XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
JANNSEN TAN
Deputy Attorney General
State Bar No. 237826
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7549
Facsimile: (916) 327-2247

Attorneys for Complainant

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

In the Matter of the Accusation Against: **Dale Robert Stemple, M.D.** **22150 Vine Ct** **Palo Cedro, CA 96073-8706** **Physician's and Surgeon's Certificate No. C 36399,** Respondent.	Case No. 800-2015-014255 OAH No. **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about March 24, 1975, the Medical Board issued Physician's and Surgeon's Certificate No. C 36399 to Dale Robert Stemple, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2019, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

6. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

///

DRUGS AT ISSUE

7. Zolpidem Tartrate, brand name Ambien, among others, is a sedative and hypnotic used for short term treatment of insomnia. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

8. Hydrocodone, brand name Norco, Vicodin, among others, is a semi-synthetic opioid derived from codeine. It is commonly used in combination with Acetaminophen. It is a schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

9. Diazepam, brand name Valium, is a benzodiazepine drug used to treat a wide range of conditions, including anxiety, panic attacks, insomnia, seizures (including status epilepticus), muscle spasms (such as in tetanus cases), restless legs syndrome, alcohol withdrawal, benzodiazepine withdrawal, opiate withdrawal syndrome and Ménière's disease. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

10. Fentanyl, brand name Duragesic, is a potent, synthetic opioid analgesic with a rapid onset and short duration of action used for pain. It is a schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

11. Alprazolam, brand name Xanax, is a short-acting anxiolytic of the benzodiazepine class of psychoactive drugs used for treatment of panic disorder, and anxiety disorders. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

12. Carisoprodol, brand name Soma, is a centrally acting skeletal muscle relaxant. Effective January 11, 2012, it was reclassified from a non controlled substance to a Federal Schedule IV controlled substance pursuant to Controlled Substances Act. It is a dangerous drug pursuant to Business and Professions Code section 4022.

///

13. Morphine, sold under different trade names, is an opioid analgesic drug. It is the main psychoactive chemical in opium. Like other opioids, such as oxycodone, hydromorphone, and heroin, morphine acts directly on the central nervous system (CNS) to relieve pain. It is a schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

14. Hydromorphone hydrochloride (generic name for "Dilaudid") is a dangerous drug as defined in section 4022 and a Schedule II controlled substance as defined by section 11055, subdivision (d) of the Health and Safety Code, and a Schedule II controlled substance as defined by section 1308.12 (d) of Title 21 of the Code of Federal Regulations.

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence –Patient A)

15. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the code, in that he committed gross negligence in his care and treatment of Patient A, as more particularly alleged hereinafter.

16. Respondent is a physician and surgeon who at all times alleged herein practiced medicine in Weaverville, CA.

17. On or about May 14, 2004, Respondent saw Patient A for an initial evaluation. Patient A was a 48-year-old female patient who presented with migraine headaches, anxiety and hip pain. Her medication list revealed that she was taking Esgic-Plus and alprazolam. Respondent continued to prescribe Esgic-Plus and alprazolam to Patient A.

18. Respondent next saw Patient A on or about September 2006. Patient A complained of pain in her neck radiating to her arms. Respondent started prescribing Vicodin for the pain. Respondent failed to enter into a pain contract with Patient A.

19. Respondent saw Patient A infrequently once or twice a year. Patient A continued to complain of headaches and back pain. She continued to smoke and developed angina in January 2013. Patient A had 35 Enhanced External Counterpulsation treatments from on or about February 21, 2013 until April 23, 2013. She stopped smoking, but continued to have back pain.

///

She had her dose of hydrocodone-APAP 10/325 increased from 120 per month to 180 per month on or about November 7, 2014. Respondent failed to enter into a pain contract with Patient A.

20. On or about September 24, 2015, Respondent attempted to decrease Patient A's hydrocodone dosage, but on or about November 2, 2015, Patient A's dosage returned to 180 pills per month because of having a "hard month." Patient A continued on the dose of 180 Norco 10/325 and alprazolam 1 mg twice daily.

21. On or about July 21, 2015, Patient A tested positive for opiates, hydrocodone and hydromorphone in a urine test. She tested negative for alprazolam.

22. During the period of May 14, 2004[1] to 2015, Respondent failed to adequately document Patient A's pain assessment, physical and psychological status and function; substance abuse history; history of prior pain treatments; assessments of underlying or co-existing conditions; and medical indication for the use of controlled substances.

23. During the period of May 14, 2004 to 2015, Respondent saw Patient A 36 times; had a pain assessment 22 times; and her medications were discussed 15 times. Respondent only documented one urine drug screen during this time and failed to document a pain contract. Respondent failed to document if he had checked CURES.[2]

24. Respondent committed gross negligence in his care and treatment of Patient A which included, but not limited to the following:

A. Respondent failed to monitor Patient A's care closely. Respondent failed to evaluate Patient A regularly and only saw Patient A once or twice a year with continuing use of narcotics and barbiturates.

B. Respondent failed to adequately document and discuss objectives, plans, diagnostic evaluations, and treatments.

///

///

[1] Information provided for the patients outside the statutory timeframe is for informational purposes only.

[2] Controlled Substance Utilization Review Evaluation System.

C. Respondent failed to document and/or discuss the risks and benefits of controlled substances along with other treatment modalities.

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts – Patient A)

25. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient A, as more particularly alleged hereinafter. Paragraphs 15 through 24, above, are hereby incorporated by reference and realleged as if fully set forth herein.

26. Respondent committed repeated negligent acts in his care and treatment of Patient A which included, but were not limited to the following:

A. Respondent failed to adequately document Patient A's pain assessment, physical and psychological status and function; substance abuse history; history of prior pain treatments; assessments of underlying or co-existing conditions; and medical indication for the use of controlled substances.

B. Respondent failed to document and/or consider obtaining additional evaluations and consultations.

THIRD CAUSE FOR DISCIPLINE
(Gross Negligence –Patient B)

27. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the code, in that he committed gross negligence in his care and treatment of Patient B, as more particularly alleged hereinafter.

28. On or about October 13, 2003, Respondent saw Patient B for an initial evaluation. Patient B was a 36-year-old, female patient. Patient B filled up a registration and patient consent form on the same date. Respondent failed to adequately document Patient B's initial and subsequent evaluations.

29. Respondent noted that Patient B was subsequently seen on or about July 14, 2005. Respondent failed to adequately document the examination.

///

30. Patient B had lyme serologies done on or about May 16, 2007 with a positive screen and a negative Western blot.

31. On or about July 19, 2007, Respondent saw Patient B. Respondent documented the chief complaint as "2 mo of right sided facial pain." She was documented to have a positive lyme titer that had been treated with doxycycline and amoxicillin. Patient B was also treated with Tegretol. She had a lymph node biopsy and a positive titer for bartonella henselae diagnostic of Cat Scratch Disease.

32. During the period of May 2007 through December 2008, Respondent saw Patient B multiple times for multiple issues including but not limited to facial pain, lyme disease and trigmenial neuralgia.

33. On or about December 8, 2008, Respondent saw Patient B for an office visit. Patient B's chief complaint was lyme disease. Respondent documented that "[Patient B] continued to complain of fatigue, fogged thinking, tremulousness and circumoral pain. Her Igenics Lyme titer is positive for IGG and IGM bands 41 and 34 which is diagnostic for active lyme disease."

34. On or about January 2010, Respondent started Patient B on IV Rocephin.

35. On or about March 16, 2010, Respondent saw Patient B for an office visit. Respondent listed down the chief complaint as "Lyme Disease Disability." Respondent documented that Patient B has been on "IV Rocefin for 10 weeks." Respondent documented that Patient B was not improved enough to go back to work."

36. On or about October 17, 2013, Respondent saw Patient B for an office visit. Respondent documented the chief complaint as "fatigue, wellness. "Respondent documented that "[Patient B] feels she is going downhill; her tremors have intensified. She feels exhausted. She has more pain in her joints and muscles. She is ready to go back on antibiotics for lyme disease. We will give one mo. of high dose amoxicillin followed by one mo. of Zithromax and Tindamax."

37. On or about October 8, 2014, Respondent saw Patient B for an office visit. Respondent noted the chief complaint as "Syncope, MRI results." Respondent documented that patient B "passed out while exercising on her treadmill today, afterward she was very weak and

shakey (sic) 'like my BP was very low'. She had no chest pains or diaphoresis. She is still feeling weak now." Respondent added: "Her MRI of her brain is entirely normal, therefore we will forego the IV antibiotic therapy we had discussed and instead she will take 3 weeks of minocycline therapy. She still has poor memory and difficulty comprehending. Therefore, she is not to drive her car until she finishes the antibiotic course."

38. On or about December 30, 2014, Respondent saw Patient B for pancreatitis and Lyme disease. Patient B complained of epigastric pain and abdominal swelling. Respondent documented that "labs were drawn for her Lyme disease. She does have a somewhat elevated complement C4A level, but her IgG components are all normal." Respondent documented Patient B's medication as: carisoprodol, Celebrex, mocydine, and Norco.

39. Respondent continued to see Patient B during the period of December 2014 to December 2016. Respondent saw Patient B more than a hundred times over the course of Patient B's treatment. Despite multiple courses of antibiotics, Patient B's symptoms did not significantly improve. Respondent documented multiple references to K.J., MD and M.H., Pham D, regarding therapy for lyme disease and babesosis. However, no written consult was documented. Patient B has had continued antibiotics with minimal improvement of her symptoms. She also had been on Vicodin and Norco intermittently because of abdominal bloating and menopausal symptoms.

40. Respondent committed gross negligence in his care and treatment of Patient B in that Respondent failed to adequately obtain and/or document additional evaluations and consultations for Patient B, despite poor results and multiple treatments that do not conform to practice guidelines.

FOURTH CAUSE FOR DISCIPLINE
(Repeated Negligent Acts – Patient B)

41. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient B, as more particularly alleged hereinafter. Paragraphs 27 through 40, above, are hereby incorporated by reference and realleged as if fully set forth herein.

///

42. Respondent committed repeated negligent acts in his care and treatment of Patient B which included, but were not limited to the following:

A. Respondent failed to adequately document evaluations of Patient B's of activities of daily living.

B Respondent failed to discuss and/or document the risks and benefits of the use controlled substances.

FIFTH CAUSE FOR DISCIPLINE
(Gross Negligence – Patient C)

43. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the code, in that he committed gross negligence in his care and treatment of Patient C, as more particularly alleged hereinafter.

44. On or about July 25, 2005, Respondent saw Patient C for an office visit. Respondent saw Patient C after her 10th episode of pancreatitis. She had a history of heart failure, myocardial infarction, seizures, consumed alcohol and was on fentanyl patches and Norco. She had arthritis and a history of an osteoid osteoma. She had continuing problems with abdominal pain, migraine headaches, back pain and stiffness.

45. Patient C had a pain contract signed on July 30, 2007. However, multiple deviations from the contract did not cause any adverse results or reprimand to the patient.

46. On or about April 2008, Patient C requested to be switched to methadone. She complained that Norco was not effective. Respondent acquiesced.

47. On or about August of 2008, Patient C was hospitalized. Patient C claimed that her fentanyl patches were mailed to the wrong address and burned by the recipient.

48. On or about January and February of 2010, Patient C reported that the fentanyl patches were coming off of her skin and needed more. During the course of treatment Respondent recommended medical marijuana for nausea and emesis, and Patient C had certificates for medical cannabis dated September 20, 2010, and October 11, 2011.

49. On or about December 2010, Patient C asked for an early refill of her Xanax and increase in her Dilaudid. During the course of treatment, Patient C complained that she was not

///

happy with her pain levels. She had a urine toxicology screen performed on or about August 16, 2005.

50. On or about May 2012, Patient C's Duragesic was increased to 175 micrograms per hour and her Dilaudid up to 20 milligrams a day.

51. On or about March, 2012, Respondent also prescribed benzodiazepines in addition to the opiates because Patient C's husband died and she was distraught. Soma and diazepam was added on or about November 2012.

52. Respondent saw Patient C more than a hundred times during the course of treatment. Respondent prescribed carisoprodol, hydromorphone, diazepam, fentanyl, duragesic, Xanax, and Ambien intermittently until November 2013. Patient C's level of pain was evaluated 87 times. Her narcotic use was discussed 45 times and her activity of daily living assessed 36 times. She was able to stop alcohol use on May 8, 2013. She also had problems with hydronephrosis and had an extensive urologic evaluation. She had multiple occasions of trying other patient's pain medications and had her pain regimen modified extensively. Patient C restarted alcohol use and was referred to Behavioral Health, but was never actually seen.

53. Respondent committed gross negligence in his care and treatment of Patient C in that Respondent failed to appropriately manage Patient C's pain. Patient C, in effect, managed her own medications, requested changes, and despite attempting to decrease the dose, was usually given the drug she requested.

SIXTH CAUSE FOR DISCIPLINE
(Repeated Negligent Acts– Patient C)

54. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient C, as more particularly alleged hereinafter. Paragraphs 43 through 53, above, are hereby incorporated by reference and realleged as if fully set forth herein.

55. Respondent committed repeated negligent acts in his care and treatment of Patient C which included, but were not limited to, failing to adequately document indication, magnitude of pain, and effectiveness of therapy of Patient C.

SEVENTH CAUSE FOR DISCIPLINE
(Repeated Negligent Acts – Patients D ,E, F)

56. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients D, E, and F, as more particularly alleged hereinafter.

Patient D

57. On or about August 2, 2012, Respondent saw Patient D for an initial evaluation. Patient D was a 75-year-old male who was seen for diabetes mellitus, renal failure, coronary artery disease, chronic back pain and degenerative joint disease of both lower extremities. Patient D's pain had been treated with MS Contin. Patient D was also allergic to Dilaudid.

58. Respondent saw Patient D, 50 times over the next four years. Patient D was hospitalized from July 28, 2012 to July 31, 2012 for an inadvertent overdose. Patient D was treated for management of pain, diabetes and heart disease. He was evaluated by cardiology and orthopedics.

59. Patient D passed away at his home on or about January 30, 2016. He was found to have a large quantity of unused fentanyl patches in his home at the time of his death. His pain had been managed with Norco (hydrocodone), morphine and topical fentanyl. Respondent failed to utilize and/or document urine screens and a pain contract.

60. Respondent committed repeated negligent acts in his care and treatment of Patient D which included, but were not limited to, failing to administer, monitor and/or document a urine test and pain contract.

Patient E

61. On or about September 16, 2009, Respondent saw Patient E for an office visit. Patient E was a 45-year-old female who complained of lumbar and cervical spine disease. Her medication consisted of Baclofen, Morphine, Percocet, Neurontin, extended release Tramadol and Tizanidine. Her pain medications were managed with monthly visits and she had a variety of other medications used over the five years she was managed. She had a TENS unit and an application for a power wheelchair.

/ / /

62. Patient E reported that her medications were stolen August 12, 2010 and on multiple occasions tried other people's pain medications. Respondent also failed to enforce the pain contract and reprimand Patient E for non-compliance. She continued to have modifications in her medications and on or about July 20, 2011, she was "weaned down" on her MS Contin. She had problems with depression and had some improvement with Wellbutrin. She had a pelvic fracture on or about November 25, 2012, which significantly increased her pain medications by other caregivers and Respondent made efforts to taper her narcotics with marginal success.

63. On or about May 30, 2014, Patient E had a urinary drug screen done and was positive for hydromorphone but negative for lorazepam and carisoprodol. She had the results explained to her and because she did not comply with her pain contract, she was discharged from the practice. Over the five years she was cared for, she was seen 56 times in the office. Her level of pain was recorded 51 times. Her function for activity of daily living was recorded 27 times and her pain medications were changed or discussed 29 times. She had pain contracts signed and documented twice and had urinary drug screen in the office done twice.

64. Respondent committed repeated negligent acts in his care and treatment of Patient E which included, but were not limited to:

A. Respondent failed to perform and/or document a history of previous therapy and evaluation of previous substance abuse history.

B. Respondent also failed to enforce the Pain Contract and reprimand Patient E for non-compliance.

Patient F

65. On or about April 11, 2003, Respondent saw Patient F for an initial visit. There are no records of office visits until May 22, 2008. The next documented visit was June 9, 2009. She had been complaining of chronic neck pain, managed with Vicodin or Norco until July, 2011.

66. Patient F was hospitalized on July 13, 2011 with gastrointestinal bleeding. She had a right colectomy, but subsequently had septic shock, and ischemic bowel which required total colectomy. She had increasing abdominal pain and required intravenous hydration and total parenteral nutrition three times a week. Prior to her abdominal surgery she was 135 lbs, and

during her illness she got down to 79 lbs. She had multiple hospitalizations with infections, abscesses and dehydration. Patient F's pain management included topical fentanyl, Dilaudid, Norco, meloxicam and toradol. She was evaluated weekly and her pain was assessed. She had Gattex, a parenteral drug to improve bowel function, which did not adequately relieve the problems.

67. Patient F had a urine drug screen on April 20, 2016, which showed methamphetamines and hydrocodone, medications that were not prescribed and she was discharged from the practice.

68. Patient F had been seen 177 times from May 27, 2006 through April 27, 2016. She had pain assessments on 115 of these visits. She had discussions of her pain medications on 51 of these visits. She had urinary drug screens done three times and documented CURES reports twice. She had a Pain Contract signed on November 3, 2014.

69. Respondent committed repeated negligent acts in his care and treatment of Patient F which included, but were not limited to, failing to document and/or review previous therapy and history of substance abuse.

EIGHTH CAUSE FOR DISCIPLINE
(Failure to Maintain Adequate and Accurate Medical Records)

70. Respondent is further subject to discipline under sections 2227 and 2334, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate medical records in the care and treatment of Patient A, B, C, D, E, and F, as more particularly alleged hereinafter: Paragraphs 7 through 69, above, are hereby incorporated by reference and realleged as if fully set forth herein.

DISCIPLINARY CONSIDERATIONS

71. To determine the degree of discipline, if any, to be imposed on Respondent Dale Robert Stemple, M.D., Complainant alleges that on or about August 11, 1999, in a prior disciplinary action entitled *In the Matter of the Accusation Against Dale Robert Stemple, M.D.*, before the Medical Board of California, in Case Number 12-1995-46029, Respondent's license was revoked, revocation stayed, and placed on probation for five (5) years with terms and

conditions, including psychotherapy, prohibition from practicing invasive cardiac procedures, education course, ethics course, oral clinical or written examination, psychiatric evaluation, monitoring, proctoring and other standard terms and conditions. It was alleged that Respondent engaged in gross negligence in the treatment and care of ten (10) patients. That decision is now final and is incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. C 36399, issued to Dale Robert Stemple, M.D.;

2. Revoking, suspending or denying approval of Dale Robert Stemple, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Dale Robert Stemple, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: April 13, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SA2015301329
33293353.docx