, the Hand and Seal of the South Dakota Board of Medical and Osteopathic Examiners on December 22, 2014.



Margaret B. Hansen, Executive Director
South Dakota Board of Medical & Osteopathic Examiners

1 SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

2 *

3 IN THE MATTER OF: * TRANSCRIPT OF

4 THE LICENSE APPLICATION OF * HEARING

5 COLIN JAY BOONE *

6 *

7 BEFORE: Mr. Paul E. Henry, Hearing Examiner
300 North Dakota Avenue, Suite 216
8 Sioux Falls, South Dakota 57104

9 APPEARANCES: Mr. William H. Golden
Assistant Attorney General
10 317 North Main Avenue

11 Sioux Falls, South Dakota 57104

12 Attorney for the South Dakota Board of
Medical and Osteopathic Examiners.
13
ALSO PRESENT: Ms. Margaret B. Hansen, PA-C, MPAS
14 Executive Director
South Dakota Board of Medical and Osteopathic
15 Examiners

16 Ms. Misty Rallis
Board Investigator
17 South Dakota Board of Medical and Osteopathic
Examiners
18
Mr. Sean Levy
19
PROCEEDINGS: The above-entitled matter came on for hearing
20 on the 6th day of February, 2015, commencing
at the hour of 9:00 a.m. at the offices of
21 the South Dakota Board of Medical and
Osteopathic Examiners, Sioux Falls, South
22 Dakota.

23

* * * * * * * * * * *

24

25

INDEX TO WITNESSES

	Direct	Cross	Redirect	Recross
FOR THE BOARD:				
MISTY RALLIS				
By Mr. Golden:	6		24	
By Mr. Boone:		23		
By Hearing Examiner Henry:	25			
FOR THE APPLICANT:				
COLIN J. BOONE				
By Mr. Boone:	27		33	
By Mr. Golden:		31		
SEAN LEVY				
By Mr. Boone:	35			
By Mr. Golden:		36		

Closing Statement by Mr. Golden: 40, 48
Closing Statement by Mr. Boone: 46
Recommendation by Hearing Examiner Henry: 50

INDEX TO EXHIBITS

BOARD EXHIBITS

NUMBER	DESCRIPTION	MARKED	OFFERED	RULED ON
1	Application.	4	9	9
2	Recommendation letter.	4		
3	Petition.	4	16	16
4	Notice.	4	16	17
5	(Not marked.)			
6	Subpoena.	4	15	15
7	Brief.	4		

INDEX TO EXHIBITS (Continued)

NUMBER	DESCRIPTION	MARKED	OFFERED	RULED ON
8	Superseding Indictment.	4	14	14
9	Government's Trial Brief.	4	14	14
10	Defendant's Trial Memorandum; Response to Govt's Motion.	4	14	14
11	Order.	4	14	14
12	09/22/14 SDBMOE letter.	4	11	11
13	10/20/14 SDBMOE notice letter.	4	12	12
14	Online article.	4	19	21

APPLICANT EXHIBITS

LETTER	DESCRIPTION	MARKED	OFFERED	RULED ON
A	01/29/15 Cowman letter.	4	30	31
B	Iowa's Top Cops award.	4	30	31
C	Award of Valor letter.	4	30	31
D	Boone resume.	4	30	31
E	Fed Ex envelope.	4	30	31

Original transcript and exhibits provided to the South Dakota Board of Medical and Osteopathic Examiners.

1 (Board Exhibit Numbers 1, 2, 3, 4, 6, 7, 8, 9, 10,
2 11, 12, 13, and 14 marked for identification.)
3 (Applicant Exhibits A, B, C, D, and E marked for
4 identification.)
5 HEARING EXAMINER HENRY: At this juncture then let's
6 go on the record with the matter of Colin Jay Boone.
7 Would the parties note their appearance, please?
8 MR. GOLDEN: William Golden on behalf of the Medical
9 Board Staff.
10 MR. BOONE: Colin Boone on behalf of myself.
11 HEARING EXAMINER HENRY: Very well. Mr. Boone, you
12 may know that these matters are deemed confidential.
13 There won't be other members allowed in unless you grant
14 permission or in part waive confidentiality. May I
15 assume that's what you're doing because also present is
16 Mr. Sean Levy and he is present in the room?
17 MR. BOONE: Yes, sir.
18 MR. GOLDEN: This is a paramedic's license and their
19 hearings are actually public.
20 HEARING EXAMINER HENRY: This is a public matter?
21 MR. GOLDEN: This is a public one.
22 HEARING EXAMINER HENRY: I stand corrected. Thank
23 you, Mr. Golden. This is a public matter.
24 Next if I could just direct a couple things. Let's
25 talk about notice. Mr. Golden, when would you contend

1 that notice was provided in the case?
2 MR. GOLDEN: We will be offering that as Exhibit
3 Number 4.
4 HEARING EXAMINER HENRY: Good, I won't go into it at
5 this juncture. Let's then proceed. Mr. Golden, would
6 you like to proceed first?
7 MR. GOLDEN: Yes, Your Honor. This is an application
8 case, which means that Mr. Boone has the burden of proof
9 by a preponderance. So at this point in time we would be
10 willing to proceed and go first.
11 HEARING EXAMINER HENRY: Well, generally we wouldn't
12 do that. Generally we would have the party bearing the
13 burden typically go first. However, given the fact that
14 you're law trained and perhaps Mr. Boone doesn't have the
15 degree of law training that you have had, maybe that
16 would be beneficial in this case that you could outline
17 your position and certainly anything could be addressed
18 in rebuttal if you wish to go back on the record. Do you
19 think that's adequate and fair under the circumstances
20 here?
21 MR. GOLDEN: I have no objections so long as
22 Mr. Boone has no objections to it.
23 HEARING EXAMINER HENRY: In essence, of course, with
24 all that rambling what I'm opting for him to do is give a
25 free shot for Mr. Golden so you can see where the Board

1 sits on the matter. Generally you just have to talk and
2 it might be more difficult if you don't really have a
3 great familiarity with how legal proceedings take place.
4 With that in mind, no objection to that?
5 MR. BOONE: No objection, sir.
6 HEARING EXAMINER HENRY: Mr. Golden, will you proceed
7 then?
8 MR. GOLDEN: Thank you. I would call Misty Rallis.
9 MISTY RALLIS,
10 called as a witness at 9:03 a.m., having been first duly
11 sworn, testified as follows:
12 DIRECT EXAMINATION
13 BY MR. GOLDEN:
14 Q Misty, would you please introduce yourself to the Hearing
15 Examiner?
16 A I am Misty Rallis, the Board Investigator for the South
17 Dakota Board of Medical and Osteopathic Examiners.
18 Q What is your training and education?
19 A I am a licensed Registered Nurse.
20 Q And where did you go to school at?
21 A The University of South Dakota.
22 Q And what year did you graduate?
23 A December of 2013.
24 Q And as the Board Investigator what are your duties?
25 A I receive files based off of an application or a

1 complaint and then gather the information on that
2 application or complaint, and then complete a report
3 based off of the information gathered.
4 Q Do you make recommendations in those reports?
5 A I do not.
6 Q Where do the reports go to?
7 A The reports go to the Executive Director and then are
8 disseminated to a review panel.
9 Q And what is the review panel made up of, who?
10 A The review panel is made up of a Board member.
11 Q And that Board member makes the recommendation and the
12 decision in the case?
13 A Yes.
14 Q Now, how did the matter of Colin Boone come to your
15 attention?
16 A I received the file after Mr. Boone applied for a student
17 status for EMT.
18 Q What is student status for EMT?
19 A Student status allows them while they are in their
20 program to do their ride alongs in the ambulance and to
21 be able to complete their testing.
22 Q Is Colin Boone currently licensed in South Dakota for any
23 medical profession?
24 A Not to my knowledge.
25 Q I'm going to show you what's been marked as Exhibit 1.

1 May I display the exhibit for purposes of laying
2 foundation?
3 HEARING EXAMINER HENRY: You may.
4 Q Do you recognize what Exhibit 1 is?
5 A Exhibit 1 is Mr. Boone's Application for Advanced Life
6 Support, Student Status.
7 Q Is this application a general application that is used?
8 A Yes.
9 Q Which licensees use this general application?
10 A All of our licensees use the same general application.
11 Q Do they ask questions in the application as far as if
12 someone is involved in any legal proceedings?
13 A Yes.
14 Q Have you reviewed the application in this matter?
15 A Yes.
16 Q Is this something that is regularly filled out and then
17 supplied to the Board?
18 A Yes.
19 Q Is that the beginning of the licensing application
20 process?
21 A Yes.
22 Q Have you reviewed Exhibit Number 1?
23 A Yes.
24 Q Is that Mr. Boone's application?
25 A Yes.

1 MR. GOLDEN: I would offer Exhibit Number 1?
2 HEARING EXAMINER HENRY: Do you have any objection to
3 the exhibit being considered by me and eventually by the
4 Board?
5 MR. BOONE: No, sir.
6 HEARING EXAMINER HENRY: Exhibit 1 is received.
7 BY MR. GOLDEN:
8 Q I would turn your attention to Page 3 of the exhibit,
9 Question Number 8. Did Mr. Boone go ahead and answer
10 Question 8 "yes"?
11 A Yes.
12 Q What's the significance of that?
13 A On this when he answered "yes", he reported that he was
14 charged with a civil rights violation from an incident
15 when working with the Des Moines Police Department.
16 Q Right off the bat have you -- is that a correct statement
17 concerning Mr. Boone?
18 A Could you rephrase that question?
19 Q Does that question, from your investigation, is that a
20 true statement of what -- is that reporting truthful,
21 does it follow with what you know?
22 A Yes, he was cited on a civil rights violation or charged
23 with a civil rights violation.
24 Q So on his application he truthfully reported the
25 information?

1 A Correct.
2 Q Based on that, did you go ahead and begin an
3 investigation?
4 A Board staff sent Mr. Boone an amendment requesting
5 additional information on what he reported on his
6 application.
7 Q And what is that called when the Board staff requests
8 additional information?
9 A An amendment.
10 Q I'm now going to show you what's been marked as Exhibit
11 Number 12. I did not put in Number 12. So the
12 amendment -- I believe you have the Number 12 in the
13 exhibits, I just don't have it in Trial Director.
14 Exhibit Number 12, the amendment, what is that?
15 A The amendment was sent to Mr. Boone requesting a detailed
16 explanation regarding the civil rights violation that he
17 reported on his application. And then we also asked him
18 to provide any copies of police reports, court documents
19 regarding this, and his Nebraska criminal history or the
20 state in which it occurred.
21 Q Okay. Did Mr. Boone respond to that?
22 A Mr. Boone responded, which is the second page of the
23 exhibit, supplying us with the Indictment for the Count 1
24 of unreasonable use of force.
25 Q Now, is this a standard form that's used by the Board?

1 A Yes.
2 Q Is this sent out when the Board has questions concerning
3 an application?
4 A Yes.
5 MR. GOLDEN: I would offer Exhibit Number 12 at this
6 time.
7 HEARING EXAMINER HENRY: Mr. Boone, do you have any
8 objection to the exhibit?
9 MR. BOONE: No, sir.
10 HEARING EXAMINER HENRY: Very well. Exhibit 12 is
11 received.
12 BY MR. GOLDEN:
13 Q I would direct your attention on Number 12 to the portion
14 that's highlighted there.
15 HEARING EXAMINER HENRY: Ms. Rallis, can you use the
16 Trial Director and can I see the paper one?
17 A Yes, I can, now that it's up.
18 HEARING EXAMINER HENRY: Thank you.
19 BY MR. GOLDEN:
20 Q Besides the Indictment, was there any other information
21 that was provided?
22 A No.
23 Q Was there an explanation that was provided?
24 A No.
25 Q After receiving the amendment, did this matter come to

1 your attention?
2 A Yes.
3 Q And upon it coming to your attention, what did you do
4 next?
5 A At that time I sent Mr. Boone a notice that his
6 application was being placed under investigation.
7 Q Is that a normal part of the procedure?
8 A Yes.
9 Q Do you recognize what I am showing you now marked as
10 Exhibit Number 13?
11 A Yes.
12 Q What is that?
13 A That's the notice letter that I sent to Mr. Boone.
14 Q And what date was that sent on?
15 A October 20, 2014.
16 MR. GOLDEN: I would offer Exhibit Number 13 at this
17 time.
18 HEARING EXAMINER HENRY: Mr. Boone?
19 MR. BOONE: No objection.
20 HEARING EXAMINER HENRY: Exhibit 13 is received.
21 BY MR. GOLDEN:
22 Q After you sent the letter what did you do next, did you
23 begin your investigation?
24 A Yes, at that point after sending that letter and I had
25 reviewed the application and the amendment response.

1 Q At some point did you get some court documents?
2 A Yes.
3 Q What documents did you go ahead and -- how did you get
4 the court documents?
5 A I obtained the court documents through Pacer.
6 Q What is Pacer?
7 A It's an online judiciary system to look up federal
8 charges.
9 Q And what state were you looking?
10 A Iowa.
11 Q From the Iowa system did you go ahead and obtain any
12 documents?
13 A I obtained the Government's brief, I obtained the
14 Indictment, I obtained Mr. Boone's brief, and an Order
15 for the trial.
16 Q I'm going to show you what's been marked as Exhibit
17 Number 8. Do you recognize what that is?
18 A That is the Indictment.
19 Q I am now showing you what's Exhibit Number 9. Do you
20 recognize what that is?
21 A Yes.
22 Q What is that?
23 A That's the Government's trial brief.
24 Q Do you recognize what I'm showing you is Exhibit Number
25 10?

1 A That's the Defendant's trial memorandum and response to
2 the Government's motion.
3 Q And all of these, Exhibit Number 8, 9, and 10, were all
4 obtained off of the federal Pacer website and are
5 documents that were filed with the Court?
6 A Yes.
7 MR. GOLDEN: I would offer Exhibit Number 8, 9, and
8 10.
9 HEARING EXAMINER HENRY: Mr. Boone?
10 MR. BOONE: No objection.
11 HEARING EXAMINER HENRY: Those exhibits are received,
12 Numbers 8, 9, and 10.
13 Q I am now showing you what is Exhibit 11. Do you
14 recognize what that is?
15 A Yes. That is the Order that I received off of the Pacer
16 website.
17 Q And the same way you received the other documents from
18 the Federal Court?
19 A Correct.
20 MR. GOLDEN: I would offer Exhibit Number 11 at this
21 time.
22 MR. BOONE: No objection.
23 HEARING EXAMINER HENRY: With no objection to 11, it
24 will be received. However, I would feel better if I held
25 it in my hands. How many pages do you have on that one,

1 do you know?
2 MR. GOLDEN: Two. We can print it for you if you
3 would like.
4 HEARING EXAMINER HENRY: Can I see the second page,
5 please? Thank you. That was 12?
6 MR. GOLDEN: That would be 11.
7 HEARING EXAMINER HENRY: Exhibit 11 is received.
8 BY MR. GOLDEN:
9 Q At some point in time during your investigation did you
10 issue, have a Subpoena issued by the Executive Director
11 in this matter?
12 A Yes.
13 Q What was the purpose for issuing the Subpoena?
14 A The Subpoena was sent and requested all of the court
15 documents, any police videos that pertained to the
16 Indictment in Iowa.
17 Q I'm now showing you what's marked as Exhibit Number 6.
18 Do you recognize what that is?
19 A Yes. That's the cover letter that went out for the
20 Subpoena and the Subpoena is the second page, and then I
21 believe the confirmation of delivery is the third page.
22 MR. GOLDEN: I would offer Exhibit Number 6 at this
23 time.
24 MR. BOONE: No objection.
25 HEARING EXAMINER HENRY: Exhibit 6 is received.

1 Q I'm going to show you what is Exhibit Number 3. Do you
2 recognize what Exhibit Number 3 is?
3 A Exhibit 3 is the cover letter and the Petition that was
4 sent to Mr. Boone.
5 Q And was there also a Fed Ex receipt with that as well, or
6 is it an e-mail?
7 A There is a -- it was e-mailed and mailed. I do not
8 believe that was sent by Fed Ex.
9 MR. GOLDEN: I would offer Number 3 at this time.
10 MR. BOONE: No objection.
11 HEARING EXAMINER HENRY: Exhibit 3 is received.
12 Q I'm now showing you what's been marked as Exhibit Number
13 4. Do you recognize what that is?
14 A That is the Notice of Hearing that was sent to Mr. Boone.
15 Q And the first page that is showing there, what is that?
16 A The first page is the cover letter just stating that the
17 hearing has been scheduled and the second page is the
18 Notice of Contested Case.
19 Q And what was the date that it was sent?
20 A Could you go back to the top? Is it the 18th?
21 December 18th, 2014.
22 Q And the final page on the exhibit?
23 A Is the e-mail showing that it was e-mailed and both
24 regular mailed.
25 MR. GOLDEN: I would offer Exhibit Number 4 at this

1 time.
2 HEARING EXAMINER HENRY: Any objection?
3 MR. BOONE: No objection.
4 HEARING EXAMINER HENRY: Exhibit 4 is received.
5 Q I am now going to show you what's been marked as Exhibit
6 Number 2. Do you recognize what that is?
7 A The recommendation letter that was sent.
8 Q What is a recommendation letter?
9 A The recommendation letter was written after the Board
10 member made their recommendation on the file. So this
11 was to notify Mr. Boone that the Board would be
12 recommending the denial of his EMT student status
13 application.
14 Q Now, you have previously testified as to what the Board
15 member would be reviewing, which was your report?
16 A Correct.
17 Q And when you're investigating an applicant, do you ask
18 for information from the applicant?
19 A Yes.
20 Q In this case did you ask for information from Mr. Boone?
21 A Information was asked from Mr. Boone in the amendment
22 letter that was prior to me starting my investigation,
23 and information was also asked in the Subpoena sent to
24 him.
25 Q Was there any information that was supplied from the

1 Subpoena?
2 A No.
3 Q And we have already reviewed what was supplied in the
4 amendment?
5 A Yes.
6 Q Based on the information that was provided to you, was
7 that sufficient to complete your investigation of the
8 underlying allegations of excessive force when he was a
9 police officer?
10 A No.
11 Q Based on -- was that information that he supplied -- that
12 he supplied to the Board member through your report then?
13 A What -- would you ask the question again?
14 Q The information that you didn't receive.
15 A If I didn't receive it, it was not presented to the Board
16 member, is that what you're asking?
17 Q What I am asking is: Was the Board member aware the
18 information wasn't provided that was requested?
19 A I believe with the amendment response, yes, they were
20 notified that that was not provided.
21 Q So the information that was provided would have been
22 consistent with the court documents, the Subpoena and the
23 amendment, and that was supplied -- that was the extent
24 of your investigation?
25 A Yes.

1 MR. GOLDEN: I have no further questions.
2 HEARING EXAMINER HENRY: Hold on for just a minute,
3 Mr. Boone.
4 MR. BOONE: Yes.
5 MR. GOLDEN: I missed one.
6 HEARING EXAMINER HENRY: That's fine, Mr. Golden.
7 You may proceed. Again, no harm can come of you
8 continuing on at this juncture.
9 DIRECT EXAMINATION
10 BY MR. GOLDEN (Resumed):
11 Q Exhibit Number 14, did you do an online search concerning
12 Mr. Boone?
13 A Yes.
14 Q And what -- did you find any information from your
15 search?
16 A There was a news article.
17 Q And I'm showing you now Exhibit Number 14. Are you
18 familiar with that?
19 A Yes.
20 Q Is that the information that you found concerning
21 Mr. Boone's charges in Iowa?
22 A Yes.
23 MR. GOLDEN: I would offer Exhibit Number 14 at this
24 time.
25 HEARING EXAMINER HENRY: Mr. Boone, have you had the

1 opportunity to see all of Exhibit Number 14?
2 MR. BOONE: No, I haven't looked at Number 14, no.
3 HEARING EXAMINER HENRY: Mr. Golden, have you
4 supplied him with a copy of the paper Number 14?
5 MR. GOLDEN: I did not, Your Honor. I did go ahead
6 and forward him a copy or an opportunity to review them
7 prior to the hearing, but I would have --
8 HEARING EXAMINER HENRY: I will hand him Exhibit
9 Number 14 at this juncture so he can review the exhibit.
10 I guess Trial Director could have done that as well.
11 While that happens, let's go off the record briefly.
12 (Discussion off the record from 9:24 a.m. to 9:25
13 a.m.)
14 HEARING EXAMINER HENRY: Let's go back on the record.
15 Mr. Boone now has had the time to review those documents,
16 the exhibit. Do you have any objection to Exhibit 14?
17 MR. BOONE: I would object to that one.
18 HEARING EXAMINER HENRY: And what is the reason for
19 your objection?
20 MR. BOONE: Factual basis.
21 HEARING EXAMINER HENRY: What do you mean by that?
22 MR. BOONE: I don't know where that person got their
23 information. I don't believe it's a factual account of
24 what happened. It's not a trial. A newspaper person or
25 editor does not have to -- they can print what they

1 believe happened, they don't have to print what actually
2 happened. From what I read in there, and if you look at
3 that compared to what was in the court documents, there
4 was several areas that are not consistent.
5 HEARING EXAMINER HENRY: For those reasons and more I
6 will sustain the objection. Would you like to offer it
7 for any other reasons, Mr. Golden, than the ones proposed
8 just generally?
9 MR. GOLDEN: Your Honor, we were going to have a very
10 narrow scope that we are offering this for.
11 HEARING EXAMINER HENRY: What would that scope be?
12 MR. GOLDEN: The scope first, Your Honor, is there is
13 a picture of the alleged victim that is attached.
14 Second, Your Honor, we are not going to be asking the
15 Hearing Examiner in this matter to make any ruling
16 concerning the underlying accusation. And as such, we
17 are not asking for this to come in for the purpose of
18 substance. We are asking for the fact that this is an
19 event, there is information that is clearly out there,
20 some of this information is in the court documents as
21 well, we are not going to ask you in the court documents
22 to make a substantive finding on truth.
23 We are offering this as evidence of one, for the
24 picture of the victim in the case; two, for the purposes
25 of additional information that the event occurred and is

1 part of the attempted investigation; and also to show
2 partially that we lack information and this is what we --
3 this is some of the information that the Board had and is
4 the reason for requesting the additional information that
5 wasn't provided. So we are not asking for the truth of
6 the matter asserted. We are just strictly saying this is
7 justification for requesting additional information.
8 HEARING EXAMINER HENRY: I'm going to sustain the
9 objection. I could elaborate on the reasons, but there
10 are many reasons. We don't have any information
11 suggesting what's portrayed here is true and certainly
12 the Board wouldn't have the opportunity to have the
13 people come and testify and be subject to
14 cross-examination. There is nothing contained in here
15 that would assure this body and the Defendant that the
16 picture is accurate, who took the picture, what may have
17 been done to the picture to enhance it, and if that's
18 truly and accurately the way that the alleged victim did
19 appear. Because of that, I see some possible prejudicial
20 effect. I will sustain the objection based in part on
21 what I have just elaborated.
22 MR. GOLDEN: Thank you, Your Honor. Now we are done
23 with our presentation.
24 HEARING EXAMINER HENRY: Mr. Boone, you now have the
25 opportunity to do some cross-examination of the

1 investigator if you wish.
2 MR. BOONE: I just have a few questions.
3 HEARING EXAMINER HENRY: You may proceed.
4 CROSS-EXAMINATION
5 BY MR. BOONE:
6 Q When that case was turned in, who turned in that
7 application with the statements about the incident that
8 happened?
9 A The application shows that it was submitted by you.
10 Q Okay. And the charge that you first received, who turned
11 that in?
12 A With the amendment response, is that what you're asking?
13 Q The first charge that you received from the initial
14 explanation or the request for the initial explanation of
15 what happened.
16 A With the request for the amendment request, is that --
17 Q Yeah, who turned the charge in to you?
18 A We received that from you, the amendment response.
19 MR. BOONE: That's all I have.
20 HEARING EXAMINER HENRY: Ms. Rallis, the amendment
21 response you're specifically referring to is what?
22 THE WITNESS: That second -- the amendment was sent,
23 the first page, requesting the information, Exhibit 12.
24 HEARING EXAMINER HENRY: Very well.
25 THE WITNESS: The second page of that is what he

1 provided for his response.
2 MR. GOLDEN: For clarification, may I ask one
3 question?
4 HEARING EXAMINER HENRY: Yes, Mr. Golden.
5 REDIRECT EXAMINATION
6 BY MR. GOLDEN:
7 Q Ms. Rallis, when you're saying first page, you're talking
8 about Exhibit 12, and that would be the amended response
9 that was sent to Mr. Boone?
10 A Correct. We sent him the first page as a blank page, and
11 then he signed that page, returned it to us with that
12 second page.
13 Q And the second page would be referring to the Indictment?
14 A The Indictment, yes.
15 MR. GOLDEN: Thank you.
16 HEARING EXAMINER HENRY: Hold on for a moment,
17 please. Ms. Rallis, explain to me the "Sent to client"
18 note on that Exhibit 12, second page. "Sent to client
19 1-3-14." What is that mark and what does it mean?
20 THE WITNESS: That is not our note so I do not know
21 where that came from.
22 MR. BOONE: Sir, may I comment on that?
23 HEARING EXAMINER HENRY: Yes, go ahead.
24 MR. BOONE: That was from the court system when I was
25 served with that.

1 HEARING EXAMINER HENRY: Are you saying that you were
2 served with an Indictment on January 3, 2014, or what are
3 you saying?
4 MR. BOONE: It was sent to me in the mail on that
5 date, the actual form was.
6 HEARING EXAMINER HENRY: And by "form", are you
7 talking about the Indictment?
8 MR. BOONE: Yes, sir.
9 EXAMINATION
10 BY HEARING EXAMINER HENRY:
11 Q Ms. Rallis, I see that the September 22, 2014, date
12 appears at the top of the Exhibit 12. Is that the date
13 that you prepared and sent the document?
14 A That's the date the Board staff sent it, yes.
15 Q So it was sent by the Board staff?
16 A September 22, 2014. And then I believe the date on his
17 signature when he returned it was September 30, 2014.
18 Q And it was your testimony that he returned to you a copy
19 of the Indictment which was attached to Exhibit 12; is
20 that correct?
21 A Correct.
22 Q And do you know the date that he sent you the Indictment?
23 A I believe that would be that September 30, 2014, the date
24 that he signed.
25 Q Oh. I thought that was the receipt date by him, he

1 acknowledged receipt on that date.
2 A That would have been the -- I'm not sure if that was the
3 date he sent it to us or if that -- I don't have the date
4 which it was received in our office. I would have to
5 look.
6 Q That's fine. I don't need that information if it's not
7 available by you testifying. If you don't know, that's
8 fine.
9 MR. BOONE: Sir, I could actually answer your
10 question.
11 HEARING EXAMINER HENRY: I don't think I'm going to
12 need it. Thanks. Do you have any other questions for
13 this witness?
14 MR. BOONE: No, sir.
15 HEARING EXAMINER HENRY: Mr. Golden, do you have any
16 redirect for your witness?
17 MR. GOLDEN: None, Your Honor.
18 HEARING EXAMINER HENRY: Well, at this time then we
19 are done with you. Thank you for your testimony.
20 (Whereupon, the witness was excused at 9:35 a.m.)
21 HEARING EXAMINER HENRY: Mr. Golden, do you have
22 anything further?
23 MR. GOLDEN: No.
24 HEARING EXAMINER HENRY: Mr. Boone, how would you
25 like to proceed at this juncture? Do you want to call a

1 witness or do you want to be sworn in and testify, what
2 would you like?
3 MR. BOONE: I would like to be sworn in and testify
4 first.
5 HEARING EXAMINER HENRY: Very well.
6 MR. GOLDEN: Could we go off the record for a second?
7 HEARING EXAMINER HENRY: We can.
8 (Discussion off the record from 9:35 a.m. to 9:36
9 a.m.)
10 HEARING EXAMINER HENRY: Let's go back on the record
11 in the matter. Mr. Boone, would you please stand and be
12 sworn in?
13 COLIN J. BOONE,
14 called as a witness at 9:36 a.m., having been first duly
15 sworn, testified as follows:
16 HEARING EXAMINER HENRY: Mr. Boone, tell us what it
17 is you would like us to hear.
18 DIRECT TESTIMONY
19 MR. BOONE: The first thing I would like to bring up
20 is about the Subpoena. If you look at the Exhibit E that
21 I produced for the Court, it's an envelope from Fed Ex.
22 That was when the Subpoena was delivered to my residence.
23 If you notice on the little yellow sticker on the front,
24 that's that big Fed Ex envelope, the first one. If you
25 notice the top little sticker on the delivery date, it

1 was 12/31. On 12/30 I left to go to Minneapolis, I spent
2 I believe three days up there. And then I go straight to
3 work, which is over in Chamberlain. I did not get that
4 package until Monday, January 5, at 3:00 is when I get
5 back from work.
6 If you look at the Subpoena, I was supposed to
7 produce those documents that morning at 10:00. I did not
8 receive the Subpoena until after when I was supposed to
9 appear and produce that evidence. So therefore, it
10 almost would have been impossible for me to produce that
11 evidence at that time.
12 At 3:00 on the 5th I read the Subpoena. I went ahead
13 and called my attorney and I also spoke with the judge
14 presiding over the case and told them I had a Subpoena to
15 produce the information. They both told me that if they
16 needed that information that the Board would have to
17 Subpoena that.
18 On the 6th, January 6, I went into the Board's office
19 and I tried to explain to them that I got the Subpoena
20 after the date of the Subpoena and what the judge and my
21 attorney had told me. The investigator went ahead and
22 told me at that time that Mr. Golden would be contacting
23 me about missing the date.
24 At that time I waited for Mr. Golden to contact me.
25 And then the next thing I know, it's set for hearing and

1 they said I didn't cooperate with the Subpoena.
2 If I had any of the information, I would have
3 produced it. I do not have any of that information that
4 they requested. I do not have any of the videotapes on
5 it. I do not have any of the police reports. Basically
6 all I have is the charges and the continuations of my
7 court dates because it was continued several times.
8 That's all I have.
9 So I feel if I would have had it, I would have
10 cooperated with you because it's only beneficial for me
11 to cooperate with them so I can try to get my student
12 status. I couldn't cooperate with their date because I
13 didn't get the Subpoena until after the date it was due.
14 So that's where I kind of am at with the Subpoena.
15 If you go ahead and look at the Exhibits A, B, C, and
16 D, Exhibit A is the letter from my instructor in the
17 class, the advanced EMT class. I have finished all of
18 the classroom portion of it. All I'm waiting on is
19 basically for the student status to do the ride along
20 time and do the field work.
21 B is a form that I produced to you. I believe that
22 their kind of assertion is bad moral character from this
23 charge. If you look at B, it's actually a Congressional
24 Hearing Minutes where I was recognized for heroic
25 measures in 2011 for saving some kids from an accident.

1 And C is the Sullivan Brothers Award that I received
2 and I received it in I think 2012, but it's from the same
3 incident.
4 And then those I think would show the opposite, that
5 I have very good morals and that I was willing to go
6 above and beyond the call.
7 And then D I added was just my resume to show you my
8 work history, some of my education, and show kind of a
9 history of myself.
10 And that's pretty much all I have to testify about
11 today. I just wanted to make you aware of those facts.
12 HEARING EXAMINER HENRY: Are you proposing that the
13 body accept this as an exhibit? I'm holding Exhibit A.
14 Do you propose this as an exhibit to be received by the
15 forum?
16 MR. BOONE: Yes, sir.
17 HEARING EXAMINER HENRY: Mr. Golden, have you had the
18 opportunity to review Exhibit A?
19 MR. GOLDEN: No, Your Honor. If I may.
20 HEARING EXAMINER HENRY: Let me hand you -- because
21 we are going to do the same thing for all of them. I
22 will hand you proposed A, proposed B, C, and D consisting
23 of several pages.
24 MR. GOLDEN: Was the Fed Ex marked as an exhibit?
25 MR. BOONE: Yes, sir. It's E.

1 HEARING EXAMINER HENRY: I will hand you that as
2 well. We can go off the record for a moment, please.
3 (Whereupon, a recess was taken from 9:43 a.m. to 9:54
4 a.m.)
5 HEARING EXAMINER HENRY: Let's go back on the record.
6 At this juncture, Mr. Boone, have you completed -- you're
7 still under oath. Have you completed all the statements
8 you wish to be heard at this juncture?
9 MR. BOONE: Yes, I have.
10 HEARING EXAMINER HENRY: Very well. Mr. Golden, do
11 you have any cross-examination of Mr. Boone?
12 MR. GOLDEN: Briefly. I also have no objections to
13 his exhibits. I believe that's A, B, C, and D.
14 HEARING EXAMINER HENRY: Thank you. I should have
15 asked about that. A, B, C, D, and the envelope was E.
16 Mr. Golden, any thoughts about that?
17 MR. GOLDEN: No objection.
18 HEARING EXAMINER HENRY: All five of the exhibits
19 proposed by Mr. Boone are received. You may go ahead,
20 Mr. Golden.
21 CROSS-EXAMINATION
22 BY MR. GOLDEN:
23 Q I'm going to show you what's been marked as Exhibit
24 Number 12. I'm showing you the highlighted portion.
25 A Yes, sir.

1 Q Between the time of September 22, 2014, and today have
2 you ever supplied a written explanation of what occurred?
3 A No, I haven't.
4 Q Have you supplied any other documentation besides the
5 Indictment?
6 A No, I have not.
7 Q Would you agree with me that the Board has given you
8 numerous opportunities to supply that information?
9 A Numerous? I don't know about numerous, but I would say
10 --
11 Q How about two?
12 A I would say there was two opportunities, yes.
13 Q Okay. And you understand even if the date on the
14 Subpoena you were out of town and you eventually received
15 it on the 5th, you could have still supplied that
16 information at a later date; correct?
17 A I was waiting to be contacted by you to figure out a way
18 of doing that per what the investigator told me that you
19 would be contacting me, and you didn't contact me. Then
20 I got the hearing date with that and I figured I would
21 wait until the hearing and explain what happened because
22 I tried to explain that to the investigator that that's
23 what happened.
24 Q You have an attorney in Iowa who is representing you?
25 A Yes.

1 Q He has that information?
2 A Yes.
3 Q He has the court documents?
4 A Yes.
5 Q You clearly are in contact with him and working with him?
6 A Yes.
7 Q There was a federal trial in this matter on the
8 Indictment and there was I believe a not guilty verdict
9 on one count and a hung jury on the rest?
10 A Yes.
11 Q And you are now waiting for retrial later this year?
12 A Correct.
13 Q So this matter is still pending?
14 A Correct.
15 MR. GOLDEN: No further questions.
16 HEARING EXAMINER HENRY: Very well. Mr. Boone, do
17 you have anything else you would like to offer from what
18 Mr. Golden just asked of you, does that elicit any
19 response that you would like to make? And you're still
20 under oath at this juncture.
21 REDIRECT TESTIMONY
22 MR. BOONE: The only thing I would like to maybe add
23 that you brought up that I would maybe explain to the
24 Court is that the hung jury, I don't know, Mr. Golden
25 might object to this, some of the jurors were questioned

1 and I do -- it was 11 for not guilty and one for guilty
2 and they couldn't come to a deciding factor so it was a
3 hung jury. That's all, the only thing that I forgot to
4 tell you in my opening statement.
5 HEARING EXAMINER HENRY: Very well. Thank you for
6 that.
7 (Whereupon, the witness was excused.)
8 HEARING EXAMINER HENRY: Now, you have brought along
9 with you Mr. Sean -- is it Levy or Levy?
10 MR. LEVY: Levy, sir.
11 HEARING EXAMINER HENRY: Is it L-E-V-Y?
12 THE WITNESS: Yes, sir.
13 HEARING EXAMINER HENRY: You have brought him along
14 with you. Is that for the purpose of having him testify
15 here today?
16 MR. BOONE: Yes, sir.
17 HEARING EXAMINER HENRY: Would you like to proceed
18 with having him testify?
19 MR. BOONE: Yes.
20 HEARING EXAMINER HENRY: Mr. Levy, we'll have you
21 sworn in.
22 SEAN LEVY,
23 called as a witness at 9:55 a.m., having been first duly
24 sworn, testified as follows:
25 HEARING EXAMINER HENRY: Mr. Boone, you may proceed

1 and ask questions of Sean Levy.
2 DIRECT EXAMINATION
3 BY MR. BOONE:
4 Q Mr. Levy, can you explain your history in the EMS field
5 to us?
6 A Sure. I have 20 plus years as an EMT paramedic and
7 retired from the Fire Department back in Atlanta.
8 Q Atlanta, Georgia?
9 A Atlanta, Georgia, yes, sir.
10 Q Have you worked with EMS systems in the state of Iowa?
11 A In Iowa, no.
12 Q Or I'm sorry, I'm used to being in Iowa.
13 A South Dakota.
14 Q South Dakota?
15 A Yes, sir.
16 Q Which ones are those?
17 A I have worked for Med-Star, Rosebud Ambulance Service,
18 and for Crow Creek Ambulance Service.
19 Q And during your working with especially Med-Star and Crow
20 Creek have you had the opportunity to work with Colin
21 Boone?
22 A Yes.
23 Q What kind of working relationship have we had in the
24 past?
25 A We have had a very good working relationship. Very

1 competent EMT, goes above and beyond helping not only
2 with the skills that he can do, but setting up other
3 things that I do as a paramedic.
4 Q Would you have any concern or problems with -- have you
5 ever noticed any concerns or problems with any of the way
6 I've dealt with people when I have been working with you?
7 A No.
8 Q Do you have any concerns with any of the skills that --
9 I'll strike that.
10 Do you believe I'm a hazard to anybody that I would
11 treat as an EMT or an advanced EMT?
12 A As far as I've seen working with you and also as being a
13 friend, no, I don't.
14 MR. BOONE: That's all I have.
15 HEARING EXAMINER HENRY: Very well. Mr. Golden, do
16 you have any questions of Mr. Levy?
17 MR. GOLDEN: Just briefly.
18 CROSS-EXAMINATION
19 BY MR. GOLDEN:
20 Q Would you go ahead and state your name for the record?
21 A Sean T. Levy.
22 Q And where did you go to high school at?
23 A I went to Jonesboro Senior High in Georgia, Jonesboro,
24 Georgia.
25 Q Did you have any education after that?

1 A EMT school, paramedic school.
2 Q Where would that be at?
3 A Well, I did both -- EMT school I went through Atlanta
4 Metropolitan College. And then the Fire Department put
5 on the paramedic school that was also based through the
6 college, but was taught at the Fire Department.
7 Q Do you have a degree from that college?
8 A No. It was just the Certificate of Paramedicine.
9 Q And where did you work after that?
10 A I worked in Atlanta, City of Hayesville Fire Department
11 there in Atlanta.
12 Q And what were your job duties during that time?
13 A Well, they were progressive through the years. I started
14 as a firefighter EMT, then firefighter paramedic, then
15 moved up to Sergeant, and later Lieutenant.
16 Q Okay. At some point you came to South Dakota?
17 A Yes, sir.
18 Q Why was that?
19 A My wife is a nurse and did travel nursing and went to
20 Texas for a year, and then ended up in South Dakota. She
21 actually took a job with IHS through a contract. We
22 lived on the reservation there for two years and I worked
23 as a paramedic there in Rosebud. Once her contract was
24 up, we moved to South Dakota and I started working at
25 Med-Star and then went to Crow Creek also. Med-Star was

1 a part-time job, I was still working at Rosebud, Crow
2 Creek.
3 Q Can I stop you there? Which years are you talking about?
4 A Here in the last three years.
5 Q Okay. Thank you.
6 A And then I left Med-Star and went to Crow Creek and was
7 working both Rosebud and Crow Creek.
8 Q You're licensed with the South Dakota Medical Board?
9 A Yes, sir.
10 Q And how do you know Colin Boone?
11 A I originally knew him through work at Med-Star, and we
12 have become not only co-workers, but friends. So that's
13 how I know him.
14 Q When you say "at work", what type of work?
15 A EMS.
16 Q Okay.
17 A Mr. Boone is an EMT, basic, and I am a paramedic so we
18 work on the truck together, on the ambulance together.
19 Q Okay. And currently where is that at?
20 A We were working at Crow Creek. Since it's so far away I
21 actually work with the South Dakota Department of
22 Corrections now and I'm currently looking for a part-time
23 job working in Sioux Falls as a paramedic. So right now
24 I'm not working as a paramedic, but that's only been over
25 the last couple of weeks. Just the wear and tear on the

1 vehicle and gas prices going back and forth, I was going
2 200 some miles and then going over working and driving
3 160 some miles back home so it was just too much being
4 away from the family.
5 Q So how long did you actually work with Mr. Boone?
6 A Over a year.
7 Q And what opportunities did you have to see him actually
8 out in the field?
9 A We were on the truck together quite a few times and
10 running calls together. You know, I would put his skills
11 up -- I'm no expert, but 20 plus years -- I would put his
12 skills up against any EMT and think that he would be an
13 asset to the state.
14 He has already had the educational portion of the
15 training. But with the osteopathic license to get the
16 actual physical training to be able to do the skills that
17 he has been trained in class for, I think he would be an
18 asset, not only to the reservation, but to the state of
19 South Dakota.
20 Q You are not aware of -- you don't have any of the facts
21 or anything, you weren't involved or have any of the
22 facts that occurred down in Iowa?
23 A No, sir, I do not. I didn't know Mr. Boone when that --
24 Q So you're not here to testify about any of that?
25 A No, sir, I am not.

1 MR. GOLDEN: All right. I have no further questions.
2 HEARING EXAMINER HENRY: Very well. Mr. Boone, based
3 on what Mr. Golden asked, do you have anything further to
4 ask of Mr. Levy?
5 MR. BOONE: No, sir.
6 HEARING EXAMINER HENRY: Mr. Levy, then that will
7 conclude our questioning of you.
8 (Whereupon, the witness was excused.)
9 HEARING EXAMINER HENRY: And at this juncture, back
10 to you, Mr. Boone. Do you have anything else that you
11 wish to add, any further witnesses or exhibits you would
12 like to discuss?
13 MR. BOONE: I do not, sir.
14 HEARING EXAMINER HENRY: Then at this juncture we
15 will have the opportunity to make some arguments by both
16 sides. Mr. Golden, typically you would probably have the
17 opportunity to go last. However, in this circumstance
18 for the reasons stated before, I'm going to ask you to go
19 first if you would, please.
20 MR. GOLDEN: Thank you, Your Honor. Your Honor, I
21 direct your attention to Exhibit Number 4. Your Honor,
22 this is a rather unusual situation where somebody is
23 facing -- I may have pulled up the wrong exhibit for you.
24 This is an unusual situation, Your Honor, because
25 Mr. Boone is facing a federal Indictment down in Iowa. I

1 understand that he has went through trial once and there
2 is a hung jury. Clearly since there is a second trial
3 coming up, this is a felony charge, there is uncertainty
4 about what his status will be following that trial. He
5 may be successful, he may not be successful.
6 But having said that, even if he is successful or
7 unsuccessful, this is an event by its very nature that
8 involved a traffic accident, that involved an individual
9 who was being arrested by law enforcement, and there is
10 some dispute according to the records as to what his
11 status was as far as medical condition.
12 We are not arguing about the truth or veracity of any
13 of those facts. However, that is something that would be
14 reviewed normally by the Board member in order to
15 determine whether or not those events would have any
16 bearing on his future licensing. It specifically bears
17 on whether or not when Mr. Boone responds to a crisis or
18 situation that involves an individual who is either in
19 some type of distress, how he handles that situation.
20 And so the underlying facts, not necessarily if there is
21 a conviction or even if there is an acquittal, would
22 still be something that the Board would evaluate in
23 determining whether or not Mr. Boone is appropriate for a
24 license.
25 The current State of South Dakota law places the

1 burden on the applicant to show good moral character.
2 This is one of those situations where a felony -- the
3 state typically will argue or the Board argues that a
4 felony by its general nature shows bad moral character.
5 The Supreme Court has just I believe within the last
6 couple of days issued a decision stating that the State
7 can still rely, even if there isn't a conviction in a
8 case, on the underlying facts to determine it.
9 The problem here today is Mr. Boone has been afforded
10 the opportunity first in the application, second in the
11 amendment -- we can split hairs over when he was served
12 the Subpoena and whether or not he had opportunity to go
13 ahead and supply those documents. But at any point in
14 time the purpose of that Subpoena was to give him notice
15 the Board wants this information. They can't accept --
16 they cannot finish his application because the Board does
17 not consider it to be a complete application if it
18 doesn't have all of the necessary information in order to
19 determine who Colin Boone is, what his moral character
20 is, what his status is. And our courts have made it
21 fairly clear the person who typically has this
22 information is the applicant. They hold the burden.
23 They need to provide that information.
24 And so the first argument from the Staff and the
25 Board is this is an incomplete application and as such,

1 there is no action that can be taken because the
2 information is requested, it hasn't been supplied, and as
3 such, we have passed the 120 days that by rule, unless
4 somebody asks for an extension for that time period, then
5 the application is closed. And so that would be the
6 first argument, is that this is a situation where it's an
7 incomplete application based on the fact that the Board
8 doesn't have the information.
9 The second alternative argument is if this is deemed
10 to be a completed application, the Board has an
11 investigation, the investigation asked for information.
12 The information resides in a sister state, Iowa. The
13 Board does not have jurisdiction to subpoena those
14 records or to command or the ability to get them other
15 than what has been done, which is to review Pacer, pull
16 the documents that are available online, and request the
17 applicant, who has a defense attorney, the defense
18 attorney clearly has access to all of this information,
19 the defense attorney could also ask for -- could supply
20 us all of the court documents. That is not privileged.
21 I understand there may be some issues with videotapes,
22 reports, and other things that there may be agreements
23 with the U.S. Attorney's office that they can't turn
24 those over. But the party who can get that released or
25 provide some information would be Mr. Boone through that

1 attorney could make that request. I haven't heard that
2 that request was made. In the alternative, I'm sure
3 there are other documents or at least a written statement
4 that Mr. Boone could have supplied.
5 Your Honor, I will point out that in one of the cover
6 letters it notates a conversation that I had with
7 Mr. Boone where he was requesting a contested case
8 hearing and I memorized or memorialized in that letter
9 that I had explained to him that normally we wait for
10 criminal proceedings to be completed because otherwise it
11 places him at a disadvantage because he could put himself
12 at jeopardy if he testifies. So I want to make sure that
13 the Hearing Examiner and the Board understands that we
14 are here today on this matter because Mr. Boone has made
15 that request and that the opportunity to delay this or to
16 wait until the other matter proceeded and was concluded
17 was given to him. So we are not trying to proceed on a
18 civil action while criminal action is going because that
19 clearly places Mr. Boone at a disadvantage. We are doing
20 this at his request.
21 But having said that, we are still in the same
22 situation, which is the Board doesn't have access to the
23 information in order to make this decision. And as such,
24 since the burden is on Mr. Boone, the information was
25 requested from Mr. Boone, it hasn't been supplied from

1 Mr. Boone, and it is his obligation to meet that burden.
2 These are charges that raise grave concerns when
3 you're sending somebody out on an ambulance or under a
4 high stress situation and going into a very similar
5 situation to which he is accused at this time of using
6 excessive force. So it is not only a matter of not
7 supplying the information, it's a highly relevant issue.
8 And as such, since it is -- if the Board cannot go ahead
9 and fully evaluate it, then that means Mr. Boone hasn't
10 met his burden or even come close to it because in order
11 to meet his burden, he would have to supply the
12 information for somebody to make a judgment. So we are
13 not even getting to the point of being able to say based
14 on the information he supplied, the Board has no concerns
15 over his action; or, the Board has concerns over his
16 action based on the following information that he
17 provided and they have reviewed. So by the very nature
18 of not supplying the information when he has the burden,
19 in essence he didn't provide the evidence one way or
20 another for his issue to be made, then he has to fill in
21 his application.
22 So for those two reasons, I think either one of them,
23 the first argument of an incomplete application is
24 because the Board can't make a decision. The second is
25 without the information being supplied, then Mr. Boone

1 hasn't met his burden of showing good moral character
2 concerning this incident that he hasn't supplied
3 information to the Board and it's not within the Board's
4 at this point purview or ability to gain access to the
5 information that Mr. Boone has either through his defense
6 attorney or made that request or at least supplied
7 whatever information he could.
8 So for those two reasons we would ask for a denial at
9 this time.
10 HEARING EXAMINER HENRY: Thank you, Mr. Golden.
11 Mr. Boone, would you like to proceed?
12 MR. BOONE: I would. I think that I have cooperated
13 with the Board. I produced -- I first informed them of
14 the charge, I didn't try to hide it. I informed them of
15 the charge, that's what I had at the time. When I did
16 finally get the Subpoena after the time I was supposed to
17 submit the information, I made several phone calls to my
18 attorney and the judge in the case trying to get that
19 information from them. I was told by the judge and my
20 attorney that they would have to subpoena the information
21 themselves. I went ahead and tried to work with the
22 Board by going in and explaining that I did not have the
23 videotapes, I do not have the police reports, I do not
24 have access to those, and that I was trying to work with
25 them. I was informed by their investigator that their

1 attorney would contact me and work with me on that
2 situation. Their attorney, Mr. Golden, has never
3 contacted me about it.
4 The next thing I know, I get the brief describing
5 that I didn't cooperate with the Board. I think I have
6 cooperated with the Board. If they would -- if there was
7 a way we could do it where I could work with them, I
8 would be more than willing to do that.
9 I think that -- and if you do look at the date on
10 that Subpoena, if I was in town, which I didn't get it
11 until after the Subpoena, but if you look at that, that
12 was delivered on 12/31. Well, January 1st and 2nd were a
13 holiday, the 3rd and 4th were a weekend. So even if I
14 would have received that on the 31st, I don't think
15 that's reasonable to think that I could get records and
16 stuff over a holiday and over a weekend. But that's kind
17 of irrelevant because I did not receive that until after
18 the hearing. After the hearing I went ahead and
19 contacted my attorney and the judges and they both
20 advised me of the same thing.
21 I went in to the Board, tried to explain that to
22 them, and they said that they would have their attorney
23 contact me. That never happened.
24 As far as the bad character or bad moral character, I
25 think I've showed that I do have good moral character. I

1 was 15 years as a police officer, I was a decorated
2 police officer for saving people's lives. I was awarded
3 the Medal of Valor and the Sullivan Award, which is
4 Iowa's basically lifesaving or heroic award.
5 You have heard testimony from a paramedic that works
6 with me daily that says that I am a competent EMT, that I
7 would not endanger somebody's life, that I know how to do
8 the skills.
9 And I believe that one incident doesn't justify or
10 doesn't sum up somebody's whole moral character in one
11 ten-minute incident that happened. I think if you look
12 at my history, if you look at my work history, that that
13 would show a better characteristic of how I am as a
14 person instead of a ten-minute snippet when I was working
15 as a police officer.
16 And so if you take those two into consideration, I
17 think that I would not be a risk to the Board or the
18 State of South Dakota in providing some care to the
19 people that I provide care to. That's all I have, sir.
20 HEARING EXAMINER HENRY: Thank you. Is there
21 anything else from either party?
22 MR. GOLDEN: Yes, a brief reply.
23 HEARING EXAMINER HENRY: Very well. You may go
24 ahead.
25 MR. GOLDEN: If you look at the Government's trial

1 brief, one of the things that they bring up is that
2 Mr. Boone had prior problems at his employment. This was
3 not a first incident. So the information that's being
4 requested is not looking at just a solo incident, but a
5 pattern. And that is one of the things that was
6 addressed in the Government's brief. And so this is not
7 a solo ten-minute episode.
8 Also concerning the Subpoena, it's a very convenient
9 matter to say, "I didn't get it in time to reply." We
10 can quibble about that. It's not the issue. You saw the
11 amendment, which was on September 22. That asked for
12 this information. This has been requested since
13 September 22.
14 As we sit here today, you as a Hearing Examiner, you
15 do not have an explanation for what occurred. You do not
16 have any information of what occurred that's been
17 supplied by Mr. Boone. That's the only issue that we are
18 really here on is we don't have the information necessary
19 to make this decision. That's why the application is
20 incomplete. That is why Mr. Boone can't meet his
21 requirements of good moral character, because he has the
22 information and he hasn't supplied it. So for those two
23 reasons we would ask you to deny.
24 HEARING EXAMINER HENRY: Very well. Do you have
25 anything in response to that, Mr. Boone?

1 MR. BOONE: No, sir.
2 HEARING EXAMINER HENRY: At this juncture then I
3 would like to take a recess for 15 minutes and at that
4 time let's reconvene and I will hopefully be in a
5 position to give some Findings on the case and some
6 Conclusions of Law and I'll make my recommendation at
7 that juncture. Thank you.
8 (Whereupon, a recess was taken from 10:22 a.m. to
9 10:36 a.m.)
10 HEARING EXAMINER HENRY: Let's go back on the record.
11 At this time your Hearing Officer has made consideration
12 of all the testimony and the exhibits received, and I've
13 made some findings.
14 Those findings are, at least in part, that the Board
15 has jurisdiction over the matter that's conferred by the
16 appropriate South Dakota Codified Law. Both parties in
17 this matter have had adequate notice and opportunity to
18 be heard.
19 I also find that Mr. Boone had the burden in this
20 matter and does have the burden in this matter of proving
21 good moral character. And he made fair notice of a
22 problem area when he made application in this matter.
23 However, after he made that disclosure, the Board went on
24 to ask for further information of him.
25 The only -- the singular item that he supplied after

1 that was a copy of the Indictment. Mr. Boone certainly
2 exercised control over many other documents relevant to
3 the matter and the bare document that he did provide
4 casts some questions about good moral character. The
5 document, meaning the Indictment in this matter, contains
6 a couple of counts; both of those counts are felonies.
7 And the nature of the charges are ones that would give
8 rise to some suspicion about good moral character.
9 The Board went on to conduct a more thorough
10 investigation and was able to discover more information
11 or to get more information, including Government briefs,
12 briefs that were prepared by the Defendant or his
13 attorney in the matter, that is, Mr. Boone. But again,
14 Mr. Boone made no effort to supply those to the Board to
15 help them make a decision in this case.
16 The problem here, Mr. Boone, is that when the issue
17 became more serious after the Government -- after the
18 Board investigation revealed a pretty lengthy and
19 troublesome criminal case, Mr. Boone, you didn't do
20 anything to arrest the fears that arose. The Board has a
21 duty to be a safeguard in a case like this. And in doing
22 so, they critically analyze what's on the application.
23 They requested more information of you, and again, as I
24 stated before, you didn't give them -- you did not give
25 them information sufficient to arrest the question that

1 got raised. That burden was on you.
2 There is a lot of evidence here that in the opposite,
3 viewed the opposite way, that even if the Board had the
4 burden of coming forth, the stuff that they have amassed
5 casts some serious questions about your moral character.
6 But that's not the burden. The burden was on you to
7 provide good evidence of good moral character, and you
8 never disclosed this evidence that makes you look bad,
9 and you had control over it.
10 For those reasons my recommendation to the Board is
11 this: That they deny your application and they deny it
12 for the reasons argued by Mr. Golden that you failed to
13 demonstrate good moral character as required by the
14 appropriate South Dakota Codified Law. Thank you.
15 MR. GOLDEN: Would you like me to prepare Findings of
16 Fact consistent with your decision?
17 HEARING EXAMINER HENRY: I was just going to go
18 there, Mr. Golden. If you would prepare Findings of
19 Facts and Conclusions and also include my recommendation
20 that the application be denied.
21 MR. GOLDEN: Okay. I will serve that on Mr. Boone.
22 Is your current address where we should send it?
23 MR. BOONE: Yes, sir.
24 MR. GOLDEN: And we will have a March 11 Board
25 hearing that we will attempt to -- can we go off the

record a second?

(Discussion off the record.)

MR. GOLDEN: We will have a transcript at that point and we will serve you notice. The intent would be to try to get it on the March 11 Board meeting. So we'll attempt to try to go ahead and get it on the March Board meeting.

MR. BOONE: I'm not going to be able to make the March 11 Board meeting. My trial is due to start March 9.

MR. GOLDEN: Would it be okay if we went to the June meeting then?

MR. BOONE: That's fine.

MR. GOLDEN: Okay.

HEARING EXAMINER HENRY: With nothing further, we will be in recess.

(Whereupon, the proceedings were concluded at 10:45 a.m.)

* * * * * * * * *

STATE OF SOUTH DAKOTA)
: CERTIFICATE
COUNTY OF LINCOLN)

I, Terri Lembcke Schildhauer, Registered Professional Reporter and Notary Public in the above-named County and State:

Do hereby certify that the witnesses were first duly sworn by me to testify to the truth, the whole truth, and nothing but the truth relative to the matter in hearing; and that the foregoing pages 1 - 53, inclusive, are a true and correct transcript of my stenotype notes made during the time of the proceedings of the South Dakota Board of Medical and Osteopathic Examiners.

I further certify that I am not a relative or employee or attorney or counsel of any of the parties or a relative or employee of such attorney or counsel, and that I am not financially interested in this action.

In testimony whereof, I have hereto set my hand this 5th day of March, 2015.

_/s/Terri Lembcke Schildhauer____
Terri Lembcke Schildhauer, RPR
Registered Professional Reporter
and Notary Public

My Commission Expires: 7/19/17

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/s/Terri [1] 54/22

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01/29/15 [1] 3/14
09/22/14 [1] 3/8

1

1-3-14 [1] 24/19
10 [6] 3/5 4/1 13/25 14/3 14/8 14/12
10/20/14 [1] 3/9
10:00 [1] 28/7
10:22 [1] 50/8
10:36 [1] 50/9
10:45 [1] 53/17
11 [13] 3/7 3/8 3/8 4/2 14/13 14/20 14/23 15/6 15/7 34/1 52/24 53/5 53/9
12 [18] 3/8 3/9 3/9 4/2 10/11 10/11 10/12 10/14 11/5 11/10 11/13 15/5 23/23 24/8 24/18 25/12 25/19 31/24
12/30 [1] 28/1
12/31 [2] 28/1 47/12
120 [1] 43/3
13 [5] 3/9 4/2 12/10 12/16 12/20
14 [21] 3/3 3/3 3/4 3/4 3/5 3/5 3/7 3/7 3/8 3/9 3/10 4/2 19/11 19/17 19/23 20/1 20/2 20/4 20/9 20/16 24/19
15 [5] 2/24 2/24 3/14 48/1 50/3
16 [3] 2/21 2/21 2/22
160 [1] 39/3
17 [2] 2/22 54/25
18th [2] 16/20 16/21
19 [1] 3/10
1st [1] 47/12

2

20 [3] 12/15 35/6 39/11
200 [1] 39/2
2011 [1] 29/25
2012 [1] 30/2
2013 [1] 6/23
2014 [8] 12/15 16/21 25/2 25/11 25/16 25/17 25/23 32/1
2015 [2] 1/20 54/19
21 [1] 3/10
216 [1] 1/7
22 [5] 25/11 25/16 32/1 49/11 49/13
23 [1] 2/5
24 [1] 2/5
25 [1] 2/6
27 [1] 2/9
2nd [1] 47/12

3

30 [8] 3/14 3/15 3/16 3/17 3/18 25/17 25/23 28/1
300 [1] 1/7
31 [8] 2/9 3/14 3/15 3/16 3/17 3/18 28/1 47/12
317 [1] 1/10
31st [1] 47/14
33 [1] 2/9
35 [1] 2/11
36 [1] 2/12
3:00 [2] 28/4 28/12
3rd [1] 47/13

4

40 [1] 2/13
46 [1] 2/13
48 [1] 2/13
4th [1] 47/13

5

50 [1] 2/14
53 [1] 54/10
57104 [2] 1/8 1/11
5th [3] 28/12 32/15 54/19

6

6th [2] 1/20 28/18

7

7/19/17 [1] 54/25

9

9:00 [1] 1/20
9:03 [1] 6/10
9:24 [1] 20/12
9:25 [1] 20/12
9:35 [2] 26/20 27/8
9:36 [2] 27/8 27/14
9:43 [1] 31/3
9:54 [1] 31/3
9:55 [1] 34/23

A

a.m [14] 1/20 6/10 20/12 20/13 26/20 27/8 27/9 27/14 31/3 31/4 34/23 50/8 50/9 53/18
ability [2] 43/14 46/4
able [5] 7/21 39/16 45/13 51/10 53/8
about [20] 4/25 23/7 24/8 25/7 27/20 28/23 30/10 31/15 31/16 32/9 32/11 38/3 39/24 41/4 41/12 47/3 49/10 51/4 51/8 52/5
above [4] 1/19 30/6 36/1 54/5
above-entitled [1] 1/19
above-named [1] 54/5
accept [2] 30/13 42/15
access [4] 43/18 44/22 46/4 46/24
accident [2] 29/25 41/8
according [1] 41/10
account [1] 20/23
accurate [1] 22/16
accurately [1] 22/18
accusation [1] 21/16
accused [1] 45/5
acknowledged [1] 26/1
acquittal [1] 41/21
action [6] 43/1 44/18 44/18 45/15 45/16 54/17
actual [2] 25/5 39/16
actually [8] 4/19 21/1 26/9 29/23 37/21 38/21 39/5 39/7
add [2] 33/22 40/11
added [1] 30/7
additional [5] 10/5 10/8 21/25 22/4 22/7
address [1] 52/22
addressed [2] 5/17 49/6
adequate [2] 5/19 50/17
advanced [3] 8/5 29/17 36/11
advised [1] 47/20
afforded [1] 42/9
after [18] 7/16 11/25 12/22 12/24 17/9 28/8 28/20 29/13 36/25 37/9 46/16 47/11 47/17 47/18 50/23 50/25 51/17 51/17
again [4] 18/13 19/7 51/13 51/23
against [1] 39/12
agree [1] 32/7
agreements [1] 43/22
ahead [17] 9/9 10/2 13/3 13/11 20/5 24/23 28/12 28/21 29/15 31/19 36/20 42/13 45/8 46/21 47/18 48/24 53/6
all [23] 5/24 8/10 14/3 14/3 15/14 20/1 23/19 29/6 29/8 29/17 29/18 30/10 30/21 31/7 31/18 34/3 36/14 40/1 42/18 43/18 43/20 48/19 50/12
allegations [1] 18/8
alleged [2] 21/13 22/18
allowed [1] 4/13
allows [1] 7/19
almost [1] 28/10
along [3] 29/19 34/8 34/13
alongs [1] 7/20
already [2] 18/3 39/14
also [15] 1/13 4/15 10/17 16/5 17/23 22/1 28/13 31/12 36/12 37/5 37/25 43/19 49/8 50/19 52/19
alternative [2] 43/9 44/2
am [14] 6/16 6/19 12/9 13/19 14/13 17/5 18/17 29/14 38/17 39/25 48/6 48/13 54/14 54/17
amassed [1] 52/4
ambulance [5] 7/20 35/17 35/18 38/18 45/3
amended [1] 24/8
amendment [18] 10/4 10/9 10/12 10/14 10/15 11/25 12/25 17/21 18/4 18/19 18/23 23/12 23/16 23/18 23/20 23/22 42/11 49/11
analyze [1] 51/22
another [1] 45/20
answer [2] 9/9 26/9
answered [1] 9/13
any [42] 7/22 8/12 9/2 10/18 11/7 11/20 13/11 15/15 17/2 17/25 19/14 20/16 21/7 21/15 22/10 26/12 26/15 29/2 29/3 29/4 29/5 31/11 31/16 32/4 33/18 36/4 36/5 36/5 36/8 36/8 36/16 36/25 39/12 39/20 39/21 39/24 40/11 41/12 41/15 42/13 49/16 54/15
anybody [1] 36/10
anything [9] 5/17 26/22 33/17 39/21 40/3 40/10 48/21 49/25 51/20
appear [2] 22/19 28/9
appearance [1] 4/7
APPEARANCES [1] 1/9
appears [1] 25/12
applicant [8] 2/7 3/12 4/3 17/17 17/18 42/1 42/22 43/17
application [37] 1/4 2/19 5/7 6/25 7/2 8/5 8/7 8/7 8/9 8/10 8/11 8/14 8/19 8/24 9/24 10/6 10/17 11/3 12/6 12/25 17/13 23/7 23/9 42/10 42/16 42/17 42/25 43/5 43/7 43/10 45/21 45/23 49/19 50/22 51/22 52/11 52/20
applied [1] 7/16
appropriate [3] 41/23 50/16 52/14
are [45] 4/12 4/19 6/24 7/7 7/19 14/4 14/11 19/17 21/4 21/10 21/14 21/17 21/18 21/21 21/23 22/5 22/6 22/10 22/22 25/1 25/2 25/6 26/19 30/12 30/21 31/19 33/5 33/11 35/16 38/3 39/20 41/12 43/16 44/3 44/14 44/17 44/19 44/21 45/2 45/12 49/17 50/14 51/6 51/7 54/10
area [1] 50/22
areas [1] 21/4
argue [1] 42/3
argued [1] 52/12
argues [1] 42/3
arguing [1] 41/12
argument [4] 42/24 43/6 43/9 45/23
arguments [1] 40/15
arose [1] 51/20
arrest [2] 51/20 51/25
arrested [1] 41/9
article [2] 3/10 19/16
as [56]
ask [13] 8/11 17/17 17/20 18/13 21/21 24/2 35/1 40/4 40/18 43/19 46/8 49/23 50/24
asked [8] 10/17 17/21 17/23 31/15 33/18 40/3 43/11 49/11
asking [7] 18/16 18/17 21/14 21/17 21/18 22/5 23/12

A

asks [1] 43/4
asserted [1] 22/6
assertion [1] 29/22
asset [2] 39/13 39/18
Assistant [1] 1/9
assume [1] 4/15
assure [1] 22/15
Atlanta [6] 35/7 35/8 35/9 37/3 37/10 37/11
attached [2] 21/13 25/19
attempt [2] 52/25 53/6
attempted [1] 22/1
attention [6] 7/15 9/8 11/13 12/1 12/3 40/21
attorney [19] 1/9 1/12 28/13 28/21 32/24 43/17 43/18 43/19 44/1 46/6 46/18 46/20 47/1 47/2 47/19 47/22 51/13 54/15 54/16
Attorney's [1] 43/23
available [2] 26/7 43/16
Avenue [2] 1/7 1/10
award [5] 3/15 3/16 30/1 48/3 48/4
awarded [1] 48/2
aware [3] 18/17 30/11 39/20
away [2] 38/20 39/4

B

back [11] 5/18 16/20 20/14 27/10 28/5 31/5 35/7 39/1 39/3 40/9 50/10
bad [5] 29/22 42/4 47/24 47/24 52/8
bare [1] 51/3
based [11] 6/25 7/3 10/2 18/6 18/11 22/20 37/5 40/2 43/7 45/13 45/16
basic [1] 38/17
basically [3] 29/5 29/19 48/4
basis [1] 20/20
bat [1] 9/16
be [53] 4/13 5/2 5/9 5/16 5/17 6/2 7/21 14/24 15/6 17/11 17/15 21/11 21/14 22/13 24/8 24/13 25/23 27/1 27/3 27/11 28/22 30/14 31/8 32/17 32/19 37/2 39/12 39/16 39/17 41/4 41/5 41/5 41/13 41/22 42/17 43/1 43/5 43/10 43/21 43/22 43/25 44/10 45/20 47/8 48/17 50/4 50/18 51/21 52/20 53/4 53/8 53/11 53/16
bearing [2] 5/12 41/16
bears [1] 41/16
became [1] 51/17
because [18] 4/15 22/19 29/7 29/10 29/12 30/20 32/21 40/24 42/16 43/1 44/10 44/11 44/14 44/18 45/10 45/24 47/17 49/21
become [1] 38/12
been [23] 6/10 7/25 10/10 13/16 16/12 16/17 17/5 18/21 22/17 26/2 27/14 28/10 31/23 34/23 36/6 38/24 39/17 42/9 43/2 43/15 44/25 49/12 49/16
before [3] 1/7 40/18 51/24
begin [2] 10/2 12/23
beginning [1] 8/19
behalf [2] 4/8 4/10
being [9] 9/3 12/6 35/12 36/12 39/3 41/9 45/13 45/25 49/3
believe [15] 10/12 15/21 16/8 18/19 20/23 21/1 25/16 25/23 28/2 29/21 31/13 33/8 36/10 42/5 48/9
beneficial [2] 5/16 29/10
besides [2] 11/20 32/4
better [2] 14/24 48/13
Between [1] 32/1
beyond [2] 30/6 36/1
big [1] 27/24
blank [1] 24/10
BOARD [71]
Board's [2] 28/18 46/3
body [2] 22/15 30/13
BOONE [82]
Boone's [4] 8/5 8/24 13/14 19/21
both [8] 16/23 28/15 37/3 38/7 40/15 47/19 50/16 51/6
brief [9] 2/25 3/4 13/13 13/14 13/23 47/4 48/22 49/1 49/6
briefly [3] 20/11 31/12 36/17
briefs [2] 51/11 51/12
bring [2] 27/19 49/1
Brothers [1] 30/1
brought [3] 33/23 34/8 34/13
burden [16] 5/8 5/13 42/1 42/22 44/24 45/1 45/10 45/11 45/18 46/1 50/19 50/20 52/1 52/4 52/6 52/6

C

call [3] 6/8 26/25 30/6
called [5] 6/10 10/7 27/14 28/13 34/23
calls [2] 39/10 46/17
came [3] 1/19 24/21 37/16
can [21] 5/25 11/15 11/16 11/17 15/2 15/4 19/7 20/9 20/25 27/7 29/11 31/2 35/4 36/2 38/3 42/7 42/11 43/1 43/24 49/10 52/25
can't [4] 42/15 43/23 45/24 49/20
cannot [2] 42/16 45/8
care [2] 48/18 48/19
case [16] 5/1 5/8 5/16 7/12 16/18 17/20 21/24 23/6 28/14 42/8 44/7 46/18 50/5 51/15 51/19 51/21
casts [2] 51/4 52/5
certainly [3] 5/17 22/11 51/1
Certificate [2] 37/8 54/1
certify [2] 54/7 54/14
Chamberlain [1] 28/3
character [16] 29/22 42/1 42/4 42/19 46/1 47/24 47/24 47/25 48/10 49/21 50/21 51/4 51/8 52/5 52/7 52/13
characteristic [1] 48/13
charge [7] 23/10 23/13 23/17 29/23 41/3 46/14 46/15
charged [2] 9/14 9/22
charges [5] 13/8 19/21 29/6 45/2 51/7
circumstance [1] 40/17
circumstances [1] 5/19
cited [1] 9/22
City [1] 37/10
civil [5] 9/14 9/22 9/23 10/16 44/18
clarification [1] 24/2
class [3] 29/17 29/17 39/17
classroom [1] 29/18
clear [1] 42/21
clearly [5] 21/19 33/5 41/2 43/18 44/19
client [2] 24/17 24/18
close [1] 45/10
closed [1] 43/5
Closing [2] 2/13 2/13
co [1] 38/12
co-workers [1] 38/12
Codified [2] 50/16 52/14
COLIN [10] 1/5 2/8 4/6 4/10 7/14 7/22 27/13 35/20 38/10 42/19
college [3] 37/4 37/6 37/7
come [7] 7/14 11/25 19/7 21/17 22/13 34/2 45/10
coming [3] 12/3 41/3 52/4
command [1] 43/14
commencing [1] 1/20
comment [1] 24/22
Commission [1] 54/25
compared [1] 21/3
competent [2] 36/1 48/6
complaint [2] 7/1 7/2
complete [4] 7/2 7/21 18/7 42/17
completed [4] 31/6 31/7 43/10 44/10
concern [1] 36/4
concerning [7] 9/17 11/2 19/11 19/20 21/16 46/2 49/8
concerns [5] 36/5 36/8 45/2 45/14 45/15
conclude [1] 40/7
concluded [2] 44/16 53/17
Conclusions [2] 50/6 52/19
condition [1] 41/11
conduct [1] 51/9
conferred [1] 50/15
confidential [1] 4/12
confidentiality [1] 4/14
confirmation [1] 15/21
Congressional [1] 29/23
consider [1] 42/17
consideration [2] 48/16 50/11
considered [1] 9/3
consistent [3] 18/22 21/4 52/16
consisting [1] 30/22
contact [5] 28/24 32/19 33/5 47/1 47/23
contacted [3] 32/17 47/3 47/19
contacting [2] 28/22 32/19
contained [1] 22/14
contains [1] 51/5
contend [1] 4/25
contested [2] 16/18 44/7
continuations [1] 29/6
continued [2] 3/1 29/7
continuing [1] 19/8
contract [2] 37/21 37/23
control [2] 51/2 52/9
convenient [1] 49/8
conversation [1] 44/6
conviction [2] 41/21 42/7
cooperate [4] 29/1 29/11 29/12 47/5
cooperated [3] 29/10 46/12 47/6
copies [1] 10/18
Cops [1] 3/15
copy [4] 20/4 20/6 25/18 51/1
correct [11] 9/16 10/1 14/19 17/16 24/10 25/20 25/21 32/16 33/12 33/14 54/11
corrected [1] 4/22
Corrections [1] 38/22
could [19] 4/24 5/16 5/17 9/18 16/20 20/10 22/9 26/9 27/6 32/15 43/19 43/19 44/1 44/4 44/11 46/7 47/7 47/7 47/15
couldn't [2] 29/12 34/2
counsel [2] 54/15 54/16
count [2] 10/23 33/9
counts [2] 51/6 51/6
COUNTY [2] 54/2 54/5
couple [4] 4/24 38/25 42/6 51/6
course [1] 5/23
court [18] 10/18 13/1 13/4 13/5 14/5 14/18 15/14 18/22 21/3 21/20 21/21 24/24 27/21 29/7 33/3 33/24 42/5 43/20
courts [1] 42/20
cover [4] 15/19 16/3 16/16 44/5
Cowman [1] 3/14
Creek [7] 35/18 35/20 37/25 38/2 38/6 38/7 38/20
criminal [4] 10/19 44/10 44/18 51/19
crisis [1] 41/17
critically [1] 51/22
cross [7] 2/2 22/14 22/25 23/4 31/11 31/21 36/18
cross-examination [6] 22/14 22/25 23/4 31/11 31/21 36/18
Crow [7] 35/18 35/19 37/25 38/1 38/6 38/7 38/20
current [2] 41/25 52/22

C

currently [3] 7/22 38/19 38/22

D

daily [1] 48/6
DAKOTA [27] 1/1 1/7 1/8 1/11 1/12 1/14 1/17 1/21 1/22 3/23 6/17 6/21 7/22 35/13 35/14 37/16 37/20 37/24 38/8 38/21 39/19 41/25 48/18 50/16 52/14 54/1 54/12
date [22] 12/14 16/19 25/5 25/11 25/12 25/14 25/16 25/22 25/23 25/25 26/1 26/3 26/3 27/25 28/20 28/23 29/12 29/13 32/13 32/16 32/20 47/9
dates [1] 29/7
day [2] 1/20 54/19
days [3] 28/2 42/6 43/3
dealt [1] 36/6
December [2] 6/23 16/21
December 18th [1] 16/21
deciding [1] 34/2
decision [7] 7/12 42/6 44/23 45/24 49/19 51/15 52/16
decorated [1] 48/1
deemed [2] 4/12 43/9
Defendant [2] 22/15 51/12
Defendant's [2] 3/5 14/1
defense [4] 43/17 43/17 43/19 46/5
degree [2] 5/15 37/7
delay [1] 44/15
delivered [2] 27/22 47/12
delivery [2] 15/21 27/25
demonstrate [1] 52/13
denial [2] 17/12 46/8
denied [1] 52/20
deny [3] 49/23 52/11 52/11
Department [6] 9/15 35/7 37/4 37/6 37/10 38/21
Des [1] 9/15
describing [1] 47/4
DESCRIPTION [3] 2/18 3/2 3/13
detailed [1] 10/15
determine [3] 41/15 42/8 42/19
determining [1] 41/23
did [36] 6/20 6/22 7/14 9/9 10/2 10/11 10/21 11/25 12/3 12/22 12/22 13/1 13/3 13/3 13/11 15/9 17/20 19/11 19/14 20/5 20/5 22/18 28/3 28/7 36/22 36/25 37/3 37/9 37/19 39/5 39/7 46/15 46/22 47/17 51/3 51/24
didn't [13] 18/14 18/15 29/1 29/13 32/19 39/23 45/19 46/14 47/5 47/10 49/9 51/19 51/24
difficult [1] 6/2
direct [8] 2/2 4/24 6/12 11/13 19/9 27/18 35/2 40/21
Director [6] 1/14 7/7 10/13 11/16 15/10 20/10
disadvantage [2] 44/11 44/19
disclosed [1] 52/8
disclosure [1] 50/23
discover [1] 51/10
discuss [1] 40/12
Discussion [3] 20/12 27/8 53/2
display [1] 8/1
dispute [1] 41/10
disseminated [1] 7/8
distress [1] 41/19
do [71]
document [3] 25/13 51/3 51/5
documentation [1] 32/4
documents [21] 10/18 13/1 13/3 13/4 13/5 13/12 14/5 14/17 15/15 18/22 20/15 21/3 21/20 21/21 28/7 33/3 42/13 43/16 43/20 44/3 51/2
does [8] 9/19 9/21 20/25 24/19 33/18 42/16 43/13 50/20
doesn't [6] 5/14 42/18 43/8 44/22 48/9 48/10
doing [4] 4/15 32/18 44/19 51/21
don't [16] 6/2 10/13 20/22 20/23 21/1 22/10 26/3 26/6 26/7 26/11 32/9 33/24 36/13 39/20 47/14 49/18
done [5] 20/10 22/17 22/22 26/19 43/15
down [2] 39/22 40/25
driving [1] 39/2
due [2] 29/13 53/9
duly [4] 6/10 27/14 34/23 54/7
during [4] 15/9 35/19 37/12 54/11
duties [2] 6/24 37/12
duty [1] 51/21

E

e-mail [2] 16/6 16/23
e-mailed [2] 16/7 16/23
editor [1] 20/25
education [3] 6/18 30/8 36/25
educational [1] 39/14
effect [1] 22/20
effort [1] 51/14
either [4] 41/18 45/22 46/5 48/21
elaborate [1] 22/9
elaborated [1] 22/21
elicit [1] 33/18
else [3] 33/17 40/10 48/21
employee [2] 54/15 54/16
employment [1] 49/2
EMS [3] 35/4 35/10 38/15
EMT [14] 7/17 7/18 17/12 29/17 35/6 36/1 36/11 36/11 37/1 37/3 37/14 38/17 39/12 48/6
endanger [1] 48/7
ended [1] 37/20
enforcement [1] 41/9
enhance [1] 22/17
entitled [1] 1/19
envelope [4] 3/18 27/21 27/24 31/15
episode [1] 49/7
especially [1] 35/19
essence [2] 5/23 45/19
evaluate [2] 41/22 45/9
even [8] 32/13 41/6 41/21 42/7 45/10 45/13 47/13 52/3
event [3] 21/19 21/25 41/7
events [1] 41/15
eventually [2] 9/3 32/14
ever [2] 32/2 36/5
evidence [7] 21/23 28/9 28/11 45/19 52/2 52/7 52/8
Ex [6] 3/18 16/5 16/8 27/21 27/24 30/24
examination [11] 6/12 19/9 22/14 22/25 23/4 24/5 25/9 31/11 31/21 35/2 36/18
Examiner [7] 1/7 2/6 2/14 6/15 21/15 44/13 49/14
EXAMINERS [8] 1/1 1/12 1/15 1/17 1/21 3/23 6/17 54/13
excessive [2] 18/8 45/6
excused [3] 26/20 34/7 40/8
Executive [3] 1/14 7/7 15/10
exercised [1] 51/2
exhibit [63]
exhibits [13] 2/16 2/17 3/1 3/12 3/23 4/3 10/13 14/11 29/15 31/13 31/18 40/11 50/12
expert [1] 39/11
Expires [1] 54/25
explain [7] 24/17 28/19 32/21 32/22 33/23 35/4 47/21
explained [1] 44/9
explaining [1] 46/22
explanation [6] 10/16 11/23 23/14 23/14 32/2 49/15
extension [1] 43/4
extent [1] 18/23

F

facing [2] 40/23 40/25
fact [4] 5/13 21/18 43/7 52/16
factor [1] 34/2
facts [7] 30/11 39/20 39/22 41/13 41/20 42/8 52/19
factual [2] 20/20 20/23
failed [1] 52/12
fair [2] 5/19 50/21
fairly [1] 42/21
Falls [4] 1/8 1/11 1/21 38/23
familiar [1] 19/18
familiarity [1] 6/3
family [1] 39/4
far [5] 8/11 36/12 38/20 41/11 47/24
fears [1] 51/20
February [1] 1/20
Fed [6] 3/18 16/5 16/8 27/21 27/24 30/24
federal [5] 13/7 14/4 14/18 33/7 40/25
feel [2] 14/24 29/9
felonies [1] 51/6
felony [3] 41/3 42/2 42/4
few [2] 23/2 39/9
field [3] 29/20 35/4 39/8
figure [1] 32/17
figured [1] 32/20
file [2] 7/16 17/10
filed [1] 14/5
files [1] 6/25
fill [1] 45/20
filled [1] 8/16
final [1] 16/22
finally [1] 46/16
financially [1] 54/17
find [2] 19/14 50/19
finding [1] 21/22
findings [5] 50/5 50/13 50/14 52/15 52/18
fine [4] 19/6 26/6 26/8 53/13
finish [1] 42/16
finished [1] 29/17
Fire [4] 35/7 37/4 37/6 37/10
firefighter [2] 37/14 37/14
first [25] 5/6 5/10 5/13 6/10 16/15 16/16 21/12 23/10 23/13 23/23 24/7 24/10 27/4 27/14 27/19 27/24 34/23 40/19 42/10 42/24 43/6 45/23 46/13 49/3 54/7
five [1] 31/18
follow [1] 9/21
following [2] 41/4 45/16
follows [3] 6/11 27/15 34/24
force [3] 10/24 18/8 45/6
foregoing [1] 54/10
forgot [1] 34/3
form [4] 10/25 25/5 25/6 29/21
forth [2] 39/1 52/4
forum [1] 30/15
forward [1] 20/6
found [1] 19/20
foundation [1] 8/2
free [1] 5/25
friend [1] 36/13
friends [1] 38/12
front [1] 27/23
fully [1] 45/9
further [9] 19/1 26/22 33/15 40/1 40/3 40/11 50/24 53/15 54/14
future [1] 41/16

G

gain [1] 46/4
gas [1] 39/1
gather [1] 7/1
gathered [1] 7/3
general [5] 1/9 8/7 8/9 8/10 42/4
generally [4] 5/11 5/12 6/1 21/8
Georgia [4] 35/8 35/9 36/23 36/24
get [18] 13/1 13/3 28/3 28/4 29/11 29/13 39/15 43/14 43/24 46/16 46/18 47/4 47/10 47/15 49/9 51/11 53/5 53/6
getting [1] 45/13
give [6] 5/24 42/14 50/5 51/7 51/24 51/24
given [3] 5/13 32/7 44/17
go [37] 4/6 5/4 5/10 5/13 5/18 6/20 7/6 7/7 9/9 10/2 13/3 13/11 16/20 20/5 20/11 20/14 24/23 27/6 27/10 28/1 28/2 29/15 30/5 31/2 31/5 31/19 36/20 36/22 40/17 40/18 42/12 45/8 48/23 50/10 52/17 52/25 53/6
goes [1] 36/1
going [21] 7/25 10/10 13/16 16/1 17/5 21/9 21/14 21/21 22/8 26/11 30/21 31/23 39/1 39/1 39/2 40/18 44/18 45/4 46/22 52/17 53/8
Golden [33] 1/9 2/5 2/9 2/12 2/13 4/8 4/23 4/25 5/5 5/25 6/6 19/6 19/10 20/3 21/7 24/4 26/15 26/21 28/22 28/24 30/17 31/10 31/16 31/20 33/18 33/24 36/15 40/3 40/16 46/10 47/2 52/12 52/18
good [13] 5/4 30/5 35/25 42/1 46/1 47/25 49/21 50/21 51/4 51/8 52/7 52/7 52/13
got [4] 20/22 28/19 32/20 52/1
Government [2] 51/11 51/17
Government's [6] 3/4 13/13 13/23 14/2 48/25 49/6
Govt's [1] 3/6
graduate [1] 6/22
grant [1] 4/13
grave [1] 45/2
great [1] 6/3
guess [1] 20/10
guilty [3] 33/8 34/1 34/1

H

had [23] 5/15 12/24 19/25 20/15 22/3 28/14 28/21 29/2 29/9 30/17 35/20 35/23 35/25 39/14 42/12 44/6 44/9 46/15 49/2 50/17 50/19 52/3 52/9
hairs [1] 42/11
hand [5] 20/8 30/20 30/22 31/1 54/18
handles [1] 41/19
hands [1] 14/25
Hansen [1] 1/13
happened [9] 20/24 21/1 21/2 23/8 23/15 32/21 32/23 47/23 48/11
happens [1] 20/11
harm [1] 19/7
has [30] 5/8 5/22 11/2 16/17 20/15 32/7 33/1 33/3 39/14 39/17 41/1 42/5 42/9 42/21 43/10 43/15 43/17 43/18 44/14 45/14 45/15 45/18 45/20 46/5 47/2 49/12 49/21 50/11 50/15 51/20
hasn't [6] 43/2 44/25 45/9 46/1 46/2 49/22
have [125]
haven't [3] 20/2 32/3 44/1
having [7] 6/10 27/14 34/14 34/18 34/23 41/6 44/21
Hayesville [1] 37/10
hazard [1] 36/10
he [53] 4/16 9/13 9/13 9/13 9/22 9/24 10/5 10/16 18/8 18/11 18/12 20/9 23/25 24/11 25/17 25/18 25/22 25/24 25/25 26/3 33/1 33/3 36/2 39/12 39/14 39/17 39/17 41/1 41/4 41/5 41/6 41/19 42/11 42/12 44/7 44/11 44/12 45/5 45/11 45/14 45/16 45/18 45/19 45/20 46/2 46/7 49/21 49/22 50/21 50/22 50/23 50/25 51/3
hear [1] 27/17
heard [4] 31/8 44/1 48/5 50/18
hearing [22] 1/4 1/7 1/19 2/6 2/14 6/14 16/14 16/17 20/7 21/15 28/25 29/24 32/20 32/21 44/8 44/13 47/18 47/18 49/14 50/11 52/25 54/9
hearings [1] 4/19
held [1] 14/24
help [1] 51/15
helping [1] 36/1
Henry [3] 1/7 2/6 2/14
her [1] 37/23
here [12] 5/20 22/11 22/14 34/15 38/4 39/24 42/9 44/14 49/14 49/18 51/16 52/2
hereby [1] 54/7
hereto [1] 54/18
heroic [2] 29/24 48/4
hide [1] 46/14
high [3] 36/22 36/23 45/4
highlighted [2] 11/14 31/24
highly [1] 45/7
him [21] 5/24 10/17 17/24 20/4 20/6 20/8 24/10 25/25 33/5 33/5 34/13 34/14 34/18 38/11 38/13 39/7 42/14 44/9 44/11 44/17 50/24
himself [1] 44/11
his [30] 9/24 10/5 10/17 10/19 12/5 17/12 24/1 25/16 31/13 39/10 39/11 41/4 41/10 41/16 42/16 42/19 42/20 44/20 45/1 45/10 45/11 45/15 45/15 45/20 45/21 46/1 46/5 49/2 49/20 51/12
history [6] 10/19 30/8 30/9 35/4 48/12 48/12
hold [3] 19/2 24/16 42/22
holding [1] 30/13
holiday [2] 47/13 47/16
home [1] 39/3
Honor [13] 5/7 20/5 21/9 21/12 21/14 22/22 26/17 30/19 40/20 40/20 40/21 40/24 44/5
hopefully [1] 50/4
hour [1] 1/20
how [12] 6/3 7/14 13/3 14/25 26/24 32/11 38/10 38/13 39/5 41/19 48/7 48/13
However [5] 5/13 14/24 40/17 41/13 50/23
hung [4] 33/9 33/24 34/3 41/2

I

I'll [2] 36/9 50/6
I'm [25] 5/24 7/25 10/10 13/16 13/24 15/17 16/1 16/12 19/17 22/8 26/2 26/11 29/18 30/13 31/23 31/24 35/12 35/12 36/10 38/22 38/24 39/11 40/18 44/2 53/8
I've [4] 36/6 36/12 47/25 50/12
identification [2] 4/2 4/4
IHS [1] 37/21
impossible [1] 28/10
incident [8] 9/14 23/7 30/3 46/2 48/9 48/11 49/3 49/4
include [1] 52/19
including [1] 51/11
inclusive [1] 54/10
incomplete [4] 42/25 43/7 45/23 49/20
INDEX [3] 2/1 2/16 3/1
Indictment [17] 3/3 10/23 11/20 13/14 13/18 15/16 24/13 24/14 25/2 25/7 25/19 25/22 32/5 33/8 40/25 51/1 51/5
individual [2] 41/8 41/18
information [70]
informed [3] 46/13 46/14 46/25
initial [2] 23/13 23/14
instead [1] 48/14
instructor [1] 29/16
intent [1] 53/4
interested [1] 54/17
introduce [1] 6/14
investigating [1] 17/17
investigation [13] 9/19 10/3 12/6 12/23 15/9 17/22 18/7 18/24 22/1 43/11 43/11 51/10 51/18
investigator [8] 1/16 6/16 6/24 23/1 28/21 32/18 32/22 46/25
involved [4] 8/12 39/21 41/8 41/8
involves [1] 41/18
Iowa [11] 13/10 13/11 15/16 19/21 32/24 35/10 35/11 35/12 39/22 40/25 43/12
Iowa's [2] 3/15 48/4
irrelevant [1] 47/17
is [169]
isn't [1] 42/7
issue [6] 15/10 45/7 45/20 49/10 49/17 51/16
issued [2] 15/10 42/6
issues [1] 43/21
issuing [1] 15/13
it [73]
it's [17] 11/17 13/7 20/23 20/24 26/6 27/21 28/25 29/10 29/23 30/2 30/25 38/20 43/6 45/7 46/3 49/8 49/10
item [1] 50/25
its [2] 41/7 42/4

J

January [4] 25/2 28/4 28/18 47/12
January 1st [1] 47/12
January 3 [1] 25/2
January 5 [1] 28/4
January 6 [1] 28/18
JAY [2] 1/5 4/6
jeopardy [1] 44/12
job [4] 37/12 37/21 38/1 38/23
Jonesboro [2] 36/23 36/23
judge [4] 28/13 28/20 46/18 46/19
judges [1] 47/19
judgment [1] 45/12
judiciary [1] 13/7
juncture [12] 4/5 5/5 19/8 20/9 26/25 31/6 31/8 33/20 40/9 40/14 50/2 50/7
June [1] 53/11
jurisdiction [2] 43/13 50/15
jurors [1] 33/25
jury [4] 33/9 33/24 34/3 41/2
just [19] 4/24 6/1 10/13 16/16 19/2 21/8 22/6 22/21 23/2 30/7 30/11 33/18 36/17 37/8 38/25 39/3 42/5 49/4 52/17
justification [1] 22/7
justify [1] 48/9

K

kids [1] 29/25
kind [5] 29/14 29/22 30/8 35/23 47/16
knew [1] 38/11
know [16] 4/12 9/21 15/1 20/22 24/20 25/22 26/7 28/25 32/9 33/24 38/10 38/13 39/10 39/23 47/4 48/7
knowledge [1] 7/24

L

L-E-V-Y [1] 34/11
lack [1] 22/2
last [4] 38/4 38/25 40/17 42/5
later [3] 32/16 33/11 37/15
law [7] 5/14 5/15 41/9 41/25 50/6 50/16 52/14
laying [1] 8/1
least [3] 44/3 46/6 50/14

L

left [2] 28/1 38/6
legal [2] 6/3 8/12
Lembcke [3] 54/4 54/22 54/22
lengthy [1] 51/18
Let [1] 30/20
let's [9] 4/5 4/24 5/5 20/11 20/14 27/10 31/5 50/4 50/10
letter [18] 2/20 3/8 3/9 3/13 3/14 3/16 12/13 12/22 12/24 15/19 16/3 16/16 17/7 17/8 17/9 17/22 29/16 44/8
letters [1] 44/6
Levy [14] 1/18 2/10 4/16 34/9 34/9 34/10 34/20 34/22 35/1 35/4 36/16 36/21 40/4 40/6
license [4] 1/4 4/18 39/15 41/24
licensed [3] 6/19 7/22 38/8
licensees [2] 8/9 8/10
licensing [2] 8/19 41/16
Lieutenant [1] 37/15
life [2] 8/5 48/7
lifesaving [1] 48/4
like [17] 5/6 15/3 21/6 26/25 27/2 27/3 27/17 27/19 33/17 33/19 33/22 34/17 40/12 46/11 50/3 51/21 52/15
LINCOLN [1] 54/2
little [2] 27/23 27/25
lived [1] 37/22
lives [1] 48/2
long [2] 5/21 39/5
look [13] 13/7 21/2 26/5 27/20 28/6 29/15 29/23 47/9 47/11 48/11 48/12 48/25 52/8
looked [1] 20/2
looking [3] 13/9 38/22 49/4
lot [1] 52/2

M

made [16] 7/9 7/10 17/10 42/20 44/2 44/14 45/20 46/6 46/17 50/11 50/13 50/21 50/22 50/23 51/14 54/11
mail [3] 16/6 16/23 25/4
mailed [4] 16/7 16/7 16/23 16/24
Main [1] 1/10
make [15] 7/4 21/15 21/22 30/11 33/19 40/15 44/1 44/12 44/23 45/12 45/24 49/19 50/6 51/15 53/8
makes [2] 7/11 52/8
many [3] 14/25 22/10 51/2
March [6] 52/24 53/5 53/6 53/9 53/10 54/19
March 11 [3] 52/24 53/5 53/9
March 9 [1] 53/10
Margaret [1] 1/13
mark [1] 24/19
marked [15] 2/18 2/23 3/2 3/13 4/2 4/3 7/25 10/10 12/9 13/16 15/17 16/12 17/5 30/24 31/23
matter [28] 1/3 1/19 4/6 4/20 4/23 6/1 7/14 8/14 11/25 15/11 21/15 22/6 27/11 33/7 33/13 44/14 44/16 45/6 49/9 50/15 50/17 50/20 50/20 50/22 51/3 51/5 51/13 54/9
matters [1] 4/12
may [18] 4/12 4/14 8/1 8/3 19/7 22/16 23/3 24/2 24/22 30/19 31/19 34/25 40/23 41/5 41/5 43/21 43/22 48/23
maybe [3] 5/15 33/22 33/23
me [24] 9/3 17/22 24/17 25/4 28/10 28/15 28/21 28/22 28/23 28/24 29/10 30/20 32/7 32/18 32/19 32/19 47/1 47/1 47/3 47/20 47/23 48/6 52/15 54/8
mean [2] 20/21 24/19
meaning [1] 51/5
means [2] 5/8 45/9
measures [1] 29/25
Med [6] 35/17 35/19 37/25 37/25 38/6 38/11
Med-Star [6] 35/17 35/19 37/25 37/25 38/6 38/11
Medal [1] 48/3
medical [12] 1/1 1/12 1/14 1/17 1/21 3/23 4/8 6/17 7/23 38/8 41/11 54/12
meet [3] 45/1 45/11 49/20
meeting [4] 53/5 53/7 53/9 53/12
member [8] 7/10 7/11 17/10 17/15 18/12 18/16 18/17 41/14
members [1] 4/13
memorandum [2] 3/5 14/1
memorialized [1] 44/8
memorized [1] 44/8
met [2] 45/10 46/1
Metropolitan [1] 37/4
might [2] 6/2 33/25
miles [2] 39/2 39/3
mind [1] 6/4
Minneapolis [1] 28/1
minute [4] 19/2 48/11 48/14 49/7
minutes [2] 29/24 50/3
missed [1] 19/5
missing [1] 28/23
Misty [6] 1/16 2/4 6/8 6/9 6/14 6/16
Moines [1] 9/15
moment [2] 24/16 31/2
Monday [1] 28/4
moral [15] 29/22 42/1 42/4 42/19 46/1 47/24 47/25 48/10 49/21 50/21 51/4 51/8 52/5 52/7 52/13
morals [1] 30/5
more [8] 6/2 21/5 47/8 51/9 51/10 51/11 51/17 51/23
morning [1] 28/7
motion [2] 3/6 14/2
moved [2] 37/15 37/24
MPAS [1] 1/13
Mr [15] 1/7 1/9 1/18 2/5 2/5 2/9 2/9 2/11 2/12 2/13 2/13 4/23 19/10 21/7 34/20
Mr. [101]
Mr. Boone [67]
Mr. Boone's [4] 8/5 8/24 13/14 19/21
Mr. Golden [24] 4/25 5/5 5/25 6/6 19/6 20/3 24/4 26/15 26/21 28/22 28/24 30/17 31/10 31/16 31/20 33/18 33/24 36/15 40/3 40/16 46/10 47/2 52/12 52/18
Mr. Levy [4] 35/4 36/16 40/4 40/6
Mr. Sean [2] 4/16 34/9
Ms [6] 1/13 1/16 23/20 24/7 24/17 25/11
Ms. [1] 11/15
Ms. Rallis [1] 11/15
much [2] 30/10 39/3
my [26] 7/24 14/25 17/22 27/22 28/13 28/20 29/6 29/11 29/16 30/7 30/7 30/8 34/4 37/19 46/17 46/19 47/19 48/12 48/12 50/6 52/10 52/19 53/9 54/11 54/18 54/25
myself [2] 4/10 30/9

N

name [1] 36/20
named [1] 54/5
narrow [1] 21/10
nature [4] 41/7 42/4 45/17 51/7
Nebraska [1] 10/19
necessarily [1] 41/20
necessary [2] 42/18 49/18
need [3] 26/6 26/12 42/23
needed [1] 28/16
never [3] 47/2 47/23 52/8
news [1] 19/16
newspaper [1] 20/24
next [5] 4/24 12/4 12/22 28/25 47/4
no [42] 5/21 5/22 6/4 6/5 9/5 11/9 11/22 11/24 12/19 14/10 14/22 14/23 15/24 16/10 17/3 18/2 18/10 19/1 19/7 20/2 20/2 26/14 26/23 30/19 31/12 31/17 32/3 32/6 33/15 35/11 36/7 36/13 37/8 39/11 39/23 39/25 40/1 40/5 43/1 45/14 50/1 51/14
None [1] 26/17
normal [1] 12/7
normally [2] 41/14 44/9
North [2] 1/7 1/10
not [69]
Notary [2] 54/5 54/23
notates [1] 44/6
note [3] 4/7 24/18 24/20
notes [1] 54/11
nothing [3] 22/14 53/15 54/9
notice [14] 2/22 3/9 4/25 5/1 12/5 12/13 16/14 16/18 27/23 27/25 42/14 50/17 50/21 53/4
noticed [1] 36/5
notified [1] 18/20
notify [1] 17/11
now [19] 7/14 10/10 10/25 11/17 12/9 13/19 14/13 15/17 16/12 17/5 17/14 19/17 20/15 22/22 22/24 33/11 34/8 38/22 38/23
NUMBER [37] 2/18 3/2 5/3 8/22 9/1 9/9 10/11 10/11 10/12 10/14 11/5 11/13 12/10 12/16 13/17 13/19 13/24 14/3 14/7 14/20 15/17 15/22 16/1 16/2 16/9 16/12 16/25 17/6 19/11 19/17 19/23 20/1 20/2 20/4 20/9 31/24 40/21
Numbers [2] 4/1 14/12
numerous [3] 32/8 32/9 32/9
nurse [2] 6/19 37/19
nursing [1] 37/19

O

oath [2] 31/7 33/20
object [2] 20/17 33/25
objection [18] 6/4 6/5 9/2 11/8 12/19 14/10 14/22 14/23 15/24 16/10 17/2 17/3 20/16 20/19 21/6 22/9 22/20 31/17
objections [3] 5/21 5/22 31/12
obligation [1] 45/1
obtain [1] 13/11
obtained [5] 13/5 13/13 13/13 13/14 14/4
occurred [6] 10/20 21/25 32/2 39/22 49/15 49/16
October [1] 12/15
October 20 [1] 12/15
off [12] 6/25 7/3 9/16 14/4 14/15 20/11 20/12 27/6 27/8 31/2 52/25 53/2
offer [11] 9/1 11/5 12/16 14/7 14/20 15/22 16/9 16/25 19/23 21/6 33/17
OFFERED [3] 2/18 3/2 3/13
offering [3] 5/2 21/10 21/23
office [3] 26/4 28/18 43/23
officer [5] 18/9 48/1 48/2 48/15 50/11
offices [1] 1/20
Oh [1] 25/25
okay [10] 10/21 23/10 32/13 37/16 38/5 38/16 38/19 52/21 53/11 53/14
once [2] 37/23 41/1
one [18] 4/21 11/16 14/25 19/5 20/17 21/23 24/2 27/24 33/9 34/1 42/2 44/5 45/19 45/22 48/9 48/10 49/1 49/5
ones [3] 21/7 35/16 51/7
online [4] 3/10 13/7 19/11 43/16
only [10] 29/10 33/22 34/3 36/1 38/12 38/24 39/18 45/6 49/17 50/25
opening [1] 34/4
opportunities [3] 32/8 32/12 39/7
opportunity [12] 20/1 20/6 22/12 22/25

O

opportunity... [8] 30/18 35/20 40/15 40/17 42/10 42/12 44/15 50/17
opposite [3] 30/4 52/2 52/3
opting [1] 5/24
order [7] 3/7 13/14 14/15 41/14 42/18 44/23 45/10
Original [1] 3/23
originally [1] 38/11
osteopathic [9] 1/1 1/12 1/14 1/17 1/21 3/23 6/17 39/15 54/13
other [12] 4/13 11/20 14/17 21/7 26/12 32/4 36/2 43/14 43/22 44/3 44/16 51/2
otherwise [1] 44/10
our [6] 8/10 22/23 24/20 26/4 40/7 42/20
out [9] 8/16 11/2 15/19 21/19 32/14 32/17 39/8 44/5 45/3
outline [1] 5/16
over [14] 28/3 28/14 38/24 39/2 39/6 42/11 43/24 45/15 45/15 47/16 47/16 50/15 51/2 52/9

P

PA [1] 1/13
PA-C [1] 1/13
Pacer [5] 13/5 13/6 14/4 14/15 43/15
package [1] 28/4
page [18] 9/8 10/22 15/4 15/20 15/21 16/15 16/16 16/17 16/22 23/23 23/25 24/7 24/10 24/10 24/11 24/12 24/13 24/18
pages [3] 14/25 30/23 54/10
panel [3] 7/8 7/9 7/10
paper [2] 11/16 20/4
paramedic [10] 35/6 36/3 37/1 37/5 37/14 37/23 38/17 38/23 38/24 48/5
paramedic's [1] 4/18
Paramedicine [1] 37/8
part [7] 4/14 12/7 22/1 22/20 38/1 38/22 50/14
part-time [2] 38/1 38/22
partially [1] 22/2
parties [3] 4/7 50/16 54/15
party [3] 5/12 43/24 48/21
passed [1] 43/3
past [1] 35/24
pattern [1] 49/5
Paul [1] 1/7
pending [1] 33/13
people [3] 22/13 36/6 48/19
people's [1] 48/2
per [1] 32/18
perhaps [1] 5/14
period [1] 43/4
permission [1] 4/14
person [4] 20/22 20/24 42/21 48/14
pertained [1] 15/15
Petition [2] 2/21 16/3
phone [1] 46/17
physical [1] 39/16
picture [5] 21/13 21/24 22/16 22/16 22/17
place [1] 6/3
placed [1] 12/6
places [3] 41/25 44/11 44/19
please [7] 4/7 6/14 15/5 24/17 27/11 31/2 40/19
plus [2] 35/6 39/11
point [10] 5/9 12/24 13/1 15/9 37/16 42/13 44/5 45/13 46/4 53/3
police [9] 9/15 10/18 15/15 18/9 29/5 46/23 48/1 48/2 48/15
portion [4] 11/13 29/18 31/24 39/14
portrayed [1] 22/11
position [2] 5/17 50/5
possible [1] 22/19
prejudicial [1] 22/19
prepare [2] 52/15 52/18
prepared [2] 25/13 51/12
preponderance [1] 5/9
present [3] 1/13 4/15 4/16
presentation [1] 22/23
presented [1] 18/15
presiding [1] 28/14
pretty [2] 30/10 51/18
previously [1] 17/14
prices [1] 39/1
print [3] 15/2 20/25 21/1
prior [3] 17/22 20/7 49/2
privileged [1] 43/20
probably [1] 40/16
problem [3] 42/9 50/22 51/16
problems [3] 36/4 36/5 49/2
procedure [1] 12/7
proceed [11] 5/5 5/6 5/10 6/6 19/7 23/3 26/25 34/17 34/25 44/17 46/11
proceeded [1] 44/16
proceedings [6] 1/19 6/3 8/12 44/10 53/17 54/12
process [1] 8/20
produce [4] 28/7 28/9 28/10 28/15
produced [4] 27/21 29/3 29/21 46/13
profession [1] 7/23
Professional [2] 54/4 54/23
program [1] 7/20
progressive [1] 37/13
proof [1] 5/8
propose [1] 30/14
proposed [4] 21/7 30/22 30/22 31/19
proposing [1] 30/12
provide [7] 10/18 42/23 43/25 45/19 48/19 51/3 52/7
provided [11] 3/23 5/1 11/21 11/23 18/6 18/18 18/20 18/21 22/5 24/1 45/17
providing [1] 48/18
proving [1] 50/20
public [6] 4/19 4/20 4/21 4/23 54/5 54/23
pull [1] 43/15
pulled [1] 40/23
purpose [4] 15/13 21/17 34/14 42/14
purposes [2] 8/1 21/24
purview [1] 46/4
put [5] 10/11 37/4 39/10 39/11 44/11

Q

question [8] 9/9 9/10 9/18 9/19 18/13 24/3 26/10 51/25
questioned [1] 33/25
questioning [1] 40/7
questions [11] 8/11 11/2 19/1 23/2 26/12 33/15 35/1 36/16 40/1 51/4 52/5
quibble [1] 49/10
quite [1] 39/9

R

raise [1] 45/2
raised [1] 52/1
Rallis [10] 1/16 2/4 6/8 6/9 6/16 11/15 23/20 24/7 24/17 25/11
rambling [1] 5/24
rather [1] 40/22
read [2] 21/2 28/12
really [2] 6/2 49/18
reason [2] 20/18 22/4
reasonable [1] 47/15
reasons [10] 21/5 21/7 22/9 22/10 40/18 45/22 46/8 49/23 52/10 52/12
rebuttal [1] 5/18
receipt [3] 16/5 25/25 26/1
receive [5] 6/25 18/14 18/15 28/8 47/17
received [23] 7/16 9/6 11/11 12/20 14/11 14/15 14/17 14/24 15/7 15/25 16/11 17/4 23/10 23/13 23/18 26/4 30/1 30/2 30/14 31/19 32/14 47/14 50/12
receiving [1] 11/25
recess [4] 31/3 50/3 50/8 53/16
recognize [10] 8/4 12/9 13/17 13/20 13/24 14/14 15/18 16/2 16/13 17/6
recognized [1] 29/24
recommendation [10] 2/14 2/20 7/11 17/7 17/8 17/9 17/10 50/6 52/10 52/19
recommendations [1] 7/4
recommending [1] 17/12
reconvene [1] 50/4
record [14] 4/6 5/18 20/11 20/12 20/14 27/6 27/8 27/10 31/2 31/5 36/20 50/10 53/1 53/2
records [3] 41/10 43/14 47/15
Recross [1] 2/2
redirect [4] 2/2 24/5 26/16 33/21
referring [2] 23/21 24/13
regarding [2] 10/16 10/19
Registered [3] 6/19 54/4 54/23
regular [1] 16/24
regularly [1] 8/16
relationship [2] 35/23 35/25
relative [3] 54/9 54/14 54/16
released [1] 43/24
relevant [2] 45/7 51/2
rely [1] 42/7
rephrase [1] 9/18
reply [2] 48/22 49/9
report [3] 7/2 17/15 18/12
reported [4] 9/13 9/24 10/5 10/17
Reporter [2] 54/5 54/23
reporting [1] 9/20
reports [7] 7/4 7/6 7/7 10/18 29/5 43/22 46/23
representing [1] 32/24
request [9] 23/14 23/16 23/16 43/16 44/1 44/2 44/15 44/20 46/6
requested [8] 15/14 18/18 29/4 43/2 44/25 49/4 49/12 51/23
requesting [6] 10/4 10/15 22/4 22/7 23/23 44/7
requests [1] 10/7
required [1] 52/13
requirements [1] 49/21
reservation [2] 37/22 39/18
residence [1] 27/22
resides [1] 43/12
respond [1] 10/21
responded [1] 10/22
responds [1] 41/17
response [11] 3/6 12/25 14/1 18/19 23/12 23/18 23/21 24/1 24/8 33/19 49/25
rest [1] 33/9
resume [2] 3/17 30/7
Resumed [1] 19/10
retired [1] 35/7
retrial [1] 33/11
returned [3] 24/11 25/17 25/18
revealed [1] 51/18
review [8] 7/8 7/9 7/10 20/6 20/9 20/15 30/18 43/15
reviewed [6] 8/14 8/22 12/25 18/3 41/14 45/17
reviewing [1] 17/15
ride [2] 7/20 29/19
right [3] 9/16 38/23 40/1
rights [4] 9/14 9/22 9/23 10/16

R

rise [1] 51/8
risk [1] 48/17
room [1] 4/16
Rosebud [4] 35/17 37/23 38/1 38/7
RPR [1] 54/22
rule [1] 43/3
RULED [3] 2/18 3/2 3/13
ruling [1] 21/15
running [1] 39/10

S

safeguard [1] 51/21
said [4] 29/1 41/6 44/21 47/22
same [6] 8/10 14/17 30/2 30/21 44/21 47/20
saving [2] 29/25 48/2
saw [1] 49/10
say [5] 32/9 32/12 38/14 45/13 49/9
saying [4] 22/6 24/7 25/1 25/3
says [1] 48/6
scheduled [1] 16/17
Schildhauer [3] 54/4 54/22 54/22
school [6] 6/20 36/22 37/1 37/1 37/3 37/5
scope [3] 21/10 21/11 21/12
SDBMOE [2] 3/8 3/9
Sean [7] 1/18 2/10 4/16 34/9 34/22 35/1 36/21
search [2] 19/11 19/15
second [16] 10/22 15/4 15/20 16/17 21/14 23/22 23/25 24/12 24/13 24/18 27/6 41/2 42/10 43/9 45/24 53/1
see [7] 5/25 11/16 15/4 20/1 22/19 25/11 39/7
seen [1] 36/12
send [1] 52/22
sending [2] 12/24 45/3
Senior [1] 36/23
sent [25] 10/4 10/15 11/2 12/5 12/13 12/14 12/22 15/14 16/4 16/8 16/14 16/19 17/7 17/23 23/22 24/9 24/10 24/17 24/18 25/4 25/13 25/14 25/15 25/22 26/3
September [7] 25/11 25/16 25/17 25/23 32/1 49/11 49/13
September 22 [5] 25/11 25/16 32/1 49/11 49/13
September 30 [2] 25/17 25/23
Sergeant [1] 37/15
serious [2] 51/17 52/5
serve [2] 52/21 53/4
served [3] 24/25 25/2 42/11
Service [2] 35/17 35/18
set [2] 28/25 54/18
setting [1] 36/2
several [4] 21/4 29/7 30/23 46/17
She [1] 37/20
shot [1] 5/25
should [2] 31/14 52/22
show [12] 7/25 10/10 13/16 16/1 17/5 22/1 30/4 30/7 30/8 31/23 42/1 48/13
showed [1] 47/25
showing [11] 12/9 13/19 13/24 14/13 15/17 16/12 16/15 16/23 19/17 31/24 46/1
shows [2] 23/9 42/4
sides [1] 40/16
signature [1] 25/17
signed [2] 24/11 25/24
significance [1] 9/12
similar [1] 45/4
since [5] 38/20 41/2 44/24 45/8 49/12
singular [1] 50/25
Sioux [4] 1/8 1/11 1/21 38/23
sir [25] 4/17 6/5 9/5 11/9 24/22 25/8 26/9 26/14 30/16 30/25 31/25 34/10 34/12 34/16 35/9 35/15 37/17 38/9 39/23 39/25 40/5 40/13 48/19 50/1 52/23
sister [1] 43/12
sit [1] 49/14
sits [1] 6/1
situation [9] 40/22 40/24 41/18 41/19 43/6 44/22 45/4 45/5 47/2
situations [1] 42/2
skills [6] 36/2 36/8 39/10 39/12 39/16 48/8
snippet [1] 48/14
so [41] 5/9 5/21 5/25 9/24 10/11 17/10 18/21 20/9 22/5 24/20 25/15 28/9 29/9 29/11 29/14 33/13 34/2 38/12 38/17 38/20 38/23 39/3 39/5 39/24 41/20 42/24 43/5 44/12 44/17 45/6 45/12 45/17 45/22 46/8 47/13 48/16 49/3 49/6 49/22 51/22 53/5
solo [2] 49/4 49/7
some [25] 13/1 13/1 15/9 21/20 22/3 22/19 22/25 29/25 30/8 33/25 37/16 39/2 39/3 40/15 41/10 41/19 43/21 43/25 48/18 50/5 50/5 50/13 51/4 51/8 52/5
somebody [4] 40/22 43/4 45/3 45/12
somebody's [2] 48/7 48/10
someone [1] 8/12
something [3] 8/16 41/13 41/22
sorry [1] 35/12
SOUTH [26] 1/1 1/8 1/11 1/12 1/14 1/17 1/21 1/21 3/23 6/16 6/21 7/22 35/13 35/14 37/16 37/20 37/24 38/8 38/21 39/19 41/25 48/18 50/16 52/14 54/1 54/12
specifically [2] 23/21 41/16
spent [1] 28/1
split [1] 42/11
spoke [1] 28/13
staff [6] 4/9 10/4 10/7 25/14 25/15 42/24
stand [2] 4/22 27/11
standard [1] 10/25
Star [6] 35/17 35/19 37/25 37/25 38/6 38/11
start [1] 53/9
started [2] 37/13 37/24
starting [1] 17/22
state [13] 10/20 13/9 35/10 36/20 39/13 39/18 41/25 42/3 42/6 43/12 48/18 54/1 54/6
stated [2] 40/18 51/24
statement [6] 2/13 2/13 9/16 9/20 34/4 44/3
statements [2] 23/7 31/7
stating [2] 16/16 42/6
status [10] 7/17 7/18 7/19 8/6 17/12 29/12 29/19 41/4 41/11 42/20
stenotype [1] 54/11
sticker [2] 27/23 27/25
still [8] 31/7 32/15 33/13 33/19 38/1 41/22 42/7 44/21
stop [1] 38/3
straight [1] 28/2
stress [1] 45/4
strictly [1] 22/6
strike [1] 36/9
student [7] 7/16 7/18 7/19 8/6 17/12 29/11 29/19
stuff [2] 47/16 52/4
subject [1] 22/13
submit [1] 46/17
submitted [1] 23/9
subpoena [30] 2/24 15/10 15/13 15/14 15/20 15/20 17/23 18/1 18/22 27/20 27/22 28/6 28/8 28/12 28/14 28/17 28/19 28/20 29/1 29/13 29/14 32/14 42/12 42/14 43/13 46/16 46/20 47/10 47/11 49/8
substance [1] 21/18
substantive [1] 21/22
successful [3] 41/5 41/5 41/6
such [6] 21/16 42/25 43/3 44/23 45/8 54/16
sufficient [2] 18/7 51/25
suggesting [1] 22/11
Suite [1] 1/7
Sullivan [2] 30/1 48/3
sum [1] 48/10
Superseding [1] 3/3
supplied [20] 8/17 17/25 18/3 18/11 18/12 18/23 20/4 32/2 32/4 32/15 43/2 44/4 44/25 45/14 45/25 46/2 46/6 49/17 49/22 50/25
supply [5] 32/8 42/13 43/19 45/11 51/14
supplying [3] 10/23 45/7 45/18
Support [1] 8/6
supposed [3] 28/6 28/8 46/16
Supreme [1] 42/5
sure [4] 26/2 35/6 44/2 44/12
suspicion [1] 51/8
sustain [3] 21/6 22/8 22/20
sworn [8] 6/11 27/1 27/3 27/12 27/15 34/21 34/24 54/8
system [3] 13/7 13/11 24/24
systems [1] 35/10

T

take [3] 6/3 48/16 50/3
taken [3] 31/3 43/1 50/8
talk [2] 4/25 6/1
talking [3] 24/7 25/7 38/3
taught [1] 37/6
tear [1] 38/25
tell [2] 27/16 34/4
ten [3] 48/11 48/14 49/7
ten-minute [3] 48/11 48/14 49/7
Terri [3] 54/4 54/22 54/22
testified [4] 6/11 17/14 27/15 34/24
testifies [1] 44/12
testify [8] 22/13 27/1 27/3 30/10 34/14 34/18 39/24 54/8
testifying [1] 26/7
testimony [7] 25/18 26/19 27/18 33/21 48/5 50/12 54/18
testing [1] 7/21
Texas [1] 37/20
than [3] 21/7 43/15 47/8
Thank [15] 4/22 6/8 11/18 15/5 22/22 24/15 26/19 31/14 34/5 38/5 40/20 46/10 48/20 50/7 52/14
Thanks [1] 26/12
that [328]
that's [35] 4/15 5/19 10/25 11/14 12/13 13/23 14/1 15/19 19/6 22/17 23/19 25/14 26/6 26/7 27/24 29/8 29/14 30/10 31/13 32/22 34/3 36/14 38/12 38/24 46/15 47/15 47/16 48/19 49/3 49/16 49/17 49/19 50/15 52/6 53/13
their [13] 4/7 4/18 7/19 7/20 7/21 17/10 20/22 29/12 29/22 46/25 46/25 47/2 47/22
them [17] 7/19 20/6 28/14 28/19 29/11 30/21 43/14 45/22 46/13 46/14 46/19 46/25 47/7 47/22 51/15 51/24 51/25
themselves [1] 46/21
then [33] 4/5 5/5 6/7 7/1 7/2 7/7 8/16 10/17 15/20 18/12 24/11 25/16 26/18 28/2 28/25 30/4 30/7 32/19 37/4 37/14 37/14 37/20 37/25 38/6 39/2 40/6 40/14 43/4 45/9 45/20 45/25 50/2 53/12
there [39] 4/13 11/14 11/20 11/23 16/5 16/7 16/15 17/25 19/16 21/2 21/3 21/12 21/19 21/19 22/9 22/14 28/2 32/12 33/7 33/8 37/11 37/22 37/23 38/3 41/1 41/2 41/3 41/9 41/20 41/21 42/7 43/1 43/21 43/22 44/3 47/6 48/20 52/2 52/18
therefore [1] 28/9
these [3] 4/12 14/3 45/2
they [29] 7/19 8/11 18/19 20/25 20/25 21/1

T

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thing [7] 27/19 28/25 30/21 33/22 34/3 47/4 47/20
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third [1] 15/21
this [93]
thorough [1] 51/9
those [23] 7/4 14/11 20/15 21/5 28/7 30/4 30/11 35/16 41/13 41/15 42/2 42/13 43/13 43/24 45/22 46/8 46/24 48/16 49/22 50/14 51/6 51/14 52/10
thought [1] 25/25
thoughts [1] 31/16
three [2] 28/2 38/4
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time [30] 5/9 11/6 12/5 12/17 14/21 15/9 15/23 16/9 17/1 19/24 20/15 26/18 28/11 28/22 28/24 29/20 32/1 37/12 38/1 38/22 42/14 43/4 45/5 46/9 46/15 46/16 49/9 50/4 50/11 54/11
times [2] 29/7 39/9
today [6] 30/11 32/1 34/15 42/9 44/14 49/14
together [4] 38/18 38/18 39/9 39/10
told [6] 28/14 28/15 28/21 28/22 32/18 46/19
too [1] 39/3
took [2] 22/16 37/21
top [4] 3/15 16/20 25/12 27/25
town [2] 32/14 47/10
traffic [1] 41/8
trained [2] 5/14 39/17
training [4] 5/15 6/18 39/15 39/16
transcript [4] 1/3 3/23 53/3 54/11
travel [1] 37/19
treat [1] 36/11
trial [15] 3/4 3/5 10/13 11/16 13/15 13/23 14/1 20/10 20/24 33/7 41/1 41/2 41/4 48/25 53/9
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truck [2] 38/18 39/9
true [3] 9/20 22/11 54/10
truly [1] 22/18
truth [6] 21/22 22/5 41/12 54/8 54/8 54/9
truthful [1] 9/20
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type [2] 38/14 41/19
typically [4] 5/13 40/16 42/3 42/21

U

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uncertainty [1] 41/3
under [5] 5/19 12/6 31/7 33/20 45/3
underlying [4] 18/8 21/16 41/20 42/8
understand [3] 32/13 41/1 43/21
understands [1] 44/13
University [1] 6/21
unless [2] 4/13 43/3
unreasonable [1] 10/24
unsuccessful [1] 41/7
until [7] 28/4 28/8 29/13 32/21 44/16 47/11 47/17
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used [3] 8/7 10/25 35/12
using [1] 45/5

V

Valor [2] 3/16 48/3
vehicle [1] 39/1
veracity [1] 41/12
verdict [1] 33/8
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videos [1] 15/15
videotapes [3] 29/4 43/21 46/23
viewed [1] 52/3
violation [4] 9/14 9/22 9/23 10/16

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wait [3] 32/21 44/9 44/16
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wear [1] 38/25
website [2] 14/4 14/16
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whereof [1] 54/18
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William [2] 1/9 4/8
willing [3] 5/10 30/5 47/8
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within [2] 42/5 46/3
without [1] 45/25
witness [9] 6/10 26/13 26/16 26/20 27/1 27/14 34/7 34/23 40/8
witnesses [3] 2/1 40/11 54/7
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written [3] 17/9 32/2 44/3
wrong [1] 40/23

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Yeah [1] 23/17
year [4] 6/22 33/11 37/20 39/6
years [7] 35/6 37/13 37/22 38/3 38/4 39/11 48/1
yellow [1] 27/23
yes [60]
you [242]
you're [13] 4/15 5/14 17/17 18/16 23/12 23/21 24/7 24/7 31/6 33/19 38/8 39/24 45/3
your [44] 5/7 5/17 6/18 6/24 7/14 9/8 9/19 11/13 12/1 12/3 12/23 15/9 17/15 18/7 18/12 18/24 19/14 20/5 20/19 21/9 21/12 21/14 22/22 25/18 26/9 26/16 26/17 26/19 30/19 35/4 35/19 36/20 37/12 40/20 40/20 40/21 40/21 40/24 44/5 50/11 52/5 52/11 52/16 52/22
yourself [1] 6/14

Exhibit 1

License Application - Advanced Life Support - Student Status

License application# 16249 Submitted on: 9-22-2014

2-6-2015
In re Colin J. Boone
BMOE
01 TS

Name Information

COLIN JAY BOONE , EMTSTUDENT

Alternates *None reported.*

Address

****Default****

Type	Home Address
Public?	N
Name/Attention	
Address	3409 51st #414 Sioux Falls, SD 57106

Identification

Date of Birth	4-18-1976
Birth Place	Parkston, South Dakota UNITED STATES **Gender:**M **SSN:** XXX-XX-3986 **NPI:**
US Citizen	Y

Race/Ethnicity/Languages (ALL OPTIONAL)

What is your race? (check all that may apply):	White: Y Black or African American: N American Indian or Alaska Native: N Asian: N Native Hawaiian/Other Pacific Islander: N Other:
Ethnicity: Are you Hispanic, Latino/a, or of Spanish origin? (check all that may apply)	No: Y Mexican, Mexican American, Chicano/a: N Puerto Rican: N Cuban: N Another Hispanic, Latino/a, or of Spanish origin:
Do you speak a language other than English at home?	N
What is this language? (if you answered Yes to above)	N

Education

Name	Avera School of Emergency Medicine
Location	Sioux Falls, SD
Degree	EMT certification
Status	Graduated
Dates Attended	09/2013 to 12/2013
Graduated	12/2013

ALS Course Information

Course Name	Advanced EMT
Provider	Yankton County EMS
Location	Yankton County EMS ,

Exam History

Have you taken and passed the examination? **Y** Score:

State or Professional Licensure

No information reported.

Chronology of Activities

From: 07/2014	**Activity:**Work
To:	Crow Creek Sioux Ambulance

Exhibit 1

206 Sam Boy Dr.
Fort Thompson, SD 57339

Contact: Travis Comes Flying **Ph:**605-245-2345 **Email:**
EMT Ambulance Percent Clinical: 100% Administrative: 0%

From: 03/2013
To: 07/2013

Activity: Work
Medstar Ambulance
916 Redwood Blvd
Brandon, SD

Contact: Kris Johnson **Ph:** **Email:**
EMT Percent Clinical: 100% Administrative: 0%

Malpractice Liability Claims Information

No information reported.

Required Disclosures

Definitions:

All questions use the following definitions whether actions were formally, informally, voluntarily or involuntarily committed: Questions refer to both you and your licensure.

A. **Adverse Action** shall refer to having been terminated, stipulated, restricted, limited, conditioned, counseled, reprimanded, suspended, revoked, refused, denied, not renewed, withdrawn or relinquished.

B. **Claim(s)** shall refer to any malpractice, administrative, civil, or criminal final judgments including any pending claims, lawsuits, judgments, and/or settlements.

C. **Complaint** shall refer to any communications which express concerns, warnings or dissatisfaction about personal or profession conduct and rising to the level that the meetings or comments are documented in a written or digital format.

D. **Entity** shall refer to any licensing or disciplinary board, professional agency or committee, academic program, clinic, hospital, or other health-related entity, or governmental agency or organization.

E. **Health related program** shall refer to private or public insurance, Medicare and Medicaid.

F. **Illegal use of drugs** shall refer to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22. The term does include the unlawful use of prescription controlled substances. It does **not** include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law.

G. **Investigation** shall refer to any formal or informal inquiry to acquire and examine facts.

H. **Licensure** shall refer to type of licensure and using any licensure nomenclature such as any registration, permit, certificate, and license. Examples include the subject of this application, DEA registration, etc.

I. **Minor traffic offense** shall refer to any violation which is punishable by a maximum of 30 days in jail, a $500 fine or both and does not result in a change of driving privileges.

J. **Proceeding** shall refer to whether you have appeared or been requested to appear in private or in public, for a meeting, counseling, hearing, administrative, civil or criminal actions, or been questioned, reviewed, charged, arrested, plead guilty, plead no contest, convicted, received a suspended imposition of sentence or suspended sentence by any entity.

K. **Sexual impropriety** shall refer to misconduct including but not limited to discrimination, complaint, assault, the possession of child pornography, sexual contact with patients or other acts, expressions or gestures that disrespect privacy and are demeaning.

L. **You** shall refer to you or any licensure held by you.

01 Is this a true statement for your licensure? "My licensure has not experienced adverse action."	Y
02 Is this a true statement for you? "I have not experienced adverse action."	Y
03 Has your licensure been subject to any complaint, investigation or proceeding involving any entity?	N

Exhibit 1

04 Have you been subject to any complaint, investigation or proceeding involving any entity? N

05 Have you been dishonorably discharged from a branch of the United States military or National Guard? N

06 Have you had any adverse action during any education, residency or training program N

07 Have you had adverse action with your membership or privileges with any entity regarding your ability to participate in any health related program? N

*08 Have you been subject to a criminal or civil complaint, investigation or proceeding other than minor traffic offenses? Y

Explanation: Charged with a civil rights violation from an incident that happen when working with Des Moines Police Department.

09 Have you had a complaint, investigation or proceeding in any manner concerning sexual impropriety? N

10 Is this a true statement for you? "I have not been reported to NPDB (National Practitioners Data Bank) or HIPDB (Healthcare Integrity and Protection Data Bank)." Y

11 Is this a true statement for you? "I have experienced no adverse action in privileges at any hospital, clinic or health related entity." Y

12 Have you had any claims paid by you or paid on your behalf for any reason? N

13 Have you had any liability insurance company, including malpractice carriers, change, deny or cancel your coverage? N

14 Have you stopped working or practicing for any period of time greater than or equal to 30 consecutive calendar days? N

15 Do you have a physical, mental or emotional condition which may adversely affect your practice? N

16 Have you been treated for or do you have a diagnosis for any Mental Health condition. (If yes, please ask your treating provider to send a status letter to the Board office). N

17 Does your use of alcohol or drugs affect your ability to provide appropriate care to patients? N

18 Are you currently using illegal drugs or prescription controlled medications in an illegal manner? N

Agreements

I am aware of the Health Insurance Portability and Accountability Act of 1996 (thereinafter called HIPAA) and understand the provisions dealing with the privacy of my medical records. With such knowledge an understanding, I agree to the following:

- a. I do hereby authorize the use or disclosure of my health information by the South Dakota Board of Medical & Osteopathic Examiners (SDBMOE), for purposes of licensure in the state of South Dakota.
- b. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and hospitals, and treatment for alcohol and drug abuse.

I further release, discharge and exonerate all third parties or person(s) from any and all claims, damages, and liabilities of any nature, who in good faith and without malice, release the HIPAA information to the SDBMOE.

AUTHORIZATION AND RELEASE:
Any references to the terms "Users" or "Users of this Application" in this authorization shall include the following entities:

- The South Dakota State Board of Medical and Osteopathic Examiners together with its board members, staff members, legal counsels, investigators, agents, employees, contractees, and authorized representatives hereinafter collectively referred to as SDBMOE;
- Any other state or national medical licensing, medical reporting or medical regulatory board;
- The Federation of State Medical Boards;
- Any other South Dakota or United States agency in furtherance of and incompliance with SDBMOE's duties and responsibilities under my South Dakota Medical Practices Act and its administrative regulations.

I am the person described herein. I have not engaged in any acts prohibited by the criminal or medical statutes of the State of South Dakota. I am the person named on any diploma or certificated that I have received, I am

Exhibit 1

the lawful holder of said diploma or certificate, and the diploma or certificate was given to me in the regular course of instruction and examination without fraud or misrepresentation.

The following deals with SDBMOE consulting with and receiving information from third parties:

I authorize SDBMOE to consult with any third person or party who may have information or evidence concerning my professional, ethical, mental and physical qualifications, or any other matter that SDBMOE deems relevant regarding my continuing qualifications for licensure with SDBMOE. These third persons and parties include hospitals, institutions or organizations, my references, physicians, therapists, previous and present employers, past and present business and professional associates, and local, state, federal or foreign governmental agencies and instrumentalities, courts of any jurisdiction, associations, institutions or law enforcement agencies, together with their representatives thereof, who have custody or control of any documents, records, information or evidence that SDBMOE deems relevant to my Application. **I specifically authorize any state, federal or international law enforcement agency to conduct a background investigation and to report the findings thereof to the SDBMOE.**

I authorize such third persons and parties to unconditionally release to SDBMOE any such information, including documents, records regarding charges or complaints filed against me, formal, or informal, pending or closed, or any other pertinent data or evidence whether favorable or unfavorable that SDBMOE deems relevant to licensure, and to permit the SDBMOE to inspect, receive, and make copies of such documents, records, evidence, and other information for SDBMOE's evaluation of my professional, ethical, mental and physical qualifications that SDBMOE deems relevant to licensure.

I release, discharge and exonerate from any and all claims, damages and liabilities whatsoever such third persons and parties, together with their authorized representatives, who in good faith and without malice, consult with and release to SDBMOE such information, evidence, files or records requested by SDBMOE that SDBMOE deems relevant to licensure.

I declare and affirm under the penalties of perjury that:

This application for licensure, which includes all the information I have provided and the questions I have answered in the South Dakota Common License Application Form and Addenda thereto, have been examined by me, and to the best of my knowledge and belief, are in all things true and correct. I state unconditionally and without reservation that I absolutely understand each and every question contained in this application for licensure, that I and I have answered all of them completely and truthfully. If any user discovers any derogatory information regarding my personal background that was not disclosed when completing this application, the users may immediately cease all processing of this application, and I agree that such nondisclosure shall disqualify me for licensure in South Dakota.

I understand and agree that my submission of this application and actions subsequent thereto, but prior to licensure, shall bear directly upon my qualifications for licensure, and I fully understand that the SDBMOE may consider all such actions in its determination whether to grant licensure. To that end, I agree that any unprofessional or harassing behavior on my part, or on the part of any agent of mine, with the SDBMOE's members or staff shall establish grounds for the immediate cessation of all processing of this application and disqualify me for licensure in South Dakota. A determination regarding derogatory information or of unprofessional or harassing behavior shall be the sole determination of the SDBMOE, and I will not assert that any other entity, judicial, or otherwise, may make such determination. I understand and agree that cessation of processing of this application by the users as a result of the acts of omissions by myself as described in this paragraph shall not require the SDBMOE, to offer me a hearing or any other due process right, or any other statutory or constitutional rights, and that I will not assert that I am entitled to a hearing.

Signed: Colin Boone 04/18/1976

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
101 N MAIN AVE, SUITE 301
SIOUX FALLS, SD 57104
SDBMOE@STATE.SD.US
P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV

Via electronic and regular mail

November 3, 2014

2

Colin J. Boone
3409 51st #414
Sioux Falls, SD 57106
booneemt@gmail.com

Dear Mr. Boone:

Please be advised that the investigative panel of the South Dakota Board of Medical and Osteopathic Examiners will be recommending the denial of your EMT Student Status application. The director of your educational program has been notified.

If you wish to contest this recommendation you have the following rights:

1. To contest the recommendation at an administrative hearing which will be conducted in accordance with SDCL 1-26. This matter will be presented to a neutral administrative judge.

2. To be represented by an attorney of your own choosing at the administrative hearing if you so desire.

3. The recommendation of the administrative judge will be referred to the South Dakota Board of Medical and Osteopathic Examiners. The Board may accept, reject or modify the recommendation.

4. If you participate in an administrative hearing, you would then have the right to file an appeal to Circuit Court.

If you wish to contest this recommendation or have questions, please contact the Board's Attorney, Mr. William H. Golden, by phone at (605) 201-8588 prior to November 10, 2014.

Sincerely,

Jane Phalen

Jane Phalen
SD Medical Board Staff

EXHIBIT
2
2-6-15 TS

cc: Mr. William H. Golden, esq.
State of South Dakota Office of Attorney General
Assistant Attorney General/Civil Litigation Division
Counsel to the South Dakota Board of Medical and Osteopathic Examiners

From: SDBMOE
To: "booneemt@gmail.com"
Subject: Investigation by the SD Medical Board
Date: Tuesday, November 04, 2014 8:41:51 AM
Attachments: Investigative Recommendation Letter.pdf
Importance: High

Dear Mr. Boone:

Attached please find a letter from the SD Medical Board informing you of the Board's investigative panel's recommendation in the matter of the investigation of your application for Student Status. This letter is also being mailed to you today.

Sincerely,

Jane Phalen
SD Medical Board Staff

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
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SIOUX FALLS, SD 57104
SDBMOE@STATE.SD.US
P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV

2-6-2015
In re Colin J. Boone
BMOE
03 TLS

Via electronic and regular mail

December 22, 2014

Colin J. Boone
3409 51st #414
Sioux Falls, SD 57106
booneemt@gmail.com

Dear Mr. Boone:

Enclosed please find the Petition in the matter of the recommendation for the denial of your application for Student Status.

The Notice of Hearing was provided to you earlier this month.

Please direct any questions to the Board Counsel, William H. Golden, at 605-201-8588.

Sincerely,

Jane Phalen

Jane Phalen
SD Medical Board Staff

Enclosure

cc: William H. Golden, esq.
State of South Dakota Office of Attorney General
Assistant Attorney General/Civil Litigation Division

THE BOARD OF MEDICAL AND
OSTEOPATHIC EXAMINERS OF THE
STATE OF SOUTH DAKOTA

IN THE MATTER OF:	)	NO. 14-189
	)	
COLIN JAY BOONE APPLICANT/EMT STUDENT STATUS	))	PETITION FOR BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS
	)	
Respondent.	)	
	)	

COMES NOW, the Executive Secretary of the South Dakota Board of Medical and Osteopathic Examiners ("Secretary") and files this Petition pursuant to SDCL 36-4B-6, 31, SDCL 1-26 and South Dakota's Administrative Rules (ARSD) 20:78:04 and 05. Respondent, Colin Jay Boone, submitted an application for Advanced Life Support Student Status. Respondent's address as reported to the Board is 3409 51st St. #414 Sioux Falls 57106.

After investigation, a recommendation was made pursuant to ARSD 20:78:04:04 for the BMOE to deny his application for student status. Respondent has contested this recommendation. The Secretary, pursuant to ARSD 20:78:04 and ARSD 20:78:05, therefore files this Petition for a contested case hearing.

A. TIME, PLACE AND NATURE OF HEARING

Hearing. A contested case hearing on this licensure action shall be heard by a Hearing Examiner pursuant to ARSD 20:78:05:04. The hearing shall begin at 9:00 pm on Friday, February 6, 2014, in the BMOE Conference Room, 101 North Main Avenue, Suite 215, Sioux Falls, South Dakota 57104.

Answer. Respondent may file an Answer within twenty (20) days of the date he is served with this Petition. An Answer, if filed, should specifically admit, deny, or otherwise answer all allegations contained in sections C and D of this Petition. The Answer and any other pleading must be filed with the Board at the following address: BMOE, 101 North Main Avenue, Suite 301, Sioux Falls, South Dakota 57104.

Presiding Officer. The Hearing Examiner will preside over the hearing and make a recommended decision consisting of proposed Findings of Fact, Conclusions of Law, and an Order, to the Board. ARSD 20:78:05:06. The Board will read the record, transcript of the contested case proceeding, and all exhibits, and make its decision thereon at a BMOE meeting following the contested case hearing. The Board may request that the parties appear to present oral argument and objections to the Hearing Examiner's recommended decision. ARSD 20:78:05:06.

Hearing Procedures. The procedural rules governing the conduct of the hearing are found at SDCL chs. 36-4B and 1-26, and ARSD chs. 20:78:05. The contested case proceeding is an adversarial proceeding. At the hearing, you have the right to be present, to appear personally, and/or to be represented by legal counsel at your own expense. You will be allowed the opportunity to respond to the allegations of the Petition, to produce evidence on your behalf, to present witnesses, to cross-examine witnesses, and to examine and respond to any documents introduced at hearing. These and other due process rights will be forfeited if they are not exercised at the hearing.

The hearing is open to the public.

Any decision of the BMOE based on the contested case proceeding may be appealed to the circuit court and the State Supreme Court as provided by law.

Pre-hearing Conferences and Continuances. Any party may request a pre-hearing conference to discuss evidentiary issues related to hearing, or may request a continuance, by filing a motion for a prehearing conference with the BMOE at the address above.

Prosecution. Counsel for the Secretary is responsible for representing the public interest (the State) in this proceeding. Counsel for the Secretary is: William H. Golden, Assistant Attorney General, South Dakota Attorney General's Office, 101 North Main Avenue, Suite 301, Sioux Falls, South Dakota 57104. Copies of all pleadings filed in this matter must be provided to Counsel for the Secretary at this address.

Communications. You may not contact Board members in any manner, including by phone, letter, in person, or by e-mail about this Petition. BMOE members may only receive information about the case when all parties have notice and an opportunity to participate, such as at the hearing or in pleadings you file with the BMOE office and serve upon all parties in this case. *See* SDCL 1-26-26.

B. LEGAL AUTHORITY AND JURISDICTION

Jurisdiction. The BMOE has jurisdiction in this matter pursuant to SDCL 36-4B.

Legal Authority. If any of the allegations against you are founded, the BMOE has authority to take disciplinary action against you under SDCL 36-4B-6, 31 and 36-4-30, and ARSD 20:78:04 and 05.

Default. If you fail to appear at the hearing, the Board may enter a default decision or proceed with the hearing and render a decision in your absence, in accordance with SDCL 1-26.

C. SECTIONS OF STATUTES AND RULES INVOLVED

Count I

Mr. Boone is subject to review under SDCL 36-4B-6 for failing to prove good moral character when he submitted his application on September 22, 2014, and disclosed that he was charged with a civil rights violation due to an incident that occurred while he was working for the Des Moines Police Department.

D. FACTUAL CIRCUMSTANCES

1. Mr. Boone submitted an application for a South Dakota Advanced Life Support Student Status on September 22 2014.
2. Mr. Boone was placed under investigation due to the federal charges and for investigation of his moral character.
3. On December 17, 2013, Mr. Boone was indicted for Unreasonable Use of Force under Title 18, United States Code, Section 242. While acting under the color of law as a police officer with the Des Moines Police Department he kicked O.P.H, willfully depriving him of his rights which are secured and

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

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SDBMOE@STATE.SD.US
P 605-367-7781 F 605-367-7786
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2-6-2015
In re Colin J. Boone
BMOE
04 TLS

Via electronic and regular mail

December 17, 2014

Colin J. Boone
3409 51st #414
Sioux Falls, SD 57106
booneemt@gmail.com

Dear Mr. Boone:

Enclosed please find a Notice of Hearing for a contested case in regard to the recommendation for the denial of your application for advanced life support student status. This matter will be presented to an Administrative Law Judge (ALJ) from the South Dakota Office of Hearing Examiners for hearing on Friday, February 6, 2015 beginning at 9:00 am. The contested case hearing will be held in the Board Room at 101 N. Main Ave., Suite 215, Sioux Falls, SD.

You have the right to be represented by an attorney of your own choosing at the contested case hearing if you so desire. After the hearing, the recommendation of the ALJ will be referred to the South Dakota Board of Medical and Osteopathic Examiners for consideration at a Board meeting where the Board may accept, reject, or modify the recommendation of the hearing examiner. If you participate in the administrative hearing, you would then have the right to file an appeal to circuit court.

Please direct questions to the Board Attorney, William H. Golden, by phone to 605-201-8588.

Sincerely,

Jane Phalen

Jane Phalen
Board Staff

Enclosure

cc: William H. Golden, esq.
State of South Dakota Office of Attorney General
Assistant Attorney General/Civil Litigation Division
Counsel to the South Dakota Board of Medical and Osteopathic Examiners

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

* *

IN THE MATTER OF THE APPLICATION FOR STUDENT STATUS SUBMITTED TO THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS	NOTICE OF HEARING IN CONTESTED CASE

RE: COLIN J. BOONE

* *

Please take notice that a contested case hearing has been scheduled before an Administrative Law Judge of the Office of Hearing Examiners in the above captioned matter. The hearing will take place on Friday, February 6, 2015, in the Board Room, Suite 303, 101 N. Main Ave., Sioux Falls, SD, beginning at 9:00 am.

Dated this 18th day of December, 2014.

William H. Golden, esq.
Assistant Attorney General/Civil Litigation Division
317 N. Main Ave.
Sioux Falls, SD 57104
Attorney for the South Dakota Board of Medical and Osteopathic Examiners
(605) 201-8588

From:	SDBMOE
To:	"booneemt@gmail.com"
Subject:	Notice of Contested Case Hearing
Date:	Thursday, December 18, 2014 4:26:28 PM
Attachments:	Notice of Hearing and .pdf
Importance:	High

Dear Mr. Boone:

Attached please find information that is also being mailed to you today.

Sincerely,

Jane Phalen
SD Medical Board Staff

STATE OF SOUTH DAKOTA

OFFICE OF ATTORNEY GENERAL
1302 East Highway 14, Suite 1
Pierre, South Dakota 57501-8501
Phone (605) 773-3215
Fax (605) 773-4106
TTY (605) 773-6585
www.state.sd.us/atg

MARTY J. JACKLEY
ATTORNEY GENERAL

CHARLES D. McGUIGAN
CHIEF DEPUTY ATTORNEY GENERAL

6

December 22, 2014

Colin Boone
3405 51st #414
Sioux Falls, SD 57106

Re: Colin Jay Boone #14-189

Dear Mr. Boone:

Please find attached a subpoena duces tecum requesting documents and videos concerning the federal charge. Please provide these documents by January 5, 2015, to the BMOE Office. If you require personal service on the Subpoena please let me know.

In our discussion, I had made it clear that we would not proceed on the licensing action if you wished to postpone the hearing pending a final decision in your criminal matter. You stated that you wish to proceed with the contested case in the civil licensing matter. At your request, the hearing has been set for February 6, 2015, in Sioux Falls, South Dakota.

Sincerely,

William H. Golden
Assistant Attorney General

WHG/

EXHIBIT
6
2-6-15 TLS

STATE OF SOUTH DAKOTA
DEPARTMENT OF HEALTH
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

STATE OF SOUTH DAKOTA) **SUBPOENA**
: SS
COUNTY OF MINNEHAHA) **DUCES TECUM**

TO: Colin Jay Boone
3409 51st #414
Sioux Falls, SD 57106

In the matter of: In Re: Colin Boone, Docket #14-189

GREETINGS

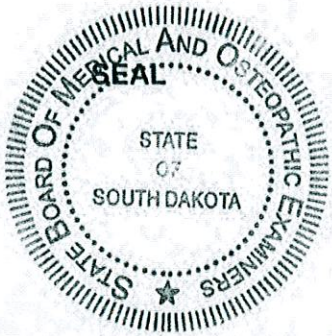
YOU ARE HEREBY COMMANDED to be and appear at the office of the South Dakota Board of Medical and Osteopathic Examiners, 101 N. Main Ave., Suite 301, Sioux Falls, SD, 57104, at 10:00AM on January 5, 2015, then and there to give testimony on the part of the South Dakota Board of Medical and Osteopathic Examiners, in the matter noted above which is an administrative proceeding pending before the South Dakota Board of Medical and Osteopathic Examiners.

You are further commanded to produce for examination at the time, date and place stated above, the following:

Any and all police reports, videos and records of disciplinary action you were subject to as a police officer and any and all documentation on the current federal charges

In lieu of your appearance as above stated, you may, on or before 10:00AM on January 5, 2015, mail or otherwise deliver to the undersigned legible copies of the documents and items you are commanded to produce in response to this subpoena. If such documents and items are produced in advance of the date and time set for your appearance, your appearance will not be required.

WITNESS, the Hand and Seal of the South Dakota Board of Medical and Osteopathic Examiners on December 22, 2014.



Margaret B. Hansen, Executive Director
South Dakota Board of Medical & Osteopathic Examiners

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Bill date	12/23/2014
Total Billed	$17.23
Tracking ID Balance due	$0.00
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Sender Information

Margaret Hansen
SDBMOE
101 N. Main Ave., Suite 301
SIOUX FALLS SD 57104
US

Recipient Information

Colin Boone
3409 51st Street # 414
SIOUX FALLS SD 57108
US

Shipment Details

Ship date	12/23/2014
Payment type	Shipper
Service type	FedEx Express Saver
Zone	02
Package type	FedEx Envelope
Weight	0.00 lbs
Pieces	1
Meter No.	5282744
Declared value	$0.00

Charges

Transportation Charge	12.90
Fuel Surcharge	0.98
Residential Delivery	3.35
Weekday Delivery	0.00
Total charges	**$17.23**

Original Reference

Customer reference no.	NO REFERENCE INFORMATION
Department no.	
Reference #2	
Reference #3	

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SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
101 N MAIN AVE, SUITE 301
SIOUX FALLS, SD 57104
SDBMOE@STATE.SD.US
P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV

2-6-2015
In re Colin J. Boone
BMOE
07 TLS

Via electronic mail and Federal Express

January 23, 2015

Colin J. Boone
3409 51st #414
Sioux Falls, SD 57106
booneemt@gmail.com

Dear Mr. Boone:

Enclosed please find the Brief in support of the denial of your application for student status.

The Notice of Hearing in your case, which will be held on Friday, February 6, 2015, at 9:00 am, was mailed to you early in December 2014.

Please direct any questions to the Board counsel, William H. Golden, at 605-201-8588.

Sincerely,

Jane Phalen

Jane Phalen
SD Medical Board Staff

THE BOARD OF MEDICAL AND
OSTEOPATHIC EXAMINERS OF THE
STATE OF SOUTH DAKOTA

IN THE MATTER OF:	)	NO. 14-189
	)	
COLIN JAY BOONE APPLICANT FOR ADVANCED LIFE SUPPORT STUDENT STATUS	)))	BRIEF FOR BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS
	)	
Respondent.	)	

COMES NOW, the Executive Secretary of the South Dakota Board of Medical and Osteopathic Examiners and offers the following brief in support of its recommendation for denial of an advanced life support student status to Colin Jay Boone.

FACTS

Mr. Boone submitted an application for a South Dakota Advanced Life Support Student Status on September 22, 2014. In his application, Mr. Boone disclosed that he was under federal indictment.

On December 17, 2013, Mr. Boone was indicted for unreasonable use of force under Title 18, United States Code Section 242. Mr. Boone was working as a law enforcement officer with the Des Moines Police Department he allegedly kicked O.P.H. and willfully deprived him of his rights, security and protections by the constitution and laws of the United States for freedom from the use of unreasonable force by a law enforcement officer. The allegations claim that while Mr. Boone was working as a law enforcement office he was dispatched to a traffic accident, and upon arriving at the scene found an individual who was unresponsive. During Mr. Boone's interactions with the

individual, it is alleged that he assaulted the individual without provocation. Mr. Boone was placed under investigation due to these federal charges, and he was asked to provide copies of all police reports and court documents regarding the reported incident to the Board staff along with his detailed explanation and response. Mr. Boone failed to provide the requested information.

EVIDENTIARY GROUNDS FOR EXHIBITS

Administrative hearings are not required to follow the technical rules of evidence but are to be applied fairly to both parties. *Daily v. City of Sioux Falls*, 2011 S.D. 48, 802 N.W. 2d 905. Administrative hearings are controlled by the following statute for evidence to be admitted:

SDCL 1-26-19 Rules of evidence in contested cases. In contested cases:

(1) Irrelevant, incompetent, immaterial, or unduly repetitious evidence shall be excluded. The rules of evidence as applied under statutory provisions and in the trial of civil cases in the circuit courts of this state, or as may be provided in statutes relating to the specific agency, shall be followed. When necessary to ascertain facts not reasonably susceptible of proof under those rules, evidence not otherwise admissible thereunder may be admitted except where precluded by statute if it is of a type commonly relied upon by reasonably prudent persons in the conduct of their affairs. Agencies shall give effect to the rules of privilege recognized by law. Objections to evidentiary offers may be made and shall be noted in the record. Subject to these requirements, when a hearing will be expedited and the interests of the parties will not be prejudiced substantially, any part of the evidence may be received in written form;

(2) A party may conduct cross-examinations required for a full and true disclosure of the facts;

(3) Notice may be taken of judicially cognizable facts. In addition, notice may be taken of generally recognized technical or scientific facts within the agency's specialized knowledge. Parties present at the hearing shall be informed of the matters to be noticed, and those matters shall be noted in the record, referred to therein, or appended thereto. Any such party shall be given a reasonable opportunity on request to refute the officially noticed matters by

evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the agency.

Our Court has set out the following requirements for meeting the necessary due process rights of Parties in the hearing:

Application of the technical rules of evidence is not constitutionally required. *United States v. Fell*, 360 F.3d 135, 144–45 (2d Cir.2004). Numerous courts have recognized that this is especially true in administrative proceedings. *See, e.g.*, *R & B Transp., L.L.C. v. U.S. Dep't of Labor, Admin. Review Bd.*, 618 F.3d 37, 45 (1st Cir.2010); *Hardisty v. Astrue*, 592 F.3d 1072, 1075 (9th Cir.2010); *Lybesha v. Holder*, 569 F.3d 877, 882 (8th Cir.2009) (citing *Tun v. Gonzales*, 485 F.3d 1014, 1025–26 (8th Cir.2007)). Yet it cannot be doubted that the applicable rules of evidence must be applied in a fair and even-handed manner. *See Withrow*, 421 U.S. at 46, 95 S.Ct. at 1464 ("[A] 'fair trial in a fair tribunal is a basic requirement of due process.' " (quoting *Murchison*, 349 U.S. at 136, 75 S.Ct. at 625)). *Daily v. City of Sioux Falls*, 802 N.W. 2d 905 (S.D. 2011).

BASIS FOR RECOMMENDATION FOR DENIAL OF AN ADVANCED STUDENT STATUS TO COLIN BOONE

The purpose of the Medical Board is to "safeguard the public health and protect the public from incompetence, deception and fraud" *Katz v. South Dakota State Board of Medical and Osteopathic Examiners*, 432 N.W.2d 274 (S.D. 1988). In the petition filed by the Executive Secretary in this matter, the qualifications for a licensee application places the burden of proof on the applicant to show good moral character. SDCL 36-4B-13. The Legislature may define that which constitutes unprofessional or dishonorable conduct which may absolutely disqualify a person from the practice of medicine. *Katz*, 432 N.W.2d at 274. Further, the Court has held the right to practice medicine is not a fundamental right. *Id.* at footnote 6.

The review panel for the Medical Board recommended the denial of an advanced life support student status to Colin Boone for failing to establish good moral character when completing his application process. In this matter,

Colin Boone has been indicted and charged with a felony. South Dakota courts have held that conviction of a felony may constitute grounds for proof of a lack of good moral character. *See Katz*, 432 N.W.2d at 274. Case at bar, our courts have also specifically stated that in regard to a paramedic license, that SDCL 36-4B-31 and 36-4-30 expressly authorizes the denial of licensure for convictions of a felony. The court has expressly stated that felony convictions may be considered conclusive evidence of an absence of good moral character. *In Re Application of Benton*, 2005 S.D. 2, 691 N.W.2d 598. The court, also in *Benton*, acknowledged that failing to fully disclose information to the Board or parsing of words can be weighed against an applicant. *Benton*, 2005 S.D. 2 at ¶ 14, 691 N.W.2d at 602-3. On the case at bar, while we do not have a conviction for the felony charges, only a potential felony, the conduct still exists. Further, Mr. Boone has failed to cooperate with the Board in that he did not provide the requested documents or any mitigating evidence on his behalf so that the Board may fully evaluate his application and his claim of good moral character. *Benton*, 2005 S.D. 2 at ¶ 22, 691 N.W.2d at 605.

Concerning professional license, our court has stated:

> We have repeatedly held in attorney discipline cases that those attorneys who seek to defend their license against complaints must fully cooperate with, and inform the Disciplinary Board of all relative facts. To do otherwise weighs "heavily against the plea that we exercise leniency in imposing discipline." *In re Discipline of Tidball*, 503 N.W.2d 850, 855 (S.D. 1993).

Application of Widdison, 539 N.W.2d 671, 678-79 (S.D. 1995). In this case, Colin Boone has subsequently been subpoenaed with the request to provide

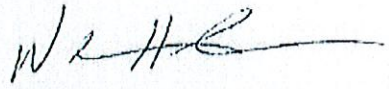
the documents surrounding the allegations of the assault on an individual at a crash scene. This is highly relevant information in determining Colin Boone's fitness and moral character for advanced life support student status.

Mr. Boone has taken the position that he does not need to supply this information, and that it is the Board's responsibility to collect the information. As such, Mr. Boone has not fully completed his application, and it should be denied for that reason because he has exceeded the 120 days allowed by South Dakota administrative rule for completion of an application. Or, in the alternative and based upon the information provided, that the burden falls upon Mr. Boone, the applicant, to provide evidence of good moral character, and that the federal indictment and refusal to comply with the Board's request is a failure by Mr. Boone to prove the required good moral character.

CONCLUSION

It is hereby requested that Colin Boone's application for advanced life support student status hereby be denied.

Dated this 22nd day of January 2015.



William H. Golden
Assistant Attorney General
500 East Capitol Avenue
Pierre, South Dakota 57501-5070
Telephone: (605) 773-3215

STATE OF SOUTH DAKOTA } S.S.
MINNEHAHA COUNTY
I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on the record in my office.
Executive Secretary
By MBH by JTP
Date 1-23-15

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the Brief for Board of Medical and Osteopathic Examiners in the Matter of *Colin Jay Boone Applicant/Advanced Life Support Student Status*, No. 14-189 was served by United States mail, first class, postage prepaid upon Colin J. Boone, 3409 51st #414, Sioux Falls, South Dakota 57106, on this 22nd day of January 2015.

William H. Golden
Assistant Attorney General
500 East Capitol Avenue
Pierre, South Dakota 57501-5070
Telephone: (605) 773-3215

STATE OF SOUTH DAKOTA } S.S.
MINNEHAHA COUNTY
I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on the record in my office.
Executive Secretary
By MBH by JTP
Date 1-23-15

From:	SDBMOE
To:	"booneemt@gmail.com"
Subject:	Brief in Support of Denial of Student Status
Date:	Wednesday, January 21, 2015 3:57:03 PM
Attachments:	Brief for Colin Jay Boone.pdf
Importance:	High

Dear Mr. Boone:

Attached please find the Brief in this matter. This is also being sent to you by regular mail.

Sincerely,

Jane Phalen
SD Medical Board Staff

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city	Sioux Falls, SD
Shipper	US
state	57106
Ship (P/U) date	515 240-7286
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Recipient state	
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Total pieces	1
Terms	Not Available
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Service	FedEx Standard Overnight
Weight	0.5 lbs
Delivered To	FedEx Location
Total shipment weight	0.5 lbs / 0.23 kgs
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CLERK OF DISTRICT COURT
SOUTHERN DISTRICT OF IOWA

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF IOWA

UNITED STATES OF AMERICA,	)	
	)	Criminal No. 4:13-cr-139
	)	
v.	)	SUPERSEDING INDICTMENT
	)	
COLIN J. BOONE,	)	18 U.S.C.
	)	18 U.S.C.
Defendant.	)	

2-6-2015
In re Colin J. Boone
BMOE
08 TLS

THE GRAND JURY CHARGES:

COUNT 1
(Unreasonable Use of Force)

On or about February 19, 2013, in the Southern District of Iowa, the defendant, COLIN J. BOONE, while acting under color of law as a police officer with the Des Moines Police Department kicked O.P.H., willfully depriving him of the right, secured and protected by the Constitution and laws of the United States, to be free from the use of unreasonable force by a law enforcement officer. The offense resulted in bodily injury to O.P.H.

This is a violation of Title 18, United States Code, Section 242.

THE GRAND JURY FURTHER CHARGES:

COUNT 2
(Obstruction)

On or about February 19, 2013, in the Southern District of Iowa, the defendant, COLIN J. BOONE, acting in relation to and contemplation of a matter within the jurisdiction of a department and agency of the United States, knowingly concealed, covered up, falsified, and made a false entry in a document, that is an "Arrest Incident Report", with the intent to impede, obstruct, and

influence the investigation and proper administration into his conduct.

This is a violation of Title 18, United States Code, Section 1519.

A TRUE BILL.

/s/
FOREPERSON

Nicholas A. Klinefeldt
United States Attorney

By: */s/Richard E. Rothrock*
Richard E. Rothrock
Assistant United States Attorney

2-6-2015
In re Colin J. Boone
BMOE
09 725

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF IOWA

UNITED STATES OF AMERICA,	)	
	)	Criminal No. 4:13-CR-139
v.	)	
	)	
COLIN J. BOONE,	)	GOVERNMENT'S TRIAL BRIEF
	)	
Defendant.	)	

The United States of America, by and through its undersigned counsel, submits its Trial Brief for the Court's consideration.

TABLE OF CONTENTS

I. Charged Offenses 1
II. Summary of Facts 2
III. Types of Evidence to Be Presented 4
A. Fact Witnesses 4
B. Expert Witnesses 5
C. Video Recordings 5
D. Dispatch Transcript 6
E. Photographs 6
F. Diagrams 6
G. Reports 6
H. Training Materials 7
IV. Issues to be Resolved 7
A. Sentencing Considerations and Prior Convictions & Conduct 7
B. Expert Testimony 7
C. Evidence of Prior Acts 8

I. Charged Offenses

Colin Boone was charged in a two-count superseding indictment with Count 1, unreasonable use of force, and Count 2, obstruction, which each occurred on or about February 19, 2013. (Docket No. 32). The elements for unreasonable use of force are: (1) that the defendant acted under color of law; (2) that the defendant deprived the person of a protected federal right; (3)

that the defendant acted willfully; and (4) that bodily injury resulted from the violation. *See* 18 U.S.C. § 242; Pattern Crim. Jury Instr. 5th Cir., § 2.18 (2012) (modified). A defendant acts willfully if he acts voluntarily and intentionally, with a bad purpose or motive to disobey or disregard the law. *See* Pattern Crim. Jury Instr. 5th Cir., § 2.18 (2012); Fed. Jury Prac. & Instr. § 29.05 (6th ed. 2014) (modified). Deprivation of a protected federal right occurs when a law enforcement officer uses unreasonable force, force greater than reasonably necessary. *See Graham v. Connor*, 490 U.S. 386, 393, 396-7 (1989) (holding that reasonableness must be judged from the perspective of a reasonable officer on the scene); *United States v. Harrison*, 671 F.2d 1159, 1162 (8th Cir. 1982).

The elements for obstruction, as charged in Count 2, are: (1) the defendant knowingly falsified or made a false entry in a document; (2) the defendant did so with the intent to impede, obstruct, or influence an investigation or matter; and (3) the investigation or matter was within the jurisdiction of a department or agency of the United States. *See* 18 U.S.C. § 1519; Eighth Circuit Manual of Model Jury Instructions, § 3.06 (2014).

II. Summary of Facts

On February 19, 2013, two Des Moines Police Department officers were on duty, driving in Des Moines. At approximately 2:30 a.m., they observed a van against a concrete wall, and saw the van then roll backwards. The officers stopped to investigate and observed the sole occupant of the van, later identified as Orville Hill, lying in between seats in of the van. The doors of the van were locked. The officers pounded on the windows, but Hill was nonresponsive, possibly unconscious. Hill then began moving around inside the van, but did not comply with officers' directions to open the doors. Two other officers arrived at the scene. Hill started the van and

attempted to drive away. The officers broke out a window of the van and unlocked the door. The officers shut the van off, forcibly removed Hill from the van and took him to the ground. Hill was noncompliant with the officer's commands to lay still. He was thrashing on the ground but was not actively fighting with the officers. Three of the officers were restraining Hill and working to place him in handcuffs. The fourth officer was upright, circling around Hill and the three officers on the ground.

At that point, shortly after officers took Hill to the ground, Officer Colin Boone arrived on scene. Boone ran from his patrol vehicle to where Hill was on the ground with officers and immediately kicked Hill in the head. The kick knocked teeth from Hill's mouth and caused blood to freely flow from Hill's mouth. The kick also caused the officer restraining Hill's right shoulder to fall backward. The officers all restrained Hill and finished placing him in handcuffs. Medics were called and additional officers responded to the scene. While waiting for medics to arrive, Hill continued to move around and make noise. Various officers helped restrain Hill to keep him from moving around on the ground.

Medics arrived and transported Hill to the hospital. Hill explained that he has had seizures. He said that while driving earlier he had felt a seizure coming on. He recalled trying to pull his van off the road prior to the onset of the seizure. Hill has no other recollection of the incident until he was in the ambulance.

Boone made statements to officers at the scene about kicking Hill. Boone at first planned to conduct follow up investigation at the hospital. He then had another officer handle the follow up so he could go back to the station to prepare a report. Back at the station Boone made

additional statements about kicking Hill in front of two officers as well as to a person working in dispatch.

All officers who used any force to restrain Hill, including Boone, completed an arrest incident report (AIR). Boone's AIR stated that he kicked Hill in the shoulder and did not disclose the fact that he had kicked Hill in the head, or that he caused injury. Two of the initial responding officers were field training officers. They each contacted superiors to express concerns over Boone kicking Hill in the face.

Prior to this incident Boone had been counseled about the use of force and report writing. In August of 2012, Boone was required to attend additional training on use of force following an internal review of two separate incidents. During the course of his performance evaluation in 2012 Boone was counseled about writing arrest incident reports, that include use of force.

III. Types of Evidence to be Presented

The Government believes the following types of evidence will be presented at trial. The parties anticipate reaching stipulations regarding the foundation and admission of certain evidence and will advise the Court of what stipulations are reached. The Government does not believe there are any issues with the proposed witnesses' competency to testify, or the authentication of proposed exhibits. The Government likewise does not anticipate any issues during trial, aside from standard evidentiary objections during the examination of witnesses.

A. Witness Testimony (Fact Witnesses)

The Government intends to introduce testimony from witnesses with knowledge of what occurred on February 19, 2013. These witnesses are comprised of law enforcement officers and civilians. The witnesses may include medical professionals who would provide testimony about

the treatment of Hill at the hospital the night of this incident. The Government also intends to introduce testimony from witnesses about use of force training provided by the Des Moines Police Department (see "Expert Witnesses" section below). Each of these witnesses would testify based upon personal knowledge, as required by Federal Rule of Evidence 602.

B. Expert Witnesses

Both parties will introduce testimony from witnesses with specialized knowledge in the area of use of force by law enforcement officers. The Government intends to offer testimony from two such witnesses about training provided by the Des Moines Police Department. This would include training and instruction received by Boone. Such testimony would be factual in nature. Some of the law enforcement witnesses may offer opinions based upon their perceptions and personal knowledge, which would be admissible under Federal Rule of Evidence 701.

The defense also intends to offer testimony from a witness about use of force. The Government believes that witness would testify about different types of techniques that can be used in restraining an individual. Testimony from each of these witnesses may include opinions based upon the particular witness's specialized knowledge. It appears that such opinion testimony would be admissible under Federal Rule of Evidence 702.

C. Video Recordings

The Government intends to offer video recordings from law enforcement vehicles at the scene in this case. The Government may also offer still shots or photographs taken from such videos. Some of the videos have audio recordings included with them while other have only video. Video recordings can be admitted through testimony identifying what the video depicts

and confirming that the depiction is accurate. *United States v. Smith*, 591 F.3d 974, 979 (8th Cir. 2010).

D. Dispatch Transcript

The Government may offer a transcript, or portion thereof, of audio recordings from dispatch calls related to this incident. This transcript would be offered as an exhibit. "It is well settled in this circuit the jury may use transcripts of taped conversations during trial and deliberations." *United States v. Placensia*, 352 F.3d 1157, 1165 (8th Cir. 2003).

E. Photographs

The Government will offer photographs taken at the scene as well as at the hospital. Photographs or still shots taken from videos admitted at trial may also be presented at trial. The Government may also offer photographs of Hill taken on other dates. Photographs that accurately show a place or scene are admissible. *United States v. Neal*, 527 F.2d 63, 65 (8th Cir. 1975).

F. Diagrams

The Government intends to offer diagrams of the intersection where this incident occurred. Such diagram may include indications of where particular vehicles were parked during the incident. The Government may also offer a diagram with the outline a body to help show where officers were at while restraining Hill when Boone approached. The Government anticipates offering these diagrams as exhibits at trial. In the alternative they may be used as demonstrative aids and marked for identification purposes, but not offered into evidence.

G. Reports

The Government will offer one or more reports written by Boone about this incident.

H. Training Materials

The Government will offer written materials used by the Des Moines Police Department for use of force training.

IV. Issues to be Resolved

The Government believes that the following issues need to be resolved prior to the admission of the corresponding evidence.

A. Sentencing Considerations and Prior Convictions & Conduct

The Government raised these issues in its Motion in Limine. (Docket No. 50). The Government believes that these issues, which are standard trial issues, can be resolved by the Court during pre-trial conference outside the presence of the jury.

B. Expert Testimony

The defense will seek to introduce testimony of Dr. Terry Davis. The purpose of this testimony would be to provide an opinion about why Hill behaved the way he did at the scene. The testimony and videos admitted at trial will show that Hill acted erratically, was resistive and did not comply with officers' directions. Hill also made noise, often unintelligible, throughout a majority of the time he was at the scene. Dr. Davis' testimony would be offered to counter testimony by Hill that he believed he had suffered from a seizure. Dr. Davis may even offer one or more alternative explanations for why Hill behaved the way he did. Such testimony could represent extrinsic evidence regarding Hill's truthfulness. The testimony would be insufficiently reliable for that purpose, but more importantly inadmissible under Federal Rule of Evidence 608.

As set forth in its Motion to Exclude Expert Testimony (Docket No. 51), the Government believes that such evidence would be irrelevant and inadmissible. Hill's behavior and what

officers saw and heard prior to Boone kicking Hill is most certainly relevant to whether Boone used unreasonable force. There are various possibilities for why Hill behaved in the way that he did, as well as for why he may not recall what occurred. The issue of *why* he behaved a certain way has no bearing on whether Boone used unreasonable force. Such evidence would not assist the jury in determining whether the elements of the offense are established by the evidence in this case. Therefore, such testimony presents a substantial risk of confusing the issues and misleading the jury. The evidence should be excluded under Federal Rules of Evidence 402 and/or 403. Even if such evidence were admissible under these rules, Dr. Davis' opinion, as well as the basis it rests upon, are not sufficiently reliable and should therefore be excluded under Federal Rule of Evidence 702.

C. Evidence of Prior Acts

The Government will seek admission of evidence that due to two separate prior incidents, Boone was required to receive additional instruction on use of force. The Government would also intend to offer testimony about the instruction actually provided to Boone. This evidence is relevant and highly probative to whether Boone acted willfully, an element of unreasonable use of force. The Government does not intend to offer any other evidence of the prior incidents (such as specifics or underlying facts of those incidents). The Government does not believe grounds exist to exclude such evidence.

The Government may also seek to introduce evidence that based upon Boone's previous prior use of force report writing, he was counseled about the appropriate way to write such reports. This would include what type of information Boone was instructed to include and how to write

those types of reports. That evidence would be relevant to whether he acted knowingly for the charge of obstruction.

Respectfully submitted,

Nicholas A. Klinefeldt
United States Attorney

By: */s/ Kelly Mahoney*

Kelly Mahoney
Assistant United States Attorney
U.S. Courthouse Annex, Suite 286
110 East Court Avenue
Des Moines, Iowa 50309-2053
Tel: (515) 473-9300
Fax: (515) 473-9292
Email: kelly.mahoney@usdoj.gov

CERTIFICATE OF SERVICE

I hereby certify that on October 22, 2014, I electronically filed the foregoing with the Clerk of Court using the CM ECF system. I hereby certify that a copy of this document was served on the parties or attorneys of record by:

____ U.S. Mail _____ Fax _____ Hand Delivery

X ECF/Electronic filing X Other means

UNITED STATES ATTORNEY

By: */s/ Kelly Mahoney*
Assistant United States Attorney

2-6-2015
In re Colin J. Boone
BMOE
010 TLS

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF IOWA
CENTRAL DIVISION

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	Criminal No. 4:13-CR-0139
	)	
vs.	)	DEFENDANT'S TRIAL
	)	MEMORANDUM AND
COLIN J. BOONE,	)	RESPONSE TO GOVERNMENT'S
	)	MOTION IN LIMINE
Defendant.	)	

TABLE OF CONTENTS

SUMMARY OF FACTS 1

EXPERT WITNESSES 3

OTHER WITNESSES 3

ISSUES TO BE RESOLVED BEFORE TRIAL 4

SUMMARY OF FACTS

In the early morning hours of February 19, 2013, while on duty, two Des Moines police officers observed a van with front-end damage up over the curb blocking the sidewalk near the intersection of Hartford and Indianola Roads. The officers stopped to investigate and saw Orville Hill lying between the seats of the van. The doors of the van were locked. Officers pounded on the window and woke Hill up. In the meantime, two other officers arrived on the scene. Upon seeing the officers, Hill panicked , jumped around the interior of the van, eventually jumped into the driver seat's, started the van and attempted to drive away. Fortunately, the van had some kind

DEFENDENTS TRIAL MEMORANDIDEFENDENTS TRIAL MEMORANDUM-

of damage and although the motor was racing, the van would not move and Hill was unable to flee. The officers were able to smash the windows and violently extracted Hill from the van and threw him to the cement. The officers immediately jumped on top of Hill who was resisting being handcuffed.

Officer Colin Boone was on duty that night. He heard the police calls over the radio. After the first call he decided to head over to the scene since he is an OWI expert and generally handles impaired driver arrests. However, as he was proceeding to the scene, more calls came out indicating the driver was not exiting the vehicle. Finally a call came out that the driver was taking off. Hearing that call, Officer Boone increased his speed to assist with what he believed was turning into a dangerous high speed chase involving an impaired driver.

As officer Boone arrived, he witnessed Hill on the ground; he was actively resisting with at least two officers on top of him. Hill was not yet under control and not yet handcuffed. Hill's left arm was in a "push up" position and he was attempting to get up. Officer Boone believed Hill was likely on some type of drug which would account for his resistance to officers. At that time none of the officers knew if Hill was armed. Officer Boone attempted to deliver a sweep kick to knock Hill's left arm out from in front of him. Where Boone's foot actually came in contact with Hill's body will be determined at trial.

After Boone delivered the kick, the officers were able to handcuff Hill. Because Hill continued to resist and kick even after his hands had been cuffed, officers had to forcibly apply a hobble restraint on Hill's legs. Later Hill was transported to a local hospital where he refused chemical testing for drug or alcohol intoxication.

Following the incident, Hill claimed he had an epileptic seizure and claimed he could

not remember any of the events that transpired that evening. Mr. Hill has a long history of previous arrests for drug & theft offenses.

EXPERT WITNESSES

Dr. Phil Hayden: Use of force expert: Dr. Hayden is a retired FBI supervisory special agent and is a court certified expert on police use of force, law enforcement tactics, and high risk arrests.

Dr. Terry A. Davis: Dr. Davis is a board certified forensic psychiatrist. He also served as community mental health director for Douglas County Mental Hospital, the largest mental hospital in the State of Nebraska. Dr. Davis is very knowledgeable concerning the symptoms of epilepsy and seizure disorders. Dr. Davis is also very knowledgeable about the symptoms of drug intoxication. Dr. Davis has examined Mr. Hill's medical records, his criminal records, and the police videos of the arrest of Mr. Hill. Dr. Davis is prepared to offer his opinion whether the behavior exhibited by Mr. Hill the night in question is consistent with a person suffering an epileptic seizure. Dr. Davis is also prepared to offer his opinion whether the behavior exhibited by Mr. Hill on the night in question is more consisted with stimulant intoxication.

OTHER WITNESSES

Officer Stewart Barnes: Officer Stewart Barnes is a Des Moines police officer who may testify as to Colin Boone's reputation for honesty and truthfulness.

Andy Holtz: Former employer and long time acquaintance of Mr Hill who may testify as to Mr. Hill's reputation for having a character for untruthfulness. (See Fed.R.Evid. 608(a)).

ISSUES TO BE RESOLVED BEFORE TRIAL; GOVERNMENT'S MOTION TO EXCLUDE EXPERT TESTIMONY: DR. TERRY A. DAVIS

1. The government argues that why Mr. Hill was exhibiting the behavior he did on the night in question is entirely irrelevant. The government further argues whether it was a seizure or some type of drug intoxication doesn't matter. This is not true. The arrest and the level of force necessary to effectuate an arrest differs substantially depending on the cause of the suspect's resistance. Dr Davis will testify that a person having an epileptic seizure will typically not engage in purposeful movements, such as attempting to drive a car away, nor do seizures last for the length of time that Mr. Hill struggled and resisted officer's commands. The defense use of force expert, and, we suspect, the government's use of force experts will testify the arrest of an intoxicated suspect presents special dangers and risks to the officers involved.

2. The government argues that Dr. Davis' anticipated testimony amounts to a medical diagnosis, and further argues it is not a generally accepted method of diagnosis. The government makes this allegation without citing any support. We assume the government bases its objection on the fact that Dr. Davis has not personally examined Mr. Hill. The government seems more concerned with the expert's determinations and uses the manner to which he reaches them as a point of contention. To this, what *Daubert v. Merrell Dow Pharmaceuticals*, 509 U.S. 579 (1993) ultimately stands for is of importance. In particular, *Daubert* states; "[t]he inquiry envisioned by Rule 702 is, we emphasize, *a flexible one*. Its overarching subject is the scientific validity and thus the evidentiary relevance and reliability—of the principles that underlie a proposed submission. *The focus, of course, must be solely on principles and methodology, not on the conclusions that they generate*." Daubert, 509 U.S. at 594-95. (*emphasis added*).

By seeking exclusion, the government is attempting to foreclose the defense's opinion testimony

from the purview of the jury. The government is setting a standard that is not for the court, but the jury to decide. *See Kuhn v. Wyeth, Inc.*, 686 F.3d 618, 625 (8th Cir. 2012) (quoting *Milward v. Acuity Specialty Prods. Grp.*, 639 F.3d 11, 15 (1st Cir.2011)) ("[p]roponents of expert testimony need not demonstrate that the assessments of their experts are correct, and trial courts are not empowered "to determine which of several competing scientific theories has the best provenance.") "Vigorous cross-examination, presentation of contrary evidence, and careful instruction on the burden of proof are the traditional and appropriate means of attacking shaky but admissible evidence." *Daubert,* 509 U.S. at 596.

In the field of forensic medicine opinions relative to particular events are routinely given without examining the subject of the opinion. For instance, in will contests contesting the mental competency of the deceased, medical opinions in those instances are most often given without examining the deceased, since of course, by the time of the contest, that would be impossible by virtue of the person who is the subject of the contest is dead. In civil cases, medical doctors are routinely called by one side or the other for medical record reviews and routinely give medical opinions about a particular medical issue or event without having examined the subject. Often times those opinions are given years after the event occurred. Here, Dr. Davis not only will have reviewed the medical records of Mr. Hill, but has the added advantage of viewing the video tape of the behavior in question. Here Dr. Davis does not have to rely on the patient's subjective history, which is often inaccurate and influenced by subjective motives, such as hoping to recover a large monetary award. He has, what many doctors would love to have, a video tape of the actual event.

Officer Boone, arrived on the scene of what he reasonably believed was police

attempting to arrest an actively resisting suspect who, Boone reasonably believed, was under the influence of an intoxicant. Dr. Davis' testimony will support the basis for Officer Boone's impression at the scene and, we contend, is highly relevant. The reasonableness of Officer Boone's impression and his subsequent actions to assist in the arrest, are highly relevant. The jury will be asked to determine whether Office Boone acted reasonably under the circumstances. Dr. Davis' testimony has a direct bearing on the reasonableness of Officer Boone's actions.

The government has requested a *Daubert* hearing. The defense does not believe any *Daubert* hearing is necessary. Here, Dr. Davis' testimony will assist the trier of fact and will meet the criteria of Rule of Evidence 702. The jury is unlikely to possess the necessary expertise in medical diagnosis to determine what was occurring with Mr. Hill on the night in question. Dr. Davis will testify that any opinions are based on sufficient data and facts, and that his testimony is the product of reliable principles and methods. Dr. Davis will testify as to his extensive training and experience in the field of psychiatry, his certifications in forensic psychiatry and his extensive career testifying in numerous courts both federal and state.

3. **Sentencing Issue:** The defense does not intend to offer evidence on how the United States Sentencing Guidelines might apply in this case.

4. **Prior Convictions and Conduct**: The defense is aware of Federal Rule of Evidence 609. The defense will comply with that rule.

5. **Defendant's Prior Acts**: Through discussion of counsel, the defense believes this issue is resolved.

/s/ Michael L. Smart
MICHAEL L. SMART
FEDERAL PUBLIC DEFENDER'S OFFICE
701 Pierce Street, Suite 400
Sioux City, Iowa 51101
Phone 712-352-0552
Alt phone: 712-252-4158
Email: Mike_Smart@fd.org

CERTIFICATE OF SERVICE

I hereby certify that on October 23, 2014, I electronically filed this document with the Clerk of Court using the ECF system which will serve it on the appropriate parties.

/s/ Ellen Workman, Paralegal

2-6-2015
In re Colin J. Boone
BMOE
011 TLS

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF IOWA

UNITED STATES OF AMERICA,	*	
	*	4:13-cr-139
Plaintiff,	*	
	*	
v.	*	
	*	
COLIN BOONE,	*	
	*	ORDER
	*	
Defendant.	*	
	*	

On November 1, 2014, a jury acquitted Colin Boone ("Defendant") on Count Two of the Superseding Indictment. Clerk's No. 85. The jury was unable to reach a verdict on Count One and the Court, accordingly, declared a mistrial. Clerk's Nos. 84, 91. On November 12, 2014, the Court set Defendant's retrial on Count Two for February 9, 2015. Clerk's No. 93.

On January 8, 2015, the Government filed a motion to continue the February 9 trial date due to the substitution of Department of Justice counsel. Clerk's No. 101. The Motion states that Defendant resists the request for continuance. *Id.* On January 15, 2015, counsel for both the Government and Defendant contacted the Court by telephone to advise that Defendant no longer resists the Government's Motion and to suggest that a March 9, 2015 trial date would be acceptable to both parties.

Because Defendant now consents to the Government's request for a continuance, the Motion to Continue is hereby GRANTED. Trial in this case is rescheduled for March 9, 2015.

The deadline for filing pretrial motions is extended to February 23, 2015.

IT IS SO ORDERED.

Dated this _15th_ day of January, 2015.

Robert W. Pratt

ROBERT W. PRATT, Judge
U.S. DISTRICT COURT

Exhibit 3

September 22, 2014

Colin Boone

RE: Your SD Application is **Incomplete** – and will not be processed. This is due to missing information or as otherwise noted below:

- **You reported being charged with a civil rights violation.**
  - **Provide copies of any and all police reports, court documents and your Nebraska (or the state in which the incident occurred) Criminal History.**
  - **Provide a complete, detailed, signed and dated explanation regarding this event.**

Statement: I understand the Student Status application which I have already submitted to the SDBMOE shall be attached to this amendment, and together shall constitute my entire application for a Student Status.

Print or Type Name of Applicant: COLIN BOONE

Applicant Signature **(Must be original, blue or non-black ink)** **Date** 9-30-14

Return this to the Board office by: mail, email, or fax

General e-mail: SDBMOE@state.sd.us

SD Board of Medical & Osteopathic Examiners
101 North Main Avenue Suite 301
Sioux Falls, SD 57104

Fax: 605-367-7786

2-6-2015
In re Colin J. Boone
BMOE
012 TLS

Thank you,

RS

South Dakota Board of Medical and Osteopathic Examiners Staff

RECEIVED
DEC 17 2013
CLERK OF DISTRICT COURT
SOUTHERN DISTRICT OF IOWA

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF IOWA

UNITED STATES OF AMERICA,	)	
	)	Criminal No. 4:13-cr-139
v.	)	INDICTMENT
COLIN J. BOONE,	)	18 U.S.C. § 242
Defendant.	)	

THE GRAND JURY CHARGES:

COUNT1
(Unreasonable Use of Force)

On or about February 19, 2013, in the Southern District of Iowa, the defendant, COLIN J. BOONE, while acting under color of law as a police officer with the Des Moines Police Department kicked O.P.H., willfully depriving him of the right, secured and protected by the Constitution and laws of the United States, to be free from the use of unreasonable force by a law enforcement officer. The offense resulted in bodily injury to O.P.H.

This is a violation of Title 18, United States Code, Section 242.

A TRUE BILL.

/s/
FOREPERSON

Nicholas A. Klinefeldt
United States Attorney

By: _____
Richard E. Rothrock
Assistant United States Attorney

SENT TO CLIENT
1-3-14

AMMENDMENT WITH RESPONSE-0(AMMENDMENT WITH RESPONSE-0(

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
101 N MAIN AVE, SUITE 301
SIOUX FALLS, SD 57104
SDBMOE@STATE.SD.US
P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV

October 20, 2014

Colin Boone
3409 51st St #414
Sioux Falls, SD 57106

Dear Mr. Boone:

This letter serves as notice that your student status advanced life support application has been placed under investigation for the reported charge of a civil rights violation in your application. Your application is being investigated by a review panel which will be making a recommendation at the end of its review. Once a recommendation is made, you have certain rights which are outlined in this letter.

At this time, no recommendation has been made. Your patience is appreciated during this process as application does take longer when there is an investigative review in process.

Please be aware of the following:

Exparte communication is prohibited pursuant to SDCL 1-26-26. This means that neither you, nor any attorney(s) on your behalf, nor any other third party is to contact any Board members by phone, letter, facsimile, email, in person, or by any other method. You are entitled to due process rights during the complaint process as well as once a recommendation is made.

Your rights:

1.) You have the right to contest the recommendation at an administrative hearing which will be conducted in accordance with SDCL 1-26. This matter will be presented to a neutral administrative judge.
2.) You have the right to be represented by an attorney of your own choosing at the administrative hearing if you so desire.
3.) The recommendation of the administrative judge will be referred to the South Dakota Board of Medical and Osteopathic Examiners. The board may accept, reject or modify the recommendation.
4.) If you participate in a hearing, you would then have the right to file an appeal to Circuit Court.

Should you have any questions or concerns, please send them via email to Misty.Rallis@state.sd.us or by US mail.

Thank you for your cooperation in this matter.

Sincerely,

Misty Rallis

Misty Rallis
Board Investigator

2-6-2015
In re Colin J. Boone
BMOE
013 TLS

YANKTON COUNTY EMERGENCY MEDICAL SERVICES
805 CAPITOL STREET
YANKTON SD 57078

(605) 668-9033

January 29th, 2015

South Dakota Board of Medical and Osteopathic Examiners
101 N. Main Avenue, Suite 301
Sioux Falls, S.D. 57104

Dear SDBMOE,

As the Instructor Coordinator for the Yankton Advanced EMT Course (SDBMOE Course #14-006), I would like to let you know that Colin Boone was an active and eager participant in the classroom portion of the course that was held from September through November last year. Colin was only absent for two of the twenty scheduled classes, and he completed every section exam with an ending test average of 94.6%, which was above the class average.

I am providing this information in case it is relevant to you for Colin's scheduled hearing next week for student status approval.

If you have any questions, please feel free to contact me at (605) 760-4248. Thank you.

Sincerely,

Troy Cowman, NRP
Senior Paramedic
Instructor Coordinator
Yankton County EMS
Yankton, S.D.

EXHIBIT
Applicant A
2-6-15 TCS

United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE UNITED STATES CONGRESS

House of Representatives

EXHIBIT
Applicant B
2-6-15 TS

TRIBUTE TO IOWA'S TOP COPS

HON. TOM LATHAM
Thursday, May 10, 2012

Mr. LATHAM of Iowa: Mr. Speaker, I rise today to recognize six members of the Des Moines Police Department, Sergeant Michael McTaggart, Reserve Officer John Carter, and Senior Police Officers Colin Boone, Aaron Cawthorn, Jeremy Sprague, and Robin Swank, for being named Iowa's TOP COPS for 2012.

In the early morning of August 28th, 2011, these officers responded to a report of a car accident in Des Moines to find a vehicle on its side completely engulfed in flames. Inside the car, the cries for help of three teenage girls could be heard. Fighting jagged metal and fire hot enough to melt glass, Des Moines' finest didn't hesitate in risking their own lives to save the lives of the three trapped young girls. The quick action of these officers embodies the professionalism the Des Moines Police Department instills in its officers, but it's the selfless courage displayed immediately by these law enforcement professionals that truly makes this story inspiring. All six officers involved in the rescue were awarded the DMPD's highest honor, the Medal of Valor.

For their display of courage, the National Association of Police Organizations bestowed these officers with Iowa's 2012 TOP COP Honorable Mention award. This award is a tribute to outstanding law enforcement officers who display actions above and beyond the call of duty. Each year, TOP COPS are nominated nationwide by their fellow police officers, but only one case from each state is selected to be honored with this award. Each state's TOP COPS are invited to an award ceremony in Washington D.C., which is attended by celebrities, politicians and members of the national law enforcement community alike to pay tribute to these local heroes.

Mr. Speaker, the extraordinary heroism displayed in the face of danger by these police officers is nothing short of awe-inspiring. These members of the Des Moines Police Department are a testament to the high quality of our state's law enforcement community. I know I speak for all of my colleagues in the United States Congress in congratulating Jeremy, Robin, Colin, Aaron, John and Michael, and thanking all of Iowa's police officers for their selfless efforts in protecting communities across our great state. Thank you.

Tom Latham

Honorable Tom Latham
Member of Congress

Terry E. Branstad
Governor
Kim Reynolds
Lt. Governor

Steven L. Ponsetto
Acting Commissioner

September 21st, 2012

Officer Colin Boone
#25 E. 1st Street
Des Moines, Iowa 50309

Dear Officer Boone,

It is with great pleasure I inform you of your selection to receive the Sullivan Brother's Award of Valor for your heroic actions on August 28th, 2011.

The Honorable Terry Branstad, Governor of the State of Iowa, requests your presence at an awards ceremony to be held at the State Capitol, East Rotunda, on November 8th, 2012 at 3:30 pm. Governor Branstad will honor you, along with five other individuals, whose unselfish actions went above and beyond the normal call of duty. Your immediate family members are invited to attend as well.

Please RSVP to me at 515-577-9715.

On behalf of the Sullivan Brother's Award of Valor Review Committee, I congratulate you on receiving this prestigious award and look forward to seeing you at the State Capitol on November 8th, 2012.

M. Weidman

Mark Weidman
Sullivan Brother's Award of Valor program coordinator
State Fire Marshal Division

EXHIBIT
Applicant C
2-6-15 TLS

THE RESUME OF:

COLIN BOONE
3409 51st Street #414
Sioux Falls, SD 57106
boone4951@gmail.com

EMERGENCY MEDICAL TECHNICIAN

UPDATED: 03 November 2014

EXHIBIT
Applicant D
2-6-15 TS

INTRODUCTION

Mr. Boone graduated in 1995 form Mason City High School in Mason City, Iowa with a high school diploma geared for college entrance. Mr. Boone is a graduate of Metro Community College in Omaha, Nebraska with an Associate's Degree in Professional Studies. Mr. Boone obtained certification as an Iowa law enforcement officer by graduating from both the Iowa Department of Public Safety's Academy and the Des Moines Police Department's Regional Academy.

Mr. Boone has spent over 12 years in law enforcement with two elite law enforcement agencies in the State of Iowa. Mr. Boone has worked several areas of law enforcement including Patrol, Traffic, Security, and Airport units with the two departments. Mr. Boone has received many awards and commendations while serving the departments including the top D.R.E., Kip Hayward Award, and the Medal of Valor. Mr. Boone has taught for the Des Moines Police Academy, Iowa Law Enforcement Academy, and Iowa Drug Recognition Program covering computer and traffic enforcement areas of training.

Mr. Boone attended and completed the Avera School of Emergency Medicine in 2013. Mr. Boone became certified through the State of South Dakota and the National Registry of Emergency Medical Technicians in 2013. Mr. Boone has worked as a communication dispatcher and an EMT in the field of ambulance services.

WORK EXPERIENCE

07/20/2014-Present	Emergency Medical Technician Crow Creek Sioux Ambulance
03/02/2014-07/10/2014	Emergency Medical Technician Med-Star Ambulance Service
08/20/2013-03/02/2014	Communication Dispatcher- 36 hours/week Med-Star Ambulance Service
02/28/2010-05/01/2013	Patrol Services Division/ 1st Watch- 40+ hours /week Des Moines Police Department
04/14/2003-02/29/2010	Special Operation Unit/ Traffic Unit-50+ hours/week Des Moines Police Department
04/29/2002-04/14/2003	Special Operation Unit/ Airport Unit-40+ hours /week Des Moines Police Department
11/09/2000-04/29/2002	Patrol Services Division/1st Watch-50+ hours/week Des Moines Police Department
07/09/ 1999-06/01/2000	Patrol Division-40+ hours/week Iowa Capitol Police / Department of Public Safety
06/01/1996-06/01/1999	Detector Dog International-60+ hours/week Gretna, Nebraska

FORMAL EDUCATION

08/1995-05/1996	University of Northern Iowa- (30 Hours) Cedar Falls, Iowa
08/1996-12/1996	North Iowa Area Community College- (16 Hours) Mason City, Iowa
08/1997-05/1998	Metro Community College- (40 Hours) Associate Degree of Professional Studies Omaha, Nebraska
08/1998-04/1999	Bellevue University- (11 Hours) Bellevue, Nebraska
11/2000	Des Moines Area Community College- (3 Hours) Ankeny, Iowa

EXHIBIT

Applicant E
3-6-15 TLS

FedEx® Express

Extremely Urgent

Page 1 of 1

From: (605) 367-7781
Margaret Hansen
SDBMOE
101 N. Main Ave., Suite 301
Sioux Falls, SD 57104

Origin ID: FSDA

FedEx Express

J142214092303uv

Ship Date: 23DEC14
ActWgt: 0.5 LB
CAD: 5282744/INET3550

Delivery Address Bar Code

SHIP TO: (515) 240-7286
Colin Boone
3409 51st Street # 414
SIOUX FALLS, SD 57106

BILL SENDER

Ref #
Invoice #
PO #
Dept #

TRK# 0201 7723 6924 2880

MON - 29 DEC AA
EXPRESS SAVER

73 FSDA

57106
SD-US
FSD

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EXHIBIT
Applicant
3-6-

THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

****

Re: TODD A. THORNTON

TEMPORARY APPROVAL ORDER

****

Todd A. Thornton and the South Dakota Board of Medical and Osteopathic Examiners (the Board) have entered into a Stipulation and Agreement. The Board has authorized the executive director to execute this temporary approval order pending consideration by the Board at its next Board Meeting.

For this reason, said document has been temporarily approved pending consideration by the Board.

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

By: Margaret B. Hansen Date: 4/27/2015

Margaret B. Hansen
Executive Director

STATE OF SOUTH DAKOTA } S.S.
MINNEHAHA COUNTY
I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on the record in my office.
Executive Secretary
By MBH by JPP
Date 4-27-15

THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

****

In Re: TODD A. THORNTON
APPLICANT

STIPULATION AND
AGREEMENT

****

This Stipulation and Agreement, made and entered into by the South Dakota Board of Medical and Osteopathic Examiners, hereinafter referred to as "BMOE", and Todd A. Thornton, applicant, hereinafter referred to as "Mr. Thornton", witness to the following:

Mr. Thornton entered into an Order on Agreed Settlement with the Nebraska Department of Health and Human Services Division of Public Health in April of 2014. The BMOE is authorized to take action due to discipline by another state, territorial or provincial licensing board or the licensing board of the District of Columbia. This Stipulation and Agreement shall mirror the requirements set forth in the Order on Agreed Settlement imposed by the Nebraska Department of Health and Human Services Division of Public Health which is attached hereto and incorporated herein.

Informal Agreement: It is the intent of the parties hereto to provide for the informal compromise and settlement of all issues which could be raised by a formal contested hearing.

Waiver of Rights: Mr. Thornton understands he has the right to consult with an attorney of his own choosing and has a right to an administrative hearing on the facts in this matter. He understands and agrees that by signing this Stipulation and Agreement, he is waiving his rights to counsel and to a hearing. He further understands and agrees that by signing this Stipulation and Agreement he is voluntarily and knowingly giving up his right to present oral and documentary evidence, to present rebuttal evidence, to cross-examine witnesses against him, and to appeal the BMOE's decision to Circuit Court.

Disclosure Waiver: Mr. Thornton understands that the BMOE has reporting requirements and he consents to the documents relating to this matter being provided to the required entities and to state licensing authorities upon request.

It is further agreed that this Stipulation and Agreement is a public record of the BMOE and the State of South Dakota, and it shall be published on the BMOE website and reported to the national data banks and all other entities deemed necessary by the BMOE in compliance with state and federal law.

Mr. Thornton has unconditionally agreed to the Stipulation and Agreement by affixing his signature to this document.

By: Todd A. Thornton Date: 4-17 ,2015
Todd A. Thornton

By: _____ Date: _____ ,2015
Attorney for Mr. Thornton (optional)

By: K L Bjordahl MD Date: 4-23 ,2015
Dr. Kevin Bjordahl
Board member
South Dakota Board of Medical and Osteopathic Examiners

STATE OF SOUTH DAKOTA } S.S.
MINNEHAHA COUNTY
I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on the record in my office.
Executive Secretary
By MBH by JPP
Date 4-22-15

COPY

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
STATE OF NEBRASKA

STATE OF NEBRASKA ex rel. JON BRUNING, Attorney General,	)	
Plaintiff,	)	
vs.	)	PETITION FOR DISCIPLINARY ACTION
TODD A. THORNTON, E.M.T., E.M.T. INSTRUCTOR,	)	
Defendant.	)	

The Plaintiff alleges as follows:

ALLEGATIONS COMMON TO ALL CAUSES OF ACTION:

1. Jurisdiction is based on NEB. REV. STAT. §§ 38-176 (Reissue 2008), and 38-186 (Cum. Supp. 2012).

2. At all times relevant herein, the Defendant, Todd A. Thornton, E.M.T., E.M.T. Instructor, has been the holder of an Emergency Medical Technician ("E.M.T.") license (#12080) and an E.M.T. Instructor License (#177) issued by the Nebraska Department of Health and Human Services Division of Public Health ("Department").

3. The Department is the agency in the State of Nebraska authorized to enforce the provisions of the Uniform Credentialing Act regulating the practice of Emergency Medical Services.

4. The Nebraska Board of Emergency Medical Services considered the investigation of this matter and made a disciplinary recommendation to the Attorney General, which recommendation has been considered. Such matters are privileged pursuant to NEB. REV. STAT. §§ 38-1,105 and 38-1,106 (Reissue 2008).

5. On December 26, 2012, while employed as instructor of an E.M.T. class at N.C.C., in Norfolk, Nebraska, the Defendant engaged in a telephone text message conversation with a one of his students in said class at N.C.C. During the text conversation, the Defendant asked said student if she was interested in having an extramarital affair.

FIRST CAUSE OF ACTION

6. Paragraphs 1 through 5 are incorporated herein by reference.

7. NEB. REV. STAT. § 38-178 (2012 Cum. Supp.) provides that a professional license may be disciplined for unprofessional conduct.

8. NEB. REV. STAT. § 38-179 (Reissue 2008) defines unprofessional conduct as " . . . any departure from or failure to conform to the standards of acceptable and prevailing practice of a profession or the ethics of a profession, regardless of whether a person, consumer, or entity is injured, or conduct that is likely to deceive or defraud the public or is detrimental to the public interest, including, but not limited to . . . (15) such acts as may be defined in rules and regulations".

9. Title 172 NAC Chapter 11-010.02 (17) of the *Regulations Governing the Licensure of Out-Of-Hospital Emergency Care Providers* defines unprofessional

conduct as sexual harassment, which includes making unwelcome sexual advances and requesting sexual favors.

10. Defendant's conduct above is grounds for discipline.

SECOND CAUSE OF ACTION

11. Paragraphs 1 through 10 are incorporated herein by reference.

12. NEB. REV. STAT. § 38-178 (2012 Cum. Supp.) provides that a professional license may be disciplined for unprofessional conduct.

13. NEB. REV. STAT. § 38-179 (Reissue 2008) defines unprofessional conduct as " . . . any departure from or failure to conform to the standards of acceptable and prevailing practice of a profession or the ethics of a profession, regardless of whether a person, consumer, or entity is injured, or conduct that is likely to deceive or defraud the public or is detrimental to the public interest, including, but not limited to . . . (15) such acts as may be defined in rules and regulations".

14. Title 172 NAC Chapter 13-014.02(18) of the *Regulations Governing Emergency Medical Service Training Agencies* defines unprofessional conduct as sexual harassment of students, which includes making unwelcome sexual advances and requesting sexual favors.

15. Defendant's conduct above is grounds for discipline.

PRAYER FOR RELIEF

WHEREFORE, the Plaintiff prays that the Chief Medical Officer set this matter for hearing, order appropriate disciplinary action pursuant to NEB. REV. STAT. § 38-196 (Reissue 2008) and tax the costs of this action to the Defendant.

STATE OF NEBRASKA ex rel. JON BRUNING, Attorney General, Plaintiff,

BY: JON BRUNING, #20351
Attorney General

BY: _____
Edward Vierk, #22118
Assistant Attorney General
2115 State Capitol
Lincoln, NE 68509
(402) 471-3824

Attorneys for Plaintiff

34-295-14

CERTIFICATE OF SERVICE

COMES NOW the undersigned and certifies that on the 19th day of March, 2014, a copy of the foregoing *PETITION FOR DISCIPLINARY ACTION* was sent by First-Class United States Mail, postage prepaid, to the following Defendant:

Todd A. Thornton, E.M.T.
87724 Willow Ridge Avenue
Long Pine, Nebraska 68217

Edward Vierk
Assistant Attorney General

FILED

APR 30 2014

DHHS Hearing Office

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
STATE OF NEBRASKA

STATE OF NEBRASKA ex rel. JON BRUNING, Attorney General,	)	140970
Plaintiff,	)	ORDER ON AGREED SETTLEMENT
vs.	)	
TODD A. THORNTON, E.M.T., E.M.T. INSTRUCTOR,	)	
Defendant.	)	

A proposed Agreed Settlement was filed with the Department on April 17, 2014.

ORDER

1. The Agreed Settlement is adopted, attached hereto and incorporated by reference.

2. The facts as set out in the Petition are taken as true and adopted herein.

3. The Department shall issue a license marked probationary in such a manner as the Department shall determine.

4. The parties shall comply with all of the terms of the Agreed Settlement.

DATED this 30 **day of** April**, 2014.**

Joseph M. Acierno, M.D., J.D.
Chief Medical Officer
Director, Division of Public Health
Dept. of Health & Human Services

CERTIFICATE OF SERVICE

COMES NOW the undersigned and certifies that on the 30th day of April, 2014, a copy of the foregoing **ORDER ON AGREED SETTLEMENT** was sent certified United States Mail, postage prepaid, return receipt requested to Defendant, **Todd A. Thornton, 87724 Willow Ridge Avenue, Long Pine, Nebraska 68217** and by **e-mail to Edward Vierk, Assistant Attorney General, at the e-mail address: ago.health@nebraska.gov**.

Beth Davidson
DHHS Hearing Office
P.O. Box 98914
Lincoln, Nebraska 68509-8914
P. (402) 471-7237 F. (402) 471-7276

34-295.3-14

7011 1570 0001 7617 2941

RECEIVED
4/17/2014
In Camera Only

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
STATE OF NEBRASKA

STATE OF NEBRASKA ex rel. JON BRUNING, Attorney General,	)	
Plaintiff,	)	
vs.	)	AGREED SETTLEMENT
TODD A. THORNTON, E.M.T., E.M.T. INSTRUCTOR,	)	
Defendant.	)	

The Plaintiff and the Defendant, Todd A. Thornton, E.M.T., E.M.T. Instructor, in consideration of the mutual covenants and agreements contained herein, agree as follows:

1. The Defendant, Todd A. Thornton, E.M.T., E.M.T. Instructor, was issued an E.M.T. license (#12080) and an E.M.T. Instructor License (#177) by the Nebraska Department of Health and Human Services Division of Public Health ("Department").

2. The Defendant acknowledges receipt of a copy of the Petition for Disciplinary Action and waives the need for further service of the Petition for Disciplinary Action upon him.

3. Before disciplinary measures may be taken against the Defendant's licenses, the Defendant is entitled to a hearing as provided by law. The Defendant waives the right to a hearing. The Defendant also waives any right to judicial review of a disciplinary order which approves the terms of this Agreed Settlement.

4. No coercion, threats, or promises, other than those stated herein, were made to the Defendant to induce him to enter into this Agreed Settlement.

5. The Defendant acknowledges that he is licensed to practice as an E.M.T. in the state of South Dakota.

6. The Defendant acknowledges that he has read the Petition for Disciplinary Action filed by the Attorney General's Office and admits the allegations in the Petition for Disciplinary Action.

7. The Plaintiff and the Defendant consent to the Department's Chief Medical Officer entering a final disciplinary order which finds that the allegations of the Petition for Disciplinary Action are true, and: (a) finds that grounds exist to revoke the Defendant's E.M.T. Instructor license; and (b) revokes the Defendant's E.M.T. Instructor license.

8. The Plaintiff and the Defendant also consent to the Department's Chief Medical Officer entering a final disciplinary order which finds that the allegations of the Petition for Disciplinary Action are true and places the Defendant's E.M.T. License on probation for the period of one (1) year, commencing (10) days after the entry of the order, with the following conditions:

> a. The Defendant shall successfully complete a course in ethics within the first six (6) months of probation. The course shall be approved by the Board of Emergency Medical Services. The Defendant shall be financially responsible for all costs associated with taking the course and shall provide proof of successful completion of the course to the Department as directed.
>
> b. The Defendant shall be affiliated as an E.M.T. only by an emergency medical service which provides quarterly reports to the Department. Quarterly reports shall be submitted to the Department by the Defendant's supervisor. Reports shall include a description of the Defendant's work habits. Reports shall be due no later than the tenth (10th) day of the month following the end of each quarter. An initial report shall be submitted as directed by the Department. A final report shall be due not less than thirty (30) days before the expiration of the probationary period.

c. The Defendant shall provide notification of his disciplinary action to all emergency medical services with which he is affiliated, and to the licensing authority in any state where he has or obtains an active E.M.T. license within five (5) days of receipt of the Order on Agreed Settlement by the Chief Medical Officer and within five (5) days of any changes in employment or any subsequent out-of-state licensure. Such notification shall include copies of the Petition for Disciplinary Action, this Agreed Settlement, and the Order on Agreed Settlement entered by the Chief Medical Officer. Written confirmation of this notification shall be provided by the Defendant to the Department within thirty (30) days of the entry of the Order on Agreed Settlement by the Chief Medical Officer or *change in employment or any subsequent out-of-state licensure.*

d. The Defendant shall submit written notification to the Department within seven (7) days of any change in employment, employment status, emergency medical service affiliation, residence or telephone number.

e. All reports, notices and other documentation requested by the Department shall be provided using report forms provided by the Department.

f. The Defendant shall promptly respond to all requests and inquiries by the Department concerning the Defendant's compliance with the terms of probation.

g. The Defendant shall obey all state and federal laws and the rules and regulations regarding the practice of emergency medical services.

h. The Defendant shall pay the costs associated with assuring compliance with this Agreed Settlement.

i. The Defendant shall appear at any meetings of the Board of Emergency Medical Services when requested.

j. Any period the Defendant may hold an inactive Nebraska E.M.T. license or is not actively affiliated with an emergency medical service shall not reduce the probationary period or satisfy the terms and conditions of probation.

9. In the event the Defendant violates any term of this probation, the Chief Medical Officer, after motion by the Attorney General and a hearing, may take further disciplinary action against the Defendant's E.M.T. License, including revocation of his license.

10. The Attorney General's Office has given notice of this Agreed Settlement to the Board of Emergency Medical Services and has received their input in accordance NEB. REV. STAT. § 38-190 (Reissue 2008).

11. If this Agreed Settlement is not approved by the Chief Medical Officer, this Agreed Settlement shall become null and void and will not be admissible for any purpose at any hearing that may be held on this matter.

AGREED TO:

By: _____
TODD A. THORNTON, E.M.T. and E.M.T. Instructor, Defendant.

STATE OF NEBRASKA)
) ss.
COUNTY OF Brown)

THIS AGREED SETTLEMENT IS ACKNOWLEDGED before me by Todd A. Thornton, E.M.T., E.M.T. Instructor, on this 14th day of April, 2014.

GENERAL NOTARY - State of Nebraska
JUDY K. COLE
My Comm. Exp. June 22, 2015

_____
Notary Public
My Commission Expires June 22nd 2015

STATE OF NEBRASKA, ex rel. JON BRUNING, Attorney General, Plaintiff,

BY: JON BRUNING, #20351
Attorney General

BY: _____
Edward Vierk, #22118
Assistant Attorney General
2115 State Capitol
Lincoln, NE 68509-8920
(402) 471-3824

Attorneys for the Plaintiff

34-295a-14

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

* *

IN THE MATTER OF THE SOUTH DAKOTA BOARD OF MEDICAL & OSTEOPATHIC EXAMINERS STIPULATION AND AGREEMENT RE: TODD A. THORNTON	NOTICE OF HEARING

* *

Please take notice that a contested case hearing has been scheduled before the South Dakota Board of Medical and Osteopathic Examiners in the above captioned matter. The hearing will take place on Thursday, June 11, 2015, in the Board Conference Room, 101 N. Main Ave., Suite 215, Sioux Falls, SD, beginning at 11:00 am (CDT).

Dated this 27 day of April, 2015.

William H. Golden, esq.
Assistant Attorney General/Civil Litigation Division
317 N. Main Ave.
Sioux Falls, SD 57104
Attorney for the South Dakota Board of Medical and Osteopathic Examiners
(605) 201-8588

THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

****

Re: TODD ALAN THORNTON
ADVANCED EMT FINAL ORDER

****

The above-entitled matter having come before the South Dakota Board of Medical and Osteopathic Examiners ("Board"), and the Board having been fully advised in the premises thereof; and

Mr. Thornton agrees that the documents relating to this matter will be provided to other state licensing authorities upon their request.

NOW; THEREFORE, the Board hereby:

APPROVES the Stipulation and Agreement and Temporary Approval Order, and this Final Order, and directs that these are public records of the Board and the State of South Dakota and shall be published on the Board's website and reported to the national data banks and any other entity deemed appropriate by the Board and in compliance with State and Federal law.

By:_____Date:_____
South Dakota Board of Medical and Osteopathic Examiners

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
101 N MAIN AVE, SUITE 301
SIOUX FALLS, SD 57104
SDBMOE@STATE.SD.US
P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV

Via electronic and regular mail

May 1, 2015

Brian D. Gilley
5109 S. Baneberry Ave.
Sioux Falls, SD 57106
pd_dex@hotmail.com

Dear Mr. Gilley:

Enclosed please find a Notice of Hearing in regard to the Consent Agreement for the Voluntary Surrender of South Dakota Paramedic License #1074 that you agreed to and signed on April 20, 2015.

This matter will be presented to the South Dakota Board of Medical and Osteopathic Examiners for hearing at the Board meeting on Thursday, June 11, 2015, beginning sometime after 11:00 am (CDT).

The meeting will be held in the Board conference room at 101 N. Main Ave., Suite 215, Sioux Falls, SD.

You have the right to attend this meeting if you wish to do so, and to have an attorney accompany you to the meeting if you so desire; however, this is not a requirement.

If you plan to attend the Board meeting please send an email to that effect to SDBMOE@state.sd.us prior to May 15, 2015.

Sincerely,

Jane Phalen

Jane Phalen
SD Medical Board Staff

Enclosure

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

* *

IN THE MATTER OF THE
SOUTH DAKOTA BOARD OF
MEDICAL & OSTEOPATHIC
EXAMINERS
CONSENT AGREEMENT FOR
VOLUNTARY SURRENDER OF
PARAMEDIC LICENSE # 1074
RE: BRIAN DEAN GILLEY

NOTICE OF HEARING

* *

Please take notice that a contested case hearing has been scheduled before the South Dakota Board of Medical and Osteopathic Examiners in the above captioned matter. The hearing will take place on Thursday, June 11, 2015, in the Board Conference Room, 101 N. Main Ave., Suite 215, Sioux Falls, SD beginning at 11:00 am (CDT).

Dated this 28 day of April, 2015.

William H. Golden, esq.
Assistant Attorney General/Civil Litigation Division
317 N. Main Ave.
Sioux Falls, SD 57104
Attorney for the South Dakota Board of Medical and Osteopathic Examiners
(605) 201-8588

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

* *

In Re: Brian Dean Gilley

CONSENT AGREEMENT
VOLUNTARY SURRENDER
OF
SOUTH DAKOTA PARAMEDIC LICENSE # 1074

* *

CONSENT AGREEMENT

I, Brian Dean Gilley, agree to voluntarily surrender my South Dakota Paramedic license #1074 while under investigation. This surrender shall take effect immediately.

I further agree that I shall immediately cease working in the State of South Dakota.

I agree that I have been informed of my right to consult with an attorney of my own choosing, and that if an attorney does not sign this agreement, this signifies that I have waived this right. I also understand that by signing this agreement I am waiving my rights to a hearing and to any appeals.

I agree that the Board has reporting requirements and I consent to documents and information relating to this investigation and surrender being provided to all required entities and to state licensing authorities upon request.

I agree that this is public information, and I understand that it shall be published on the Board's website and reported to the national databanks, the National Registry for EMT, the South Dakota EMS office, and to all other entities deemed appropriate by the Board in compliance with state and federal law.

Therefore, I, Brian Dean Gilley, paramedic, voluntarily and unconditionally surrender my South Dakota paramedic license # 1074 effective immediately by affixing my signature to this agreement.

By: ______________________ Date: 4/20/2015
Brian Dean Gilley

By: ______________________ Date: ____________
Attorney for Mr. Gilley (optional)

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

By: ______________________ Date: 4/28/15
Board Member

THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

****

Re: BRIAN DEAN GILLEY
PARAMEDIC FINAL ORDER

****

The above-entitled matter having come before the South Dakota Board of Medical and Osteopathic Examiners ("Board"), and the Board having been fully advised in the premises thereof; and

Mr. Gilley agrees that the documents relating to this matter will be provided to other state licensing authorities upon their request.

NOW; THEREFORE, the Board hereby:

APPROVES this Consent Agreement for Voluntary Surrender of South Dakota Paramedic License, and this Final Order, and directs that these are public records of the Board and the State of South Dakota and shall be published on the Board's website and reported to the national data banks and any other entity deemed appropriate by the Board and in compliance with State and Federal law.

By:_____Date:_____
South Dakota Board of Medical and Osteopathic Examiners

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

* *

IN THE MATTER OF THE SOUTH DAKOTA BOARD OF MEDICAL & OSTEOPATHIC EXAMINERS CONSENT AGREEMENT FOR VOLUNTARY SURRENDER OF PARAMEDIC LICENSE # 1074 RE: BRIAN DEAN GILLEY	NOTICE OF HEARING

* *

Please take notice that a contested case hearing has been scheduled before the South Dakota Board of Medical and Osteopathic Examiners in the above captioned matter. The hearing will take place on Thursday, June 11, 2015, in the Board Conference Room, 101 N. Main Ave., Suite 215, Sioux Falls, SD beginning at 11:00 am (CDT).

Dated this 28 day of April, 2015.

William H. Golden, esq.
Assistant Attorney General/Civil Litigation Division
317 N. Main Ave.
Sioux Falls, SD 57104
Attorney for the South Dakota Board of Medical and Osteopathic Examiners
(605) 201-8588

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
101 N MAIN AVE, SUITE 301
SIOUX FALLS, SD 57104
SDBMOE@STATE.SD.US
P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV

Via electronic and regular mail

May 1, 2015

Brian D. Gilley
5109 S. Baneberry Ave.
Sioux Falls, SD 57106
pd_dex@hotmail.com

Dear Mr. Gilley:

Enclosed please find a Notice of Hearing in regard to the Consent Agreement for the Voluntary Surrender of South Dakota Paramedic License #1074 that you agreed to and signed on April 20, 2015.

This matter will be presented to the South Dakota Board of Medical and Osteopathic Examiners for hearing at the Board meeting on Thursday, June 11, 2015, beginning sometime after 11:00 am (CDT).

The meeting will be held in the Board conference room at 101 N. Main Ave., Suite 215, Sioux Falls, SD.

You have the right to attend this meeting if you wish to do so, and to have an attorney accompany you to the meeting if you so desire; however, this is not a requirement.

If you plan to attend the Board meeting please send an email to that effect to SDBMOE@state.sd.us prior to May 15, 2015.

Sincerely,

Jane Phalen

Jane Phalen
SD Medical Board Staff

Enclosure

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

* *

IN THE MATTER OF THE
SOUTH DAKOTA BOARD OF
MEDICAL & OSTEOPATHIC
EXAMINERS
CONSENT AGREEMENT FOR
VOLUNTARY SURRENDER OF
PARAMEDIC LICENSE # 1074
RE: BRIAN DEAN GILLEY

NOTICE OF HEARING

* *

Please take notice that a contested case hearing has been scheduled before the South Dakota Board of Medical and Osteopathic Examiners in the above captioned matter. The hearing will take place on Thursday, June 11, 2015, in the Board Conference Room, 101 N. Main Ave., Suite 215, Sioux Falls, SD beginning at 11:00 am (CDT).

Dated this 28 day of April, 2015.

William H. Golden, esq.
Assistant Attorney General/Civil Litigation Division
317 N. Main Ave.
Sioux Falls, SD 57104
Attorney for the South Dakota Board of Medical and Osteopathic Examiners
(605) 201-8588

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

* *

In Re: Brian Dean Gilley

CONSENT AGREEMENT
VOLUNTARY SURRENDER
OF
SOUTH DAKOTA PARAMEDIC LICENSE # 1074

* *

CONSENT AGREEMENT

I, Brian Dean Gilley, agree to voluntarily surrender my South Dakota Paramedic license #1074 while under investigation. This surrender shall take effect immediately.

I further agree that I shall immediately cease working in the State of South Dakota.

I agree that I have been informed of my right to consult with an attorney of my own choosing, and that if an attorney does not sign this agreement, this signifies that I have waived this right. I also understand that by signing this agreement I am waiving my rights to a hearing and to any appeals.

I agree that the Board has reporting requirements and I consent to documents and information relating to this investigation and surrender being provided to all required entities and to state licensing authorities upon request.

I agree that this is public information, and I understand that it shall be published on the Board's website and reported to the national databanks, the National Registry for EMT, the South Dakota EMS office, and to all other entities deemed appropriate by the Board in compliance with state and federal law.

Therefore, I, Brian Dean Gilley, paramedic, voluntarily and unconditionally surrender my South Dakota paramedic license # 1074 effective immediately by affixing my signature to this agreement.

By: [signature] Date: 4/20/2015
Brian Dean Gilley

By:________________ Date: __________
Attorney for Mr. Gilley (optional)

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

By: [signature] Date: 4/28/15
Board Member

THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

****

Re: BRIAN DEAN GILLEY
PARAMEDIC FINAL ORDER

****

The above-entitled matter having come before the South Dakota Board of Medical and Osteopathic Examiners ("Board"), and the Board having been fully advised in the premises thereof; and

Mr. Gilley agrees that the documents relating to this matter will be provided to other state licensing authorities upon their request.

NOW; THEREFORE, the Board hereby:

APPROVES this Consent Agreement for Voluntary Surrender of South Dakota Paramedic License, and this Final Order, and directs that these are public records of the Board and the State of South Dakota and shall be published on the Board's website and reported to the national data banks and any other entity deemed appropriate by the Board and in compliance with State and Federal law.

By:_____Date:_____
South Dakota Board of Medical and Osteopathic Examiners

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

* *

IN THE MATTER OF THE
SOUTH DAKOTA BOARD OF
MEDICAL & OSTEOPATHIC
EXAMINERS
CONSENT AGREEMENT FOR
VOLUNTARY SURRENDER OF
PARAMEDIC LICENSE # 1074
RE: BRIAN DEAN GILLEY

NOTICE OF HEARING

* *

Please take notice that a contested case hearing has been scheduled before the South Dakota Board of Medical and Osteopathic Examiners in the above captioned matter. The hearing will take place on Thursday, June 11, 2015, in the Board Conference Room, 101 N. Main Ave., Suite 215, Sioux Falls, SD beginning at 11:00 am (CDT).

Dated this 28 day of April, 2015.

William H. Golden, esq.
Assistant Attorney General/Civil Litigation Division
317 N. Main Ave.
Sioux Falls, SD 57104
Attorney for the South Dakota Board of Medical and Osteopathic Examiners
(605) 201-8588

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
101 N MAIN AVE, SUITE 301
SIOUX FALLS, SD 57104
SDBMOE@STATE.SD.US
P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV

Via Federal Express
May 13, 2015

William P. Ford
24237 Dewey Lane
Hermosa, SD 57744

Re: Stipulation and Agreement

Dear Mr. Ford:

Enclosed please find a proposed Stipulation and Agreement which will be recommended by the Board's investigative review panel to the South Dakota Board of Medical and Osteopathic Examiners at a future Board meeting. Please read this document carefully. You have the right to have this document reviewed by an attorney of your own choosing if you so desire. If you agree with this recommendation, please sign and date the Stipulation and Agreement and return the original document to the Board office prior to May 22, 2015, using the Federal Express envelope provided for your convenience.

If you disagree with this recommendation, please be aware of the following:

1. You have the right to contest the recommendation and be represented by an attorney of your own choosing at an administrative hearing which will be conducted in accordance with SDCL 1-26. This matter will be presented to a neutral administrative judge.

2. The administrative judge will provide a proposed recommendation to the South Dakota Board of Medical and Osteopathic Examiners. The Board may accept, reject or modify the proposed recommendation.

3. You have the right to file an appeal to Circuit Court.

Please be advised that neither you nor any other party on your behalf may contact Board members about this recommendation in any manner, including by phone, letter, in person, or by e-mail. Board members may only receive information about the case when all parties have notice and an opportunity to participate, such as at the hearing or in pleadings you file with the Board office and serve upon all parties in this case. *See SDCL 1-26-26.*

If you wish to contest this Stipulation and Agreement, please contact Mr. William H. Golden, esq., at (605) 201-8588 prior to May 22, 2015.

Sincerely,

Jane Phalen

Jane Phalen
SD Medical Board Staff

cc: William H. Golden, esq.
Assistant Attorney General/Litigation Division
Counsel to the South Dakota Board of Medical and Osteopathic Examiners

Enclosure

THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

* *

IN RE: WILLIAM PAUL FORD, RCP — STIPULATION AND AGREEMENT

* *

This Stipulation and Agreement, made and entered into by the South Dakota Board of Medical and Osteopathic Examiners, hereinafter referred to as "the BMOE", and William P. Ford, RCP, hereinafter referred to as "Mr. Ford", witness to the following:

Mr. Ford submitted an application for a South Dakota respiratory care practitioner license. Mr. Ford previously entered into a Consent Order with the North Carolina Board of Respiratory Care on February 2, 2015, and he further agreed to comply with the requirements set forth in the North Carolina Consent Order. The BMOE is authorized to take disciplinary action pursuant to *SDCL 36-4C-15(6): The licensee or temporary permit holder is guilty of unprofessional conduct as defined by the rules established by the board or violation of the code of ethics adopted and published by the board.* This Stipulation and Agreement shall mirror the requirements and conditions set forth in the North Carolina Consent Order, a copy of which is attached hereto and incorporated herein.

Informal Agreement: It is the intent of the parties hereto to provide for the informal compromise and settlement of all issues which could be raised by a formal contested hearing.

Waiver of Rights: Mr. Ford understands he has the right to consult with an attorney of his own choosing and has a right to an administrative hearing on the facts in this matter. He understands and agrees that by signing this Stipulation and Agreement, he is waiving his rights to counsel and to a hearing. He further understands and agrees that by signing this Stipulation and Agreement he is voluntarily and knowingly giving up his right to present oral and documentary evidence, to present rebuttal evidence, to cross-examine witnesses against him, and to appeal the Board's decision to Circuit Court.

Disclosure Waiver: Mr. Ford understands that the Board has reporting requirements and he consents to the documents relating to this matter being provided to the required entities and to state licensing authorities upon request.

It is further agreed that this Stipulation and Agreement is a public record of the Board and the State of South Dakota, and it shall be published on the Board's website and reported to the national data banks and all other entities deemed necessary by the Board in compliance with state and federal law.

Mr. Ford has unconditionally agreed to this Stipulation and Agreement by affixing his signature to this document.

By:______________________________ Date:____________, 2015
William P. Ford, RCP

By:______________________________ Date:____________, 2015
Attorney for Mr. Ford (optional)

By:______________________________ Date:____________, 2015
David Erickson, MD
Board Member, South Dakota Board of Medical and Osteopathic Examiners

COPY

STATE OF NORTH CAROLINA

BEFORE THE NORTH CAROLINA
RESPIRATORY CARE BOARD

IN THE MATTER OF:	)	
	)	**CONSENT ORDER**
William P. Ford, RCP	)	
License Number – 912	)	

---

1. Jurisdiction

The North Carolina Respiratory Care Board (the Board) is an occupational licensing board of the State of North Carolina, organized under N.C. Gen. Stat. § 90-646, et seq. The Board has jurisdiction over this matter pursuant to N.C. Gen. Stat. § 90-652 and 21 N.C. Admin. Code § 61.0307.

2. Identification of Licensee

The Respiratory Care Practitioner is William P. Ford (the "Licensee"). His mailing address is 3901 Hartwell Rd. Fayetteville, NC 28304-5061. The Respiratory Care Practitioner holds North Carolina Respiratory Care License number 912 (the "License"), first issued on May 7, 2002, with an expiration date of August 31, 2015.

3. Waiver of Rights

I, William P. Ford, the Respiratory Care Practitioner, understand that I have each of the following rights:

(Initials)

WPF The right to a hearing before the Board;

WPF The right to present evidence to disprove all or some of the charges against me;

WPF The right to present evidence to limit or reduce any sanction that could be imposed for a violation;

WPF The right to confront and cross-examine witnesses and to challenge evidence presented by the Board against me;

WPF The right to present legal arguments in a brief; and

WPF The right to appeal from any final decision adverse to my license to practice respiratory care.

As noted by my initials above, I hereby freely and knowingly waive these rights without further process and agree to the terms of this Consent Order regarding my license. In order to resolve this matter by a Consent Order, I also agree that the Board staff and counsel may discuss this Consent Order with the Board *ex parte* whether or not the Board accepts this Order as written.

4. Stipulation to Facts

The Licensee and the Board stipulate to the following facts:

A. The Licensee was engaged in the practice of respiratory care in North Carolina when the events occurred that led to the initiation of this complaint.

B. The Board received a complaint on September 5, 2014 that William P. Ford's employment had been terminated from Cape Fear Valley Health due to sexual harassment. According to the complaint, two females lodged the complaints. One was the receiver of the harassment with accusations of verbal comments and some inappropriate touching. The other was witness to the acts. The complaint states that the behavior had been going on for a period of time. A full investigation was completed by Human Resources and the Licensee was terminated from his position at the hospital.

C. The Licensee attended the Board's Investigation and Informal Settlement Committee meeting on December 18, 2014 at which time he stated he is currently unemployed after his termination from CFVMC. He denied sexual harassment of the females involved. He stated that it was consensual behavior between him and the alleged victim. The subpoenaed documents provided to the Board indicate that he engaged in inappropriate touching and language between the two employees. He admitted that it could have been interpreted this way and he repeatedly asked the alleged victim if it was ok. He admitted that the behavior was unprofessional and he should not have engaged in the activity. He stated that his termination was reversed and he was allowed to resign.

D. During the Board's Investigation and Informal Settlement Committee meeting on December 18, 2014, Mr. Ford provided letters of reference from five former co-workers attesting to his exceptional ability and performance as an RCP and supervisor. He also provided a written explanation of events as well as testimony that "he will never engage in this type of behavior that could be deemed inappropriate".

E. A former co-worker testified during the Board's Investigation and Informal Settlement Committee meeting on December 18, 2014 on his behalf stating that "Paul (William) was her mentor and he was an exceptional leader".

5. Stipulated Order

A. Stipulation to Sections of Law Violated:

I, William P. Ford, the Respiratory Care Practitioner, admit that the allegations against me, if proven true, would constitute violations of N.C. Gen. Stat. § 90-659 (a)(1)(d) and the regulations set forth in 21 N.C. Admin. Code § 61 .0307 (10).

B. Stipulation to Sanction:

Under N.C. Gen. Stat. § 90-652, in lieu of proceeding to hearing, the Respiratory Care Practitioner and the Board hereby enter into this consent order whereby the Respiratory Care Practitioner and the Board agree to the following terms:

1. The Licensee agrees to accept a license to practice respiratory care on Probationary Status for a period of 24 months from the date of execution of this order; and as a specific condition of that Probationary Status the Licensee agrees to all of the following terms and limitations.

2. The Licensee agrees to continue treatment and counseling with Full Life Counseling or other Board approved provider during the probationary period. The Licensee agrees to sign a release of information form and furnish it to the counselor allowing the counselor to provide quarterly written reports to the Board of all visits with the counselor during the probationary period. The Licensee agrees to follow any plan of treatment suggested by the counselor.

3. The Licensee accepts and agrees to the assessment of a civil penalty of two hundred and fifty dollars ($250.00) pursuant to N.C. Gen. Stat. § 90-666 and 21 N.C. Admin. Code § 61.0309 and to remit this sum to the Board no later than April 30, 2015.

4. The Licensee accepts and agrees to write a two-page essay on the meaning of sexual harassment according to Board writing guidelines and submit it electronically no later than 30 days after signing this Consent Order.

5. If employed in Respiratory Care, the Licensee shall cause his immediate supervisor to submit written quarterly reports to the Board during the time the Licensee is on Probation. Each such written report shall document the Licensee's performance in the delivery of Respiratory Care, and detail any concerns of the supervisor about the Licensee's practice of Respiratory Care.

6. The Licensee also assumes financial responsibility for any costs associated with fulfilling the terms of this Consent Order.

7. To continue to comply with the Respiratory Care Practice Act, the Board's Rules, and the Board's published interpretation of those rules.

6. Public Record

The parties agree that this Consent Order is public record, as required by N.C. Gen. Stat. § 132-1. Documents that are part of the investigative file are not public record.

7. Reporting

This disciplinary action will be reported to the appropriate entities as outlined in Board policy and required by state and/or federal law or guidelines. Those entities include, but are not limited to, the National Databank maintained by the National Board for Respiratory Care and the Healthcare Integrity and Protection Data Bank (HIPDB).

8. Effective Date

All provisions of this Consent Order are effective upon the date that the Executive Director of the Board signs this Order.

9. Noncompliance with Consent Order

Failure by the Respiratory Care Practitioner to comply with the terms of this Order, either in substance or in timing, is a violation of 21 N.C. Admin. Code § 61 .0307(3). If, during the term of this Consent Order, the Board staff receives evidence that the Respiratory Care Practitioner has violated any of the above conditions, the Board may schedule a show cause hearing for a determination of the violations. If the Board determines that such violations have occurred, then the Board may suspend or revoke the license, revoke any stay, or may impose additional disciplinary action.

All provisions of this Order are effective upon this Order's effective date. Fulfillment of time-specific elements intended to coincide with active practice (such as, but not limited to; probation, supervision or therapy) will only accrue during periods of active practice in which the Respiratory Care Practitioner is compliant with the terms of this Order.

Should circumstances arise that affect the Respiratory Care Practitioner's ability to remain in compliance, the Respiratory Care Practitioner shall immediately notify the Board in writing by return receipt mail, fully describing the situation along with any attendant request for Board consideration.

Any modification of this Consent Order must be pre-approved in writing by the Board before it may occur.

THE REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK

CONSENT TO ISSUANCE OF ORDER BY RESPIRATORY CARE PRACTITIONER

I, William P. Ford, state that I have read the foregoing Consent Order; that I know and fully understand its contents; that I agree freely and without threat or coercion of any kind to comply with the terms and conditions stated herein; and that I consent to the entry of this Consent Order as a condition of maintaining my license from the North Carolina Respiratory Care Board.

William P. Ford

STATE OF NORTH CAROLINA
COUNTY OF Cumberland

There personally appeared before me, a Notary Public in and for the County of Cumberland, State of North Carolina, William P. Ford, who, after having presented documentation of his identity that was satisfactory to me, did acknowledge that he executed the foregoing Consent Order as his free and voluntary act.

This 2 day of Feb., 2015.

Carol Smith Arons
Notary Public

CAROL SMITH ARONS NOTARY PUBLIC CUMBERLAND COUNTY, N.C. (SEAL)

My Commission Expires: Aug. 31, 2015

ENTRY OF CONSENT ORDER ON BEHALF OF THE NORTH CAROLINA RESPIRATORY CARE BOARD

The foregoing Consent Order is entered at Raleigh, North Carolina, this 4th day of February, 2015.

William L. Croft PhD, RRT, RCP
William L. Croft, PhD, RRT, RCP
Executive Director, North Carolina Respiratory Care Board

FedEx® Express

Extremely Urgent

From: (605) 367-7781
Jane Phalen
SDBMOE
101 N. Main Ave., Suite 301

Sioux Falls, SD 57104

Origin ID: FSDA

FedEx Express

J151215022303uv

Ship Date: 12MAY15
ActWgt: 0.5 LB
CAD: 5282744/INET3610

Delivery Address Bar Code

Ref #
Invoice #
PO #
Dept #

SHIP TO: (910) 574-1663
William P. Ford

24237 Dewey Lane

Hermosa, SD 57744

BILL SENDER

THU - 14 MAY PM
** 2DAY **

TRK# 0201 7735 8315 4306

RES
57744
SD-US
FSD

73 RAPA

537J3/C918/EE4B

Insert shipping document here

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
101 N MAIN AVE, SUITE 301
SIOUX FALLS, SD 57104
SDBMOE@STATE.SD.US
P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV

June 3, 2015

William P. Ford
830 W. Main St.
Hermosa, SD 57744

Re: Certified Copies of Stipulation and Agreement and temporary approval order

Dear Mr. Ford:

Enclosed please find certified copies of the documents in the matter of: 1) the Stipulation and Agreement that you entered into with the South Dakota Board of Medical and Osteopathic Examiners on May 27, 2015; 2) the Temporary Approval Order signed by the executive director on June 3, 2015.

This matter will be presented to the Board at the next Board meeting on Thursday, June 11, 2015. You were previously provided with a Notice of Hearing in this matter. You have the right to attend this meeting and be represented by an attorney of your own choosing at your own expense if you so desire; however, this is not a requirement.

A report of this action will be sent to the National Practitioner Data Bank and you may receive a notification from the databank regarding this report. We will also publish this information on the Board's website and report it to the other entities deemed appropriate by the Board in compliance with state and federal law.

This letter is intended as service by mail.

Sincerely,

Jane Phalen

Jane Phalen
Board Staff

Enclosure: Certified Copies of the Documents

THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

****

Re: WILLIAM PAUL FORD, RCP

TEMPORARY APPROVAL ORDER

****

William Paul Ford, RCP, and the South Dakota Board of Medical and Osteopathic Examiners (the Board) entered into a Stipulation and Agreement. The North Carolina Board of Respiratory Care and Mr. Ford entered into a Consent Order where he agreed to fulfill the requirements set forth by the North Carolina Board of Respiratory Care. The Board has authorized the executive director to execute this temporary approval order pending consideration by the Board at its next Board Meeting.

For this reason, said document has been temporarily approved pending consideration by the Board.

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

By: Margaret B. Hansen Date: 6/3/2015

Margaret B. Hansen
Executive Director

STATE OF SOUTH DAKOTA } S.S.
MINNEHAHA COUNTY
I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on the record in my office.
Executive Secretary
By MBH by JTP
Date 6-3-15

THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

****

IN RE: WILLIAM PAUL FORD, RCP

STIPULATION AND AGREEMENT

****

This Stipulation and Agreement, made and entered into by the South Dakota Board of Medical and Osteopathic Examiners, hereinafter referred to as "the BMOE", and William P. Ford, RCP, hereinafter referred to as "Mr. Ford", witness to the following:

Mr. Ford submitted an application for a South Dakota respiratory care practitioner license. Mr. Ford previously entered into a Consent Order with the North Carolina Board of Respiratory Care on February 2, 2015, and he further agreed to comply with the requirements set forth in the North Carolina Consent Order. The BMOE is authorized to take disciplinary action pursuant to *SDCL 36-4C-15(6): The licensee or temporary permit holder is guilty of unprofessional conduct as defined by the rules established by the board or violation of the code of ethics adopted and published by the board.* This Stipulation and Agreement shall mirror the requirements and conditions set forth in the North Carolina Consent Order, a copy of which is attached hereto and incorporated herein.

Informal Agreement: It is the intent of the parties hereto to provide for the informal compromise and settlement of all issues which could be raised by a formal contested hearing.

Waiver of Rights: Mr. Ford understands he has the right to consult with an attorney of his own choosing and has a right to an administrative hearing on the facts in this matter. He understands and agrees that by signing this Stipulation and Agreement, he is waiving his rights to counsel and to a hearing. He further understands and agrees that by signing this Stipulation and Agreement he is voluntarily and knowingly giving up his right to present oral and documentary evidence, to present rebuttal evidence, to cross-examine witnesses against him, and to appeal the Board's decision to Circuit Court.

Disclosure Waiver: Mr. Ford understands that the Board has reporting requirements and he consents to the documents relating to this matter being provided to the required entities and to state licensing authorities upon request.

It is further agreed that this Stipulation and Agreement is a public record of the Board and the State of South Dakota, and it shall be published on the Board's website and reported to the national data banks and all other entities deemed necessary by the Board in compliance with state and federal law.

Mr. Ford has unconditionally agreed to this Stipulation and Agreement by affixing his signature to this document.

By: _____ Date: 5/27/ 2015

William P. Ford, RCP

By: _____ Date: _____ 2015

Attorney for Mr. Ford (optional)

By: _____ Date: 6/1/ 2015

David Erickson, MD

Board Member, South Dakota Board of Medical and Osteopathic Examiners

STATE OF SOUTH DAKOTA } S.S.
MINNEHAHA COUNTY

I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on the record in my office.

Executive Secretary

By MBH by JTP

Date 6-3-15

COPY

STATE OF NORTH CAROLINA

BEFORE THE NORTH CAROLINA
RESPIRATORY CARE BOARD

IN THE MATTER OF:	)	
	)	**CONSENT ORDER**
William P. Ford, RCP	)	
License Number – 912	)	

---

1. Jurisdiction

The North Carolina Respiratory Care Board (the Board) is an occupational licensing board of the State of North Carolina, organized under N.C. Gen. Stat. § 90-646, et seq. The Board has jurisdiction over this matter pursuant to N.C. Gen. Stat. § 90-652 and 21 N.C. Admin. Code § 61.0307.

2. Identification of Licensee

The Respiratory Care Practitioner is William P. Ford (the "Licensee"). His mailing address is 3901 Hartwell Rd. Fayetteville, NC 28304-5061. The Respiratory Care Practitioner holds North Carolina Respiratory Care License number 912 (the "License"), first issued on May 7, 2002, with an expiration date of August 31, 2015.

3. Waiver of Rights

I, William P. Ford, the Respiratory Care Practitioner, understand that I have each of the following rights:

(Initials)

WPF The right to a hearing before the Board;

WPF The right to present evidence to disprove all or some of the charges against me;

WPF The right to present evidence to limit or reduce any sanction that could be imposed for a violation;

WPF The right to confront and cross-examine witnesses and to challenge evidence presented by the Board against me;

WPF The right to present legal arguments in a brief; and

WPF The right to appeal from any final decision adverse to my license to practice respiratory care.

As noted by my initials above, I hereby freely and knowingly waive these rights without further process and agree to the terms of this Consent Order regarding my license. In order to resolve this matter by a Consent Order, I also agree that the Board staff and counsel may discuss this Consent Order with the Board *ex parte* whether or not the Board accepts this Order as written.

4. Stipulation to Facts

The Licensee and the Board stipulate to the following facts:

A. The Licensee was engaged in the practice of respiratory care in North Carolina when the events occurred that led to the initiation of this complaint.

B. The Board received a complaint on September 5, 2014 that William P. Ford's employment had been terminated from Cape Fear Valley Health due to sexual harassment. According to the complaint, two females lodged the complaints. One was the receiver of the harassment with accusations of verbal comments and some inappropriate touching. The other was witness to the acts. The complaint states that the behavior had been going on for a period of time. A full investigation was completed by Human Resources and the Licensee was terminated from his position at the hospital.

C. The Licensee attended the Board's Investigation and Informal Settlement Committee meeting on December 18, 2014 at which time he stated he is currently unemployed after his termination from CFVMC. He denied sexual harassment of the females involved. He stated that it was consensual behavior between him and the alleged victim. The subpoenaed documents provided to the Board indicate that he engaged in inappropriate touching and language between the two employees. He admitted that it could have been interpreted this way and he repeatedly asked the alleged victim if it was ok. He admitted that the behavior was unprofessional and he should not have engaged in the activity. He stated that his termination was reversed and he was allowed to resign.

D. During the Board's Investigation and Informal Settlement Committee meeting on December 18, 2014, Mr. Ford provided letters of reference from five former co-workers attesting to his exceptional ability and performance as an RCP and supervisor. He also provided a written explanation of events as well as testimony that "he will never engage in this type of behavior that could be deemed inappropriate".

E. A former co-worker testified during the Board's Investigation and Informal Settlement Committee meeting on December 18, 2014 on his behalf stating that "Paul (William) was her mentor and he was an exceptional leader".

5. **Stipulated Order**

A. **Stipulation to Sections of Law Violated:**

I, William P. Ford, the Respiratory Care Practitioner, admit that the allegations against me, if proven true, would constitute violations of N.C. Gen. Stat. § 90-659 (a)(1)(d) and the regulations set forth in 21 N.C. Admin. Code § 61 .0307 (10).

B. **Stipulation to Sanction:**

Under N.C. Gen. Stat. § 90-652, in lieu of proceeding to hearing, the Respiratory Care Practitioner and the Board hereby enter into this consent order whereby the Respiratory Care Practitioner and the Board agree to the following terms:

1. The Licensee agrees to accept a license to practice respiratory care on Probationary Status for a period of 24 months from the date of execution of this order; and as a specific condition of that Probationary Status the Licensee agrees to all of the following terms and limitations.

2. The Licensee agrees to continue treatment and counseling with Full Life Counseling or other Board approved provider during the probationary period. The Licensee agrees to sign a release of information form and furnish it to the counselor allowing the counselor to provide quarterly written reports to the Board of all visits with the counselor during the probationary period. The Licensee agrees to follow any plan of treatment suggested by the counselor.

3. The Licensee accepts and agrees to the assessment of a civil penalty of two hundred and fifty dollars ($250.00) pursuant to N.C. Gen. Stat. § 90-666 and 21 N.C. Admin. Code § 61.0309 and to remit this sum to the Board no later than April 30, 2015.

4. The Licensee accepts and agrees to write a two-page essay on the meaning of sexual harassment according to Board writing guidelines and submit it electronically no later than 30 days after signing this Consent Order.

5. If employed in Respiratory Care, the Licensee shall cause his immediate supervisor to submit written quarterly reports to the Board during the time the Licensee is on Probation. Each such written report shall document the Licensee's performance in the delivery of Respiratory Care, and detail any concerns of the supervisor about the Licensee's practice of Respiratory Care.

6. The Licensee also assumes financial responsibility for any costs associated with fulfilling the terms of this Consent Order.

7. To continue to comply with the Respiratory Care Practice Act, the Board's Rules, and the Board's published interpretation of those rules.

6. Public Record

The parties agree that this Consent Order is public record, as required by N.C. Gen. Stat. § 132-1. Documents that are part of the investigative file are not public record.

7. Reporting

This disciplinary action will be reported to the appropriate entities as outlined in Board policy and required by state and/or federal law or guidelines. Those entities include, but are not limited to, the National Databank maintained by the National Board for Respiratory Care and the Healthcare Integrity and Protection Data Bank (HIPDB).

8. Effective Date

All provisions of this Consent Order are effective upon the date that the Executive Director of the Board signs this Order.

9. Noncompliance with Consent Order

Failure by the Respiratory Care Practitioner to comply with the terms of this Order, either in substance or in timing, is a violation of 21 N.C. Admin. Code § 61 .0307(3). If, during the term of this Consent Order, the Board staff receives evidence that the Respiratory Care Practitioner has violated any of the above conditions, the Board may schedule a show cause hearing for a determination of the violations. If the Board determines that such violations have occurred, then the Board may suspend or revoke the license, revoke any stay, or may impose additional disciplinary action.

All provisions of this Order are effective upon this Order's effective date. Fulfillment of time-specific elements intended to coincide with active practice (such as, but not limited to; probation, supervision or therapy) will only accrue during periods of active practice in which the Respiratory Care Practitioner is compliant with the terms of this Order.

Should circumstances arise that affect the Respiratory Care Practitioner's ability to remain in compliance, the Respiratory Care Practitioner shall immediately notify the Board in writing by return receipt mail, fully describing the situation along with any attendant request for Board consideration.

Any modification of this Consent Order must be pre-approved in writing by the Board before it may occur.

THE REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK

CONSENT TO ISSUANCE OF ORDER BY RESPIRATORY CARE PRACTITIONER

I, William P. Ford, state that I have read the foregoing Consent Order; that I know and fully understand its contents; that I agree freely and without threat or coercion of any kind to comply with the terms and conditions stated herein; and that I consent to the entry of this Consent Order as a condition of maintaining my license from the North Carolina Respiratory Care Board.

William P. Ford

STATE OF NORTH CAROLINA
COUNTY OF Cumberland

There personally appeared before me, a Notary Public in and for the County of Cumberland, State of North Carolina, William P. Ford, who, after having presented documentation of his identity that was satisfactory to me, did acknowledge that he executed the foregoing Consent Order as his free and voluntary act.

This 2 day of Feb, 2015.

Carol Smith Arons
Notary Public

My Commission Expires: Aug. 31, 2015

CAROL SMITH ARONS NOTARY PUBLIC (SEAL) CUMBERLAND COUNTY, N.C.

ENTRY OF CONSENT ORDER ON BEHALF OF THE NORTH CAROLINA RESPIRATORY CARE BOARD

The foregoing Consent Order is entered at Raleigh, North Carolina, this 4th day of February, 2015.

William L. Croft PhD, RRT, RCP
William L. Croft, PhD, RRT, RCP
Executive Director, North Carolina Respiratory Care Board

THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

****

Re: WILLIAM PAUL FORD, RCP TEMPORARY APPROVAL ORDER

****

William Paul Ford, RCP, and the South Dakota Board of Medical and Osteopathic Examiners (the Board) entered into a Stipulation and Agreement. The North Carolina Board of Respiratory Care and Mr. Ford entered into a Consent Order where he agreed to fulfill the requirements set forth by the North Carolina Board of Respiratory Care. The Board has authorized the executive director to execute this temporary approval order pending consideration by the Board at its next Board Meeting.

For this reason, said document has been temporarily approved pending consideration by the Board.

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

By: Margaret B. Hansen Date: 6/3/2015

Margaret B. Hansen
Executive Director

THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

****

IN RE: WILLIAM PAUL FORD, RCP

STIPULATION AND AGREEMENT

****

This Stipulation and Agreement, made and entered into by the South Dakota Board of Medical and Osteopathic Examiners, hereinafter referred to as "the BMOE", and William P. Ford, RCP, hereinafter referred to as "Mr. Ford", witness to the following:

Mr. Ford submitted an application for a South Dakota respiratory care practitioner license. Mr. Ford previously entered into a Consent Order with the North Carolina Board of Respiratory Care on February 2, 2015, and he further agreed to comply with the requirements set forth in the North Carolina Consent Order. The BMOE is authorized to take disciplinary action pursuant to *SDCL 36-4C-15(6): The licensee or temporary permit holder is guilty of unprofessional conduct as defined by the rules established by the board or violation of the code of ethics adopted and published by the board.* This Stipulation and Agreement shall mirror the requirements and conditions set forth in the North Carolina Consent Order, a copy of which is attached hereto and incorporated herein.

Informal Agreement: It is the intent of the parties hereto to provide for the informal compromise and settlement of all issues which could be raised by a formal contested hearing.

Waiver of Rights: Mr. Ford understands he has the right to consult with an attorney of his own choosing and has a right to an administrative hearing on the facts in this matter. He understands and agrees that by signing this Stipulation and Agreement, he is waiving his rights to counsel and to a hearing. He further understands and agrees that by signing this Stipulation and Agreement he is voluntarily and knowingly giving up his right to present oral and documentary evidence, to present rebuttal evidence, to cross-examine witnesses against him, and to appeal the Board's decision to Circuit Court.

Disclosure Waiver: Mr. Ford understands that the Board has reporting requirements and he consents to the documents relating to this matter being provided to the required entities and to state licensing authorities upon request.

It is further agreed that this Stipulation and Agreement is a public record of the Board and the State of South Dakota, and it shall be published on the Board's website and reported to the national data banks and all other entities deemed necessary by the Board in compliance with state and federal law.

Mr. Ford has unconditionally agreed to this Stipulation and Agreement by affixing his signature to this document.

By: _____ Date: 5/27/, 2015
William P. Ford, RCP

By: _____ Date: _____, 2015
Attorney for Mr. Ford (optional)

By: _____ Date: 6/1/, 2015
David Erickson, MD
Board Member, South Dakota Board of Medical and Osteopathic Examiners

COPY

STATE OF NORTH CAROLINA

BEFORE THE NORTH CAROLINA
RESPIRATORY CARE BOARD

IN THE MATTER OF:	)	
	)	**CONSENT ORDER**
William P. Ford, RCP	)	
License Number – 912	)	

---

1. Jurisdiction

The North Carolina Respiratory Care Board (the Board) is an occupational licensing board of the State of North Carolina, organized under N.C. Gen. Stat. § 90-646, et seq. The Board has jurisdiction over this matter pursuant to N.C. Gen. Stat. § 90-652 and 21 N.C. Admin. Code § 61.0307.

2. Identification of Licensee

The Respiratory Care Practitioner is William P. Ford (the "Licensee"). His mailing address is 3901 Hartwell Rd. Fayetteville, NC 28304-5061. The Respiratory Care Practitioner holds North Carolina Respiratory Care License number 912 (the "License"), first issued on May 7, 2002, with an expiration date of August 31, 2015.

3. Waiver of Rights

I, William P. Ford, the Respiratory Care Practitioner, understand that I have each of the following rights:

(Initials)

WPF The right to a hearing before the Board;

WPF The right to present evidence to disprove all or some of the charges against me;

WPF The right to present evidence to limit or reduce any sanction that could be imposed for a violation;

WPF The right to confront and cross-examine witnesses and to challenge evidence presented by the Board against me;

WPF The right to present legal arguments in a brief; and

WPF The right to appeal from any final decision adverse to my license to practice respiratory care.

As noted by my initials above, I hereby freely and knowingly waive these rights without further process and agree to the terms of this Consent Order regarding my license. In order to resolve this matter by a Consent Order, I also agree that the Board staff and counsel may discuss this Consent Order with the Board *ex parte* whether or not the Board accepts this Order as written.

4. Stipulation to Facts

The Licensee and the Board stipulate to the following facts:

A. The Licensee was engaged in the practice of respiratory care in North Carolina when the events occurred that led to the initiation of this complaint.

B. The Board received a complaint on September 5, 2014 that William P. Ford's employment had been terminated from Cape Fear Valley Health due to sexual harassment. According to the complaint, two females lodged the complaints. One was the receiver of the harassment with accusations of verbal comments and some inappropriate touching. The other was witness to the acts. The complaint states that the behavior had been going on for a period of time. A full investigation was completed by Human Resources and the Licensee was terminated from his position at the hospital.

C. The Licensee attended the Board's Investigation and Informal Settlement Committee meeting on December 18, 2014 at which time he stated he is currently unemployed after his termination from CFVMC. He denied sexual harassment of the females involved. He stated that it was consensual behavior between him and the alleged victim. The subpoenaed documents provided to the Board indicate that he engaged in inappropriate touching and language between the two employees. He admitted that it could have been interpreted this way and he repeatedly asked the alleged victim if it was ok. He admitted that the behavior was unprofessional and he should not have engaged in the activity. He stated that his termination was reversed and he was allowed to resign.

D. During the Board's Investigation and Informal Settlement Committee meeting on December 18, 2014, Mr. Ford provided letters of reference from five former co-workers attesting to his exceptional ability and performance as an RCP and supervisor. He also provided a written explanation of events as well as testimony that "he will never engage in this type of behavior that could be deemed inappropriate".

E. A former co-worker testified during the Board's Investigation and Informal Settlement Committee meeting on December 18, 2014 on his behalf stating that "Paul (William) was her mentor and he was an exceptional leader".

5. Stipulated Order

A. Stipulation to Sections of Law Violated:

I, William P. Ford, the Respiratory Care Practitioner, admit that the allegations against me, if proven true, would constitute violations of N.C. Gen. Stat. § 90-659 (a)(1)(d) and the regulations set forth in 21 N.C. Admin. Code § 61 .0307 (10).

B. Stipulation to Sanction:

Under N.C. Gen. Stat. § 90-652, in lieu of proceeding to hearing, the Respiratory Care Practitioner and the Board hereby enter into this consent order whereby the Respiratory Care Practitioner and the Board agree to the following terms:

1. The Licensee agrees to accept a license to practice respiratory care on Probationary Status for a period of 24 months from the date of execution of this order; and as a specific condition of that Probationary Status the Licensee agrees to all of the following terms and limitations.

2. The Licensee agrees to continue treatment and counseling with Full Life Counseling or other Board approved provider during the probationary period. The Licensee agrees to sign a release of information form and furnish it to the counselor allowing the counselor to provide quarterly written reports to the Board of all visits with the counselor during the probationary period. The Licensee agrees to follow any plan of treatment suggested by the counselor.

3. The Licensee accepts and agrees to the assessment of a civil penalty of two hundred and fifty dollars ($250.00) pursuant to N.C. Gen. Stat. § 90-666 and 21 N.C. Admin. Code § 61.0309 and to remit this sum to the Board no later than April 30, 2015.

4. The Licensee accepts and agrees to write a two-page essay on the meaning of sexual harassment according to Board writing guidelines and submit it electronically no later than 30 days after signing this Consent Order.

5. If employed in Respiratory Care, the Licensee shall cause his immediate supervisor to submit written quarterly reports to the Board during the time the Licensee is on Probation. Each such written report shall document the Licensee's performance in the delivery of Respiratory Care, and detail any concerns of the supervisor about the Licensee's practice of Respiratory Care.

6. The Licensee also assumes financial responsibility for any costs associated with fulfilling the terms of this Consent Order.

7. To continue to comply with the Respiratory Care Practice Act, the Board's Rules, and the Board's published interpretation of those rules.

6. Public Record

The parties agree that this Consent Order is public record, as required by N.C. Gen. Stat. § 132-1. Documents that are part of the investigative file are not public record.

7. Reporting

This disciplinary action will be reported to the appropriate entities as outlined in Board policy and required by state and/or federal law or guidelines. Those entities include, but are not limited to, the National Databank maintained by the National Board for Respiratory Care and the Healthcare Integrity and Protection Data Bank (HIPDB).

8. Effective Date

All provisions of this Consent Order are effective upon the date that the Executive Director of the Board signs this Order.

9. Noncompliance with Consent Order

Failure by the Respiratory Care Practitioner to comply with the terms of this Order, either in substance or in timing, is a violation of 21 N.C. Admin. Code § 61 .0307(3). If, during the term of this Consent Order, the Board staff receives evidence that the Respiratory Care Practitioner has violated any of the above conditions, the Board may schedule a show cause hearing for a determination of the violations. If the Board determines that such violations have occurred, then the Board may suspend or revoke the license, revoke any stay, or may impose additional disciplinary action.

All provisions of this Order are effective upon this Order's effective date. Fulfillment of time-specific elements intended to coincide with active practice (such as, but not limited to; probation, supervision or therapy) will only accrue during periods of active practice in which the Respiratory Care Practitioner is compliant with the terms of this Order.

Should circumstances arise that affect the Respiratory Care Practitioner's ability to remain in compliance, the Respiratory Care Practitioner shall immediately notify the Board in writing by return receipt mail, fully describing the situation along with any attendant request for Board consideration.

Any modification of this Consent Order must be pre-approved in writing by the Board before it may occur.

THE REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK

CONSENT TO ISSUANCE OF ORDER BY RESPIRATORY CARE PRACTITIONER

I, William P. Ford, state that I have read the foregoing Consent Order; that I know and fully understand its contents; that I agree freely and without threat or coercion of any kind to comply with the terms and conditions stated herein; and that I consent to the entry of this Consent Order as a condition of maintaining my license from the North Carolina Respiratory Care Board.

William P. Ford

STATE OF NORTH CAROLINA
COUNTY OF Cumberland

There personally appeared before me, a Notary Public in and for the County of Cumberland, State of North Carolina, William P. Ford, who, after having presented documentation of his identity that was satisfactory to me, did acknowledge that he executed the foregoing Consent Order as his free and voluntary act.

This 2 day of Feb, 2015.

Carol Smith Arons
Notary Public

CAROL SMITH ARONS NOTARY PUBLIC CUMBERLAND COUNTY, N.C. (SEAL)

My Commission Expires: Aug. 31, 2015

ENTRY OF CONSENT ORDER ON BEHALF OF THE NORTH CAROLINA RESPIRATORY CARE BOARD

The foregoing Consent Order is entered at Raleigh, North Carolina, this 4th day of February, 2015.

William L. Croft PhD, RRT, RCP
William L. Croft, PhD, RRT, RCP
Executive Director, North Carolina Respiratory Care Board

THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

****

Re: WILLIAM PAUL FORD
APPLICANT FOR
RESPIRATORY CARE
PRACTITIONER LICENSE

FINAL ORDER

****

The above-entitled matter having come before the South Dakota Board of Medical and Osteopathic Examiners ("Board"), and the Board having been fully advised in the premises thereof; and

Mr. Ford agrees that the documents relating to this matter will be provided to other state licensing authorities upon their request.

NOW; THEREFORE, the Board hereby:

APPROVES this Stipulation and Agreement, and this Final Order, and directs that these are public records of the Board and the State of South Dakota and shall be published on the Board's website and reported to the national data banks and any other entity deemed appropriate by the Board and in compliance with State and Federal law.

By:_____Date:_____
South Dakota Board of Medical and Osteopathic Examiners

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

* *

IN THE MATTER OF THE
SOUTH DAKOTA BOARD OF
MEDICAL & OSTEOPATHIC
EXAMINERS RESPIRATORY CARE
PRACTITIONER LICENSE
RE: William Paul Ford, RCP

NOTICE OF HEARING

* *

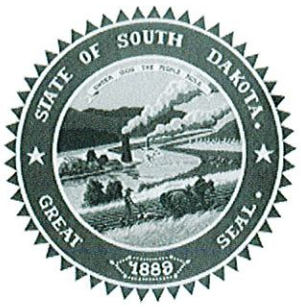
Please take notice that a contested case hearing has been scheduled before the South Dakota Board of Medical and Osteopathic Examiners in the above captioned matter. The hearing will take place on Thursday, June 11, 2015, in the Board Conference Room, 101 N. Main Ave., Suite 215, Sioux Falls, SD, beginning at 11:00 am (CDT).

Dated this 14 day of May, 2015.

William H. Golden, esq.
Assistant Attorney General/Civil Litigation Division
317 N. Main Ave.
Sioux Falls, SD 57104
Attorney for the South Dakota Board of Medical and Osteopathic Examiners
(605) 201-8588

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
101 N MAIN AVE, SUITE 301
SIOUX FALLS, SD 57104
SDBMOE@STATE.SD.US
P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV



Via federal express

May 13, 2015

William M. Griffin
3110 S. Clinton Ave., #7
Spokane Valley, WA 99216

Re: Application "Withdrawn under Investigation"

Dear Mr. Griffin:

Per your request, your application for a South Dakota physical therapist license has been withdrawn under investigation.

A contested case hearing will be held before the South Dakota Board of Medical and Osteopathic Examiners at the June 11, 2015, Board Meeting. Enclosed please find the Notice of Hearing, the Petition to the Board of Medical and Osteopathic Examiners, and the Investigative Report with the Exhibits which will be presented at the contested case hearing in this matter. Also enclosed is the proposed final order for your review.

You have the right to attend this meeting if you wish to do so, and to have an attorney accompany you to the meeting if you so desire; however, this is not a requirement.

If you plan to attend the Board meeting please send an email to that effect to SDBMOE@state.sd.us prior to May 28, 2015. If you have questions please contact the Board attorney, William H. Golden, by calling (605) 201-8588.

Sincerely,

Jane Phalen

Jane Phalen
SD Medical Board Staff

Enclosures

cc: William H. Golden, esq.
Assistant Attorney General/Civil Litigation Division
Counsel to the South Dakota Board of Medical and Osteopathic Examiners

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

* *

SOUTH DAKOTA BOARD OF MEDICAL and OSTEOPATHIC EXAMINERS APPLICATION FOR PHYSICAL THERAPIST LICENSE

NOTICE OF HEARING

WITHDRAWN UNDER INVESTIGATION

In Re: William Milo Griffin

* *

Please take notice that a contested case hearing has been scheduled before the South Dakota Board of Medical and Osteopathic Examiners in the above captioned matter. The hearing will take place on Thursday, June 11, 2015, in the Board Conference Room, 101 N. Main Ave., Suite 215, Sioux Falls, SD, beginning at 11:00 am (CDT).

Dated this 12 day of May, 2015.

William H. Golden, esq.
Assistant Attorney General/Civil Litigation Division
317 N. Main Ave.
Sioux Falls, SD 57104
Attorney for the South Dakota Board of Medical and Osteopathic Examiners
(605) 201-8588

THE BOARD OF MEDICAL AND
OSTEOPATHIC EXAMINERS OF THE
STATE OF SOUTH DAKOTA

IN THE MATTER OF:	)	NO. 15-010
	)	
William Milo Griffin	)	PETITION FOR BOARD OF
Physical Therapist Applicant	)	MEDICAL AND OSTEOPATHIC
	)	EXAMINERS
Respondent.	)	
	)	

COMES NOW, the Executive Secretary of the South Dakota Board of Medical and Osteopathic Examiners ("Secretary") and files this Petition pursuant to SDCL 36-10-27, 28, SDCL 1-26 and South Dakota's Administrative Rules 20:78:04 and 05. Respondent, William Milo Griffin, was placed under investigation by the Secretary on February 17, 2015, due to allegations of child pornography. Respondent has contested this recommendation. On April 20, 2015, a letter was received from Mr. Griffin. The Secretary, under ARSD 20:78:04 and ARSD ch. 20:78:05, therefore files this Petition for a contested case hearing.

A. TIME, PLACE AND NATURE OF HEARING

Hearing. A contested case hearing on this licensure action shall be heard by a Hearing Examiner pursuant to ARSD 20:78:05:04. The hearing shall begin at 11:00 a.m. on June 11, 2015, in the BMOE conference room, 101 North Main Avenue, Suite 215, Sioux Falls, South Dakota 57104.

Answer. Respondent may file an Answer within twenty (20) days of the date he is served with this Petition. An Answer, if filed, should specifically admit, deny, or otherwise answer all allegations contained in sections C and D of this Petition. The answer and any other pleading must be filed with the

Board at the following address: BMOE, 101 North Main Avenue, Suite 301, Sioux Falls, South Dakota 57104.

Presiding Officer. The Hearing Examiner will preside over the hearing and make a recommended decision, consisting of proposed Findings of Fact, Conclusions of Law, and an Order, to the Board. ARSD 20:78:05:06. The Board will read the record, transcript of the contested case proceeding, and all exhibits, and make its decision thereon at the BMOE meeting following the contested case hearing. The Board may request that the parties appear to present oral argument and objections to the Hearing Examiner's recommended decision. ARSD 20:78:05:06.

Hearing Procedures. The procedural rules governing the conduct of the hearing are found in SDCL chs. 36-10 and 1-26, and ARSD chs. 20:78:05. The contested case proceeding is an adversarial proceeding. At the hearing, you have the right to be present, to appear personally, and/or to be represented by legal counsel at your own expense. You will be allowed the opportunity to respond to the allegations of the Petition, to produce evidence on your behalf, to present witnesses, to cross-examine witnesses, and to examine and respond to any documents introduced at hearing. These and other due process rights will be forfeited if they are not exercised at the hearing.

The hearing is open to the public.

Any decision of the BMOE based on the contested case proceeding may be appealed to the circuit court and the State Supreme Court as provided by law.

Pre-hearing Conferences and Continuances. Any party may request a pre-hearing conference to discuss evidentiary issues related to hearing, or may request a continuance, by filing a motion for a prehearing conference with the BMOE at the address above.

Prosecution. Counsel for the Secretary is responsible for representing the public interest (the State) in this proceeding. Counsel for the Secretary is: William H. Golden, Assistant Attorney General, South Dakota Attorney General's Office, 101 North Main Avenue, Suite 301, Sioux Falls, South Dakota 57104. Copies of all pleadings filed in this matter must be provided to Counsel for the Secretary at this address.

Communications. You may not contact Board members in any manner, including by phone, letter, e-mail, or in person about this Petition. Board members may only receive information about the case when all parties have notice and an opportunity to participate, such as at the hearing or in pleadings you file with the Board office and serve upon all parties in this case. *See* SDCL 1-26-26.

B. LEGAL AUTHORITY AND JURISDICTION

Jurisdiction. The Board has jurisdiction in this matter pursuant to SDCL 36-10.

Legal Authority. If any of the allegations against you are founded, the Board has authority to take disciplinary action against you under SDCL 36-10-38 and 36-10-40, South Dakota's Administrative Rules 20:78:,04 and 05.

Default. If you fail to appear at the hearing, the Board may enter a default decision or proceed with the hearing and render a decision in your absence, in accordance with SDCL 1-26.

C. SECTIONS OF STATUTES AND RULES INVOLVED

Count I

Respondent has withdrawn his application during the BMOE investigation, and this is a reportable event pursuant to:

20:78:03:07. Application withdrawn during investigation. An applicant may withdraw an application after an investigation has been initiated by the executive secretary. An application withdrawn after investigation has been initiated shall be reported as "withdrawn under investigation" in the board's permanent license files and in any national databases to which the board is required to report licensure action.

D. FACTUAL CIRCUMSTANCES

1. On January 15, 2015, William Griffin applied for a South Dakota Physical Therapist License (investigative report Exhibit 1, Pages 3-8). Mr. Griffin did not disclose any adverse action, or any criminal or civil complaints, investigations, or proceedings on his application.
2. The employment verification from Gritman Medical Center in Moscow, Idaho, was received on January 23, 2015 (investigative report Exhibit 2, Pages 9-13). Gritman Medical Center said that they were notified by the local police department that Mr. Griffin was being investigated for child pornography. Mr. Griffin resigned from his position with Gritman Medical Center prior to them questioning him about the investigation. They are unaware of the status of the investigation.
3. On April 20, 2015, a letter was received from Mr. Griffin (investigative report Exhibit 6, Pages 21-22). The letter stated, "I have recently become aware

that an issue that I had thought was resolved has resurfaced, and may include actual legal issues. While this does not in any way involve patient care, it does fall under your guidelines, and as it isn't likely to be resolved in the near future I must therefore remove myself from consideration for a South Dakota Physical Therapy license." See attached investigative report.

4. It is hereby requested that an Order from the Board be issued stating that William Milo Griffin withdrew his application during an investigation by the BMOE.

E. SETTLEMENT

This matter may be resolved by settlement agreement. The procedural rules governing the Board's settlement process are found at ARS 20:78:04:04. If you are interested in pursuing settlement of this matter, please contact William Golden, Assistant Attorney General, at (605) 201-8588.

Signed pursuant to Article 20:78:05:02: Margaret B. Hansen Date: 5/13/2015

Margaret B. Hansen
Executive Director
South Dakota Board of Medical
And Osteopathic Examiners

Copies to: William Golden
Assistant Attorney General
South Dakota Attorney General's Office
101 N. Main Ave., Suite 301
Sioux Falls, SD 57104

William M. Griffin
3110 S. Clinton Ave., #7
Spokane Valley, WA 99216

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
101 N MAIN AVE, SUITE 301
SIOUX FALLS, SD 57104
SDBMOE@STATE.SD.US
P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV

INVESTIGATIVE REPORT

Allegation: SDCL 36-4-30 (22) Any practice or conduct which tends to constitute a danger to the health, welfare, or safety of the public or patients or engaging in conduct which is unbecoming a person licensed to practice medicine.

Docket Number: 15-010

Board Member:

Applicant: William Milo Griffin
3110 South Clinton Ave #7
Spokane Valley, WA 99216

Complainant: SDBMOE

Narrative:

On January 15, 2015, William Griffin applied for a SD Physical Therapist License (Exhibit 1, Pages 3-8). Mr. Griffin did not disclose any adverse action or criminal or civil complaints, investigation, or proceedings on his application.

The employment verification from Gritman Medical Center in Moscow, Idaho, was received on January 23, 2015 (Exhibit 2, Pages 9-13). Gritman Medical Center said that they were notified by the local police department that Mr. Griffin was being investigated for child pornography. Mr. Griffin resigned from his position with the medical center prior to them questioning him about the investigation. They are unaware of the status of the investigation.

The Moscow Police Department was contacted and a request for information was submitted (Exhibit 3, Pages 14-16). The request for information was denied due to an active and ongoing investigation (Exhibit 4, Pages 17-18).

A letter was emailed and mailed to Mr. Griffin, on February 17, 2015, to notify him that his application for a SD Physical Therapist License had been placed under investigation (Exhibit 5, Pages 19-20).

On April 20, 2015, a letter was received from Mr. Griffin (Exhibit 6, Pages 21-22). The letter stated, "I have recently become aware that an issue that I had thought was resolved has resurfaced, and may include actual legal issues. While this does not in any way involve patient care, it does fall under your guidelines, and as it isn't likely to be resolved in the near future I must therefore remove myself from consideration for a South Dakota Physical Therapy license."

Exhibit(s):

1.) Application (Pages 3-8)
2.) Employment Verification (Pages 9-13)
3.) Record Request (Pages 14-16)
4.) Letter from Moscow City Attorney (Pages 17-18)
5.) Notice Letter (Pages 19-20)
6.) Letter from Mr. Griffin (Pages 21-22)

Exhibit 1

License Application - Physical Therapist License

License application# 16590 Submitted on: 1-15-2015

Name Information

WILLIAM MILO GRIFFIN , PT

Alternates *None reported.*

Address

	****Default****
Type	Home Address
Public?	N
Name/Attention	
Address	3110 South Clinton Ave. #7 Spokane Valley, WA 99216

Identification

Date of Birth	5-23-1951
Birth Place	Hot Springs, South Dakota UNITED STATES
	Gender:M **SSN:** XXX-XX-2905 **NPI:**
US Citizen	Y

Race/Ethnicity/Languages (ALL OPTIONAL)

What is your race? (check all that may apply):	White: Y Black or African American: N American Indian or Alaska Native: N Asian: N Native Hawaiian/Other Pacific Islander: N Other:
Ethnicity: Are you Hispanic, Latino/a, or of Spanish origin? (check all that may apply)	No: Y Mexican, Mexican American, Chicano/a: N Puerto Rican: N Cuban: N Another Hispanic, Latino/a, or of Spanish origin:
Do you speak a language other than English at home?	N
What is this language? (if you answered Yes to above)	N

Education

Name	University of Washington
Location	Seattle, WA
Degree	BS Physical Therapy
Status	Graduated
Dates Attended	09/1986 to 08/1988
Graduated	08/1988

Exam History

Have you taken and passed the examination? **Y**

Type	Other Interstate Reporting Service (PT)

Date	11/02/1988
Pass/Fail	Y

State or Professional Licensure

Type	OTHER PT
State	WA
Date	Issued: 10/1988 Valid through: 05/2015

Type	OTHER PT
State	AK
Date	Issued: 05/2006 Valid through: 06/2008

Type	OTHER PT
State	OR
Date	Issued: 11/1988 Valid through: 05/2007

Type	OTHER PT
State	ID
Date	Issued: 05/2006 Valid through: 05/2015

Chronology of Activities

From: 12/1988 **To:** 09/1990	**Activity:**Work Kittitas Valley Community Hospital 820 Chestnut St. Ellensburg, WA 98926 Physical Therapist PT dept Percent Clinical: 100% Administrative: 0%
From: 09/1990 **To:** 10/1991	**Activity:**Work Jefferson General Hospital 834 Sheridan St. Pt. Townsend, WA 98368 Physical Therapist PT dept Percent Clinical: 100% Administrative: 0%
From: 11/1991 **To:** 02/1995	**Activity:**Work Puget Sound Physical Therapy Registry 16407 NE 44th Way Redmond, WA 98052 Physical Therapist Rehab Dept Percent Clinical: 100% Administrative: 0%
From: 02/1995 **To:** 06/1998	**Activity:**Work Skagit Home Health 1971 Highway 20 Sedro-Wooley, WA 98284 Physical Therapist Home health Percent Clinical: 100% Administrative: 0%
From: 09/1998	**Activity:**Work

To: 01/2002	Island Hospital 1211 24th St. Anacortes, WA 98221 Physical Therapist PT Percent Clinical: 100% Administrative: 0%
From: 01/2002 **To:** 10/2006	**Activity:**Work PT On Call 201 NE Park Place Dr., suite 246 Vancouver, WA 98664 Physical Therapist Percent Clinical: 100% Administrative: 0%
From: 10/2006 **To:** 06/2014	**Activity:**Work Gritman Therapy Solutions 810 South Main Moscow , ID 83843 Physical Therapist Percent Clinical: 100% Administrative: 0%
From: 06/2014 **To:**	**Activity:**Work Full Circle Physical Therapy 3110 South Clinton Ave no 7 Spokane Valley, WA 99216 owner PT practice Percent Clinical: 50% Administrative: 50%

Malpractice Liability Claims Information

No information reported.

Practice Information

1. What is your current employment status?:	ACTIVEMED
2. Are you currently providing direct clinical or patient care on a regular basis?	Y
3. Which of the following best describes your primary area of practice in which you will spend most of your professional time:	Physical Med. & Rehab.
4. Which of the following categories best describes your primary practice or work setting(s) where you work the most hours each week?	Office/Clinic—Solo Practice
5. How many weeks did you work in medical related positions in the past 12 months?	50

6. For all medical related positions held in South Dakota, indicate the average number of hours per week spent on each major activity:

Clinical or patient care	0 hours/week
Research	0 hours/week
Teaching/Education	0 hours/week
Administration	0 hours/week
Volunteering (medical related only)	0 hours/week
Other (specify):	0 hours/week

7. What is/will be the location of the site(s) where you spend most of your time providing direct clinical or patient care? Please enter the complete address for up to three locations and your direct patient care hours per week at each site.

Principal Location

Proposed Start Date

Direct patient care hours per week at site: 0 hrs.

8. Would you say you work primarily in South Dakota (more than anywhere else)? N

9. If not working in South Dakota, in which states do you practice?

Required Disclosures

Definitions:

All questions use the following definitions whether actions were formally, informally, voluntarily or involuntarily committed: Questions refer to both you and your licensure.

A. **Adverse Action** shall refer to having been terminated, stipulated, restricted, limited, conditioned, counseled, reprimanded, suspended, revoked, refused, denied, not renewed, withdrawn or relinquished.

B. **Claim(s)** shall refer to any malpractice, administrative, civil, or criminal final judgments including any pending claims, lawsuits, judgments, and/or settlements.

C. **Complaint** shall refer to any communications which express concerns, warnings or dissatisfaction about personal or profession conduct and rising to the level that the meetings or comments are documented in a written or digital format.

D. **Entity** shall refer to any licensing or disciplinary board, professional agency or committee, academic program, clinic, hospital, or other health-related entity, or governmental agency or organization.

E. **Health related program** shall refer to private or public insurance, Medicare and Medicaid.

F. **Illegal use of drugs** shall refer to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22. The term does include the unlawful use of prescription controlled substances. It does **not** include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law.

G. **Investigation** shall refer to any formal or informal inquiry to acquire and examine facts.

H. **Licensure** shall refer to type of licensure and using any licensure nomenclature such as any registration, permit, certificate, and license. Examples include the subject of this application, DEA registration, etc.

I. **Minor traffic offense** shall refer to any violation which is punishable by a maximum of 30 days in jail, a $500 fine or both and does not result in a change of driving privileges.

J. **Proceeding** shall refer to whether you have appeared or been requested to appear in private or in public, for a meeting, counseling, hearing, administrative, civil or criminal actions, or been questioned, reviewed, charged, arrested, plead guilty, plead no contest, convicted, received a suspended imposition of sentence or suspended sentence by any entity.

K. **Sexual impropriety** shall refer to misconduct including but not limited to discrimination, complaint, assault, the possession of child pornography, sexual contact with patients or other acts, expressions or gestures that disrespect privacy and are demeaning.

L. **You** shall refer to you or any licensure held by you.

01 Is this a true statement for your licensure? "My licensure has not experienced adverse action." Y

02 Is this a true statement for you? "I have not experienced adverse action." Y

03 Has your licensure been subject to any complaint, investigation or proceeding involving any entity? N

04 Have you been subject to any complaint, investigation or proceeding involving any N

entity?	
05 Have you been dishonorably discharged from a branch of the United States military or National Guard?	N
06 Have you had any adverse action during any education, residency or training program	N
07 Have you had adverse action with your membership or privileges with any entity regarding your ability to participate in any health related program?	N
08 Have you been subject to a criminal or civil complaint, investigation or proceeding other than minor traffic offenses?	N
09 Have you had a complaint, investigation or proceeding in any manner concerning sexual impropriety?	N
10 Is this a true statement for you? "I have not been reported to NPDB (National Practitioners Data Bank) or HIPDB (Healthcare Integrity and Protection Data Bank)."	Y
11 Is this a true statement for you? "I have experienced no adverse action in privileges at any hospital, clinic or health related entity."	Y
12 Have you had any claims paid by you or paid on your behalf for any reason?	N
13 Have you had any liability insurance company, including malpractice carriers, change, deny or cancel your coverage?	N
14 Have you stopped working or practicing for any period of time greater than or equal to 30 consecutive calendar days?	N
15 Do you have a physical, mental or emotional condition which may adversely affect your practice?	N
16 Have you been treated for or do you have a diagnosis for any Mental Health condition. (If yes, please ask your treating provider to send a status letter to the Board office).	N
17 Does your use of alcohol or drugs affect your ability to provide appropriate care to patients?	N
18 Are you currently using illegal drugs or prescription controlled medications in an illegal manner?	N

Agreements

I am aware of the Health Insurance Portability and Accountability Act of 1996 (thereinafter called HIPAA) and understand the provisions dealing with the privacy of my medical records. With such knowledge an understanding, I agree to the following:

- a. I do hereby authorize the use or disclosure of my health information by the South Dakota Board of Medical & Osteopathic Examiners (SDBMOE), for purposes of licensure in the state of South Dakota.
- b. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and hospitals, and treatment for alcohol and drug abuse.

I further release, discharge and exonerate all third parties or person(s) from any and all claims, damages, and liabilities of any nature, who in good faith and without malice, release the HIPAA information to the SDBMOE.

AUTHORIZATION AND RELEASE:
Any references to the terms "Users" or "Users of this Application" in this authorization shall include the following entities:

- The South Dakota State Board of Medical and Osteopathic Examiners together with its board members, staff members, legal counsels, investigators, agents, employees, contractees, and authorized representatives hereinafter collectively referred to as SDBMOE;
- Any other state or national medical licensing, medical reporting or medical regulatory board;
- The Federation of State Medical Boards;

- Any other South Dakota or United States agency in furtherance of and incompliance with SDBMOE's duties and responsibilities under my South Dakota Medical Practices Act and its administrative regulations.

I am the person described herein. I have not engaged in any acts prohibited by the criminal or medical statutes of the State of South Dakota. I am the person named on any diploma or certificated that I have received, I am the lawful holder of said diploma or certificate, and the diploma or certificate was given to me in the regular course of instruction and examination without fraud or misrepresentation.

The following deals with SDBMOE consulting with and receiving information from third parties:

I authorize SDBMOE to consult with any third person or party who may have information or evidence concerning my professional, ethical, mental and physical qualifications, or any other matter that SDBMOE deems relevant regarding my continuing qualifications for licensure with SDBMOE. These third persons and parties include hospitals, institutions or organizations, my references, physicians, therapists, previous and present employers, past and present business and professional associates, and local, state, federal or foreign governmental agencies and instrumentalities, courts of any jurisdiction, associations, institutions or law enforcement agencies, together with their representatives thereof, who have custody or control of any documents, records, information or evidence that SDBMOE deems relevant to my Application. **I specifically authorize any state, federal or international law enforcement agency to conduct a background investigation and to report the findings thereof to the SDBMOE.**

I authorize such third persons and parties to unconditionally release to SDBMOE any such information, including documents, records regarding charges or complaints filed against me, formal, or informal, pending or closed, or any other pertinent data or evidence whether favorable or unfavorable that SDBMOE deems relevant to licensure, and to permit the SDBMOE to inspect, receive, and make copies of such documents, records, evidence, and other information for SDBMOE's evaluation of my professional, ethical, mental and physical qualifications that SDBMOE deems relevant to licensure.

I release, discharge and exonerate from any and all claims, damages and liabilities whatsoever such third persons and parties, together with their authorized representatives, who in good faith and without malice, consult with and release to SDBMOE such information, evidence, files or records requested by SDBMOE that SDBMOE deems relevant to licensure.

I declare and affirm under the penalties of perjury that:

This application for licensure, which includes all the information I have provided and the questions I have answered in the South Dakota Common License Application Form and Addenda thereto, have been examined by me, and to the best of my knowledge and belief, are in all things true and correct. I state unconditionally and without reservation that I absolutely understand each and every question contained in this application for licensure, that I and I have answered all of them completely and truthfully. If any user discovers any derogatory information regarding my personal background that was not disclosed when completing this application, the users may immediately cease all processing of this application, and I agree that such nondisclosure shall disqualify me for licensure in South Dakota.

I understand and agree that my submission of this application and actions subsequent thereto, but prior to licensure, shall bear directly upon my qualifications for licensure, and I fully understand that the SDBMOE may consider all such actions in its determination whether to grant licensure. To that end, I agree that any unprofessional or harassing behavior on my part, or on the part of any agent of mine, with the SDBMOE's members or staff shall establish grounds for the immediate cessation of all processing of this application and disqualify me for licensure in South Dakota. A determination regarding derogatory information or of unprofessional or harassing behavior shall be the sole determination of the SDBMOE, and I will not assert that any other entity, judicial, or otherwise, may make such determination. I understand and agree that cessation of processing of this application by the users as a result of the acts of omissions by myself as described in this paragraph shall not require the SDBMOE, to offer me a hearing or any other due process right, or any other statutory or constitutional rights, and that I will not assert that I am entitled to a hearing.

Signed: William Griffin 5/23/1951

</html

Exhibit 2

From:	Michael Cardenas
To:	SDBMOE
Subject:	Verification of Professional Privileges - William Milo Griffin
Date:	Friday, January 23, 2015 3:49:57 PM
Attachments:	image001.jpg doc00293820150123134357.pdf

Please see attached form on William Milo Griffin.

Michael Cardenas
HR Administrative Coordinator
Gritman Medical Center
700 S. Main St.
Moscow, ID 83843
P: (208) 883-6414
F: (208) 883-6581

This e-mail and any attachments may contain confidential and privileged information. If you are not the intended recipient, please notify the sender immediately by return e-mail, delete this e-mail and destroy any copies. Any dissemination or use of this information by a person other than the intended recipient is unauthorized and may be illegal.

Please consider the environment - do you really need to print this email?

Exhibit 2

Verification of Professional Privileges and/or Employment – Page 1 of 2

PLEASE COMPLETE THIS VERIFICATION PER THE ATTACHED AUTHORIZATION. RETURN THE FORM DIRECTLY TO THIS OFFICE BECAUSE SOUTH DAKOTA REQUIRES PRIMARY SOURCE VERIFICATION.

Applicant Name: William Milo Griffin

Dates of Employment: (MM/DD/YY) From: 10/3/2006 To: 6/19/2014

Name of Current or Previous Facility: Gritman Therapy Solutions

Address of Current or Previous Facility: 810 South Main, Moscow, ID 83843

(Please explain "YES" answers on a separate sheet)

1. Have you ever known of poor medical practice by this individual or have you discussed concerns about this individual's practice with medical staff officers or others? ☐ Yes ☑ No
2. Have there been reports of poor relationships between this individual and other members of the hospital staff, patients, or the public? ☐ Yes ☑ No
3. Are you aware of any derogatory information related to the individual's ability to practice medicine? ☑ Yes ☐ No
4. Are you aware of any mental, physical, emotional or personal problems this individual may have that might interfere with his/her practice of medicine? ☑ Yes ☐ No
5. Has this individual ever abused drugs or alcohol? ☐ Yes ☑ No
6. Has this individual ever shown any signs of chemical dependence? ☐ Yes ☑ No
7. Are you aware of any limitations, restrictions, or any other actions of any nature taken against the individual by a hospital, managed care entity, or any other health-related entity or organization, state or federal including medical academic institutions? ☐ Yes ☑ No
8. Does this individual accept hospital policies and function accordingly? ☑ Yes ☐ No
9. Has this individual ever taken a leave of absence or break from your facility for any reason and for any length of time? ☐ Yes ☑ No

Verification of Professional Privileges and/or Employment – Page 2 of 2

Conditions under which employment ended (Voluntary or Other):

VOLUNTARY - SEE ATTACHED EXPLANATION

If Other, Explain:

Derogatory Information, if any:

Comments, if any:

Signature:
(Signature Stamp Not Acceptable) D. Cockrell

Print Name: DENNIS COCKRELL

Direct Phone Number: 208-883-6416

Title: HUMAN RESOURCES DIRECTOR

Date: 1/23/2015

EMAIL COMPLETED FORM TO:
sdbmoe@state.sd.us

Applicant Name: William Milo Griffin

Exhibit 2

700 S. Main
Moscow, ID 83843-3046
(208) 882-4511

Local Police authorities notified us that they had monitored Mr. Griffin and suspected him of being involved with child pornography. They informed us that they were confiscating his personal computers and cameras. There has been no indication that any questionable activity involved Gritman Medical Center (and Gritman Therapy Solutions) - his workplace. Before we could meet with Mr. Griffin about our concerns, he submitted his immediate written resignation. We do not know the status of the allegations.

Exhibit 2

Send to SDBMOE, 101 N MAIN AVE STE 301, SIOUX FALLS, SD 57104

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the SDBMOE Application and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the SDBMOE any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the SDBMOE or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the SDBMOE, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the SDBMOE.

I will immediately notify the SDBMOE in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a licensure being granted to me.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Applicant's Signature (must be signed in the presence of a notary)

Applicant's Printed Last Name

Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

1/16/15
Date of Signature

NOTARY

Dated 1/16/15 Signed Abigail Shelby

State of Washington County of Spokane

SUBSCRIBED AND SWORN TO before me this 16th day of, January 2015

My commission expires: 4/21/2018 (NOTARY PUBLIC SIGNATURE & SEAL)

ABIGAIL F. SHELBY
Commission Expires
NOTARY
PUBLIC
April 21, 2018
STATE OF WASHINGTON

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
101 N MAIN AVE, SUITE 301
SIOUX FALLS, SD 57104
SDBMOE@STATE.SD.US
P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV

Exhibit C

February 2, 2015

Moscow Police Department
118 East Fourth Street
Moscow, Idaho 83843

To Whom It May Concern:

Please find attached a Moscow Police Department Public Records Request. I would like to request the information regarding Case #14-M05306, regarding William Milo Griffin, whose date of birth is May 23, 1951.

My email address is Misty.Rallis@state.sd.us and the fax number is 605-367-7786.

Sincerely,

Misty Rallis

Misty Rallis
Board Investigator

MOSCOW POLICE DEPARTMENT PUBLIC RECORDS REQUEST

All requests to copy or examine public records must be made in writing. Please help us in this process by filling out this form completely. Please PRINT your name, address and telephone number. Please use dates of arrest(s) or report(s), location, suspect's name, witnesses name(s), date of birth, or crime, etc., to help describe what you are requesting.

REQUESTOR'S INFORMATION:

Name Of Requesting Person: Misty Rallis

Address: 101 N Main Ave, Suite 301

City/State/Zip Code: Sioux Falls, SD 57104

Email Address: Misty.Rallis@State.sd.us

Day Telephone No.: 605-367-7781 Fax No: 605-367-7786

REQUESTED DOCUMENTS

☒ Police report only DR # 14-M05306 (Spillman report)

Request to include:

☐ Photographs

☐ All document(s) in file

☐ Other (describe) _____

The City will respond to your request pursuant to applicable law [usually within three (3) business days]. The birth month and day for people whose names appear in the records have been removed pursuant to Idaho Code §§ 9-340B(1), 9-335(1)(c) and/or 9-335(2), and 9-337(6) because production of this information would constitute an unwarranted invasion of personal privacy and could facilitate identity theft. You have the right to appeal the denial of any part of your request by petitioning the Second Judicial District Court of Idaho within 180 calendar days of this response pursuant to Idaho Code Title 9, Chapter 3.

----------DO NOT WRITE BELOW THIS LINE ---- FOR OFFICIAL USE ONLY----------

Received by MPD Personnel: _____ Date: _____ Time: _____ No Records Found ☐

Minors ☐ Juveniles ☐

Incomplete Report ☐ Active Investigation ☐

Agency Assist _____

Referred to Prosecutor: City ☐ County ☐

Date sent to City Attorney: _____ Scan/Email to County ☐ 10-Day Letter ☐

Approved ☐ Denial Letter ☐

Date Mailed/Released _____ **City Attorney:** _____

MEMORY TRANSMISSION REPORT

Exhibit 3

TIME	:02-02-2015 15:24
FAX NO.1	:6053677786
NAME	:SD BMOE

FILE NO.	: 455
DATE	: 02.02 15:23
TO	: ☎ 912088824020
DOCUMENT PAGES	: 2
START TIME	: 02.02 15:23
END TIME	: 02.02 15:24
PAGES SENT	: 2
STATUS	: OK

SUCCESSFUL TX NOTICE

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
101 N MAIN AVE, SUITE 301
SIOUX FALLS, SD 57104
SDBMOE@STATE.SD.US
P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV

February 2, 2015

Moscow Police Department
118 East Fourth Street
Moscow, Idaho 83843

To Whom It May Concern:

Please find attached a Moscow Police Department Public Records Request. I would like to request the information regarding Case #14-M05306, regarding William Milo Griffin, whose date of birth is May 23, 1951.

My email address is Misty.Rallis@state.sd.us and the fax number is 605-367-7786.

Sincerely,

Misty Rallis

Misty Rallis
Board Investigator

Exhibit 4

Heart of the Arts

Bill Lambert
Mayor

Dan Carscallen
Council President

Wayne Krauss
Council Vice-President

Art Bettge
Council Member

Jim Boland
Council Member

Walter Steed
Council Member

John Weber
Council Member

Gary J. Riedner
City Supervisor

City of Moscow, City Hall
c/o Gary J. Riedner, City Supervisor
206 East 3rd Street
P.O. Box 9203
Moscow ID 83843
Phone (208) 883-7000
Fax (208) 883-7018

Website: www.ci.moscow.id.us
Hearing Impaired (208) 883-7019

February 4, 2015

Misty Rallis
101 N. Main Ave., Ste. 301
Sioux Falls, SD 57104

RE: Request for Public Record
Incident No. DR14-m05306

Dear Ms. Rallis:

Your request for public records noted above was received by the Police Department on February 2, 2015. Your request for information falls under the Idaho Public Records law and the City Attorney's office has reviewed this response.

The information you requested is exempt from disclosure under Idaho Code §§ 9-340B(1), 9-337(7), and 9-335(1)(a) and (e) because the investigation is active and ongoing.

The statutory exemptions asserted herein shall not constitute a waiver of any and all other legal bases or privileges which may also be applicable to the documents which are the subject to your request.

No list of persons prepared by the City may be used as a mailing list or a telephone list except by the City or another agency without first securing the permission of those on the list or accept as otherwise provided at Idaho Code § 9-348.

The denial of a request may be appealed by filing a petition in conformance with the provisions of the Idaho Public Records law, Title 9, Chapter 3. Any such petition must be filed in the Second Judicial District Court of Idaho within one hundred eighty (180) calendar days of the mailing of this response.

Please note that the exemptions from disclosure might not apply to the documents that you requested once the investigation is complete. When the investigation is complete you may make another request which will result in the release of all nonexempt public records.

Sincerely,

Roderick Hall
City Attorney

Exhibit 4

MPD

CITY OF MOSCOW 1887 IDAHO

PO Box 9203, Moscow ID 83843-1703

MISTY RALLIS
101 N MAIN AVE STE 301
SIOUX FALLS SD 57104

57104$6411 C051

US POSTAGE $ 00.
Mailed From 83843
02/04/2015
031A 0005181211

Exhibit 5

From:	Rallis, Misty
To:	"griffinw2351@gmail.com"
Subject:	South Dakota Board of Medical and Osteopathic Examiners
Date:	Tuesday, February 17, 2015 11:39:00 AM
Attachments:	2-17-15 Letter to William Milo Griffin.pdf

Mr. Griffin,
Please find attached a letter that was also sent by US mail today.

Sincerely,
Misty Rallis
Board Investigator
SD Board of Medical & Osteopathic Examiners
101 N. Main Ave., Suite 301
Sioux Falls, SD 57104
www.sdbmoe.gov

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
101 N MAIN AVE, SUITE 301
SIOUX FALLS, SD 57104
SDBMOE@STATE.SD.US
P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV

February 17, 2015

William Milo Griffin
3110 South Clinton Ave #7
Spokane Valley, WA 99216

Dear Mr. Griffin:

This letter serves as notice that your Physical Therapist License Application has been placed under investigation based on information received in a verification of employment. Your application is being investigated by a review panel which will be making a recommendation at the end of its review. Once a recommendation is made, you have certain rights which are outlined in this letter.

Please be aware of the following:

Exparte communication is prohibited pursuant to SDCL 1-26-26. This means that neither you, nor any attorney(s) on your behalf, nor any other third party is to contact any Board members by phone, letter, facsimile, email, in person, or by any other method. You are entitled to due process rights during the complaint process as well as once a recommendation is made.

Your rights:

1.) You have the right to contest the recommendation at an administrative hearing which will be conducted in accordance with SDCL 1-26. This matter will be presented to a neutral administrative judge.
2.) You have the right to be represented by an attorney of your own choosing at the administrative hearing if you so desire.
3.) The recommendation of the administrative judge will be referred to the South Dakota Board of Medical and Osteopathic Examiners. The board may accept, reject or modify the recommendation.
4.) If you participate in a hearing, you would then have the right to file an appeal to Circuit Court.

Should you have any questions or concerns, please send them via email to SDBMOE@state.sd.us or by US mail. Your patience is appreciated during this process as application does take longer when there is an investigative review in process. Thank you for your cooperation in this matter.

Sincerely,

Misty Rallis
Board Investigator

Exhibit 6

April 13, 2015

SDBMOE
101 N Main Ave., Suite 301
Sioux Falls, SD 57104

Dear Board,

I have recently become aware that an issue that I had thought was resolved has resurfaced, and may include actual legal issues. While this does not in any way involve patient care, it does fall under your guidelines, and as it isn't likely to be resolved in the near future I must therefore remove myself from consideration for a South Dakota Physical Therapy license. Should it be resolved in the future and should I wish to work in South Dakota I will of course include any pertinent details in any new application.

Thank you for your time and effort, and I am sorry to have not had everything resolved prior to my contact with you.

Sincerely,

William Griffin

From: (605) 367-7781
Jane Phalen
SDBMOE
101 N. Main Ave., Suite 301

Sioux Falls, SD 57104

Origin ID: FSDA

FedEx Express

J151215022303uv

Ship Date: 13MAY15
ActWgt: 0.5 LB
CAD: 5282744/INET3610

Delivery Address Bar Code

SHIP TO: (509) 319-1988 BILL SENDER

William M. Griffin

3110 S. Clinton Ave. #7

Spokane Valley, WA 99216

Ref #
Invoice #
PO #
Dept #

TRK# 0201 **7735 9447 2620**

THU - 14 MAY AA
STANDARD OVERNIGHT
RES
99216
WA-US
GEG

XH GEGA

537J3/C918/EE4B

After printing this label:
1. Use the 'Print' button on this page to print your label to your laser or inkjet printer.
2. Fold the printed page along the horizontal line.
3. Place label in shipping pouch and affix it to your shipment so that the barcode portion of the label can be read and scanned.

Warning: Use only the printed original label for shipping. Using a photocopy of this label for shipping purposes is fraudulent and could result in additional billing charges, along with the cancellation of your FedEx account number.
Use of this system constitutes your agreement to the service conditions in the current FedEx Service Guide, available on fedex.com.FedEx will not be responsible for any claim in excess of $100 per package, whether the result of loss, damage, delay, non-delivery,misdelivery,or misinformation, unless you declare a higher value, pay an additional charge, document your actual loss and file a timely claim.Limitations found in the current FedEx Service Guide apply. Your right to recover from FedEx for any loss, including intrinsic value of the package, loss of sales, income interest, profit, attorney's fees, costs, and other forms of damage whether direct, incidental,consequential, or special is limited to the greater of $100 or the authorized declared value. Recovery cannot exceed actual documented loss.Maximum for items of extraordinary value is $1,000, e.g. jewelry, precious metals, negotiable instruments and other items listed in our ServiceGuide. Written claims must be filed within strict time limits, see current FedEx Service Guide.

COPY

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

* *

In Re: William Milo Griffin

FINAL ORDER
APPLICATION WITHDRAWN
UNDER INVESTIGATION

* *

William Milo Griffin (Mr. Griffin) submitted an application for a South Dakota Physical Therapist License. The South Dakota Board of Medical and Osteopathic Examiners (the Board) notified Mr. Griffin that his application had been placed under investigation pursuant to South Dakota Administrative Rule (ARSD)[1]

Mr. Griffin then requested that his application for a physical therapist license be withdrawn. An application that is *"withdrawn under investigation"* is a public action of the Board and the State of South Dakota, and shall be published on the Board's website and reported to the national databanks and all other entities deemed necessary by the Board in compliance with State and Federal law pursuant to South Dakota Administrative Rule (ARSD).[2]

THEREFORE, it is hereby ordered that the application submitted by Mr. Griffin is deemed *"withdrawn under investigation"* and this Final Order of the Board is approved.

By:_______________________________ Date: ____________________

Mary Carpenter, MD, President
South Dakota Board of Medical
and Osteopathic Examiners

---

[1] ***ARSD 20:78:03:06 Investigation of application.*** *The executive secretary may determine that the information disclosed in an application or primary source documentation requires investigation to determine whether the applicant meets the qualifications or standards for issuance of a license. The executive secretary shall conduct that investigation, and may appoint a board member to assist in the investigation. The executive secretary shall notify the applicant of any issues requiring investigation. An applicant may meet with the executive secretary and appointed board member to discuss the issues under investigation.*

[2] ***ARSD 20:78:03:07. Application withdrawn during investigation.*** *An applicant may withdraw an application after an investigation has been initiated by the executive secretary. An application withdrawn after investigation has been initiated shall be reported as "withdrawn under investigation" in the board's permanent license files and in any national databases to which the board is required to report licensure action.*

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

* *

SOUTH DAKOTA BOARD OF
MEDICAL and OSTEOPATHIC
EXAMINERS APPLICATION FOR
PHYSICAL THERAPIST LICENSE

NOTICE OF HEARING

WITHDRAWN UNDER INVESTIGATION

In Re: William Milo Griffin

* *

Please take notice that a contested case hearing has been scheduled before the South Dakota Board of Medical and Osteopathic Examiners in the above captioned matter. The hearing will take place on Thursday, June 11, 2015, in the Board Conference Room, 101 N. Main Ave., Suite 215, Sioux Falls, SD, beginning at 11:00 am (CDT).

Dated this 12 day of May, 2015.

William H. Golden, esq.
Assistant Attorney General/Civil Litigation Division
317 N. Main Ave.
Sioux Falls, SD 57104
Attorney for the South Dakota Board of
Medical and Osteopathic Examiners
(605) 201-8588

SD Health Professionals Assistance Program

Operated By
Midwest Health Management Services, LLC
Financial Report and Program Update
5/1/14 to 4/30/15

5/1/14-5/31/15 Contract For Services

Page	
2- 3	Profit & Loss by Class
3	Utilization & Cost per Participant
4-6	Future Operations- Strategic Planning

May 13, 2015

Midwest Health Management Services, LLC
Profit & Loss by Class
May 1, 2014 through April 30, 2015

	SD HPAP Budget	SDHPAP Actual
Ordinary Income/Expense		
Income		
Capitation Fees		0.00
MWHMS		
SDHPAP		374,363.08
SDHPAP Contract	400,000	
SD Board of Medicine	190,000	177,181.54
SD Board of Nursing	190,000	177,181.54
SD Board of Pharmacy	10,000	10,000.00
SD Board of Dentistry	10,000	10,000.00
Total Income	400,000	374,363.08
		374,363.08
Expense		
Payroll Taxes		0.00
Mileage		0.00
Retirement Plan		0.00
Education/Conferences	4,000	770.19
Education/FSPHP	500	3841.45
Postage	1,000	608.50
Office Equipment		1,579.15
Advertising and Promotion	2,000	356.53
Bank Service Charges		1.42
Computer/ Internet Expenses		0.00
Continuing Education		0.00
Depreciation Expense		0.00
Dues and Subscriptions		0.00
Insurance Expense	54,715	37,753.02
Interest Expense		0.00
Meals and Entertainment	2,500	942.19
Office Supplies	7,000	2,436.75
Payroll Expenses	293,370	211,862.64
Professional Fees		2,642.61
Rent Expense	26,000	22,355.11
Repairs and Maintenance		0.00
Telephone Expense	4,000	3,579.71
Travel Expense	5,500	114.48
Total Expense	400,585	288,861.75
Net Ordinary Revenue		85,501.33

**Budget year correlates with contract dates (May 1, 2014- May 31, 2015)*

Midwest Health Management Services, LLC
Profit & Loss by Class
May 1, 2014 through April 30, 2015

2014-15 Budget created by estimate of historical operating costs under previous contract- until business is established we have been conservative in all expense areas

Additional details regarding above noted budget categories:

- Insurance includes professional liability/ general liability/ & workers comp as required by HPAP contract; health & dental
- **Payroll includes FICA taxes and federal unemployment**
- Professional Fees- legal fees, monthly accounting fees
- Rent amount varies; includes triple net (real estate taxes, building insurance, maintenance, garbage)
- Bank service charge-interest on first month HPAP operating expenses prior to contract payment
- **Program is operating significantly under budget in payroll, continuing to be cautious with staffing hours, as funding is no longer linked to utilization. We anticipate that as HPAP continues to have increased utilization we will need to rely on saved revenue.**

Utilization & Cost per Participant per Board:

SD Licensing Board	Number of Active SD BMOE Licenses	SD BMOE Expense to operate HPAP	Average national expense for Physician Health Program operation is $28 per license (per FSPHP)	Average monthly participation for SD BMOE 5/1/14-4/30/15	**SD Expense per participant**
Medical and Osteopathic	8,750 (from 2014 PSC meeting)	$190,000 or approximately $21.71 per active license	$245,000 (*based on national average of $28/ eligible license per FSPHP)	14 mo average **Current participant licensure breakdown:** **PA- 4** **MD- 9** **PT-A-1** **RT-1**	$13,572 (based on monthly average utilization from 5/1/14-3/6/15)

- As program utilization continues to increase, cost per participant will decrease. (we have on average 3 admissions to every 2 discharges).
- HPAP is not a self-sustaining business. Investment in the program is investment in the recovery and wellbeing of South Dakota's health care professionals. MWHMS is committed to providing quality services in the most cost effective manner possible and appreciates the participating boards' recognition that adequate funding is essential to SD HPAP's success. **MWHMS continues to develop Monitored Recovery Tracks for non-medical professionals to offset HPAP overhead through economy of scale.**

We are the only program in the country that is doing this, although SAMSA has recently recognized PHP's as being the gold standard in addressing addiction recovery.

- Cost to operate HPAP to remain steady at 400,000.00 for FY 2015; allocation for expenses is to be determined by the Program Service Committee (SDCL 36-2A).
- Current operating contract is from 5/1/14 to 5/31/15 with option to renew for seven one year extensions at the State's discretion and by mutual agreement.

Strategic Planning for current and future operations:

Scope of HPAP services defined by statute- SD CL 36-2 A: 36-2A-1. Definitions. "Health professionals assistance program," **a confidential program designed to monitor the treatment and continuing care** of any regulated health professional who may be unable to practice with reasonable skill and safety, if the professional's **mental health issues or substance use disorder i**s not appropriately managed; **Source:** SL 1996, ch 227, § 1; SL 2013, ch 171, § 1.

Operations:

**Key*: Green- Early Development Stages; Blue – In Progress; Black- Developed and operational;

A. Addressing Substance Use Concerns
B. Addressing Mental Health
C. Addressing Abuse and Neglect Complaint Referrals from Licensing Board
D. Voluntary Self-Pay/Monitored Recovery to HPAP
E. Addressing Stress Related to Medical Malpractice Claims
F. Linking with Resources for Continuum of Services
G. Marketing

A. Addressing Substance Use Concerns:

1. Diagnostic Rule-out
2. Clarify Treatment Goals
3. Recovery Monitoring and Management (as defined by the Participation Agreement and PA Addendums)

B. Addressing Mental Health Concerns:

1. Full Diagnostic Rule-out
2. Clarify Treatment Goals
3. Recovery Monitoring and Management (as defined by the Participation Agreement and PA Addendums)

C. Addressing Abuse and Neglect Complaint Referrals from Licensing Board:

1. Full Diagnostic Rule- Out (looking to rule out or identify treatment needs related to presence of a substance use disorder or mental health issue that may have contributed to complaint)
2. Clarify Treatment Goals
3. Recovery Monitoring and Management (as defined by the Participation Agreement and PA Addendum)

D. Voluntary Self Pay/ Monitored Recovery leading to HPAP:

1. Full Diagnostic Rule-Out
2. Clarify Treatment Goals

Midwest Health Management Services, LLC
Profit & Loss by Class
May 1, 2014 through April 30, 2015

3. Recovery Monitoring and Management (as defined by the Participation Agreement and PA Addendum)
    a. Non- Successful Completion
        i. Board notification (Clarify)
        ii. Notify worksite if appropriate
        iii. Refer to alternative services if appropriate
    b. Successful Participation
    c. Support reinstatement request, convert to HPAP track if applicable

E. Addressing Stress Related to Medical Malpractice Claims:

Of the 46 other state Physician Health Programs, 5 states offer services to address Malpractice Litigation (Maryland, Massachusetts, New Jersey, Colorado, and Tennessee). Each program that addresses Malpractice Litigation offers consultation, education

SD HPAP Proposed Services (will need to be approved by the HPAP Program Service Committee)

1. Offer initial consultation with Dr. Uthe
2. Refer for continued supportive services if appropriate
3. During consultation, screen for MH or SUD- if co-occurring, refer for services /HPAP Monitoring as indicated
4. **Sanford, Avera, and the Medical Association all have resources available- have info available on hand to collaborate when indicated-**
5. Work with HPAP approved providers to provide continued supportive services/ screening if appropriate
6. ***HPAP cannot treat-**outside scope defined by statute**, so if additional supportive services are requested, we propose providing an educational support group (benefit- if under HPAP- not medical, so no records kept/ and not subject to subpoena, would not have the same legal protection if under MWHMS)

G. Linking with Resources for Continuum of Service:

- **Medical Association**
    - Financial
    - Family/ Medical Marriage
    - Stress Management
    - Wellness

- **Medical School & Residency Program**
    - **Schools: (information on HPAP, prevention skills, healthy coping and protective skills)**
        - **USD School of Medicine- Residents (Craig Uthe, MD)**
        - **USD School of Medicine- Medical Students (Craig Uthe, MD, Maria Eining)**
        - **Augustana School of Nursing- Nursing Students (Janell Christensen)**
        - **SDSU (Nursing and Pharmacy Students)**

- **Community Treatment Programs and Services**

- **Sanford**
    - EAP

- Sanford Nursing Leadership

- **Avera**
  - EAP
  - LIGHT Program
  - Nursing Grand Rounds When a Nurse Diverts- Case Presentation, Prevention & Rehabilitative Considerations
  - Avera Physician Academy

- **Regional**
  - EAP
  - Diversion Committee

- **SDAHO**

Marketing Strategy (how do we increase engagement):

1. Web-Page
2. Brochures
3. Outreach Speaking
4. Networking/Conferences/ Site Visits