MINUTES
Monthly Meeting
MEDICAL LICENSURE COMMISSION OF ALABAMA
Meeting Location: 848 Washington Avenue
Montgomery, Alabama 36104

November 25, 2024

MEMBERS PRESENT IN PERSON

Jorge Alsip, M.D., Chairman
Paul M. Nagrodzki, M.D., Vice-Chairman
Craig H. Christopher, M.D.
Howard J. Falgout, M.D.
L. Daniel Morris, Esq
Pamela Varner, M.D.

MEMBERS NOT PRESENT

Kenneth W. Aldridge, M.D.
Nina Nelson-Garrett, M.D.

MLC STAFF

Aaron Dettling, General Counsel, MLC
Rebecca Robbins, Operations Director (Recording)
Nicole Roque, Administrative Assistant (Recording)
Heather Lindemann, Licensure Assistant

OTHERS PRESENT

BME STAFF

Anthony Crenshaw, Investigator
Rebecca Daniels, Investigator
Randy Dixon, Investigator
Amy Dorminey, Director of Operations
Alicia Harrison, Associate General Counsel
Effie Hawthorne, Associate General Counsel
Wilson Hunter, General Counsel
Roland Johnson, Physician Monitoring
Winston Jordan, Technology
Christy Lawson, Paralegal
Tiffany Seamon, Director of Credentialing
Scott Sides, Investigator

Call to Order: 9:00 a.m.

Prior notice having been given in accordance with the Alabama Open Meetings Act, and with a quorum of six members present, Commission Chairman, Jorge Alsip, M.D. convened the monthly meeting of the Alabama Medical Licensure Commission.

OLD BUSINESS

Minutes October 23, 2024

Commissioner Christopher made a motion that the Minutes of October 23, 2024, be approved. A second was made by Commissioner Varner. The motion was approved by unanimous vote.

NEW BUSINESS

Full License Applicants

	Name	Medical School	Endorsement
1.	Alizeh Abbas	Aga Khan Medical College, Aga Khan University	USMLE
2.	Wadey K Abdel Qader	Florida State University College of Medicine	USMLE
3.	Timothy C Albion	Rosalind Franklin University of Medicine and Science	NBME/IL
4.	Mohammad Ali	Eastern Virginia Medical School	USMLE/VA
5.	John Carl Angiel	Philadelphia College of Osteopathic Medicine Georgia Campus	COMLEX
6.	Samuel B Anich	Alabama College of Osteopathic Medicine	COMLEX
7.	Yousef M. Y. Awad	University of Cairo	USMLE
8.	Jeala B Barnett-Gentry	Southern Illinois University School of Medicine	USMLE/GA
9.	Victor Oppong Barnor	Kwame Nkrumah University of Science & Technology	USMLE/ GA
10.	Frederick Earl Barr	University of Virginia School of Medicine	NBME/CA
11.	Timothy Norman Baxter	SUNY Upstate Medical University College of Medicine	NBME/NY
12.	Austin James Bettridge	Alabama College of Osteopathic Medicine	USMLE
13.	Anna-Christina Bevelaqua	New York University School of Medicine	USMLE/NY
14.	Timothy Scott Blackwell	University of Tennessee Health Science Center College of Medicine	USMLE
15.	Craig Lee Borne	Lincoln Memorial University Debusk College of Osteopathic Medicine	COMLEX
16.	Ryan Bragiel	University of South Carolina School of Medicine	USMLE
17.	Marjory Ann Bravard	Tufts University School of Medicine	USMLE/MA
18.	Amanda Lund Brown	University of Tennessee Health Science Center College of Medicine	USMLE
19.	Madison Jade Bruce	University of Alabama School of Medicine Birmingham	USMLE
20.	Jason Jeffrey Brucker	SUNY Downstate College of Medicine	USMLE/NY
21.	Oana Radu Bulugean	Carol Davila University of Medicine and Pharmacy	USMLE/PA

	Name	Medical School	Endorsement
22.	Kimberly Ann Byrnes	Nova Southeastern University College of Medicine	COMLEX
23.	Sofia M Canete Portillo	Our Lady of the Assumption Catholic University, Asuncion	USMLE
24.	Lebnitz Joseph Charelus	Avalon University School of Medicine	USMLE
25.	Edward Hun Chung	Lincoln Memorial University Debusk College of Osteopathic Medicine	COMLEX
26.	Letitia Ann Cosbert	Howard University College of Medicine	USMLE/PA
27.	Sruthi Damodara	Nova Southeastern University College of Medicine	COMLEX
28.	John Everett Denton	Icahn School of Medicine at Mount Sinai	USMLE
29.	Andrada C Diaconescu	University of Michigan Medical School	USMLE
30.	Sana Ahmad Din	Caribbean Medical Univ School of Med / American Univ of Antigua	USMLE/PA
31.	Reza Djavadian	Wayne State University School of Medicine	USMLE
32.	Macarthur Drake	Wright State University School of Medicine	USMLE/FL
33.	Ali Marie Eakes	University of North Carolina School at Chapel Hill School of Medicine	USMLE
34.	Carter Edmunds	Wake Forest University School of Medicine	USMLE
35.	Alelegn A Enyew	Arsi University College of Health Sciences	USMLE
36.	Sasa G Muyco Espino	Virginia Commonwealth University School of Medicine	USMLE/IL
37.	Kerrie T Fearon Pounall	University of The West Indies, Jamaica	USMLE/FL
38.	Jacob Andrew Frady	Brody School of Medicine at East Carolina University	USMLE/NC
39.	Joey Michael Giordani	University of Medicine and Health Sciences, St. Kitts	LMCC
40.	Akhilesh Gonuguntla	Kasturba Medical College, Manipal University	USMLE
41.	Gabriel Charles Graham	Alabama College of Osteopathic Medicine	COMLEX/AR
42.	Andrew Grush	Meharry Medical College School of Medicine	USMLE
43.	Sadaf Gul	St. James School of Medicine	USMLE
44.	Nicholas Mark Gutierrez	Columbia University College of Physicians & Surgeons	USMLE/FL
45.	Rozina Fekadu Haile	SUNY Downstate Medical Center College of Medicine	USMLE/NY
46.	Yousef J Antoine Hakim	University of Alabama School of Medicine Birmingham	USMLE
47.	Chalonda Renee Handy	Loyola University of Chicago Stritch School of Medicine	USMLE/VA
48.	Andrew Jearald Heflin	University of Texas Medical School at Galveston	USMLE
49.	Joshua James Henderson	Morehouse School Of Medicine	USMLE
50.	Sarah E Mckenzie Hill	University of Arkansas College of Medicine	USMLE
51.	Heather Yaun Hughes	Augusta University	USMLE/VA
52.	Anne H Hylander	Lincoln Memorial University Debusk College of Osteopathic Medicine	COMLEX
53.	Mohamad Nour Jajeh	Al Andalus University for Medical Sciences Faculty of Medicine	USMLE
54.	Aria Mousa Jamshidi	George Washington Univ School of Medicine and Health Sciences	USMLE/WA
55.	Polly Merin Jasper	Medical University of South Carolina College of Medicine	USMLE
56.	Nikhil Bush Jayaram	M S Ramaiah Medical College, Bangalore University	USMLE
57.	Joseph Patrick Johnson	University of Miami Miller School of Medicine	USMLE/IN
58.	Claire Elizabeth Johnson	University of South Alabama College of Medicine	USMLE
59.	Divya Karanam	Vinayaka Mission's Medical College	USMLE
60.	Salam Haleen Kassis	American University of Beirut	USMLE/TN
61.	Maliha Khan	Dow Medical College, University of Karachi	USMLE/IL
62.	Trey Lynn Kidd	University of Alabama School of Medicine Birmingham	USMLE

	Name	Medical School	Endorsement
63.	Adam Matthew Kirstein	Saint Georges University	USMLE
64.	Matthew Ryan Knouse	Lewis Katz School of Medicine at Temple University	USMLE/NJ
65.	Matthew Reese Land	Augusta University	USMLE
66.	James Clayton Leal	Western Univ of Health Sciences, College of Osteo Med of Pacific	COMLEX/FL
67.	Jeffrey D Lee	Medical College of Wisconsin	NBME/UT
68.	James Frederick Libecco	Northeastern Ohio Universities College of Medicine	USMLE/OH
69.	Robert James Long	Uniformed Services University	USMLE/CA
70.	Mark Louis Lorthe	Howard University College of Medicine	USMLE/NY
71.	Chad Steven Lott	American University of Antigua	USMLE
72.	Jayesh Madrecha	Chicago College of Osteopathic Medicine	COMLEX/IL
73.	Hamza Malik	University of the Punjab, King Edward Medical College	USMLE/MI
74.	Kevin Patrick Mclaughlin	University of Illinois College of Medicine Chicago	NBME/GA
75.	Cody Ryan Miller	Alabama College of Osteopathic Medicine	COMLEX
76.	Krithika Reddy Muthyala	Saint Georges University	USMLE
77.	Michelle M Nguyen	University of South Alabama College of Medicine	USMLE
78.	Aman Nihal	University of Wisconsin Medical School	USMLE
79.	Angel A Nunez Galvez	Universidad Francisco Marraquin	USMLE/FL
80.	Omosefe E Ogbeifun	University of Benin	USMLE
81.	Eric Christian Olsen	University of Michigan Medical School	USMLE
82.	Kevin James Parham	Virginia Commonwealth University School of Medicine	USMLE
83.	Jacob Roy Parker	Edward Via College of Osteopathic Medicine - Auburn	COMLEX
84.	Vidhi Jayeshkumar Patel	N H L Municipal Medical College, Gujarat University	USMLE
85.	Priyanka Sunil Patel	Pramukhswami Medical College	USMLE
86.	Dalton Thomas Patterson	University of South Alabama College of Medicine	USMLE/TX
87.	Jessica C Peterson	Nova Southeastern University College of Medicine	COMLEX/FL
88.	Abdul Moiz Qureshi	Shifa College of Medicine	USMLE
89.	Areej Rahman	Alfaisal University College of Medicine	USMLE
90.	Jawaria Rahman	Jinnah Sindh Medical University	USMLE
91.	Stephen G Richardson	Edward Via College of Osteopathic Medicine-Auburn campus	COMLEX
92.	Charles L Rodriguez-Feo	Vanderbilt University School of Medicine	USMLE/WA
93.	Morgan Marie Sanders	Philadelphia College of Osteopathic Medicine - Georgia Campus	COMLEX/VA
94.	Mannat Sandhu	University of South Florida College of Medicine	USMLE
95.	Pallabi Sanyal-Dey	University of Vermont College of Medicine	USMLE/CA
96.	Andriana Slavica Saric	Midwestern University, Arizona Campus	COMLEX/GA
97.	Bhoomi Pranav Shah	Gujarat Adani Institute of Medical Sciences	USMLE
98.	Bhavan U Shah	Avalon University School of Medicine	USMLE/CT
99.	Abdelrahman N Shehata	University of Alexandria	USMLE
100.	Dominik Shephard	Alabama College of Osteopathic Medicine	COMLEX
101.	Sahana Suresh Shiggaon	University of Missouri Kansas City School of Medicine	USMLE
102.	Hamid Ali Khan Shirwany	University of Tennessee Health Science Center College of Medicine	USMLE
103.	Nabeel Ahmed Siddiqui	Windsor University	USMLE

Name	Medical School	Endorsement
104.Andrew Terry Sideris	New York Univ School of Medicine	USMLE
105.Marcus Perry Sirianno	University of Kentucky College of Medicine	USMLE
106.Rajesh B Solanki	Brody School of Medicine at East Carolina University	USMLE/TN
107.Kayla Lewis Steed	University of Alabama School of Medicine Birmingham	USMLE
108.Daniel J Stephens II	University of Washington School of Medicine	USMLE
109.Khawla Suhaila	University of Alabama School of Medicine Birmingham	USMLE
110.Katherine June Sweeney	Touro U College of Osteopathic Medicine	COMLEX
111.Philip Karstin Taylor	Touro U College of Osteopathic Medicine	COMLEX/AZ
112.Judith May Thomas	Saint James School of Medicine St. Vincent and the Grenadines	USMLE
113.Rochelle T Kolawole	University of Ghana Medical School	USMLE/MS
114.Akira Todo	New York Medical College	USMLE/NY
115.Iboro Obot Udoete	All Saints University School of Medicine	USMLE
116.Kyle Allan Ulversoy	Augusta University	USMLE
117.Catherine Samuels Uram	Drexel University College of Medicine	USMLE/AZ
118.John Anthony Vallas	Alabama College of Osteopathic Medicine	COMLEX
119.Varshini Venkatesan	Midwestern University, Arizona Campus	COMLEX
120.Caroline Elisabeth Wade	University of Tennessee Health Science Center College of Med	USMLE
121.Meghan Nicole White	University of Arkansas College of Medicine	USMLE/CA
122.Gayle Suk Wiesemann	University of Florida College of Medicine	USMLE
123.Sean Lowell Wilkes	Uniformed Services University of Health Sciences	USMLE/FL
124.Gabrielle Willhelm	University of Alabama School of Medicine Birmingham	USMLE
125.Patrick Joshua Williamson	University of Tennessee Health Science Center College of Medicine	USMLE
126.Ryan Wai Yan Wong	University of Alabama School of Medicine Birmingham	USMLE
127.Zackery Shane Wood	Nova Southeastern University College of Medicine	COMLEX/CA
128.Cade William Wyble	Louisiana State University Medical Center Shreveport	USMLE
129.David William Zaenger	University of Toledo College of Medicine	USMLE/OH
130.Rennan Solmaz Zaharias	University of South Alabama College of Medicine	USMLE
131.Nadine Zeidan	University of Florida College of Medicine	USMLE/TX
132.Xuebao Zhang	Shihezi University	USMLE
133.*Dare Victor Ajibade	Univ of Medicine & Dentistry of New Jersey	USMLE/NJ
134.*Lawrence F Brack III	Indiana Univ School of Med Indianapolis	USMLE/TN
135.*Marialaina Desrae Carter	Edward Via College of Osteo Med Auburn	COMLEX
136.Stephen David Clark	LSU School of Medicine New Orleans	USMLE/SC
137.Robert Mitchell Ermentrout	Warren Alpert Medical School of Brown Univ	USMLE/CA
138.*Thomas Joseph Fister	Lake Erie College of Osteopathic Medicine	COMLEX
139.*Taylor N Goulding-Avedisian	Ross University	USMLE
140.*Arash Momeni	Uniformed Services Univ of Health Sciences	USMLE/VA
141.Vincent Nardone	Virginia Commonwealth Univ School of Med	USMLE/VA
142.*Devin Patel	Ross University	USMLE/VA
143.Abraham S Rodriguez	Ponce School of Medicine	USMLE/PR
144.Eric James Zoog	Medical College of Pennsylvania	USMLE/VA

Name	Medical School	Endorsement

**Approved pending acceptance and payment of NDC issued by the BME.*

A motion was made by Commissioner Christopher with a second by Commissioner Nagrodzki to approve applicant numbers one through one hundred and forty-four (1-144) for full licensure. The motion was approved by unanimous vote.

Limited License Applicants

	Name	Medical School	Endorsement	Location	License
1.	Akata Essor Abung	University of Calabar	LL/AL	Mobile Infirmary IM	R
2.	Adedolapp N Adedayo	Windsor University	LL/AL	Baptist Health Montgomery FM	R
3.	Mohammad U Amin	Kabul Medical Institute	LL/AL	NAMC IM	R
4.	Pasano Bojang	Univ of Kentucky College of Medicine	LL/AL	UAB Huntsville IM	R
5.	Juliet Chioma Dike	University of Calabar	LL/AL	Mobile Infirmary IM	R
6.	Ana P Franchini Fer	Universidad Americana	LL/AL	UAB Birmingham Pathology	R
7.	Bashar Maher Ftaiha	Jordan Univ of Science & Technology	LL/AL	UAB Gastro & Hepatology	SP
8.	Mahnoor Javaid	CMH Lahore Medical College	LL/AL	NAMC Florence IM	R
9.	Yunyi Jin	Peking Univ Health Science Center	LL/AL	UAB Birmingham Neurology	R
10.	Sugnana Medithi	Osmania Medical College	LL/AL	North AL Shoals Hos Psychiatry	R
11.	Ricardo Patron Madge	Universidad Peruana Cayetano Heredia	LL/AL	NAMC IM	R
12.	Warda Shahnawaz	Jinnah Sindh Medical University	LL/AL	Mobile Infirmary IM	R
13.	Keerthi V Sreeramoju	N.R.I. Medical College, Guntur	LL/AL	Baptist Health FM	R
14.	Chiamaka Theclar Umah	University of Lagos	LL/AL	UAB Pathology	R
15.	Sarmad Zain	Nishtar Med, Bahuddin Zakaria Univ	LL/AL	NAMC IM	R

A motion was made by Commissioner Varner with a second by Commissioner Christopher to approve applicant numbers one through fifteen (1-15) for limited licensure. The motion was approved by unanimous vote.

IMLCC Report

The Commission received as information a report of the licenses that were issued via the Interstate Medical Licensure Compact from October 1, 2024, through October 31, 2024. A copy of this report is attached as Exhibit "A".

REPORTS

Physician Monitoring Report

The Commission received as information the physician monitoring report dated November 18, 2024. A copy of the report is attached as Exhibit "B".

APPLICANTS FOR REVIEW

Lon Alexander, M.D.

A motion was made by Commissioner Christopher with a second by Commissioner Nagrodzki to approve Dr. Alexander's application for full licensure. The motion was approved by unanimous vote.

DISCUSSION ITEMS

FSMB Call for Public Comment: Advisory Commission on Additional Licensing Models

A motion was made by Commissioner Christpher with a second by Commissioner Falgout to submit proposed comments to the Federation of State Medical Boards. A copy of the memorandum is attached hereto as Exhibit "C".

Eric Beck, M.D.

The Commission received for consideration alternative Continuing Medical Education courses submitted by Dr. Beck. A motion was made by Commissioner Christopher with a second by Commissioner Falgout to approve the course options submitted. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "D".

ADMINISTRATIVE FILINGS

Craig R. Jones, D.O.

The Commission received an Administrative Complaint filed by the Alabama State Board of Medical Examiners. A motion was made by Commissioner Varner with a second by Commissioner Nagrodzki to enter an order setting a hearing for January 22, 2025. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "E".

Aaron A. Hernandez-Ramirez, M.D.

The Commission received as information an update from Aaron Dettling, General Counsel, regarding the appeal filed by Aaron A. Hernandez-Ramirez, M.D. in the Alabama Court of Civil Appeals.

At 9:27 a.m., the Commission entered closed session pursuant to Alabama Code § 34-24-361.1 to hear and consider the following matters:

CLOSED SESSION UNDER ALA. CODE 34-24-361.1

Robert P. Bolling, M.D.

At the conclusion of the hearing, a motion was made by Commissioner Christopher with a second by Commissioner Nagrodzki to issue an order reinstating Dr. Bolling's Alabama medical license to a suspended status. Among other requirements, the order requires Dr. Bolling to submit a practice plan for approval by the Commission and CPEP recommendations prior to his return to the practice of medicine in the State of Alabama. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "F".

Cameron Townsend Corte, M.D.

The Commission received a proposed Joint Settlement Agreement and Consent Order between Dr. Corte and the Alabama State Board of Medical Examiners. A motion was made by Commissioner Christopher with a second by Commissioner Morris to accept the Joint Settlement Agreement and to enter an order setting a hearing to determine the final content of the Commission's order. The motion was approved by unanimous vote. A copy of the Commission's order is attached as Exhibit "G".

O'Neal Culver, M.D.

The Commission received a proposed Joint Settlement Agreement and Consent Order between Dr. Culver and the Alabama State Board of Medical Examiners. A motion was made by Commissioner Christopher with a second by Commissioner Nagrodzki to accept the Joint Settlement Agreement and to enter a Consent Decree incorporating its terms. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "H".

Michael D. Dick, M.D.

At the conclusion of the hearing, a motion was made by Commissioner Nagrodzki with a second by Commissioner Christopher to issue an order revoking Dr. Dick's Alabama medical license and assessing an administrative fine. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "I".

Anand P. Lalaji, M.D.

A motion was made by Commissioner Morris with a second by Commissioner Falgout to accept the Voluntary Surrender of Dr. Lalaji's Alabama medical license and to cancel the hearing previously scheduled in this matter. The motion was approved by unanimous vote. A copy of the Voluntary Surrender is attached hereto as Exhibit "J".

Charles T. Nevels, M.D.

The Commission reviewed proposed changes to the Joint Settlement Agreement and Consent Order submitted by Dr. Nevels' counsel. After discussion a motion was made by Commissioner Christopher with a second by Commissioner Falgout to accept the Commission's changes as discussed. The motion was approved by unanimous vote.

Daniel Alan Polansky, M.D.

The Commission received a proposed Joint Settlement Agreement and Consent Order between Dr. Polansky and the Alabama State Board of Medical Examiners. A motion was made by Commissioner Nagrodzki with a second by Commissioner Morris to accept the Joint Settlement Agreement and to enter a Consent Decree incorporating its terms. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "K".

Thomas J. Shaknovsky, D.O.

The Commission received a Motion to Dismiss the Administrative Complaint and Voluntary Surrender filed by the Alabama State Board of Medical Examiners. A motion was made by Commissioner Christopher with a second by Commissioner Nagrodzki to dismiss the Administrative Complaint and accept the Voluntary Surrender of Dr. Shaknovsky's Alabama medical license. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "L".

Meeting adjourned at 4:13 p.m.

PUBLIC MEETING NOTICE: The next meeting of the Alabama Medical Licensure Commission was announced for Wednesday, December 18, 2024, beginning at 9:00 a.m.

JORGE ALSIP, M.D., Chairman
Alabama Medical Licensure Commission

Rebecca Robbins, Director of Operations
Recording Secretary
Alabama Medical Licensure Commission

12/18/2024
Date Signed

EXHIBIT

A

IMLCC Licenses Issued October 1, 2024 - October 31, 2024 (155)

Name	License Type	License Number	Status	Issue Date	Expiration Date	State of Principal Licensure
Maheen Saleem Sheikh	MD	49796	Active	10/1/2024	12/31/2024	Arizona
Benjamin Michael Williams	MD	49814	Active	10/2/2024	12/31/2025	Arizona
Muhammad Fahad Mughal	MD	49803	Active	10/1/2024	12/31/2024	Arizona
Scott Brady Rader	DO	3887	Active	10/28/2024	12/31/2024	Arizona
Eric Alexander Hegybeli	DO	3888	Active	10/28/2024	12/31/2024	Arizona
Wendy Song	DO	3862	Active	10/16/2024	12/31/2024	Arizona
Donna Anne Woods	DO	3866	Active	10/23/2024	12/31/2024	Arizona
Mansoor Ahmad	MD	49855	Active	10/11/2024	12/31/2024	Colorado
Thoutireddy Krishna Reddy	MD	49853	Active	10/11/2024	12/31/2024	Colorado
Susan Lorraine Brashear	MD	49869	Active	10/15/2024	12/31/2024	Colorado
Shankar Perumal	MD	49817	Active	10/2/2024	12/31/2024	Colorado
Rochelle Sara Bernstein	MD	50006	Active	10/29/2024	12/31/2024	Colorado
Christopher Charles Frohne	MD	49979	Active	10/25/2024	12/31/2024	District of Columbia
Cecile Carol-Ann King	MD	49815	Active	10/2/2024	12/31/2024	Georgia
Hilary Thomas Hight	MD	49823	Active	10/3/2024	12/31/2024	Georgia
Angie Harshaw Harris	MD	49812	Active	10/2/2024	12/31/2024	Georgia
Arif Aziz	MD	50030	Active	10/31/2024	12/31/2025	Georgia
Nellie Sarah Crawford	MD	50029	Active	10/31/2024	12/31/2024	Georgia
Chad Levitt	MD	50025	Active	10/31/2024	12/31/2024	Georgia
Phillip Michael Scheanon	MD	50012	Active	10/29/2024	12/31/2025	Georgia
Jyothi Gunta	MD	50005	Active	10/29/2024	12/31/2024	Georgia
Elna N Saah	MD	49895	Active	10/21/2024	12/31/2024	Georgia
Getnet Alemu Tioum	MD	49903	Active	10/23/2024	12/31/2024	Georgia
Andre Levester McCollough	MD	49821	Active	10/2/2024	12/31/2024	Georgia
Louis Tad Cowley	MD	49978	Active	10/25/2024	12/31/2024	Idaho
Sabrina Haque	MD	49982	Active	10/25/2024	12/31/2024	Illinois
Inisyah Aamir Gomberawalla	MD	49952	Active	10/24/2024	12/31/2025	Illinois
Sona Yash Young	MD	49953	Active	10/24/2024	12/31/2024	Illinois
Kenneth Arcedrick Munnerlyn	MD	49891	Active	10/21/2024	12/31/2024	Illinois
Parveen Naaz-Ikramuddin	MD	49887	Active	10/18/2024	12/31/2024	Illinois

Kara Phyllis Fine	MD	49884	Active	10/17/2024	12/31/2025	Illinois
Byron Wayne Johnson	MD	49839	Active	10/8/2024	12/31/2025	Illinois
Osama Mohammad Qubaiah	MD	50016	Active	10/29/2024	12/31/2024	Illinois
Louis Charles Keiler III	MD	49997	Active	10/28/2024	12/31/2024	Illinois
Taryn Bolling	DO	3883	Active	10/25/2024	12/31/2024	Indiana
Muthumeena Kannappan	MD	49870	Active	10/15/2024	12/31/2024	Indiana
Krista Lynn Sexton-Cox	DO	3885	Active	10/28/2024	12/31/2024	Indiana
Luke Nelligan	DO	3886	Active	10/28/2024	12/31/2024	Indiana
Maggie Jane Limoges-Davies	DO	3863	Active	10/16/2024	12/31/2024	Iowa
Sean Bandzar	MD	49906	Active	10/23/2024	12/31/2025	Kansas
Steven Randall Shelton	MD	50015	Active	10/29/2024	12/31/2024	Kentucky
Jill Ann Hammersley	MD	49888	Active	10/18/2024	12/31/2024	Louisiana
Francine Belleville	MD	49881	Active	10/17/2024	12/31/2024	Louisiana
Jessica Galandak	MD	49882	Active	10/17/2024	12/31/2024	Louisiana
Drew Michael Ledet	MD	49877	Active	10/16/2024	12/31/2024	Louisiana
Ryan Vega	MD	49872	Active	10/15/2024	12/31/2024	Louisiana
Almas Syed	MD	49875	Active	10/16/2024	12/31/2024	Louisiana
Tyler Sandow	MD	50022	Active	10/30/2024	12/31/2024	Louisiana
Katherine Swing	MD	50027	Active	10/31/2024	12/31/2024	Louisiana
Juan Martin Gimenez	MD	50028	Active	10/31/2024	12/31/2024	Louisiana
Ian Hien Nguyen	MD	49998	Active	10/28/2024	12/31/2024	Louisiana
Lisa Angelica Moreno-Walton	MD	49838	Active	10/8/2024	12/31/2024	Louisiana
Stephen Anthony Quinet	MD	49836	Active	10/8/2024	12/31/2024	Louisiana
Mary E Westerman	MD	49797	Active	10/1/2024	12/31/2024	Louisiana
Jenny LeBoeuf	MD	49826	Active	10/4/2024	12/31/2024	Louisiana
David Quentin Alleva	MD	49833	Active	10/7/2024	12/31/2024	Louisiana
Mohammad Ali Almubaslat	MD	49996	Active	10/28/2024	12/31/2024	Louisiana
Alana D Piersanti	MD	49807	Active	10/1/2024	12/31/2024	Maryland
Christopher Ezekiel Jackson	MD	50004	Active	10/29/2024	12/31/2024	Maryland
Valerie Ellen Goodman	DO	3890	Active	10/30/2024	12/31/2024	Maryland
Jiaying Zhang	MD	50008	Active	10/29/2024	12/31/2025	Maryland
Naveed Hussain Shah	MD	49851	Active	10/11/2024	12/31/2024	Maryland

Charles Simmons	MD	49856	Active	10/11/2024	12/31/2024	Maryland
John McBroom	MD	49857	Active	10/11/2024	12/31/2025	Maryland
Madeeha Shams	MD	49883	Active	10/17/2024	12/31/2024	Maryland
Gilbert Ochieng Mbeo	MD	49885	Active	10/17/2024	12/31/2024	Maryland
Teja Singh Jr.	MD	49847	Active	10/11/2024	12/31/2024	Michigan
Daniel Seth Passerman	DO	3884	Active	10/28/2024	12/31/2024	Michigan
Garson Kwock See Lee	MD	49832	Active	10/7/2024	12/31/2024	Michigan
Kai Phillipp Olshausen	MD	49798	Active	10/1/2024	12/31/2025	Michigan
Aimee Marie Nefcy	MD	50026	Active	10/31/2024	12/31/2024	Michigan
Brian William Nielsen	MD	49860	Active	10/11/2024	12/31/2024	Michigan
Stephanie Coleman	MD	49861	Active	10/11/2024	12/31/2024	Michigan
Umayr Ahmad Azimi	MD	49893	Active	10/21/2024	12/31/2024	Michigan
Donald John Chadwick	MD	49873	Active	10/15/2024	12/31/2024	Minnesota
Travis Gaujot Bias	DO	3855	Active	10/2/2024	12/31/2025	Minnesota
Amina Goodwin	MD	50014	Active	10/29/2024	12/31/2024	Mississippi
Jefferson Hopkins Harman	MD	49816	Active	10/2/2024	12/31/2024	Mississippi
Jayson Vincent Singson Lingan	MD	49799	Active	10/1/2024	12/31/2024	Montana
Eli Jacob Muhrer	MD	49993	Active	10/28/2024	12/31/2024	Montana
Eric Cuauhtemoc Munoz	MD	49858	Active	10/11/2024	12/31/2025	Nebraska
Jonathan Grant Reed	MD	49859	Active	10/11/2024	12/31/2025	Nebraska
Timothy Benjamin James Jeider	MD	50017	Active	10/29/2024	12/31/2025	Nevada
Daniel Gore Miner	MD	49904	Active	10/23/2024	12/31/2024	New Hampshire
Tariq Halasa	MD	49994	Active	10/28/2024	12/31/2024	New Jersey
Mustafa Imran	MD	49845	Active	10/11/2024	12/31/2024	New Jersey
Kavitha Shah	MD	49837	Active	10/8/2024	12/31/2024	New Jersey
Tehmina Habib	MD	49800	Active	10/1/2024	12/31/2024	New Jersey
Christin Barry	MD	49951	Active	10/24/2024	12/31/2024	New Jersey
Marian Pokuah	MD	49892	Active	10/21/2024	12/31/2024	New Jersey
Rachael Esther Levine	MD	49865	Active	10/11/2024	12/31/2024	Ohio
Nicholas Michael Hastings	DO	3861	Active	10/16/2024	12/31/2025	Ohio
Zohaib Ahmed	MD	49871	Active	10/15/2024	12/31/2024	Ohio
Sally A Passerby	MD	49889	Active	10/18/2024	12/31/2024	Ohio

Austin Al-Kazaz	MD	50011	Active	10/29/2024	12/31/2024	Ohio
Levi Harper	MD	49846	Active	10/11/2024	12/31/2024	Ohio
Dmitri Andreyevich Gagarin	MD	49819	Active	10/2/2024	12/31/2024	Ohio
Marilyn J Kindig Stahl	DO	3856	Active	10/3/2024	12/31/2024	Ohio
Amy Briana Kirby	MD	49902	Active	10/23/2024	12/31/2024	Oklahoma
Justin Lane McCoy	MD	49894	Active	10/21/2024	12/31/2024	Oklahoma
Amanda Christian	MD	49864	Active	10/11/2024	12/31/2024	Oklahoma
Ashish Soni	MD	49896	Active	10/21/2024	12/31/2025	Tennessee
Steven B Mazza	MD	49897	Active	10/21/2024	12/31/2024	Tennessee
Debra Melanie Jaffe	MD	49981	Active	10/25/2024	12/31/2024	Tennessee
Kwasi K Ampomah	DO	3879	Active	10/24/2024	12/31/2024	Tennessee
Naushaba Hasan	MD	50002	Active	10/29/2024	12/31/2024	Tennessee
Bryce Jacob Busenlehner	MD	49874	Active	10/15/2024	12/31/2024	Tennessee
Melissa P Cheers	MD	49862	Active	10/11/2024	12/31/2024	Tennessee
Elizabeth Jane Michael	MD	49849	Active	10/11/2024	12/31/2024	Tennessee
Michael T Froehler	MD	49866	Active	10/11/2024	12/31/2024	Tennessee
Philip Arnold Brooks	MD	49905	Active	10/23/2024	12/31/2024	Tennessee
David Daniel Hagaman	MD	49854	Active	10/11/2024	12/31/2024	Tennessee
Roya Na Masoud	DO	3858	Active	10/11/2024	12/31/2024	Tennessee
Jeffrey Alan Keenan	MD	49820	Active	10/2/2024	12/31/2024	Tennessee
Judith Andrea Mills	DO	3889	Active	10/29/2024	12/31/2024	Tennessee
Carla Francesca LoPinto-Khoury	MD	50009	Active	10/29/2024	12/31/2024	Tennessee
Hasan Huseyin Sonmezturk	MD	50010	Active	10/29/2024	12/31/2024	Tennessee
Giacomo Mohandas Meeker	MD	50023	Active	10/30/2024	12/31/2024	Tennessee
Delecia Rogers Lafrance	MD	50013	Active	10/29/2024	12/31/2024	Tennessee
Abraham Palamootil Thomas	MD	49827	Active	10/4/2024	12/31/2024	Texas
Sivagowri Tharmendira	MD	49835	Active	10/8/2024	12/31/2024	Texas
Navin S Thakur	MD	49824	Active	10/3/2024	12/31/2024	Texas
Alpen Patel	MD	49795	Active	10/1/2024	12/31/2024	Texas
Carl Alexander Zehner	MD	49804	Active	10/1/2024	12/31/2024	Texas
Gloria F Oyeniyi	MD	49805	Active	10/1/2024	12/31/2024	Texas
Hyeon Ju Ryoo Ali	MD	49806	Active	10/1/2024	12/31/2025	Texas

Jean Nicolas Vauthey	MD	49802	Active	10/1/2024	12/31/2024	Texas
Rochelle Marie Sexton	MD	49808	Active	10/1/2024	12/31/2024	Texas
David Ezra Morris	MD	49813	Active	10/2/2024	12/31/2024	Texas
Shahid Hussain	MD	49818	Active	10/2/2024	12/31/2024	Texas
Garrett Lane Simmons	MD	49822	Active	10/2/2024	12/31/2025	Texas
Lisa Angela King	MD	49825	Active	10/4/2024	12/31/2024	Texas
Gaurav Sharan	MD	49828	Active	10/4/2024	12/31/2024	Texas
Dzifaa Kofi Lotsu	MD	49850	Active	10/11/2024	12/31/2025	Texas
Phillip Ryan Hendley	MD	49852	Active	10/11/2024	12/31/2024	Texas
Gustavo Nivael Del Toro	DO	3859	Active	10/11/2024	12/31/2024	Texas
Osazee Emmanuel Oviawe	MD	49876	Active	10/16/2024	12/31/2025	Texas
Kathryn Lai	MD	49878	Active	10/16/2024	12/31/2024	Texas
Wassim Taher Radwan Abd El Wahab	MD	49879	Active	10/16/2024	12/31/2024	Texas
Amanda S Dodson-Mooring	DO	3864	Active	10/17/2024	12/31/2024	Texas
Mohsin A Siddiqui	DO	3882	Active	10/25/2024	12/31/2025	Texas
Chukwujekwu Ikenna Okpalaji	MD	49980	Active	10/25/2024	12/31/2024	Texas
Micheline Silvie Tantchou	MD	49983	Active	10/25/2024	12/31/2024	Texas
Rebecca Ann Pohlmann	MD	49984	Active	10/25/2024	12/31/2024	Texas
Richard Reza Jahan-Tigh	MD	49992	Active	10/28/2024	12/31/2024	Texas
Keta Joshipura Pandit	MD	49995	Active	10/28/2024	12/31/2024	Texas
Brian Curtis McMullin	DO	3860	Active	10/15/2024	12/31/2024	Utah
Jesse Lucinda James	MD	49863	Active	10/11/2024	12/31/2025	Utah
Phillip Dove	MD	49890	Active	10/21/2024	12/31/2024	Washington
Jeanine Ann Sommerville	MD	49831	Active	10/7/2024	12/31/2024	Washington
Abel Tewodros	MD	49834	Active	10/7/2024	12/31/2024	Washington
Saima Mumtaz Ahmad	MD	50007	Active	10/29/2024	12/31/2024	Washington
Krista L D'Amore	MD	50018	Active	10/30/2024	12/31/2024	Wisconsin
Jazmine Smith	MD	49801	Active	10/1/2024	12/31/2024	Wisconsin
Evlyn Isabel Eickhoff	MD	49848	Active	10/11/2024	12/31/2024	Wisconsin

**Total licenses issued since April 2017 - 4,821*

EXHIBIT

B

STATE *of* ALABAMA

MEDICAL LICENSURE COMMISSION

To: Medical Licensure Commission

From: Nicole Roque

Subject: November Physician Monitoring Report

Date: 11/18/2024

The physicians listed below are currently being monitored by the MLC.

Physician:	**Gary M. Bullock, D.O.**
Order Type:	MLC
Due Date:	6/27/2024
Order Date:	8/25/2023
License Status:	Active-Probation
Requirements:	Administrative Cost ($27,460.27)
	Administrative Fine ($20,000)
	No Prescribing
Received:	PDMP Compliant
	*No payment has been received.

Physician:	**Kristin J. Dobay, M.D.**
Order Type:	MLC
Due Date:	Other
Order Date:	5/3/2024
License Status:	Active-Restricted
Requirements:	APHP Report
	Limited Practice
	Therapist Report
	Worksite Report
Received:	Report from Rob Hunt with supporting documents

Physician:	**Shakir Raza Meghani, M.D.**
Order Type:	BME/MLC
Due Date:	Monthly
Order Date:	11/20/2023
License Status:	Active
Requirements:	Check PDMP Monthly
Received:	PDMP Compliant

EXHIBIT

C

STATE *of* ALABAMA

MEDICAL LICENSURE COMMISSION

MEMORANDUM

To: Medical Licensure Commission

From: Rebecca Robbins

Date: October 7, 2024

Subject: FSMB Call for Public Comments: Advisory Commission on Additional Licensing Models – Draft Guidance Document

---

The Advisory Commission on Additional Licensing Models (Advisory Commission), a group formed by the Federation of State Medical Boards (FSMB), the Accreditation Council for Graduate Medical Education (ACGME), and Intealth is seeking comment and feedback on its Draft Guidance Document concerning pathways by which internationally trained physicians may become eligible for medical licensure from a medical board in the United States.

In the draft document, included with this memorandum, the Advisory Commission makes recommendations on the following:

- Rulemaking authority should be delegated, and resources allocated, to the state medical board for implementing additional licensure pathways
- An offer of employment prior to application for an additional pathway
- ECFMG Certification and graduation from a recognized medical school
- Completion of post-graduate training (PGT) outside the United States
- Possession of a license/registration/authorization to practice medicine in another country or jurisdiction and medical practice experience
- A limit on "time out of practice" before becoming eligible to apply for an additional pathway
- A requirement for a period of temporary provisional licensure prior to eligibility to apply for a full and unrestricted license to practice medicine
- Eligibility for a full and unrestricted license to practice medicine
- Standard data collection requirements

Comments are due by **December 6, 2024.** If the Commission has no comments, this item should be received as information.

Rebecca Robbins

Subject: FW: Feedback Requested on Draft Recommendations from Advisory Commission on Additional Licensing Models

Dear Executive Directors, Board Chairs and Presidents,

I am alerting you to the opening of a public comment period for draft preliminary recommendations for assisting the state and territorial medical boards and legislators in developing or modifying additional licensing pathways for physicians who have completed training internationally. These preliminary recommendations were drafted by the Advisory Commission on Additional Licensing Models, a group formed by FSMB, the Accreditation Council for Graduate Medical Education (ACGME), and Intealth.

I encourage you and your board to review the draft guidance document and recommendations and to provide your comments and feedback to the Advisory Commission by December 6, 2024. Please find links below to a press release announcing the public comment period, the guidance document with draft preliminary recommendations, and the survey instrument to provide your comments and feedback.

View the press release here.
View the supporting draft guidance document and its nine recommendations linked here.
Provide your comments and feedback to the draft recommendations by December 6 here.

Your participation in this public comment period is instrumental in helping the Advisory Commission on Additional Licensing Models create supplemental recommendations that will be considered later in 2025.

If you have any questions, please do not hesitate to reach out to me or FSMB's VP of Engagement, Andrea Ciccone, JD, copied on this email. FSMB is grateful for your willingness to participate in this public comment period and we look forward to your valuable feedback.

Thanks,
Hank

Humayun "Hank" Chaudhry, DO, MACP, FRCP
President and Chief Executive Officer

Federation of State Medical Boards
1775 Eye Street NW | Suite 410 | Washington, DC 20006
o. 817-868-4044 | hchaudhry@fsmb.org | www.fsmb.org

ADVISORY COMMISSION ON ADDITIONAL LICENSING MODELS

Advisory Commission on Additional Licensing Models Releases Draft Preliminary Recommendations for Public Comment
Public comment period runs through December 6

WASHINGTON, D.C.- The Advisory Commission on Additional Licensing Models has released draft preliminary recommendations for public comment. The recommendations, once finalized, are intended for state medical boards, state legislators, policymakers and interested stakeholders to help inform those jurisdictions interested in developing or modifying additional licensing pathways for physicians who have completed training internationally.

The draft guidance with preliminary recommendations is available for viewing here.

The Advisory Commission encourages interested parties to **submit comments about the draft recommendations through December 6, 2024 at the survey link** here.

The Advisory Commission compiled the draft preliminary recommendations in response to a growing number of U.S. state and territorial legislatures interested in modifying traditional post-graduate training requirements for medical licensure of physicians who have completed training internationally by eliminating the traditional requirement for completion of ACGME-accredited graduate medical education (GME) in the U.S. The draft preliminary recommendations, outlined in nine specific areas and largely focused on eligibility requirements or considerations for entry into additional licensure pathways for physicians who have completed training internationally, are intended to support alignment of existing and future policies and statutes.

Upon completion of the public comment period, the Advisory Commission will review the feedback and comments received and release its preliminary guidance for formal consideration in early 2025.

Additional recommendations from the Advisory Commission, which will be essential to supplement the initial recommendations being shared today for feedback, are anticipated later in 2025 to address other important areas, such

as the criteria or assurances that should be required for a physician to transition from provisional to full and unrestricted licensure.

About the Advisory Commission on Additional Licensing Models

The Advisory Commission on Additional Licensing Models was established in December 2023 by the Federation of State Medical Boards (FSMB), Intealth™, and the Accreditation Council for Graduate Medical Education (ACGME). The Advisory Commission was principally formed to provide guidance about additional pathways for the state licensure of physicians who have completed training and practiced outside of the United States.

About FSMB

The Federation of State Medical Boards (FSMB) is a national non-profit organization representing the medical boards within the United States and its territories that license and discipline allopathic and osteopathic physicians and, in some jurisdictions, other health care professionals. The FSMB serves as the voice for state medical boards, supporting them through education, assessment, research and advocacy while providing services and initiatives that promote patient safety, quality health care and regulatory best practices. The FSMB serves the public through Docinfo.org, a free physician search tool which provides background information on the more than 1 million doctors in the United States. To learn more about the FSMB, visit www.fsmb.org.

About Intealth

Intealth is a private, nonprofit organization that brings together the expertise and resources for advancing quality in health care education worldwide in order to improve health care for all. Through strategic integration of its divisions, ECFMG® and FAIMER®, Intealth offers a flexible and multi-layered portfolio of services. These services enhance and support the education and training of health care professionals, verify their qualifications required to practice, and inform the development of health workforce policies around the world. By leveraging these combined competencies, Intealth powers innovation in areas critical to the health professions. Learn more at www.intealth.org.

About ACGME

The Accreditation Council for Graduate Medical Education (ACGME) is an independent, 501(c)(3), not-for-profit organization that sets and monitors

voluntary professional educational standards essential in preparing physicians to deliver safe, high-quality medical care to all Americans. Graduate medical education (GME) refers to the period of education in a particular specialty (residency) or subspecialty (fellowship) following medical school; the ACGME oversees the accreditation of residency and fellowship programs in the US.

Advisory Commission on Additional Licensing Models
DRAFT GUIDANCE DOCUMENT

There are currently two primary pathways by which internationally trained physicians may become eligible for medical licensure from a state medical board in the United States and its territories:

1. Completion of one to three years, depending on the state or territory,[1] of U.S.-based graduate medical education (GME) accredited by the Accreditation Council for Graduate Medical Education (ACGME), accompanied by certification by ECFMG®, a division of Intealth™, and successful passage of all three Steps of the United States Medical Licensing Examination® (USMLE®), is the most common current pathway to medical licensure for international medical graduates (IMGs) in the United States. In addition to expanding a physician's knowledge and skills in one or more medical or surgical specialties, U.S.-based GME affords time for participants to acclimate to the U.S. health care system, culture and social norms, and the medical illnesses and conditions that are most prevalent (e.g., heart disease, cancer, accidents) among those residing in the United States.
2. "Eminence" pathways (usually sought by prominent mid-career physicians from abroad) have long existed in many states and typically do not require ECFMG Certification or successful passage of any Step of the USMLE. It is likely that such pathways will continue to be an option for highly qualified and fully trained internationally trained physicians. These pathways are most often used for those deemed to have "extraordinary ability," and include "eminent specialist" or "university faculty" pathways for physicians pursuing academic or research activities, and they typically align with the O-1 (extraordinary ability) visa issued by the U.S. State Department.[2] Of note, most state medical boards also have existing statutes or regulations allowing the licensing of IMGs at their discretion, though in practice these are not easy to achieve or available commonly. A few medical boards explicitly allow postgraduate training (PGT) – also known as postgraduate medical education (PGME) – outside of the United States or Canada, from countries such as England, Scotland, Ireland, Australia, New Zealand and the Philippines.

Beginning in 2023, eight (8) states have enacted legislation creating additional licensing pathways for internationally trained physicians that does <u>not</u> require completion of ACGME-accredited GME training in the United States.

---

[1] International Medical Graduates GME Requirements, Board-by-Board Overview, FSMB
[2] https://www.uscis.gov/working-in-the-united-states/temporary-workers/o-1-visa-individuals-with-extraordinary-ability-or-achievement

These newly established additional licensing pathways are designed principally for internationally-trained and internationally-practicing physicians who wish to enter the U.S. health care workforce. A primary goal of these pathways in many jurisdictions, according to testimony and statements by sponsors and supporters, is to address U.S. health care workforce shortages, especially in rural and underserved areas.

It must be noted that U.S. federal immigration and visa requirements will impact the practical ability of those who are not U.S. citizens or permanent U.S. residents (green card holders) to utilize any additional pathway. Additionally, the ubiquity of specialty-board certification as a key factor in employment and privileging decisions is likely to impact the efficacy of non-traditional licensing pathways. States may, therefore, wish to consider other health care workforce levers, such as advocating for increased state and Medicare/Medicaid funding to expand U.S. GME training slots, offering some means of transition assistance to IMGs, and expanding the availability and utilization of enduring immigration programs like the Conrad 30 waiver program, Health and Human Services (HHS) waivers, regional commission waivers, and the United States Citizenship and Immigration Service (USCIS) Physician National Interest Waiver.

While the additional pathway legislation introduced and enacted since 2023 varies from state to state, this consensus-based guidance highlights areas of similarities among them and suggests considerations and resources related to each, where such may exist. Areas of concordance among most, if not all, state laws advancing additional licensure pathways – as addressed in more detail later in this document – include the following:

1. **Rulemaking authority should be delegated, and resources allocated, to the state medical board for implementing additional licensure pathways**
2. **An offer of employment prior to application for an additional pathway**
3. **ECFMG Certification and graduation from a recognized medical school**
4. **Completion of post-graduate training (PGT) outside the United States**
5. **Possession of a license/registration/authorization to practice medicine in another country or jurisdiction and medical practice experience**
6. **A limit on "time out of practice" before becoming eligible to apply for an additional pathway**
7. **A requirement for a period of temporary provisional licensure prior to eligibility to apply for a full and unrestricted license to practice medicine**
8. **Eligibility for a full and unrestricted license to practice medicine**
9. **Standard data collection requirements**

The Advisory Commission on Additional Licensing Models, established in December 2023 and convened on four separate occasions in 2024, would like to offer the following set of initial recommendations for consideration by state medical boards, state legislators, policymakers, and other relevant stakeholders, specific to the above nine areas of concordance. The purpose of these recommendations is to support alignment of policies, regulations and statutes, where possible, and to add clarity and specificity to statutory and

procedural language to better protect the public – the principal mission of all state medical boards – and to advance the delivery of quality health care to all citizens and residents of the United States.

These initial recommendations focus on eligibility requirements and related considerations for entry into an additional licensure pathway. To ensure that physicians entering these pathways are prepared to safely practice in the United States, these pathways should optimally include assessment and supervisory components for which additional guidance is under development by the advisory commission and will be forthcoming in 2025.

1. **Rulemaking authority should be delegated, and resources allocated, to the state medical board for implementing additional licensure pathways.**

Many states that have enacted additional pathway legislation have explicitly included state medical boards in the implementation process to assure the ability of the state to support safe medical practice.

Additional licensure pathways will likely incur increased processes, time and resources for state medical boards. State legislatures should consider additional funding and resources that may need to be allocated through state appropriations to fully implement, operationalize, and evaluate an additional new pathway for medical licensure.

States evaluating how to proceed may wish to consider first authorizing their state medical boards to establish a smaller pilot program with primary care specialties that typically require a shorter period of post-graduate training, which may be more comparable internationally, and which may serve to increase access to care in rural and underserved areas. This may enable state medical boards and private partners to build the necessary infrastructure and trust for adoption of additional licensure pathways and evaluate the programs before a substantial increase in applicants or expansion to other specialties is welcomed.

***Recommendation 1a*: States should empower their medical boards to promulgate rules and regulations should they choose to enact additional licensure pathway requirements for qualified, internationally trained physicians.**

***Recommendation 1b:* State legislatures should ensure state medical boards have the necessary resources to fully implement, operationalize, and evaluate any new, additional licensure pathways including the ability to hire or assign staff with knowledge and understanding of licensing international medical graduates.**

2. **An offer of employment prior to application for an additional pathway.**

Internationally trained physicians applying for a license to practice medicine under these new additional licensure pathways have typically required in statute to have an offer of employment from a medical facility that can assure supervision and assessment of the IMG's proficiency. All states that have enacted additional pathway legislation at the time of this document's publication have included such a requirement, whether it is employment with an associated ACGME-accredited program, a Federally Qualified Health Center (FQHC), a Community Health Center (CHC), a Rural Health Clinic (RHC), or other state-licensed medical facility that has capacity and experience with medical education and assessment. The employer should be an entity with sufficient infrastructure that allows for supportive education and training resources for the IMG, as well as supervisory and assessment resources, including peer-review.

Recommendation 2a: **States should require internationally trained physicians applying under an additional licensure pathway to have an offer of employment from a medical facility, as defined by the state medical board.**

Recommendation 2b: **State medical boards should have the authority to determine which medical facilities are able to supervise and assess the IMG's proficiency and capabilities (e.g., an ACGME-accredited program, an FQHC, a CHC, an RHC or other state-licensed medical facility that has capacity and experience with medical education and assessment).**

3. **ECFMG Certification and graduation from a recognized medical school.**

Internationally trained physicians applying under an additional licensure pathway should be graduates of a recognized medical school. All states that have enacted pathway legislation at the time of this document's publication have included this requirement.

Recognition or inclusion in directories from organizations such as the World Health Organization (WHO) or the *World Directory of Medical Schools* (*World Directory*)[3] may serve as a helpful proxy for this requirement. The latter directory is the product of a collaboration between the World Federation for Medical Education (WFME) and FAIMER®, a division of Intealth.

Traditionally, IMGs have been required to obtain ECFMG Certification, a qualification that includes verification of their graduation from a *World Directory* recognized medical school, passage of USMLE Steps 1 and 2, and demonstration of English language proficiency via the Occupational English Test (OET) Medicine.

[3] https://www.wdoms.org/

Recommendation 3: **States should require ECFMG Certification for internationally trained physicians to enter an additional licensure pathway.**

State medical boards may also wish to require IMGs to provide additional supporting materials of the medical education they have undertaken outside the United States. In such instances, primary source verification and review of credentials that utilizes resources such as Intealth's Electronic Portfolio of International Credentials (EPIC℠)[4] may be useful.

4. Completion of post-graduate training (PGT) outside the United States.

States that have introduced or enacted additional pathway legislation have generally included a requirement that applicants should have completed PGT that is "substantially similar" to a residency program accredited by the ACGME in the United States.

There is significant variability, however, in the structure and quality of international PGT. The degree of clinical exposure may be uncertain and inconsistent across programs. Too, there is not currently an established and accepted accreditation system or authority that is able to deem international PGT programs to be "substantially similar" to ACGME-accredited PGT programs available in the United States, nor do many state medical boards have the capacity, resources, or expertise to assess international programs for this purpose on their own. Until such a formal accreditation system exists, the term "substantially similar" may need to be defined and determined by the state medical board.[5] Arriving at definitions and determinations of substantial similarity will have significant implications for state medical boards to plan for and obtain additional resources and support, and expertise to evaluate international training programs that have significant variability in structure, content and quality.

Recommendation 4a: **Completion of formal, accredited PGT outside the United States should be a requirement for entry into an additional licensure pathway.**

Formal postgraduate training and accreditation is not available in all countries and jurisdictions. In its absence, medical boards may be inclined to consider alternative forms of training on a case-by-case basis. These circumstances and experiences – including apprenticeship, clerkship, or observership models – may differ widely in objective measures of quality that do not involve fellowship training or involve quasi-residency arrangements that may or may not support an international physician's education and experience for additional pathway eligibility.

---

[4] https://www.ecfmg.org/psv/

[5] Development of a program for recognition of international systems of accreditation of PGT is currently being led by the Word Federation for Medical Education, with anticipated launch in mid-2025.

Recommendation 4b: **State medical boards may make use of a variety of existing proxies for determining that a PGT program completed outside the United States is "substantively similar" for purposes of additional licensure pathway eligibility for internationally trained physicians, including whether the IMG's program has been accredited by ACGME International (ACGME-I) and/or whether the IMG has completed an ACGME-accredited fellowship training program in the United States. Boards may also wish to ask the IMG to produce their training program's curriculum (and case requirements, for surgical specialties) for review.**

A "number of years in-practice" threshold in a given specialty in place of formal PGT may also be used on a case-by-case basis by the state medical board as an alternative metric, as long as it also includes additional requirements, such as ECFMG Certification and passage of all three Steps of the USMLE program. Where boards have access to, or can partner with, organizations with relevant experience and expertise, they may seek to determine the nature of such practice, including degree of clinical exposure, interaction with patients and performance of procedures; where applicable, this information is likely to be valuable in making determinations of competency and practice readiness.

5. **Possession of a license/registration/authorization to practice medicine in another country or jurisdiction and medical practice experience.**

Most states that have enacted additional pathway legislation have included a requirement that applicants be licensed or authorized to practice medicine in another country. Practice experience requirements in current statutes vary from three to five years. Additional pathway legislation commonly also includes a requirement that the license obtained overseas be "in good standing" and that attempt be made to verify the physician's discipline and criminal background history. State medical boards should consider primary source verification of any documentation from applicants related to licensure, employment and practice history.

Recommendation 5: **States should require internationally trained physicians applying for a license under an additional licensure pathway to be fully licensed, registered, or authorized to practice medicine in another country or jurisdiction and to provide evidence of medical practice experience of at least three years.**

6. **A limit on "time out of practice" before becoming eligible to apply for an additional licensure pathway.**

An international physician's time out of active practice before applying for an additional licensing pathway is typically and explicitly limited in currently enacted legislation, in line with extant guidelines required for medical licensure renewal of most physicians licensed in the United States. Time out of practice is a major challenge and concern for state medical boards in terms of assuring patient safety and public protection, regardless of where the training or initial licensure occurred, given that the practice of medicine changes

so rapidly. Many state medical boards, and this is often included in their respective Medical Practice Acts, already recommend a formal re-entry process when a licensed physician has been out of practice for more than a certain number of years (the most often cited period of time in most statutes is two years).[6]

Recommendation 6: **States should consider limits on time out of practice for physicians entering additional licensing pathways that are consistent with re-entry to practice guidelines for other physician applicants within their jurisdiction.**

States that have enacted additional licensing pathway legislation have listed varying ranges for the number of years of IMG practice, from continuous practice preceding application to within the preceding five years. States should be cognizant that requiring continuous practice may be difficult for many applicants to manage and/or demonstrate, especially if they have to navigate the U.S. immigration system, adjust to displacement, or face any number of non-immigration barriers faced by domestic physicians that require time away from active practice, including, but not limited to, sickness, caregiving or raising children.

7. **A requirement for a period of temporary provisional licensure prior to eligibility to apply for a full and unrestricted license to practice medicine.**

All states that have enacted additional pathway legislation as of the date of publication of this guidance have explicitly included a provision that applicants for additional pathways to a full and unrestricted medical license first begin with a temporary provisional license to practice medicine.

"Supervision" is mentioned as a part of this provision by some states in their enacted legislation. For example, a few states have enacted legislation that allows internationally trained physicians to practice under the "supervision of a licensed physician for two years" as part of their pathway. Supervision and support for internationally trained physicians are crucial to navigate and bridge cultural and boundary differences, and to enable qualified internationally trained physicians to learn the technical and operational side of the U.S. health care system, including the process of billing and the use of electronic health records. Such supervision and support are also essential for public protection. Examples of supervisory structures that could be helpful include a collaborative practice arrangement, preceptorships and/or more formalized training models that include opportunities for progressive assessment of the international physician's caseload and practice. States may also choose to require a "declaration of fitness" made by supervising physicians or verification of compliance with a state's continuing medical education (CME) requirements in order to progress to full and unrestricted licensure.[7]

---

[6] board-requirements-on-re-entry-to-practice.pdf (fsmb.org)

[7] Continuing Medical Education, Board-by-Board Overview, FSMB

The Advisory Commission on Additional Licensing Models is exploring resources available to assist state medical boards with the potential structure of an assessment program and provisional supervised licensure, and anticipates proposing recommendations on this matter sometime in 2025.

***Recommendation 7a*: States should require a period of temporary provisional licensure for qualified internationally trained physicians under an additional licensure pathway before they become eligible to apply for a full and unrestricted license.**

***Recommendation 7b*: During their period of temporary provisional licensure, applicants should be supervised by licensed physicians within the same specialty as the applicant's intended practice.**

***Recommendation 7c*: During this period of temporary provisional licensure, applicants should receive progressive assessment (as defined by the state medical boards and suggested in this section) and adequate support by the employer to help the international physician navigate and bridge cultural and boundary differences, including understanding billing, coding and electronic health records.**

States have taken a variety of approaches in specifying the duration of provisional licensure, with two or three years being the most common time periods cited in legislation. However, there have been some legislative proposals for a two-step progression, by which an IMG first becomes eligible for a restricted or limited license after at least two years of provisional licensure, but still practices in areas or specialties with the greatest medical need, with or without ongoing supervision; provisional, restricted, and limited licensees under this arrangement are *required* in order to practice at these facilities for the entire duration of their time prior to full licensure.

8. Eligibility for a full and unrestricted license to practice medicine.

All states that have enacted additional pathway legislation have included a provision that at the conclusion of the provisional or restricted licensure period, the qualified international physician should become eligible to apply for a full and unrestricted license to practice medicine. There is a small but meaningful linguistic divergence in enacted legislation thus far, however, with wording indicating that state medical boards *may* or *shall* grant a full and unrestricted license to the IMG applicant.

State medical boards ordinarily and typically retain the authority to make licensure decisions for all licensees, even after a period of provisional licensure. Automatic transition to full and unrestricted licensure, by contrast, is neither ordinary nor typical. State medical boards may wish to consider working with their legislatures to retain the ability to exercise their due diligence and assess each applicant on their merits before determining whether they meet the state's criteria for full licensure.

States may also consider explicit requirements for provisional licensees before being granted eligibility for full licensure, such as passing USMLE Step 3 (already a requirement for all other IMGs for licensure), passing the employer's (or facility's) assessment and evaluation program, and having neither any disciplinary actions nor investigations pending over the course of their provisional licensure. Most states that have enacted pathway legislation have required a combination of these steps and there have been some proposals to include a letter of recommendation from the applicant's supervising physician as well.

***Recommendation 8a*: State medical boards in states that have enacted legislation to create additional licensing pathways for internationally trained physicians should work with their legislatures, where permitted, to retain their historic and statutory ability to exercise their due diligence and assess each applicant on their merits before they progress from provisional to full and unrestricted licensure.**

***Recommendation 8b:* State medical boards should add a requirement for passing USMLE Step 3 (as already required of all IMGs) for a full and unrestricted license and a proviso that the applicant not have any disciplinary actions or investigations pending from their provisional licensure period.**

9. Standard data collection requirements.

Data collection and dissemination is critical for state medical boards, state legislators, and state medical boards to better understand the impact of these types of additional licensure pathways. Significant questions remain about the efficacy of these additional pathways to address U.S. health care workforce shortages. Much of the legislation introduced thus far does not address what will likely be significant barriers to employment and the ability to practice with a full license in many states. These questions include whether physicians entering a pathway will be eligible for board certification, whether malpractice insurers will cover their practice, and whether payors will reimburse for the services provided by these physicians.

***Recommendation 9*: State medical boards, assisted by partner organizations as may be necessary, should collect information that will facilitate evaluation of these additional licensure pathways to make sure they are meeting their intended purpose. This information should include:**

- **the number of applicants**
- **the number of internationally trained physicians receiving provisional licensure under the pathway and the number denied provisional licensure under the pathway**
- **the number of individuals achieving full and unrestricted licensure,**
- **the percentage of individuals that stay and practice in their specialty of training and in rural or underserved areas**

- **the number of complaints received and disciplinary actions taken (if any)**
- **the practice setting and specialty of applicants**
- **the number of IMGs licensed through additional licensure pathways who ultimately remain in the United States versus returning to their home countries**
- **the number of individuals achieving specialty board certification**
- **the costs to the board of operating an additional licensing pathway**

EXHIBIT
D

ALABAMA STATE BOARD OF MEDICAL EXAMINERS,

Complainant,

v.

ERIC RAY BECK, M.D.,

Respondent.

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

CASE NO. 2022-099

ORDER

This matter is before the Medical Licensure Commission of Alabama on Respondent's request for approval of alternative Continuing Medical Education courses to satisfy the requirements of sections V.3. a. and b. of our final order of June 6, 2024. Upon review and consideration, Respondent's request is granted as follows:

1. Documented full and satisfactory completion of the course Proper Prescribing (RX-21) offered by PBI Education will be accepted as satisfying the requirements of Section V.3.a. of our final Order; and

2. Documented full and satisfactory completion of the course Medical Ethics and Professionalism (ME-15) offered by PBI Education will be accepted as satisfying the requirements of Section V.3.b. of our final Order.

This order does not alter or amend any term or condition of our final order in this matter, entered on June 6, 2024.

DONE on this the 4th day of December, 2024.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Jorge Alsip, M.D.
on 2024-12-04 10:53:15 CST

Jorge A. Alsip, M.D.
its Chairman

EXHIBIT
E

ALABAMA STATE BOARD OF MEDICAL EXAMINERS,

Complainant,

vs.

CRAIG RAYMOND JONES, D.O.,

Respondent.

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

CASE NO. 2024-279

ORDER SETTING HEARING
For Contested Cases Initiated by Administrative Complaint

The Medical Licensure Commission has received the verified Administrative Complaint filed by the Alabama State Board of Medical Examiners in this matter. The Commission has determined that this matter is due to be set down for hearing under the provisions of Ala. Code § 34-24-361(e). This Order shall serve as the Notice of Hearing prescribed in Ala. Admin. Code r. 545-X-3-.03(3), (4). The Commission's legal authority and jurisdiction to hold the hearing in this matter are granted by Article 8, Chapter 24, Title 34 of the Code of Alabama (1975), and the particular sections of the statutes and rules involved are as set forth in the Administrative Complaint and in this Order.

1. **Service of the Administrative Complaint**

A copy of the Administrative Complaint and a copy of this Order shall be served forthwith upon the Respondent, by personally delivering the same to Respondent if he or she can be found within the State of Alabama, or, by overnight courier, signature required, to Respondent's last known address if he or she cannot be found within the State of Alabama. The Commission further directs that personal service of process shall be made by FedEx/Nicole Rogue, who is designated as the duly authorized agent of the Commission.

2. **Initial Hearing Date**

This matter is set for a hearing as prescribed in Ala. Code §§ 34-24-360, *et seq.*, and Ala. Admin. Code Chapter 545-X-3, to be held on Wednesday, January 22, 2025, at 10:00 a.m., at 848 Washington Avenue, Montgomery, Alabama, 36104. Unless otherwise specified by the Commission, the hearing will be held in person. All parties and counsel are expected to appear and to be prepared for the hearing at this date, time, and place.

3. **Appointment of Hearing Officer**

The Commission appoints the Honorable William R. Gordon, Circuit Judge (Ret.) as the Hearing Officer in this matter, pursuant to Ala. Admin. Code r. 545-X-3-.08. The Hearing Officer shall exercise general superintendence over all pre-hearing proceedings in this matter, and shall serve as the presiding officer at the

hearing, having and executing all powers described in Ala. Admin. Code r. 545-X-3-.08(1)(a)-(g).

4. **Answer**

Respondent shall file an Answer, as prescribed in Ala. Admin. Code r. 545-X-3-.03(6), within 20 calendar days of the service of the Administrative Complaint. If Respondent does not file such an Answer, the Hearing Officer shall enter a general denial on Respondent's behalf.

5. **Rescheduling/Motions for Continuance**

All parties and attorneys are expected to check their schedules immediately for conflicts. Continuances will be granted only upon written motion and only for good cause as determined by the Chairman (or, in his absence, the Vice-Chairman) of the Medical Licensure Commission. Continuances requested on grounds of engagement of legal counsel on the eve of the hearing will not be routinely granted.

6. **Case Management Orders**

The Hearing Officer is authorized, without further leave of the Commission, to enter such case management orders as he considers appropriate to the particular case. Among any other matters deemed appropriate by the Hearing Officer, the Hearing Officer may enter orders addressing the matters listed in Ala. Admin. Code

r. 545-X-3-.03(5)(a)-(f) and/or 545-X-3-.08(1)(a)-(g). All parties will be expected to comply with such orders.

7. **Manner of Filing and Serving Pleadings**

All pleadings, motions, requests, and other papers in this matter may be filed and served by e-mail. All filings shall be e-mailed to:

- The Hearing Officer, William Gordon (wrgordon@charter.net);
- The Director of Operations of the Medical Licensure Commission, Rebecca Robbins (rrobbins@almlc.gov);
- General Counsel of the Medical Licensure Commission, Aaron Dettling (adettling@almlc.gov);
- General Counsel for the Alabama Board of Medical Examiners, Wilson Hunter (whunter@albme.gov); and
- Respondent/Licensee or his or her counsel, as appropriate.

The Director of Operations of the Medical Licensure Commission shall be the custodian of the official record of the proceedings in this matter.

8. **Discovery**

Consistent with the administrative quasi-judicial nature of these proceedings, limited discovery is permitted, under the supervision of the Hearing Officer. *See* Ala. Code § 41-22-12(c); Ala. Admin. Code r. 545-X-3-.04. All parties and attorneys

shall confer in good faith with one another regarding discovery. If disputes regarding discovery are not resolved informally, a motion may be filed with the Hearing Officer, who is authorized to hold such hearings as appropriate and to make appropriate rulings regarding such disputes.

9. Publicity and Confidentiality

Under Alabama law, the Administrative Complaint is a public document. The hearing itself is closed and confidential. The Commission's written decision, if any, will also be public. *See* Ala. Code § 34-24-361.1; Ala. Admin. Code r. 545-X-3-.03(10)(h), (11).

10. Stipulations

The parties are encouraged to submit written stipulations of matters as to which there is no basis for good-faith dispute. Stipulations can help to simplify and shorten the hearing, facilitate the Commission's decisional process, and reduce the overall costs of these proceedings. Written stipulations will be most useful to the Commission if they are submitted in writing approximately 10 days preceding the hearing. The Hearing Officer is authorized to assist the parties with the development and drafting of written stipulations.

11. Judicial Notice

The parties are advised that the Commission may take judicial notice of its prior proceedings, findings of fact, conclusions of law, decisions, orders, and judgments, if any, relating to the Respondent. *See* Ala. Code § 41-22-13(4); Ala. Admin. Code r. 545-X-3-.09(4).

12. Settlement Discussions

The Commission encourages informal resolution of disputes, where possible and consistent with public interest. If a settlement occurs, the parties should notify the Hearing Officer, the Commission's Director of Operations, and Commission's General Counsel. Settlements involving Commission action are subject to the Commission's review and approval. To ensure timely review, such settlements must be presented to the Commission no later than the Commission meeting preceding the hearing date. Hearings will not be continued based on settlements that are not presented in time for the Commission's consideration during a monthly meeting held prior to the hearing date. The Commission Vice-Chairman may assist the parties with the development and/or refinement of settlement proposals.

13. Subpoenas

The Commission has the statutory authority to compel the attendance of witnesses, and the production of books and records, by the issuance of subpoenas. *See* Ala. Code §§ 34-24-363; 41-22-12(c); Ala. Admin. Code r. 545-X-3-.05. The

parties may request that the Hearing Officer issue subpoenas for witnesses and/or documents, and the Hearing Officer is authorized to approve and issue such subpoenas on behalf of the Commission. Service of such subpoenas shall be the responsibility of the party requesting such subpoenas.

14. **Hearing Exhibits**

A. Parties and attorneys should, if possible, stipulate as to the admissibility of documents prior to the hearing.

B. The use of electronic technology, USB drives, CD's, DVD's, etc. is acceptable and encouraged for voluminous records. If the Commission members will need their laptop to view documents, please notify the Hearing Officer prior to your hearing.

C. If providing hard copies, voluminous records need not be copied for everyone but, if portions of records are to be referred to, those portions should be copied for everyone.

D. If a document is to be referred to in a hearing, copies should be available for each Commission member, the Hearing Officer, the Commission's General Counsel, opposing attorney, and the court reporter (12 copies).

E. Index exhibits/documents for easy reference.

F. Distribute exhibit/document packages at the beginning of the hearing to minimize distractions during the hearing.

15. **Administrative Costs**

The Commission is authorized, pursuant to Ala. Code § 34-24-381(b) and Ala. Admin. Code r. 545-X-3-.08(9) and (10), to assess administrative costs against the Respondent if he or she is found guilty of any of the grounds for discipline set forth in Ala. Code § 34-24-360. The Board of Medical Examiners **[X]has / [ ]has**

not given written notice of its intent to seek imposition of administrative costs in this matter.

. **16. Appeals**

Appeals from final decisions of the Medical Licensure Commission, where permitted, are governed by Ala. Code § 41-22-20 and 34-24-367.

DONE on this the 2nd day of December, 2024.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Jorge Alsip, M.D.
on 2024-12-02 16:04:26 CST

Jorge Alsip, M.D.
Its Chairman

Distribution:

- Honorable William R. Gordon (incl. Administrative Complaint)
- Rebecca Robbins
- Respondent/Respondent's Attorney
- E. Wilson Hunter
- Aaron L. Dettling

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **v.** **ROBERT PEARCE BOLLING, M.D.,** **Respondent.**	EXHIBIT F **BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2024-121**

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This contested license reinstatement proceeding came before the Medical Licensure Commission of Alabama for a contested case hearing November 25, 2024. After receiving and considering all of the relevant evidence and argument, we deny reinstatement of Respondent's medical license, stay the denial of reinstatement, and reinstate Respondent's medical license subject to probationary conditions as detailed below.

I. Introduction and Statement of the Case

The Respondent in this case is Robert Pearce Bolling, M.D. Respondent is a former licensee of this Commission who, at the relevant times, practiced medicine as a plastic surgeon in the Fayette, Alabama area. Respondent was first licensed by the Commission on September 26, 2001, having been issued license no. MD 24251.

On October 26, 2022, we issued Findings of Fact and Conclusions of Law, in which we found Respondent guilty of various acts of sexual misconduct in the practice of medicine and revoked his license to practice medicine in Alabama. Respondent now seeks reinstatement. The Board opposes Respondent's application for reinstatement.

II. Procedural History

Familiarity with the October 26, 2022, Findings of Fact and Conclusions of Law is presumed. On January 22, 2024, Respondent filed an Application for Reinstatement pursuant to Ala. Code § 34-24-337. On May 3, 2024, the Board, as prescribed in Ala. Code § 34-24-337(e), filed its "Notice of Intent to Contest Reinstatement." On June 24, 2024, as prescribed in Ala. Code § 34-24-337(g), the Board filed its Administrative Complaint setting forth the grounds for its opposition to reinstatement of Respondent's license (the "Administrative Complaint"). The Administrative Complaint contains four counts. Count One alleges that Respondent is unable to practice medicine with reasonable skill and safety to patients in violation of Ala. Code § 34-24-360(19)a. and Ala. Admin. Code r. 545-X-4-.06(17), as a result of a mental or physical condition evidenced by his commission of serial acts of sexual misconduct in the practice of medicine. In Count Two, the Board alleges that Respondent is guilty of unprofessional conduct in violation of Ala. Code § 34-24-360(2) and Ala. Admin. Code r. 545-X-4-.06 and 545-X-4-.07, based on the same underlying set of facts as Count One. Count Three alleges that Respondent is legally

presumed to be unable to practice medicine with reasonable skill and safety to his patients due to clinical incompetency, as a result of his absence from the practice of medicine for more than two years, as prescribed in Ala. Code § 34-24-360(20)a. and Ala. Admin. Code r. 540-X-23-.03. Finally, in Count Four, the Board alleges that Respondent is guilty of failure to comply with a Commission order, specifically, our October 26, 2022 Findings of Fact and Conclusions of Law, in violation of Ala. Code § 34-24-360(23) and Ala. Admin. Code r. 545-X-4-.06(6).

On November 25, 2024, we conducted a full evidentiary hearing on these charges as prescribed in Ala. Admin. Code r. 545-X-3. The case supporting the disciplinary charges was presented by the Alabama Board of Medical Examiners through its attorneys E. Wilson Hunter and Alicia Harrison. Respondent was represented by attorneys Jay N. Robinson and James A. Hoover. Pursuant to Ala. Admin. Code r. 545-X-3-.08(1), the Honorable William R. Gordon presided as Hearing Officer. Each side was offered the opportunity to present evidence and argument in support of its respective contentions, and to cross-examine the witnesses presented by the other side. After careful review, we have made our own independent judgments regarding the weight and credibility to be afforded to the evidence, and the fair and reasonable inferences to be drawn from it. Having done so, and as prescribed in Ala. Code § 41-22-16, we enter the following Findings of Fact and Conclusions of Law.

III. Findings of Fact

1. All legal and factual findings set forth in our Findings of Fact and Conclusions of Law entered on October 26, 2022, are deemed to be conclusively established. Those findings need not be re-litigated, and, standing alone, are deemed to be *prima facie* sufficient grounds for the denial of reinstatement of Respondent's license to practice medicine. The remainder of this order, however, will focus on the steps Respondent has taken to restore himself to health and fitness to practice medicine.

2. Respondent returned to [redacted] for a Professional Enhancement Program "re-check" from February 23 through March 1, 2023. (Respondent's Ex. 3.) Respondent successfully completed the "re-check," and [redacted] discharged him with the following "Return to Work Recommendations" and "Aftercare Recommendations":

> **Return to Work Recommendations:**
>
> 1. An outcome of Dr. Bolling's Alabama Board of Medicine hearing, he is currently unlicensed and he is currently not working as a physician. He has been in the process of completing requirements from the ABME and APHP, with hopes of his medical license being reinstated in the future.
> 2. Once he is licensed and if cleared to return to practice by the ABME and APHP, it is recommended he adhere to the following practice recommendations:
>
> a. Work in a group practice; solo practice is not recommended.

b. Have a chaperone present for all female patient interactions. This includes having a chaperone present for the entirety of the patient encounter.

c. No treatment or prescribing for himself, family, friends, or co-workers.

d. Patients do not need to have Dr. Bolling's cell phone number.

e. If Dr. Bolling needs to take pictures of patients for medical purposes, it is recommended he not use his personal electronic device, but a workplace device.

f. Maintain a three person rule with female staff.

g. No socializing with staff or patients outside the office.

3. It is recommended he continue monitoring with the APHP and he reported he signed an agreement to monitored for the duration of his practice (*e.g.*, a lifetime monitoring agreement). This would include monitoring to ensure he follows discharge recommendations, provide polygraphs, provide random urine drug screens/Peth/EtG tests, and follow all requirements of APHP.

4. Once he returns to the practice of medicine, it is recommended Dr. Bolling have a workplace monitor who can provide regular reports to the APHP about his behavior and adherence to these boundary recommendations. Ideally, this person would be his supervisor or lateral colleague. This does not need to be someone Dr. Bolling supervises or pays. Dr. Bolling will need to inform the workplace monitor of his boundary issues so that the monitor will know what types of behavior to monitor.

5. A PEP recheck is recommended to occur in three to six months after a return to medicine. This would include an assessment of his progress since discharge, reassess discharge recommendations, and will include a polygraph. Dr. Bolling will need to contact PEP well in advance to schedule his recheck, in order to return during his dates of choice. If Dr. Bolling, ABME, APHP, or his outpatient providers believe that he has relapsed,

his recovery is uncertain, or he is non-compliant with monitoring, or to return for support, he can schedule a recheck sooner than what is recommended.

Aftercare Recommendations:

1. It is recommended Dr. Bolling abstain from all mind altering substances including alcohol.

2. Continue to attend regular individual and a men's sexual issues group therapy with [redacted]

3. Continue attending couple's therapy with [redacted].

4. Attend appointments with his Primary Care Physician, [redacted], for routine checkups and medication management. Should he have an increase of psychiatric issues that warrant specialized care, it is recommended he work with APHP to identify an APHP approved psychiatrist.

5. Continue attending 3-4 12-Step meetings per week and continue work with his sponsor.

6. Quarterly polygraphs are recommended for the first year of his recovery. Assuming he passes his first year of polygraphs, he could decrease to bi-annual tests and [redacted] would need to be included in any discussion about a change in polygraph frequency. Questions will need to focus on his honesty about his alcoholism, sexual behavior, ensuring he has maintained appropriate boundaries with any former patients, and compliance with recommendations. He will need to test with an APHP approved polygrapher.

7. Continue to have protective software on all electronic devices.

8. Dr. Bolling does not need to engage in any volunteer work where he would use his medical degree or medical knowledge (*e.g.*, medical mission trips), and would not need to work with vulnerable female populations. Should he volunteer, he will need to talk with his sponsor and therapist to determine if volunteer opportunities are conducive to his recovery. He reported he owns

a restaurant in his hometown and works there, as well as volunteers with a men's organization.

9. [redacted] Alumni Program offers a weekly zoom meeting and quarterly alumni events [redacted], and these would offer support to Dr. Bolling. It is not a requirement he participate in these activities, but are offered for his support.

(Respondent's Ex. 3 at 4, 5.)

3. Respondent has also completed the Longitudinal Professionalism Rehabilitation Treatment program offered by [redacted] The longitudinal program is designed to provide intensive outpatient psychotherapy, education, and coaching to licensed healthcare professionals, mostly physicians and dentists. The longitudinal program seeks to address professionalism and boundary issues, but does not address issues related to clinical medical competence *per se*. The longitudinal program consists of an initial three-week immersion phase (Phase I), followed by two one-week follow-up sessions (Phases IIa and IIb), to take place at three and six months after the completion of Phase I. The longitudinal program concludes with a three-day wrap-up session (Phase III) at the one-year mark. (Respondent's Ex. at 2.) Respondent completed Phase I from November 28-December 16, 2022, Phase IIa on April 10-14, 2023, Phase IIb on July 17-21, 2023; and Phase III on November 13-15, 2023. (Respondent's Ex. 4, 5.)

4. As part of Phase III of the longitudinal program, Respondent submitted to another polygraph examination, during which he was asked the following test questions:

> 1. Since your last polygraph, have you engaged in any sexual activity with a patient, former patient, or patient surrogate?
>
> 2. Since your last polygraph, have you attempted to solicit or pursue a sexual encounter with a patient, former patient, or patient surrogate?
>
> 3. Since your last polygraph, have you engaged in sexual activity with a current or former employee or other subordinate?

(Respondent's Ex. 5 at 27.)

5. Respondent answered all of these questions in the negative, and Respondent did not evidence any significant reactions to the questions (*i.e.*, deception was not indicated). (*Id.*)

6. [redacted] summarized its conclusions and findings from Respondent's participation in the longitudinal program as follows:

> Overall, the [redacted] team was impressed by Dr. Bolling's ability to engage with and make use of the treatment process throughout the longitudinal program. His experience was not without its challenges, although as noted, Dr. Bolling demonstrated a willingness to acknowledge and openly discuss the difficulties he encountered, which included processing anger, resentments, and other negative feelings directed toward members of the [redacted] team. In our opinion, his willingness to engage with the team and work through these experiences reflects tremendous growth. He wraps up this process with much improved insight, and a genuine depth of understanding around his misconduct. He also now has the self-regulatory capacity and self-confidence to articulate this depth of understanding, and identify the steps he has taken to insure that he will not make the same mistakes again.

> Dr. Bolling has come a long way from where he was at the time of his evaluation. Back then, the [redacted] team saw an individual who was deceitful, disingenuous, and would say whatever he thought it would take to stay out of trouble. At the time, we believed he was unfit for duty, and that his attitude and lack of insight presented a danger to the health and safety of his patients. The man who completed this treatment process is someone who has been humbled, and who has executed a monumental process of self-discovery and change. We believe Dr. Bolling has made the changes he has needed to make, and we are pleased to endorse his return to practice at this time, if he is granted that privilege by the regulatory authorities in Alabama.

(Respondent's Ex. 5 at 31, 32.)

7. "With structured practice and systems of accountability in place," the report concludes, "we believe [Respondent's] risk of misconduct is presently low." (*Id.* at 30.)

8. The final report from [redacted] longitudinal treatment program includes the following "Follow-up Plan/Recommendations":

> ***Follow-up Plan/Recommendations***
>
> - Follow Up/Continuing Care Plan
>
> - We recommend that Dr. Bolling continue his involvement in individual psychotherapy with [redacted] at intervals deemed appropriate by his therapist.
>
> - We recommend that Dr. Bolling continue his involvement in couples therapy with [redacted] at intervals deemed appropriate by his therapist.
>
> - Having been discharged from aftercare at [redacted], and now [redacted], we do not see a need for Dr. Bolling to participate in scheduled rechecks.

- Relapse Prevention Plan

    - We recommend that Dr. Bolling continue his involvement in AA, SA, and other recovery activities as recommended by [redacted] and the APHP.

    - Upon his return to practice, Dr. Bolling should abide by the conditions outlined in his Boundary Protection Plan, which includes the use of a chaperone for all patient encounters, as well as refraining from communicating with patients via text message or social media.

- Monitoring Recommendations and Coordination with PHP

    - We recommend that Dr. Bolling continue to work on maintaining a positive alliance with APHP and/or ASBME and that he participate in monitoring for a length of time deemed appropriate. We recommend that he comply with the terms of his monitoring agreement(s).

    - As part of his monitoring, we recommend that Dr. Bolling undergo maintenance polygraph testing, initially every 6 months, upon his return to practice.

- The treatment team recommends that Dr. Bolling practice at all times in full accordance with relevant federal, state, local, organizational, and professional regulations, ethical guidelines, and best practices, and if he ever is unable or unwilling to adhere to these requirements, we recommend that he disengage himself from the practice of medicine immediately until further evaluation can be undertaken.

(*Id.* at 31.)

9. [redacted], Ph.D. is a licensed psychologist in the State of Kansas, and serves as Clinical Director of the [redacted]. Dr. [redacted] testified that, in his professional opinion, Respondent was committed to and participated actively in his recovery. Dr. [redacted] testified to the significant progress he had seen Respondent

make during his times at [redacted] in terms of his ownership of and responsibility for his past mistakes. Dr. [redacted] particularly commended Respondent for the good work that Respondent did on his own Boundary Protection Plan, which is specifically referenced in [redacted] "Follow-up Plan/Recommendations."

10. With respect to Respondent's return to practice, Dr. [redacted] testified that he did not see any reason at this time to speak against Respondent's return to work, adding that Respondent should not necessarily be limited in his ability to see female patients. Dr. [redacted] noted that he would be willing to refer his own family members and friends to Respondent for medical treatment. In summary, Dr. [redacted] opined that Respondent's overall risk of repeating his past boundary violations, if Respondent implements and complies with the guardrails recommended by [redacted] and [redacted] is lower than the background sexual boundary risk of all plastic surgeons.

11. In Part V.8. of our October 2022 Findings of Fact and Conclusions of Law, we informed Respondent that any application for reinstatement was *likely* to be denied unless Respondent "clearly establishe[d]" that he had fulfilled the following requirements:

> a. Respondent shall have entered into a lifetime monitoring contract with the Alabama Professionals' Health Program, Respondent shall have fully complied with such contract, and APHP shall advocate for Respondent;

b. Respondent shall have complied with and fulfilled all recommendations made by Acumen Assessments on pages 28-30 of the Health Professional Forensic Board Evaluation Final Report (May 24, 2022), with the proviso that Recommendation #2, relating to residential treatment, is deemed satisfied;

c. Respondent shall have complied with and fulfilled all recommendations made by Pine Grove Behavioral Health and Addiction Services on pages 10-11 of its Discharge Summary (August 2, 2022), with the proviso that Return to Work Recommendations 1, 2, and 3 will apply only if and after Respondent returns to practice; and

d. Respondent shall have been re-evaluated by both Acumen and Pine Grove, which evaluations shall include a comprehensive reevaluation of the issues identified on pages 18-22 of the Health Professional Forensic Board Evaluation Final Report (May 24, 2022), with both Acumen and Pine Grove agreeing that Respondent is then able to practice medicine with reasonable skill and safety to patients, subject to stated conditions.

12. The evidence before the Commission demonstrates that Respondent has mostly, but not fully, satisfied these four requirements. Specifically, no direct evidence has been presented of APHP's *affirmative advocacy* for Respondent's return to practice, and we are not satisfied that a "*comprehensive re-evaluation* of the issues identified on pages 18-22 of the Health Professional Forensic Board Evaluation Final Report (May 24, 2022)" has been presented to us.

13. Respondent has submitted documentation tending to show that he completed approximately 58.5 hours of AMA PRA Category 1™ Continuing Medical Education credits during 2023.

IV. Conclusions of Law

1. The Medical Licensure Commission of Alabama has jurisdiction over the subject matter of this cause pursuant to Act No. 1981-218, Ala. Code §§ 34-24-310, *et seq*. Under certain conditions, the Commission "shall have the power and duty to suspend, revoke, or restrict any license to practice medicine or osteopathy in the State of Alabama or place on probation or fine any licensee." Ala. Code § 34-24-360. In addition to all other authorized penalties and remedies, the Commission may impose a fine of up to $10,000 per violation, and may require the payment of administrative expenses incurred in connection with the disciplinary proceeding. Ala. Code § 34-24-381(a), (b).

2. The Commission also has power to order reinstatement, or, in appropriate circumstances, to deny reinstatement, of licenses to practice medicine in Alabama. In a contested reinstatement proceeding such as this one, the Commission has discretion to reinstate, deny reinstatement, or to reinstate a license and simultaneously impose disciplinary conditions on the license:

> The commission may deny reinstatement of a license upon a finding that the applicant has committed any of the acts or offenses set forth in Sections 34-24-360, 34-24-57, 16-47-128, or any other provision of law establishing grounds for the revocation, suspension, or discipline of a license to practice medicine. ***In addition, the commission may reinstate the license and impose any penalty, restriction, or condition of probation provided for in subsection (h) of Section 34-24-361 and Section 34-24-381 as the commission deems necessary to protect the public health and the patients of the applicant.*** If, at the conclusion of

> the hearing, the commission determines that no violation has occurred, the license of the applicant shall be reinstated.

Ala. Code § 34-24-337(h) (emphasis added).

3. Respondent was properly notified of the time, date and place of the administrative hearing and of the charges against him in compliance with Ala. Code §§ 34-24-361(e) and 41-22-12(b)(1), and Ala. Admin. Code r. 545-X-3-.03(3), (4). At all relevant times, Respondent was a licensee of this Commission and was and is subject to the Commission's jurisdiction.

4. Before making any decision on a contested case such as this one, the Commission is required to "receive and consider" a recommendation from the Board. The Board's recommendation, however, is not binding upon the Commission. *See* Ala. Code § 34-24-311. The Commission has received and duly considered the Board's non-binding recommendation to deny Respondent's application for reinstatement.

5. The facts as determined above establish violations of Ala. Code § 34-24-360(19)a and Ala. Admin. Code r. 545-X-4-.06(17) as charged in Count One of the Administrative Complaint; Ala. Code § 34-24-360(2) and Ala. Admin. Code r. 545-X-4-.06, -.07 as charged in Count Two of the Administrative Complaint; Ala. Code § 34-24-360(20)a. and Ala. Admin. Code r. 540-X-23-.03 as charged in Count Three of the Administrative Complaint; and Ala. Code § 34-24-360(23) and Ala.

Admin. Code r. 545-X-4-.06(6) as charged in Count Four of the Administrative Complaint.

V. Decision

Based on all of the foregoing, it is **ORDERED, ADJUDGED, AND DECREED:**

1. That the Respondent, Robert Pearce Bolling, M.D., is adjudged **GUILTY** of the matters charged in Count One of the Administrative Complaint.

2. That the Respondent, Robert Pearce Bolling, M.D., is adjudged **GUILTY** of the matters charged in Count Two of the Administrative Complaint.

3. That the Respondent, Robert Pearce Bolling, M.D., is adjudged **GUILTY** of the matters charged in Count Three of the Administrative Complaint.

4. That the Respondent, Robert Pearce Bolling, M.D., is adjudged **GUILTY** of the matters charged in Count Four of the Administrative Complaint.

5. That Respondent's license to practice medicine in the State of Alabama is **DENIED**; the denial is **STAYED**; and the license is **REINSTATED** subject to the following terms and conditions of **PROBATION** for a period of five years running from the date on which Respondent resumes the practice of medicine:

   a. Respondent shall enter into, maintain, and comply with a lifetime monitoring contract with the Alabama Professionals' Health Program;

b. Respondent shall complete and/or comply with the "Follow-up Plan/Recommendations" contained on page 31 of the [redacted] Longitudinal Treatment Final Discharge Summary (December 14, 2023), and as set forth within the above Finding of Fact No. 8;

c. Respondent shall complete and/or comply with the "Return to Work Recommendations and Aftercare Recommendations" contained on pages 9 and 10 of the [redacted] Final Discharge Summary (August 2, 2022), and set forth within the above Finding of Fact No. 2;

d. Respondent shall practice medicine only pursuant to a written practice plan that complies with this Order and that has been approved in advance by the Commission, which will contain, at a minimum, specific information such as the proposed name of the employer; the proposed scope of practice or type of services to be provided; the proposed days/hours of work; and typical patient populations of the proposed practice;

e. Respondent shall satisfactorily complete a rigorous clinical competency assessment conducted by the Center for Personalized Education for Professionals ("CPEP") or a similar

establishment approved in advance by the Commission, which assessment shall be properly tailored to assess Respondent's clinical competency to perform the work outlined in any proposed practice plan with reasonable skill and safety to patients, and shall successfully complete any remedial educational steps recommended by CPEP;

f. As an alternative to the preceding item e., a proposed practice plan may propose that Respondent work under a Commission-approved on-site proctor/preceptor for no less than six months or until a board-certified surgeon attests to Respondent's competency to practice medicine;

g. Respondent shall practice medicine only in a highly structured setting providing a high degree of organizational structure, support, and professional oversight; neither solo practice, nor supervision of staff, will be allowed;

h. Respondent shall submit to polygraph examinations every six months and submit the written reports of those examinations to the Board's Physician Monitor and to the Commission;

i. Respondent shall have a chaperone physically present in the same room with himself and the patient for the full duration of

all patient encounters (including telemedicine encounters), with continuous, direct visual and aural observation of all activities; all chaperones referred to in this provision shall be employed by Respondent's employer and not by Respondent himself, and shall have successfully completed the PBI Medical Chaperone Training Program;

j. Respondent shall maintain a therapeutic relationship with his therapist, [redacted], shall be seen at intervals deemed appropriate by [redacted], LPC, CSAT, and [redacted] shall make periodic reports to the Physician Monitor no less frequently than quarterly;

k. Respondent shall utilize a patient questionnaire system, no more than 10 questions, one of the questions shall be substantially "Was a third person present in the room at all times when the physician was present with you?"; and

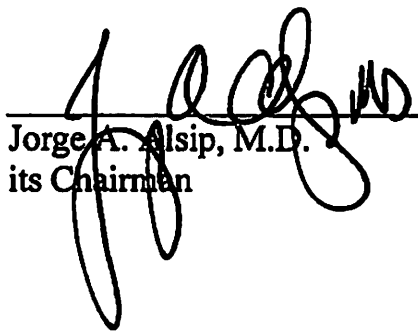
l. Respondent shall at all times conduct himself in full accordance with relevant federal, state, local, organizational and professional laws, regulations, ethical guidelines.

6. That no administrative fines nor costs of these proceedings are assessed against Respondent at this time.

DONE on this the 18th day of December, 2024.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:



Jorge A. Alsip, M.D.
its Chairman

EXHIBIT
G

ALABAMA STATE BOARD OF MEDICAL EXAMINERS,

Complainant,

vs.

CAMERON TOWNSEND CORTE, M.D.,

Respondent.

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

CASE NO. 2023-279

ORDER

This matter is before the Medical Licensure Commission of Alabama on the "Joint Settlement Agreement" filed jointly by the parties on November 18, 2024. Upon review and consideration, the parties' Joint Settlement Agreement is approved, and this matter is set for a final hearing to be held on February 26, 2025, the purpose of which shall be to determine the content of a final disposition of this matter.

DONE on this the 4th day of December, 2024.

THE MEDICAL LICENSURE COMMISSION OF ALABAMA

By:

E-SIGNED by Jorge Alsip, M.D.
on 2024-12-04 10:54:18 CST

Jorge A. Alsip, M.D.
its Chairman

EXHIBIT

H

ALABAMA STATE BOARD OF MEDICAL EXAMINERS,

Complainant,

vs.

O'NEIL CULVER, M.D.,

Respondent.

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

CASE NO. 2024-300

CONSENT DECREE

This matter comes before the Medical Licensure Commission of Alabama ("the Commission") on the Administrative Complaint ("the Administrative Complaint") filed by the Alabama State Board of Medical Examiners ("the Board") on November 22, 2024. The Board and the Respondent, O'Neil Culver, M.D. ("Respondent"), have entered into a Joint Settlement Agreement ("the Settlement Agreement"), and have asked the Commission to approve the Settlement Agreement and to embody it in this Consent Decree.

General Provisions

1. **Approval of the Settlement Agreement.** After review, the Commission finds that the Settlement Agreement represents a reasonable and appropriate disposition of the matters asserted in the Administrative Complaint. The Commission therefore approves the Settlement Agreement.

2. **Mutual Agreement and Waiver of Rights.** Respondent has consented and agreed to the entry of this Consent Decree, and has agreed to be bound by the findings of fact, conclusions of law, and terms and conditions stated herein. Respondent has validly waived his rights to an administrative hearing before the Commission, to be represented by an attorney at such hearing, and to further notice and formal adjudication by the Commission of the charges arising from the Administrative Complaint. Respondent has also validly waived any and all rights to judicial review of this Consent Decree pursuant to Ala. Code § 34-24-367, the Alabama Administrative Procedure Act, Ala. Code §§ 41-22-1, *et seq.*, by extraordinary writ, or otherwise.

3. **Public Documents.** The Administrative Complaint, the Settlement Agreement, and this Consent Decree shall constitute public records under the laws of the State of Alabama. The Administrative Complaint, the Settlement Agreement, and this Consent Decree may be published or disclosed by the Board and/or the Commission without further notice to Respondent.

4. **Additional Violations.** Any violation of the requirements of this Consent Decree, or any new violation of state or federal laws or regulations, may result in the Board filing a petition to discipline Respondent's medical license. Nothing in this Consent Decree precludes the Board from bringing new

administrative charges against Respondent based upon events and circumstances not raised in the Administrative Complaint.

5. **Retention of Jurisdiction.** The Commission retains jurisdiction for the purpose of entering such other and further orders and directives as may be required to implement the provisions of this Consent Decree.

6. **Judicial Notice.** Pursuant to Ala. Code § 41-22-13(4), Respondent is informed that the Board and/or the Commission may at any time take judicial notice of this Consent Decree, and/or any of the Findings of Fact herein, and may deem any of the findings or conclusions set forth in this Consent Decree to be conclusively established, all without further notice to Respondent.

Findings of Fact

1. Respondent has been licensed to practice medicine in the State of Alabama since October 29, 1984, having been issued license no. MD.11800. Respondent was so licensed at all relevant times.

2. The Board's 2022 Continuing Medical Education ("CME") audit revealed that Respondent did not earn any valid CME credits during calendar year 2021. When queried by the Board, Respondent stated that he had obtained the credits but was unable to upload supporting documentation due to "technical difficulties."

3. On October 21, 2022, the Board filed an Administrative Complaint with the Commission seeking the imposition of professional sanctions on Respondent due to Respondent's failure to substantiate CME compliance for calendar year 2021.

4. The Commission entered a Consent Order on November 22, 2022, assessing an administrative fine in the amount of $2,500.00, and ordering Respondent to obtain a total of 50 CME credits on or before December 31, 2022.

5. On or about December 17, 2023, Respondent submitted or caused to be submitted an Alabama medical license renewal application for calendar year 2024. In that application, Respondent certified that the annual minimum continuing medical education requirement of 25 AMA PRA Category 1™ credits had been met or would be met by December 31, 2023. Respondent further represented that, if audited, he would have supporting documents.

6. Respondent earned only four valid continuing medical education credits during 2023.

Conclusions of Law

1. The Commission has jurisdiction over the subject matter of the Administrative Complaint, and over the parties, pursuant to Ala. Code § 34-24-310, *et seq.*

2. The Commission finds as a matter of law that the determined facts constitute violations of Ala. Code § 34-24-360(23) and Ala. Admin. Code r. 545-X-5-.02.

Order/Discipline

Based upon the foregoing Findings of Fact and Conclusions of Law, it is ORDERED, ADJUDGED, AND DECREED:

1. That Respondent is assessed an administrative fine in the amount of two thousand dollars ($2,000.00). In accordance with Ala. Admin. Code r. 545-X-3-.08(8)(d)(i), Respondent is ordered to pay the administrative fine within 30 days of this Order.[1]

2. That Respondent is ordered to obtain 25 ***additional*** credits of AMA PRA Category 1™ or equivalent continuing medical education, in addition to the 25 credits already required for calendar year 2025, for a combined total of 50 credits, during calendar year 2025.

3. That no costs of this proceeding are assessed against Respondent at this time.

---

[1] "The refusal or failure by a physician to comply with an order entered by the Medical Licensure Commission" may be a separate instance of "unprofessional conduct." *See* Ala. Admin. Code r. 545-X-4-.06(6).

DONE on this the 4th day of December, 2024.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Jorge Alsip, M.D.
on 2024-12-04 10:54:40 CST

Jorge A. Alsip, M.D.
its Chairman

EXHIBIT
I

ALABAMA STATE BOARD OF MEDICAL EXAMINERS,

Complainant,

v.

MICHAEL D. DICK, M.D.,

Respondent.

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

CASE NO. 2018-031

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This matter came before the Medical Licensure Commission of Alabama for a contested case hearing on March 29, 2019, followed by additional proceedings on October 22, 2024. After receiving and considering all of the relevant evidence and argument, we find the Respondent, Michael D. Dick, M.D., guilty of six of the disciplinary charges presented by the Board, not guilty of the 10 remaining counts, and impose professional discipline as set forth below.

I. Introduction and Statement of the Case

The Respondent in this case is Michael D. Dick, M.D. ("Respondent"). Respondent is a licensee of this Commission who, at the relevant times, practiced medicine as a rheumatologist in the Decatur, Alabama area. Respondent was first licensed by the Commission on June 26, 1998, having been issued license no. MD.21873.

II. Procedural History

This case began with an Administrative Complaint filed by the Board with the Commission on or about October 10, 2018. On October 11, 2018, we entered an order summarily suspending Respondent's license to practice medicine in the State of Alabama and setting this matter for a hearing to be held on March 29, 2019. After one hearing day, Respondent was arrested on a grand jury indictment for various offenses sharing a common factual basis with the disciplinary charges asserted in the original Administrative Complaint. On April 19, 2019, we continued this matter indefinitely so that Respondent could preserve his Fifth Amendment privileges in connection with the pending criminal proceedings. In that Order, we also noted that Respondent's medical license remained suspended, and that Respondent had waived the 120-day limitation on summary suspension that would normally apply.

Eventually, Respondent was acquitted of all criminal charges, and all of the related civil lawsuits were resolved.

On May 3, 2024, the Board filed its Second Amended Administrative Complaint ("the Administrative Complaint"). The Administrative Complaint contains sixteen counts. In Counts One through Fifteen, the Board alleges that Respondent engaged in various acts of sexual misconduct in the practice of medicine involving 14 separate patients, all in violation of Alabama Code § 34-24-360(2) and Ala. Admin. Code r. 545-X-4-.07. The patients, understandably, are referred to in

the Administrative Complaint using the pseudonyms "Patient One" through "Patient Fourteen." Each sexual misconduct count deals with allegations specific to a single particular patient, except for Counts Two and Three, both of which allege separate sexual misconduct violations involving "Patient Two." Finally, in Count Sixteen of the Administrative Complaint, the Board alleges that Respondent is legally presumed to be unable to practice medicine with reasonable skill and safety to his patients due to clinical incompetency, as a result of his absence from the practice of medicine for more than two years, as prescribed in Ala. Code § 34-24-360(20)a. and Ala. Admin. Code r. 540-X-23-.03.

On October 22, 2024, we conducted a full evidentiary hearing on these charges as prescribed in Ala. Admin. Code r. 545-X-3. The case supporting the disciplinary charges was presented by the Alabama Board of Medical Examiners through its attorneys E. Wilson Hunter and Alicia Harrison. Respondent was represented by attorney Joel A. Williams. Pursuant to Ala. Admin. Code r. 545-X-3-.08(1), the Honorable William R. Gordon presided as Hearing Officer. Each side was offered the opportunity to present evidence and argument in support of its respective contentions, and to cross-examine the witnesses presented by the other side. In addition, the Board and Respondent stipulated to the admission into the administrative record of a large volume of documentary evidence for the Commission's review, including documents from criminal cases involving the

Respondent, transcripts of sworn depositions taken in connection with the civil claims, and other similar written matter. After careful review, we have made our own independent judgments regarding the weight and credibility to be afforded to the evidence, and the fair and reasonable inferences to be drawn from it. Having done so, and as prescribed in Ala. Code § 41-22-16, we enter the following Findings of Fact and Conclusions of Law.

III. Findings of Fact

1. The Respondent in this case is Michael D. Dick, M.D. Respondent was first licensed to practice medicine in the State of Alabama on June 26, 1998, having been issued license No. MD.21873. At the relevant times, Respondent practiced rheumatology at Alabama Medicine and Rheumatology, which was located at the Decatur Med-Surg clinic in Decatur, Alabama. Respondent practiced medicine as a sole practitioner.

2. As part of its review of the evidentiary record, the Commission has carefully weighed a broad constellation of factors, including the quality and quantity of the evidence relating to each of Patients One though Fourteen, judgments regarding each witness' credibility, the facial plausibility of each patient's claims, the consonance of the allegations and the evidence therefor with all other available relevant evidence, and the existence or non-existence of corroborating evidence. We have viewed all of this evidence through the lens of our professional experience,

expertise, and judgment as physicians. *See* Ala. Code § 41-22-13(5) ("The experience, technical competence, and specialized knowledge of the agency may be utilized in the evaluation of the evidence."). Taking all of the relevant available evidence into account, we find the claims of Patients One, Two, Four, and Thirteen to be supported by the preponderance of the evidence.

Patient One

3. Patient One has a lengthy history of anxiety and depression, which she testifies have worsened since her experiences with Respondent. Patient One's experiences with Respondent have led her not to want to see a physician because she is afraid of what someone might do to her.

4. Patient One's experience with Respondent in part led her to move her residence from Decatur to Moulton, because she was concerned for the safety of herself and her children. Patient One commented, "I didn't want him knowing where I lived. . . . I don't know what someone like that is capable of."

5. On Patient One's first visit to Respondent, Patient One testifies that "He was a little touchy-feely as far as putting his hands on my face. Kind of like caressing my face, telling me it's going to be okay." Patient One felt that, on her first visit to Respondent, "he overstepped that boundary, putting his hands on my face and that kind of stuff that day."

6. On a subsequent visit, Patient One testifies that Respondent was "Caressing the face, touching my thighs. Not really my knee, but my thigh area. It was just really inappropriate."

7. Patient One visited Respondent again after falling down a flight of stairs. On this visit, Patient One testifies that Respondent asked her to lie down on her left side on the examination table. At that time, "He touched around, feeling, and then he pulled my pants and panties down and continued to touch on my bottom and hip area. And I told him it was my thigh that was hurting, not my bottom and not my hip." Patient One testifies that Respondent pulled her pants and panties down such that her buttocks were fully exposed. Respondent then called a nurse for injections and administered injections to Patient One's hip. After Respondent administered the injections, Patient One attempted to pull her undergarments back up. Respondent grabbed her pants and panties at the waistline and pulled them up, as if she had not pulled them up high enough. Then, Patient One testifies, Respondent kissed her on the lips.

8. Patient One testifies that a nurse was present in the room when Respondent kissed her on the lips. Patient One testifies that she looked over at the nurse, and the nurse "just acted like it was nothing."

9. Patient One further testified that Respondent "had his hands on my thighs, telling me that it was okay. Everything was going to be all right. Then he put

[his hands] on my shoulders and then on my face, and that was right before he kissed me. But it was just a lot of inappropriate touching. And everything was as if it was just for his own sexual gratification."

10. After leaving her appointment with Respondent, Patient One went to the pharmacy. Patient One testifies that she "whispered" to the pharmacist about what had happened, and the pharmacist recommended that Patient One contact the Board of Medical Examiners. Patient One called the Board of Medical Examiners that same day. After talking to the Board of Medical Examiners, Patient One phoned the police department. The police advised her to come in and make a report, which Patient One did that same day. Patient One spoke with television and print media only after she reported her experiences to the Board and to the local police department.

Patient Two

11. During Patient Two's first visit with Respondent, Respondent was sitting on a stool with his legs apart, and he had Patient Two stand sideways between his legs and bend over. Patient Two felt uncomfortable with the way the examination went and felt that it was for Respondent's sexual gratification. Respondent, according to Patient Two, was too much in her "personal space," leaning back, and exhibiting his pelvic area. Although Patient Two was uncomfortable, she "kept it to [her]self" at that time.

12. On Patient Two's second visit, Respondent administered 16 bupivacaine injections. While administering the injections, Patient Two testifies that Respondent "took [her] hand and grabbed it close to him in a way that she perceived as "flirty" and "for sexual gratification." After this visit, Patient Two said something to her mother about the visit feeling "weird."

13. Patient Two saw Respondent a third time about a month later. Patient Two describes the events of the third visit in detail as follows:

> That's fine. I was in the room, and he had me on the table. And honestly, at this point I don't remember anything that was said after he wrapped his arms around in a way to where he could -- like, under my arms. I know he could feel my breasts. And literally, like, picked me up and, like, took me back on -- I mean like, pushed me back like kind of in a rough way onto the bed -- the exam bed.
>
> Q. All right.
>
> A. I remember him sticking his hands down my pants. And I asked him, because I thought -- I didn't know what was going on. I remember asking him, do I need to unbutton my pants, and he said, no, no. I remember his fingers going all the way down. I did not have underwear on. So there was bare skin there. I remember him just feeling around, and I remember holding his hand right here. I was feeling really uncomfortable. Then in my head, I knew kind of what was going on because he didn't want to open my pants up. And why would a rheumatologist be sticking his hand down my pants. I don't like where his fingers went. I don't like where his hand went. I was violated. That part of my body is for my husband only. I was very violated. I felt very assaulted. I felt like I was getting molested. I felt very uncomfortable. And when he took his hand out of my pants, I remember him leaning down. And I don't remember anything he was saying after this point. After this point, I don't know anything that was said.
>
> Q. Okay.

A. I'm just -- I'm freezing. And I'm trying to push it down. And he's talking to me, and all I can feel is his spit hitting on my face. On this cheek. And I can feel it right now, talking about it. And then he leans down, and he kisses me on the mouth, and he tries to push his tongue down my mouth. I never wanted any other man to kiss me like that. That was a huge violation. And he went beyond some sacred places for me that are for one person in my life only. I did not like that. And I just froze. The nurse was in there. I don't remember -- I said that she had her back turned on the little laptop, whatever she was doing in there. I did not -- I just froze. I completely froze and so I felt very violated. I honestly just felt assaulted, and that he was getting nothing but complete gratification out of this and just completely getting off of it. And when I got up, he picked me up to -- well, with my hand and sat me up. And I got up to start putting my coat on, and the nurse walked out of the room. And then he grabbed me again and he hugged me, and I could feel his erect penis on my leg. And he put his face -- I can still feel his face against my face. And I felt like he was about to kiss me again, and I kind of pulled away. And that's when he walked out.

14. Patient Two specifically testified that Respondent placed his fingers below her caesarean section scar and was "rubbing around down there," below the caesarean section scar, for his own sexual gratification. Respondent did not visually examine the area, as a physician would do if he were examining Patient Two's surgical wounds.

15. Immediately after leaving the third appointment, Patient Two testified that she was "hyperventilating," "couldn't breathe," and "completely broke down." She called her husband, and the two of them went to the Decatur Police Department that evening to make a report. About a week later, Patient Two returned to the Decatur Police Department to meet with a detective and to give a sworn statement.

16. Patient Two decided to keep her fourth appointment with Respondent because she felt that "nothing was being done" by the Decatur Police Department. She decided that "nobody would believe me" unless she obtained proof of Respondent's conduct.

17. Patient Two therefore returned—"with a purpose"—for a fourth office visit with Respondent on December 11, 2017. Patient Two used her mobile phone's camera to record video of the visit. This video, 57 minutes and 29 seconds in overall duration, is part of the evidentiary record in this case. Also included in the evidentiary record is a transcript of the dialogue taking place on this recording.

18. Although the video does not capture a full perspective of the patient encounter between Respondent and Patient Two, it does clearly depict Patient Two and Respondent standing in essentially full ventral contact with one another for approximately four minutes and thirty-seven seconds, strongly corroborating Patient Two's testimonial accounts. Upon review of this video, we have no difficulty concluding that there is no legitimate medical justification whatsoever for a physician's bodily contact with a patient as depicted on the video.

19. The transcript of the fourth patient encounter includes the following dialogue between Patient Two and Respondent:

RESPONDENT: Hi.

PATIENT TWO: Hey.

RESPONDENT: Hey.

PATIENT TWO: Dr. Dick. Oh, my gosh, I'm hurting so bad. I've got a horrible headache.

RESPONDENT: You want something for your headache?

PATIENT TWO: Huh.

RESPONDENT: You want something for your headache?

PATIENT TWO: Yes. What are you doing?

RESPONDENT: Just hugging you.

PATIENT TWO: Oh, my goodness. Like, I feel like I have a fever or something.

RESPONDENT: Yeah, you're a little warm.

* * *

PATIENT TWO: So anyway.

RESPONDENT: Sorry.

PATIENT TWO: How have you been?

RESPONDENT: Good.

PATIENT TWO: Do you like me or something?

RESPONDENT: Yeah. But you're married, so -- where's your head hurting?

20. Patient Two gave a copy of the video of her fourth visit with Respondent to an investigator for the Board of Medical Examiners.

21. In response to questioning by a Commission member, Patient Two testified that, during the four minute and thirty-seven seconds referred to above,

Respondent had his arms around her torso and was rubbing her back, and that she was "positive" that she felt his erect penis contacting her at that time.

Patient Four

22. Patient Four testifies that she has had seven brain surgeries, two bouts with spinal meningitis, and has had MRSA in her stomach. Because of her complicated medical history, she suffers from diabetes and chronic migraine headaches, trouble sleeping, and Meniere's disease. Because of all of this, Patient Four suffers from chronic pain "from head to toe."

23. Patient Four denies knowing or having spoken to any of the other patients who filed claims against Respondent.

24. Patient Four first began to see Respondent to be treated for fibromyalgia in about 2008. Patient Four saw Respondent one or two times per month from 2008 through 2016. After seeing Respondent for about four months, Patient Four testifies, Respondent began to get inappropriate and touchy with her, normally toward the end of appointments. It began with Respondent kissing her on the forehead. When Respondent would lean in and kiss Patient Four on the forehead, he would tell Patient Four that she was "sexy." Patient Four told Respondent to "get the hell off of me." Respondent would respond with a "smirky smile." When these things would happen, Patient Four testifies, a nurse was present in the room, but that she would have her back turned. Patient Four believes that Respondent did this for his own sexual

gratification, and not with the intent to make her feel better. It did not make her feel better; it instead made her angry.

25. Patient Four continued to see Respondent, because she could not find another rheumatologist in the area who would accept cash and see patients who did not have insurance. Respondent also charged much less than other doctors in the area. Patient Four testified that Respondent would make a sexual comment to her about every other visit.

26. On one visit, Patient Four testifies that Respondent "would always grab [her breasts] and lift them up and tell me that he knew a lady that could fit me for a bra perfectly like it should be." Patient Four testifies that Respondent asked her for her phone number, and she refused. Patient Four also says that on one occasion respondent advised her to lose weight—not for her own health needs—but because "he liked it thinner."

27. Patient Four described Respondent's sexualization of the medical process as follows:

> Oh, my, he always tried to make sure his groin was touching – it's according to what position. If you were laying down, it was touching your leg. If you were laying down and your arms were on the side, he always made – it would touch your arm. And if you were sitting up, because he was giving injections in the back, he would always made sure he come around with either arm to touch your breast, and come over this way and then do something -- he always worked it to where he was touching the breast. And then if he was in front of you, his hands were almost just cupping the breasts to try to give an injection in the shoulder. And then he would come up with this hand and push your hair

back out of your face, and then there goes that kiss. I won't ever forget it. He always had [drool] running out of his mouth.

28. Patient Four describes one instance in particular when Respondent was giving her a shoulder injection, he "was touching my breast, [and] it [*i.e.*, an erection] was about to bust out of his breeches."

29. Patient Four also describes occasions, about every other visit, when Respondent would "hump" his erect penis against her during medical examinations and procedures. Patient Four says that she would tell Respondent to "get the fuck off" of her and to "stop acting like your damn name." Respondent would respond again with a "smirky grin."

Patient Thirteen

30. Patient Thirteen testified that on her first visit to Respondent, her husband accompanied her. Respondent visited Respondent with complaints of pain in her hips. When Respondent began his examination, he asked Patient Thirteen to remove her shoes, at which time Respondent began "massaging," and "rubbing," and "caressing" her feet in a way that did not "feel normal" to her. As Respondent rubbed Patient Thirteen's feet for approximately three minutes, he referred to her as "baby" and asked her if it hurt. Patient Thirteen then reminded Respondent that she was having pain in her hips, not her feet. Respondent then began "touching and caressing" her hips and buttocks in a manner which made Patient Thirteen

uncomfortable. Respondent again asked if it hurt, referring to Patient Thirteen as "baby."

31. On a subsequent visit, Respondent gave injections in Patient Thirteen's hip area. Patient Thirteen's husband was present with Patient Thirteen on this visit as well. Patient Thirteen lowered her undergarment to expose the injection site, she testifies that Respondent required her to lower the undergarment further than necessary—to her upper thigh area. After Respondent gave the injection, Patient Thirteen described that Respondent touched and rubbed the injection site for about three minutes and caressed her gluteus area. The manner in which Respondent touched Patient Thirteen upset both her and her husband, who was present. Patient Thirteen testified that Respondent touched her "as if he [Respondent] were my husband."

32. On a third visit, Patient Thirteen testified that Respondent again referred to her multiple times as "baby." Patient Thirteen testified that Respondent gave her an injection in her back near where her bra clasped. After providing the injection, Patient Thirteen testified that Respondent began rubbing the injection site, her shoulders, and under her breasts. Patient Thirteen testifies that Respondent "[c]ontinued to caress and . . . rub around" in a way that was "inappropriate." On this third visit, Patient Thirteen testifies that Respondent again gave her hip injections, and again required her to lower her undergarments farther than necessary

to access the injection site. Respondent again rubbed and caressed the area of the injection site as had occurred at the first visit. After the third visit where Respondent had made her uncomfortable, Patient Thirteen decided that she wanted to seek out another physician.

33. Patient Thirteen saw Respondent a fourth and final time. On the fourth visit, Patient Thirteen and Respondent discussed how the medications were working to relieve Patient Thirteen's pain. At the end of the appointment, Patient Thirteen testifies that Respondent grabbed her face, kissed her on the cheek, and gave her a hug. Patient Thirteen testified that "only the husband or boyfriend" is allowed to touch her in the manner in which Respondent did on her fourth visit.

34. Patient Thirteen filed a police report about Respondent's behavior after seeing a report on local television news about other patients were making similar complaints.

Additional Findings of Fact

35. Respondent does not deny that he did occasionally give hugs to patients and kiss them on the forehead or on the cheek. Although Respondent denies specific memory of doing these things, his nurses did testify that that occurred, and Respondent agrees that if the nurses observed that behavior, then it must be true.

36. Two of Respondent's employees testified that they had seen Respondent kiss patients on the forehead or cheek. Four of Respondent's employees

testified that they had witnessed Respondent hugging his patients. Although Respondent has maintained that he does not recall ever kissing a patient, he also testified that, "I know it happened because my nurses tell me it happened..." Respondent also said he did not dispute the claims of certain patients who testified that he kissed them on the head or cheek.

37. Two of Respondent's former employees, GC and SL, testified to the effect that Respondent had a romantic relationship with a patient "B." According to GC, Respondent did "write a note for ["B"'s] chart dismissing himself as her physician." SL testified that Respondent waited only "several months" between treating "B" and having a relationship with her. In his deposition, Respondent admitted that he knew "if you were to wish to have a romantic relationship with a female patient, you would have to dismiss them as a patient and wait two years before you initiated any romantic interactions with them." Although this evidence does not directly bear upon any of the charges presented in the Administrative Complaint, it does, in our view, have some evidentiary value as corroborating in a general sense the patients' allegations of sexual boundary violations.

38. Respondent has been absent from the practice of medicine since at least October 11, 2018, the date on which we entered an order summarily suspending Respondent's license to practice medicine.

IV. Conclusions of Law

1. The Medical Licensure Commission of Alabama has jurisdiction over the subject matter of this cause pursuant to Act No. 1981-218, Ala. Code §§ 34-24-310, *et seq.* Under certain conditions, the Commission "shall have the power and duty to suspend, revoke, or restrict any license to practice medicine or osteopathy in the State of Alabama or place on probation or fine any licensee." Ala. Code § 34-24-360. In addition to all other authorized penalties and remedies, the Commission may impose a fine of up to $10,000 per violation and may require the payment of administrative expenses incurred in connection with the disciplinary proceeding. Ala. Code § 34-24-381(a), (b).

2. Respondent was properly notified of the time, date and place of the administrative hearing and of the charges against him in compliance with Ala. Code §§ 34-24-361(e) and 41-22-12(b)(1), and Ala. Admin. Code r. 545-X-3-.03(3), (4). At all relevant times, Respondent was a licensee of this Commission and was and is subject to the Commission's jurisdiction.

3. Before making any decision on a contested case such as this one, the Commission is required by law to "receive and consider" a recommendation from the Board. The Board's recommendation, however, is not binding upon the Commission. *See* Ala. Code § 34-24-311. The Commission has received and duly considered the Board's non-binding recommendation to find Respondent guilty of

all of the charges outlined in the Administrative Complaint, and to revoke Respondent's license to practice medicine.

4. In 1997, we adopted Sexual Misconduct In The Practice of Medicine: A Joint Statement Of Policy and Guidelines By The State Board of Medical Examiners And The Medical Licensure Commission. As amended, the Joint Statement of Policy provides in relevant part:

> (1) The prohibition against sexual contact between a physician and a patient is well established and is embodied in the oath taken by physicians, the Hippocratic Oath. The prohibition is also clearly stated in the Code of Medical Ethics of the American Medical Association. The reason for this proscription is the awareness of the adverse effects of such conduct on patients. The report of the Council on Ethical and Judicial Affairs of the American Medical Association indicates that most researchers now agree that the effects of physician-patient sexual contact are almost always negative or damaging to the patient. Patients are often left feeling humiliated, mistreated, or exploited.
>
> (2) Further, a patient has a right to trust and believe that a physician is dedicated solely to the patient's best interests. Introduction of sexual behavior into the professional relationship violates this trust because the physician's own personal interest compete[s] with the interests of the patient. This violation of trust produces not only serious negative psychological consequences for the individual patient but also destroys the trust of the public in the profession.
>
> (3) Sexual conduct with a patient occurs in many circumstances ranging from situations where a physician is unable to effectively manage the emotional aspects of the physician-patient relationship to consciously exploitative situations. Underlying most situations is a disparity of power and authority over a physically or emotionally vulnerable patient.
>
> (4) The prohibition against sexual contact between a physician and a patient is not intended to inhibit the compassionate and caring aspects of a physician's practice. Rather, the prohibition is aimed at

behaviors which overstep the boundaries of the professional relationship. When boundaries are violated, the physician's patient may become the physician's victim. The physician is the one who must recognize and set the boundaries between the care and compassion appropriate to medical treatment and the emotional responses which may lead to sexual misconduct.

(5) The Board of Medical Examiners and the Medical Licensure Commission is each charged with responsibilities for protecting the public against unprofessional actions of physicians and osteopaths licensed to practice medicine in Alabama. Immoral, unprofessional or dishonorable conduct is grounds for disciplining the license of a physician under the provisions of Code of Ala. 1975, § 34-24-360(2). A physician's sexual contact with a patient is a violation of this statute.

(6) The Board of Medical Examiners investigates allegations of sexual misconduct against physicians. The Medical Licensure Commission makes decisions following a hearing concerning disposition of formal complaints filed with it by the Board of Medical Examiners. It is the goal of each organization to ensure that the public is protected from future misconduct. In some cases, revocation of license is the only means by which the public can be protected. In other cases, the Board or the Commission may restrict and monitor the practice of a physician who has actively engaged in a rehabilitation program. Rehabilitation of a physician is a secondary goal that will be pursued if the Board and the Commission can be reasonably assured that the public is not at risk for a recurrence of the misconduct.

(7) The Board and the Commission remind physicians of their statutory duty to report sexual misconduct or any conduct which may constitute unprofessional conduct or which may indicate that a physician is unable to practice medicine with reasonable skill or safety to patients. It is the individual physician's responsibility to maintain the boundaries of the professional relationship by avoiding and refraining from sexual contact with patients.

(8) Physicians should be alert to feelings of sexual attraction to a patient and may wish to discuss such feelings with a colleague. To maintain the boundaries of the professional relationship, a physician should transfer the care of a patient to whom the physician is attracted

to another physician and should seek help in understanding and resolving feelings of sexual attraction without acting on them.

(9) Physicians must be alert to signs indicating that a patient may be encouraging a sexual relationship and must take all steps necessary to maintain the boundaries of the professional relationship including transferring the patient.

(10) Physicians must respect a patient's dignity at all times and should provide appropriate gowns and private facilities for dressing, undressing and examination. In most situations, a physician should not be present in the room when a patient is dressing or undressing.

(11) A physician should have a chaperone present during the examination of any sensitive parts of the body for the protection of both the patient and the physician. A physician should refuse to examine sensitive parts of the patient's body without a chaperone present.

(12) To minimize the understandings and misperceptions between a physician and patient, the physician should explain the need for each of the various components of an examination and for all procedures and tests.

(13) Physicians should choose their words carefully so that their communications with a patient are clear, appropriate and professional.

(14) Physicians should seek out information and formal education in the area of sexual attraction to patients and sexual misconduct and should in turn educate other health care providers and students.

(15) Physician should not discuss their intimate personal problems/lives with patients.

(16) Sexual Misconduct. Sexual contact with a patient is sexual misconduct and is unprofessional conduct within the meaning of Code of Ala. 1975, § 34-24-360(2).

(17) Sexual Contact Defined. For purposes of § 34-24-360(2), sexual contact between a physician and a patient includes, but is not limited to:

(a) Sexual behavior or involvement with a patient including verbal or physical behavior which:

1. may reasonably be interpreted as romantic involvement with a patient regardless whether such involvement occurs in the professional setting or outside of it;

2. may reasonably be interpreted as intended for the sexual arousal or gratification of the physician, the patient or both; or

3. may reasonably be interpreted by the patient as being sexual.

(b) Sexual behavior or involvement with a patient not actively receiving treatment from the physician, including verbal or physical behavior or involvement which meets any one or more of the criteria in Section 1 above and which:

1. results from the use or exploitation of trust, knowledge, influence or emotions derived from the professional relationship;

2. misuses privileged information or access to privileged information to meet the physician's personal or sexual needs; or

3. is an abuse or reasonably appears to be an abuse of authority or power.

* * *

(21) Consent. A patient's consent to initiation of or participation in sexual behavior or involvement with a physician does not change the nature of the conduct nor lift the statutory prohibition.

(22) Impairment. In some situation [sic], a physician's sexual contact with a patient may be the result of a mental condition which may render the physician unable to practice medicine with reasonable skill and safety to patients pursuant to § 34-24-360(19).

(23) Discipline. Upon a finding that a physician has committed unprofessional conduct by engaging in sexual misconduct, the Commission will impose such discipline as the Commission deems necessary to protect the public. The sanctions available to the Commission are set forth in § 34-24-361 and § 34-24-381, and include

> restriction or limitation of the physician's practice, revocation or suspension of the physician's license, and administrative fines.

Ala. Admin. Code r. 545-X-4-.07.

5. The facts as determined above establish violations of Ala. Code § 34-24-360(2) and The Joint Statement of Policy, Ala. Admin. Code r. 545-X-4-.07, as charged in Counts One, Two, Three, Five, and Fourteen of the Administrative Complaint.

6. A physician's absence from the practice of medicine for two years or more triggers a "rebuttable presumption"[1] of clinical incompetence:

> A physician's absence from clinical practice for more than two years creates a rebuttable presumption of clinical incompetence. A physician, whether he or she is an applicant or licensee, who has not actively practiced or who has not maintained continued competency, as determined by the Board, during the two-year period immediately preceding the filing of an application for licensure or reinstatement or during any consecutive two-year period may be required to complete a reentry plan as a condition of licensure/reinstatement.

Ala. Admin. Code r. 540-X-23-.03(1).

---

[1] A "presumption is a creature of law that assists in the matter of proof by providing that in certain situations proven facts may be strong enough that from them the trier of fact may conclude that the presumed fact exists. ... [R]ebuttable presumptions, found throughout the legal system, are those under which a certain quantum of evidence gives rise to an inference of some other fact, but as to which fact the opposing party may offer evidence in rebuttal. Rebuttable presumptions are generally created by law—under statutes, case law, or rules of court—for such reasons as the promotion of some public policy (as in presumptions favoring the legitimacy of children), because the presumption is based upon human experience (illustrated by the presumption against suicide), or because of the peculiarities of the case affecting the ability to produce evidence (illustrated by the statutory presumption that upon proof of certain facts a railroad is presumed negligent)." Ala. R. Evid. 301 (Advisory Committee's Notes).

7. Pursuant to the first sentence of Ala. Admin. Code r. 540-X-23-.03(1), Respondent is rebuttably presumed to be incompetent to practice medicine. Respondent has not produced any evidence tending to rebut the presumption of clinical incompetency. We therefore find that Respondent is unable to practice medicine with reasonable skill and safety to patients by reason of a demonstrated lack of clinical competency, in violation of Ala. Code § 34-24-360(20), as charged in Count Sixteen of the Administrative Complaint.

8. We reach all of these decisions based all of the facts presented, viewed through the lens of our professional experience, expertise, and judgment. *See* Ala. Code § 41-22-13(5) ("The experience, technical competence, and specialized knowledge of the agency may be utilized in the evaluation of the evidence.").

V. Decision

Based on all of the foregoing, it is **ORDERED, ADJUDGED, AND DECREED:**

1. That the Respondent, Michael D. Dick, M.D., is adjudged **GUILTY** of the matters charged in Count One of the Administrative Complaint.

2. That the Respondent, Michael D. Dick, M.D., is adjudged **GUILTY** of the matters charged in Count Two of the Administrative Complaint.

3. That the Respondent, Michael D. Dick, M.D., is adjudged **GUILTY** of the matters charged in Count Three of the Administrative Complaint.

4. That the Respondent, Michael D. Dick, M.D., is adjudged **NOT GUILTY** of the matters charged in Count Four of the Administrative Complaint.

5. That the Respondent, Michael D. Dick, M.D., is adjudged **GUILTY** of the matters charged in Count Five of the Administrative Complaint.

6. That the Respondent, Michael D. Dick, M.D., is adjudged **NOT GUILTY** of the matters charged in Count Six of the Administrative Complaint.

7. That the Respondent, Michael D. Dick, M.D., is adjudged **NOT GUILTY** of the matters charged in Count Seven of the Administrative Complaint.

8. That the Respondent, Michael D. Dick, M.D., is adjudged **NOT GUILTY** of the matters charged in Count Eight of the Administrative Complaint.

9. That the Respondent, Michael D. Dick, M.D., is adjudged **NOT GUILTY** of the matters charged in Count Nine of the Administrative Complaint.

10. That the Respondent, Michael D. Dick, M.D., is adjudged **NOT GUILTY** of the matters charged in Count Ten of the Administrative Complaint.

11. That the Respondent, Michael D. Dick, M.D., is adjudged **NOT GUILTY** of the matters charged in Count Eleven of the Administrative Complaint.

12. That the Respondent, Michael D. Dick, M.D., is adjudged **NOT GUILTY** of the matters charged in Count Twelve of the Administrative Complaint.

13. That the Respondent, Michael D. Dick, M.D., is adjudged **NOT GUILTY** of the matters charged in Count Thirteen of the Administrative Complaint.

14. That the Respondent, Michael D. Dick, M.D., is adjudged **GUILTY** of the matters charged in Count Fourteen of the Administrative Complaint.

15. That the Respondent, Michael D. Dick, M.D., is adjudged **NOT GUILTY** of the matters charged in Count Fifteen of the Administrative Complaint.

16. That the Respondent, Michael D. Dick, M.D., is adjudged **GUILTY** of the matters charged in Count Sixteen of the Administrative Complaint.

17. That, separately and severally for each of Counts One, Two, Three, Five, Fourteen, and Sixteen, Respondent's license to practice medicine in the State of Alabama is hereby **REVOKED.**

18. That Respondent shall, within 30 days of this Order,[2] pay administrative fines in the amounts of $10,000.00 as to Count One, $5,000.00 as to Count Two, $5,000.00 as to Count Three, $10,000.00 as to Count Five, and $10,000.00 as to Count Fourteen, for a total administrative fine of $40,000.00. No administrative fine is assessed as to Count Sixteen.

19. That within 30 days of this order, the Board shall file its bill of costs as prescribed in Ala. Admin. Code r. 545-X-3-.08(10)(b), and Respondent shall file any objections to the cost bill within 10 days thereafter, as prescribed in Ala. Admin.

---

[2] *See* Ala. Admin. Code r. 545-X-3-.08(8)(d)(i). Respondent is further advised that "[t]he refusal or failure by a physician to comply with an order entered by the Medical Licensure Commission" may be a separate instance of "unprofessional conduct." *See* Ala. Admin. Code r. 545-X-4-.06(6).

Code r. 545-X-3-.08(10)(c). The Commission reserves the issue of imposition of costs until after full consideration of the Board's cost bill and Respondent's objections, and this reservation does not affect the finality of this order. *See* Ala. Admin. Code r. 545-X-3-.08(10)(e).

20. That it is the present sense of the Commission that any application for reinstatement pursuant to Ala. Code § 34-24-337(e)-(j) is not likely to be granted except and unless Respondent clearly establishes to the satisfaction of the Commission that all of the following conditions have been met:

a. Respondent shall have submitted to and satisfactorily completed a comprehensive forensic boundary evaluation to be completed by Acumen Assessments or a similar establishment approved in advance by the Commission, and shall have been found safe to practice medicine with reasonable skill and safety to patients;

b. Respondent shall have submitted to and satisfactorily completed a rigorous clinical competency evaluation to be completed by the Center for Personalized Education for Professionals ("CPEP") or a similar establishment approved in advance by the Commission, covering both internal medicine and rheumatology, and shall have been found safe to practice medicine with reasonable skill and safety to patients from the standpoint of clinical competency;

c. Respondent shall have successfully completed any program of remedial education recommended by the establishment referred to in the preceding subdivision b.;

d. Respondent shall have paid in full all administrative fines and costs assessed in this proceeding; and

e. If and when reinstatement is granted, the Commission will impose such restrictions and conditions as may be necessary to protect public health and safety, including that Respondent shall practice medicine only pursuant to a written practice plan that complies with this Order and that has been approved in advance by the Commission, which will contain, at a minimum, specific information such as the proposed name of the employer; the proposed scope of practice or type of services to be provided; the proposed days/hours of work; and typical patient populations of the proposed practice.

DONE on this the 20th day of December, 2024.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Jorge Alsip, M.D.
on 2024-12-20 19:01:29 CST

Jorge A. Alsip, M.D.
its Chairman

EXHIBIT

J

ALABAMA STATE BOARD OF MEDICAL EXAMINERS,

Complainant,

v.

ANAND P. LALAJI, M.D.,

Respondent.

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

CASE NO. 2024-012

ORDER

This matter is before the Medical Licensure Commission of Alabama on Respondent's pending Voluntary Surrender of his Certificate of Qualification and license to practice medicine and/or osteopathy in the State of Alabama. The evidentiary hearing in this matter, previously set for December 3, 2024, is cancelled. The Commission will consider acceptance of Respondent's Voluntary Surrender at its next meeting, which is to be held on December 18, 2024.

DONE on this the 4th day of December, 2024.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Jorge Alsip, M.D.
on 2024-12-04 10:52:57 CST

Jorge A. Alsip, M.D.
its Chairman

EXHIBIT
K

ALABAMA STATE BOARD OF MEDICAL EXAMINERS,

Complainant,

vs.

DANIEL ALAN POLANSKY, M.D.,

Respondent.

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

CASE NO. 2024-305

CONSENT DECREE

This matter comes before the Medical Licensure Commission of Alabama ("the Commission") on the Administrative Complaint ("the Administrative Complaint") filed by the Alabama State Board of Medical Examiners ("the Board") on November 22, 2024. The Board and the Respondent, Daniel Alan Polansky, M.D. ("Respondent"), have entered into a Joint Settlement Agreement ("the Settlement Agreement"), and have asked the Commission to approve the Settlement Agreement and to embody it in this Consent Decree.

General Provisions

1. **Approval of the Settlement Agreement.** After review, the Commission finds that the Settlement Agreement represents a reasonable and appropriate disposition of the matters asserted in the Administrative Complaint. The Commission therefore approves the Settlement Agreement.

2. **Mutual Agreement and Waiver of Rights.** Respondent has consented and agreed to the entry of this Consent Decree, and has agreed to be bound by the findings of fact, conclusions of law, and terms and conditions stated herein. Respondent has validly waived his rights to an administrative hearing before the Commission, to be represented by an attorney at such hearing, and to further notice and formal adjudication by the Commission of the charges arising from the Administrative Complaint. Respondent has also validly waived any and all rights to judicial review of this Consent Decree pursuant to Ala. Code § 34-24-367, the Alabama Administrative Procedure Act, Ala. Code §§ 41-22-1, *et seq.*, by extraordinary writ, or otherwise.

3. **Public Documents.** The Administrative Complaint, the Settlement Agreement, and this Consent Decree shall constitute public records under the laws of the State of Alabama. The Administrative Complaint, the Settlement Agreement, and this Consent Decree may be published or disclosed by the Board and/or the Commission without further notice to Respondent.

4. **Additional Violations.** Any violation of the requirements of this Consent Decree, or any new violation of state or federal laws or regulations, may result in the Board filing a petition to discipline Respondent's medical license. Nothing in this Consent Decree precludes the Board from bringing new

administrative charges against Respondent based upon events and circumstances not raised in the Administrative Complaint.

5. **Retention of Jurisdiction.** The Commission retains jurisdiction for the purpose of entering such other and further orders and directives as may be required to implement the provisions of this Consent Decree.

6. **Judicial Notice.** Pursuant to Ala. Code § 41-22-13(4), Respondent is informed that the Board and/or the Commission may at any time take judicial notice of this Consent Decree, and/or any of the Findings of Fact herein, and may deem any of the findings or conclusions set forth in this Consent Decree to be conclusively established, all without further notice to Respondent.

Findings of Fact

1. Respondent has been licensed to practice medicine in the State of Alabama since April 28, 1988, having been issued license no. MD.13954. Respondent was so licensed at all relevant times.

2. On or about November 15, 2021, Respondent submitted or caused to be submitted an Alabama medical license renewal application for calendar year 2022. On that application, Respondent certified that the annual minimum continuing medical education requirement of 25 AMA PRA Category 1™ credits had been met or would be met by December 31, 2021. Respondent further represented that, if audited, he would have supporting documents.

3. Respondent earned only three valid continuing medical education credits during 2021.

4. On or about December 5, 2022, Respondent submitted or caused to be submitted an Alabama medical license renewal application for calendar year 2023. On that application, Respondent certified that the annual minimum continuing medical education requirement of 25 AMA PRA Category 1™ credits had been met or would be met by December 31, 2022. Respondent further represented that, if audited, he would have supporting documents.

5. Respondent earned only 14.5 valid continuing medical education credits during 2022.

Conclusions of Law

1. The Commission has jurisdiction over the subject matter of the Administrative Complaint, and over the parties, pursuant to Ala. Code § 34-24-310, *et seq.*

2. The Commission finds, as a matter of law, that the determined facts constitute violations of Ala. Code § 34-24-360(23) and Ala. Admin. Code r. 545-X-5-.02.

Order/Discipline

Based upon the foregoing Findings of Fact and Conclusions of Law, it is ORDERED, ADJUDGED, AND DECREED:

1. That Respondent is assessed an administrative fine in the amount of two thousand dollars ($2,000.00). In accordance with Ala. Admin. Code r. 545-X-3-.08(8)(d)(i), Respondent is ordered to pay the administrative fine within 30 days of this Order.[1]

2. That Respondent is ordered to obtain 50 ***additional*** credits of AMA PRA Category 1™ or equivalent continuing medical education, in addition to the 25 credits already required for calendar year 2025, for a combined total of 75 credits, during calendar year 2025.

3. That no costs of this proceeding are assessed against Respondent at this time.

DONE on this the 4th day of December, 2024.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Jorge Alsip, M.D.
on 2024-12-04 10:55:03 CST

Jorge A. Alsip, M.D.
its Chairman

[1] "The refusal or failure by a physician to comply with an order entered by the Medical Licensure Commission" may be a separate instance of "unprofessional conduct." *See* Ala. Admin. Code r. 545-X-4-.06(6).

EXHIBIT

L

ALABAMA STATE BOARD OF MEDICAL EXAMINERS,

Complainant,

v.

THOMAS J. SHAKNOVSKY, D.O.,

Respondent.

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

CASE NO. 2024-243

ORDER

This matter is before the Medical Licensure Commission of Alabama on Respondent's Voluntary Surrender of his Certificate of Qualification and license to practice medicine and/or osteopathy in the State of Alabama, executed on November 7, 2024, and the Board's Motion to Dismiss, filed on November 19, 2024. Upon review and consideration, the Commission accepts Respondent's Voluntary Surrender, and grants the Board's Motion to Dismiss. The Board's Administrative Complaint and Petition for Summary Suspension of License filed with the Commission on October 22, 2024 is dismissed without prejudice.

DONE on this the 4th day of December, 2024.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Jorge Alsip, M.D.
on 2024-12-04 10:55:38 CST

Jorge A. Alsip, M.D.
its Chairman