IN AND BEFORE THE OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION STATE OF OKLAHOMA

STATE OF OKLAHOMA EX REL. THE OKLAHOMA BOARD OF MEDICAL LICENSURE AND SUPERVISION,	)	
Plaintiff	)	
v.	)	**Case No. 11-08-4376**
MICHAEL EDWARD HUME, P.A., LICENSE NO. PA281,	)	
Defendant.	)	

FIRST AMENDED COMPLAINT

COMES NOW the plaintiff, the State of Oklahoma ex rel. the Oklahoma State Board of Medical Licensure and Supervision (the "Board"), by and through its attorney, E. Marissa Lane, Assistant Attorney General, and for its First Amended Complaint against the Defendant, Michael Edward Hume, P.A., Oklahoma license no. PA281, alleges and states as follows:

1. The Board is a duly authorized agency of the State of Oklahoma empowered to license and oversee the activities of physician assistants in the State of Oklahoma pursuant to 59 Okla. Stat. §§ 480 *et seq.* and 887.1 *et seq.*

BACKGROUND

2. Defendant, Michael Edward Hume, P.A., holds Oklahoma physician assistant license no. PA281 and at the time of the events in question, practiced at Vista Medical Center in Oklahoma City, Oklahoma under the supervision of William M. Valuck, D.O.

3. The Vista Medical Center is owned and operated by Pat Reynolds, a non-physician, who compensates Defendant based solely on his production. At the time of the incidents in question, Defendant treated approximately thirty-seven (37) patients per day.

4. Vista Medical Center does not accept any insurance, Medicare or Medicaid, and accepts only cash. Vista charges $250.00 for the first office visit, $140.00 for the second office visit, and $100.00 per office visit thereafter.

5. Board investigators conducted a chart audit of selected patients of Defendant identifying deficient practices with respect to the lack of medical documentation and follow up care for patients who were prescribed CDS.

6. Defendant met with Board staff on September 27, 2011 and again on February 2, 2012 to discuss the Board's concern regarding the identified deficiencies. Board staff provided education to Defendant and outlined the medical documentation and diagnostic practices expected for patients receiving CDS.

7. After the meeting with Defendant, his prescribing habits and medical documentation and medical care did not change as reflected in follow up chart audits and new complaints received.

PRESCRIBING VIOLATIONS

PATIENT SWR

8. From December 31, 2010 until February 7, 2012, Defendant wrote or authorized fifty-seven (57) prescriptions for controlled dangerous drugs to Patient SWR for alleged back pain. These prescriptions include seventeen (17) prescriptions for Hydrocodone 10 mg., a Schedule III controlled dangerous drug, for 2,460 dosage units, and forty (40) prescriptions for Xanax, Soma and Temazepam, Schedule IV controlled dangerous drugs, for 3,540 dosage units, for a total of **6,000 dosage units** for an average of **14.93 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform an adequate physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

9. Defendant's chart reflects that on the patient's **first** visit to Defendant, he prescribed Lortab 10 mg. #150, Soma #90 and Xanax #90, all without any prior medical records or tests or any documentation to substantiate the alleged back pain. Subsequent monthly visits were for the stated purpose of "Refills" as noted in the chart. Throughout the patient's treatment, Defendant did nothing to treat the patient other than prescribe increasing amounts of these three (3) controlled dangerous drugs for over a year while never obtaining any objective evidence of the patient's pain.

PATIENT FHR

10. From January 6, 2011 until January 26, 2012, Defendant wrote or authorized thirty-six (36) prescriptions for controlled dangerous drugs to Patient FHR for alleged arm pain. These prescriptions include twelve (12) prescriptions for Hydrocodone 10 mg., a Schedule III controlled dangerous drug, for 1,890 dosage units, twelve (12) prescriptions for Soma, a Schedule IV controlled dangerous drug, for 1,390 dosage units, and twelve (12) prescriptions for

Xanax, a Schedule IV controlled dangerous drug, for 1,400 dosage units, for a total of **4,680 total dosage units** at an average of **14.14 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform an adequate physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not obtain appropriate consultations, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

11. Defendant's chart reflects that on the patient's **first** visit to Defendant, he prescribed Lortab 10 mg. #120, Soma #90, and Xanax #120, all without any prior medical records or tests or any documentation to substantiate the alleged arm pain. Subsequent monthly visits were for the stated purpose of "Refills" as noted in the chart. Throughout the patient's treatment, Defendant did nothing to treat the patient other than prescribe increasing amounts of Lortab, Soma and Xanax while never obtaining any objective evidence of the patient's complaints.

PATIENT DSR

12. From April 25, 2011 until January 23, 2012, Defendant wrote or authorized twenty-seven (27) prescriptions for controlled dangerous drugs to Patient DSR for alleged pain and anxiety. These prescriptions include nine (9) prescriptions for Hydrocodone 10 mg., a Schedule III controlled dangerous drug, for 1,430 dosage units, and eighteen (18) prescriptions for Soma and Xanax, Schedule IV controlled dangerous drugs, for 1,950 dosage units, for a total of **3,380 total dosage units** at an average of **13.63 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform an adequate physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not obtain appropriate consultations, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

13. Defendant's chart reflects that on the patient's **first** visit to Defendant, he prescribed Lortab 10 mg. #120, Soma #90 and Xanax #90, all without any prior medical records or tests or any documentation to substantiate the alleged back pain and anxiety. Subsequent monthly visits were for the stated purpose of "Refills" as noted in the chart. Throughout the patient's treatment, Defendant did nothing to treat the patient other than prescribe increasing amounts of these three (3) controlled dangerous drugs while never obtaining any objective evidence of the patient's complaints.

PATIENT TRR

14. From October 19, 2010 until February 6, 2012, Defendant wrote or authorized fifty-three (53) prescriptions for controlled dangerous drugs to Patient TRR for alleged back and shoulder pain. These prescriptions include fifteen (15) prescriptions for Hydrocodone 10 mg., a Schedule III controlled dangerous drug, for 1,920 dosage units, and thirty-eight (38) prescriptions

Soma, Xanax, Temazepam, Provigil, and Ambien, Schedule IV controlled dangerous drugs, for 3,730 dosage units, for a total of **5,650 total dosage units** at an average of **13.55 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform an adequate physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not obtain appropriate consultations, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

15. Defendant's chart reflects that on the patient's **first** visit to Defendant, he prescribed Lortab 10 mg. #120 and Soma #120, all without any prior medical records or tests or any documentation to substantiate the alleged back and shoulder pain. Subsequent monthly visits were for the stated purpose of "Refills" as noted in the chart. Throughout the patient's treatment, Defendant did nothing to treat the patient other than prescribe increasing amounts of Lortab, continuing Soma, and adding Xanax, Ambien, Provigil and Temazepam, while never obtaining any objective evidence of the patient's complaints.

PATIENT DHR

16. From August 24, 2011 until February 8, 2012, Defendant wrote or authorized fifteen (15) prescriptions for controlled dangerous drugs to Patient DHR for alleged pain. These prescriptions include five (5) prescriptions for Hydrocodone 10 mg., a Schedule III controlled dangerous drug, for 660 dosage units, and fifteen (15) prescriptions for Soma and Xanax, Schedule IV controlled dangerous drugs, for 1,200 dosage units, for a total of **1,860 total dosage units** at an average of **13.10 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform an adequate physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not obtain an adequate history, that he did not order appropriate tests, that he did not obtain appropriate consultations, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

17. Defendant's chart reflects that on the patient's **first** visit to Defendant, he prescribed Lortab 10 mg. #120, Soma #120 and Xanax #120, all without any prior medical records or tests or any documentation to substantiate the alleged pain. Throughout the patient's treatment, Defendant did nothing to treat the patient other than prescribe these three (3) controlled dangerous drugs while never obtaining any objective evidence of the patient's pain.

PATIENT JSR

18. From August 24, 2011 until February 8, 2012, Defendant wrote or authorized eighteen (18) prescriptions for controlled dangerous drugs to Patient JSR for alleged pain. These prescriptions include six (6) prescriptions for Hydrocodone 10 mg., a Schedule III controlled

dangerous drug, for 970 dosage units, and twelve (12) prescriptions for Soma and Xanax, Schedule IV controlled dangerous drugs, for 1,140 dosage units, for a total of **2,110 total dosage units** at an average of **12.41 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform an adequate physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not obtain an adequate history, that he did not order appropriate tests, that he did not obtain appropriate consultations, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

19. Defendant's chart reflects that on the patient's **first** visit to Defendant, he prescribed Norco 10 mg. #140, Soma #90 and Xanax #90, all without any prior medical records or tests or any documentation to substantiate the alleged pain. Throughout the patient's treatment, Defendant did nothing to treat the patient other than prescribe these three (3) controlled dangerous drugs while never obtaining any objective evidence of the patient's pain.

PATIENT KBR

20. From November 10, 2010 until February 7, 2012, Defendant wrote or authorized forty-two (42) prescriptions for controlled dangerous drugs to Patient KBR for alleged wrist and back pain. These prescriptions include fifteen (15) prescriptions for Hydrocodone 10 mg., a Schedule III controlled dangerous drug, for 2,010 dosage units, and twenty-seven (27) prescriptions for Soma and Xanax, Schedule IV controlled dangerous drugs, for 2,880 dosage units, for a total of **4,890 total dosage units** at an average of **12.26 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform an adequate physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not obtain appropriate consultations, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

21. Defendant's chart reflects that on the patient's **first** visit to Defendant, he prescribed Lortab 10 mg. #130 and Soma #90, all without any prior medical records or tests or any documentation to substantiate the alleged wrist and back pain. Subsequent monthly visits were for the stated purpose of "Refills" as noted in the chart. Throughout the patient's treatment, Defendant did nothing to treat the patient other than prescribe increasing amounts of Lortab, Soma and Xanax while never obtaining any objective evidence of the patient's complaints.

PATIENT RBR

22. From September 15, 2010 until February 7, 2012, Defendant wrote or authorized thirty-three (33) prescriptions for controlled dangerous drugs to Patient RBR for alleged shoulder and back pain. These prescriptions include fifteen (15) prescriptions for Hydrocodone 10 mg., a Schedule III controlled dangerous drug, for 2,190 dosage units, and eighteen (18) prescriptions for Soma and Valium, Schedule IV controlled dangerous drugs, for 1,830 dosage units, for a total

of **4,020 total dosage units** at an average of **9.41 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform an adequate physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not obtain appropriate consultations, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

23. Defendant's chart reflects that on the patient's **first** visit to Defendant, he prescribed Lortab 10 mg. #120 and Soma #90, all without any prior medical records or tests or any documentation to substantiate the alleged shoulder and back pain. Subsequent monthly visits were for the stated purpose of "Refills" as noted in the chart. Throughout the patient's treatment, Defendant did nothing to treat the patient other than prescribe increasing amounts of Lortab and Soma while never obtaining any objective evidence of the patient's complaints.

DEFENDANT'S PRESCRIBING PATTERN AFTER DEFENDANT MET WITH BOARD STAFF

24. After meeting with Board staff and receiving education outlining the medical documentation and diagnostic practices expected for patients receiving CDS; Defendant's prescribing pattern and medical documentation failed to improve for the above identified patients, Patients DHR, FHR, SWR, RBR and KBR.

COMPLAINTS RECEIVED AFTER DEFENDANT MET WITH BOARD STAFF

PATIENT KAR

25. From April 10, 2012 until September 7, 2012, Patient KAR was under the care and treatment of Defendant and other physicians at the Vista Medical Center. Defendant's chart reflects that on the patient's **first** visit to Defendant on April 10, 2012, he prescribed Lortab 10 mg, #100, Xanax #90 tablets, Flexeril #90, and Trazadone #30, all without any prior medical records or tests or any documentation to substantiate the alleged back pain. Defendant had no initial patient intake form for Patient KAR and no objective information regarding prior medical history. Subsequent monthly visits had no stated purpose for the return appointment. Throughout the patient's treatment, Defendant did nothing to treat the patient other than prescribe Lortab, Xanax and Soma without obtaining objective evidence of patient's complaints.

26. From April 10, 2012 until September 7, 2012, a six month time period, Patient KAR received a total of eighteen (18) prescriptions for controlled dangerous drugs from Vista Medical Center for alleged back pain including prescriptions for Lortab 10 mg, a Schedule III controlled dangerous drug for 850 dosage units, and six (6) prescriptions for Xanax for a total of 590 dosage units and five (5) prescriptions for Soma for a total of 450 dosage units, Schedule IV controlled and dangerous drugs. Of these eighteen prescriptions, Defendant wrote eleven of these eighteen prescriptions. The remaining 7 prescriptions were written by other medical providers at Vista Medical Center. Defendant failed to order imaging tests or other appropriate tests, he did

not obtain appropriate consultations, and he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

27 Prior to coming under the care and treatment of Defendant, Patient KAR had no significant prior prescribing for any CDS for pain management. In the **two years** preceding April, 2012, the **only** CDS pain medicine prescribed for Patient KAR was Lortab 10mg #25, Lortab 7.5mg #38 and Lortab 5 mg #45. The total number of Lortab (most of which was the much lower strength Lortab) prescribed for this ***entire* 24 months period was 108 tablets** and the average **monthly** Lortab prescribed for Patient KAR during 2011 and 2012 was **less than 5 per month.** Defendant's prescribing pattern for Patient KAR represents in excess of a 2900% increase over the prior 2 years. Defendants medical chart is void of any objective medical documentation to support this increase in CDS pain medication being prescribed to Patient KAR.

28. Defendants' chart contains a document titled "Drug Test Dates", with one hand written date of 3/11 (Patient KAR did not become a patient until April 10, 2012, so it is unknown if this is even Patient KAR record); and two date stamped dates of JUN 05 2012 and SEP 06 2012, but the chart contains no results of any drug testing. There is no evidence that drug testing was done on Patient KAR as Defendant's chart is void of any drug testing results for Patient KAR from April 10, 2012 through September 6, 2012.

PATIENT CNR

29. From February 24, 2011 through August 16, 2012, Patient CNR was under the care and treatment of Defendant and other physicians at the Vista Medical Center. Defendant's chart reflects that on the patient's **first** visit to Defendant on February 24, 2011, at the time she was 30 years old, presenting with neck and back pain. Based on Patient CNR's reported medical history of "back pain after baby" and "1 yr ago in MVA", Defendant prescribed Lortab 10 mg, #120 and Soma 350 #60 and diagnosed "cervical disc disease" and "lumber DJD w/ sciatica R leg" without any prior medical records or tests or any documentation to substantiate the alleged neck and back pain. Defendant's medical records state no purpose for Patient CNR's return appointment or the reason was simply listed as "refills".

30. Defendant increased the number of CDS Hydrocodone to 180 tablets on Patient CNR's 4th return visit on June 29, 2011, without any objective medical evidence to support this increase. Patient CNR continued to receive this amount of CDS at each prescription refill while under the care of Defendant and Vista Medical Center.

31. From February 24, 2011 through August 16, 2012, Patient CNR received a total of forty-eight (48) prescriptions for controlled dangerous drugs from Vista Medical Center for alleged neck and back pain including prescriptions for Hydrocodone (Lortab or Norco) 10 mg, a Schedule III controlled dangerous drug for 3,270 dosage units, and Diazepam (Valium) 10 mg for a total of 1,050 dosage units and Carisoprodol (Soma) 350 mg for a total of 1,860 dosage units,

Schedule IV controlled and dangerous drugs. Of these forty-eight (48) prescriptions, Defendant wrote thirty-six (36) of these prescriptions. The remaining twelve (12) prescriptions were written by other medical providers at Vista Medical Center. Defendant failed to order imaging tests or other appropriate tests, he did not obtain appropriate consultations, and he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

32. In August, 2012, Patient CNR was receiving an average of 13 CDS tablets per day.

33. Prior to coming under the care and treatment of Defendant, Patient CNR had no significant prior prescribing for any CDS for pain management. In the **fourteen months** preceding becoming Defendant's patient, the **only** CDS pain medicine prescribed for Patient CNR **for the entire year,** was Hydrocodone 5 mg (1/2 the strength prescribed by Defendant) #40 and Acetaminophen and Codeine Phosphate 300mg/30mg, #20. The total number of Hydrocodone (5mg, ½ strength than Defendant prescribed) prescribed for this ***entire 14*** **month period was 40 tablets** and the average **monthly** dose of less than 3 tablets per month. Defendant's prescribing pattern for the initial Hydrocodone dose of **10 mg** for **120 tablets** to Patient CNR represents in excess of a 4100% increase over the prior 14 months. Defendant's medical chart is void of any objective medical documentation to support this increase in CDS pain medication being prescribed to Patient CNR.

34. Defendant's chart is void of any evidence of drug testing on Patient CNR during the time she is a patient of Defendants and receiving large quantities of CDS.

35. During the above stated time period, Patient CNR who is 5 feet 3 inches tall, went from 108 pounds at the initial visit, to a weight loss down to 92.4 pounds. Defendant failed to note this significant weight loss and failed to follow up with appropriate tests, consultations or order any additional testing of the patient.

PATIENT DNR

36. From September 17, 2010 through August 15, 2012, Patient DNR was under the care and treatment of Defendant and other physicians at the Vista Medical Center. Defendant's chart reflects that on the patient DNR's **first** visit to Defendant on September 17, 2010, he was 27 years old, presenting with knee and lower back pain. Based on Patient DNR's reported medical history of knee pain from back pain injuries arising from motor vehicle accidents occurring in January 2009 and January 2003. Defendant prescribed Lortab 10 mg, #130 and Soma 350 #120 and diagnosed "T-L-S chronic pain and Right knee ligament injury without any prior medical records or tests or any documentation to substantiate the alleged knee and back pain. Defendant's medical records state no purpose for Patient DNR's return appointment or the reason was simply listed as "refills".

37. Defendant increased the number of CDS Hydrocodone to 180 tablets on Patient DNR's 3rd return visit on November 11, 2010, without any objective medical evidence to support this increase. Patient DNR continued to receive this amount of CDS at each prescription refill while under the care of Defendant and Vista Medical Center.

38. From September 17, 2010 through August 15, 2012, 24 month time period, Patient DNR received a total of seventy-nine (79) prescriptions for controlled dangerous drugs from Vista Medical Center for alleged knee and back pain including prescriptions for Hydrocodone 10 mg, a Schedule III controlled dangerous drug for 3,700 dosage units, and Diazepam (Valium) 10 mg for a total of 750 dosage units and Alprazolam (Xanax) 1 mg for a total of 600 dosage units and Carisoprodol (Soma) 350 mg for a total of 2,280 dosage units, Schedule IV controlled and dangerous drugs and Temazepam 30 mg for a total of 300 dosage units. Of these seventy-nine (79) prescriptions, Defendant wrote sixty-eight (68) of these prescriptions. The remaining eleven (11) prescriptions were written by other medical providers at Vista Medical Center. Defendant failed to order imaging tests or other appropriate tests, he did not obtain appropriate consultations, and he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

39. In August, 2012, Patient DNR was receiving an average of 15 CDS tablets per day.

40. Prior to coming under the care and treatment of Defendant, Patient DNR had no significant prior prescribing for any CDS for pain management. In the **thirty-three months months** preceding becoming Defendant's patient, the **only** CDS pain medicine prescribed for Patient CNR **for this entire time,** was Hydrocodone (10 mg, 7.5 and 5mg) total tablets #113 and Oxycodone 7.5mg #30. The total number of Hydrocodone and Oxycodoneprescribed for this ***entire 33*** **month period was 143 tablets** and the average **monthly** dose of less than 4.3 tablets per month. Defendant's prescribing pattern for the initial Hydrocodone dose of **10 mg** for **130 tablets** to Patient DNR represents in excess of a 3000% increase over the prior 33 months. Defendant's medical chart is void of any objective medical documentation to support this increase in CDS pain medication being prescribed to Patient DNR.

41. Defendant's chart contains evidence of only two urine drug screens conducted on January 10, 2011 and February 11, 2011, reflecting that the urine drug screen was ***negative for opiates.*** There is no evidence that the finding of "no opiates" in the urine drug screen was discussed with Patient DNR. Defendant continued prescribing CDS in the same quantities.

42. Defendant is guilty of unprofessional conduct in that he:

A. Engaged in dishonorable or immoral conduct which is likely to deceive, defraud or harm the public in violation of 59 O.S. § 509 (8) and OAC 435:10-7-4 (11).

B. Violated any provision of the medical practice act or the rules and regulations of the Board or of an action, stipulation, or agreement of the Board in violation of 59 O.S. §509 (13), OAC 435:10-7-4(39), and OAC 435:15-5-11(7).

C. Failed to maintain an office record for each patient which accurately reflects the evaluation, treatment, and medical necessity of treatment of the patient in violation of 59 O.S. §509 (18) and OAC 435:10-7-4(41).

D. Prescribed or administered a drug or treatment without sufficient examination and the establishment of a valid physician patient relationship in violation of 59 O.S. §509 (12).

E. Prescribed, dispensed or administered a controlled substance or narcotic drugs in excess of the amount considered good medical practice, or prescribed, dispensed or administered controlled substances or narcotic drugs without medical need in accordance with published standards in violation of 59 O.S. 509(16).

F. Engaged in the indiscriminate or excessive prescribing, dispensing or administering of controlled or narcotic drugs in violation of OAC 435:10-7-4(1).

G. Prescribed, dispensed or administered controlled substances or narcotic drugs in excess of the amount considered good medical practice or prescribed, dispensed or administered controlled substances or narcotic drugs without medical need in accordance with published standard in violation of OAC 435:10-7-4(2) and (6).

Conclusion

WHEREFORE, plaintiff requests that the Board conduct a hearing, and upon proof of the allegations contained herein, impose such disciplinary action as authorized by law, up to and including the revocation or suspension of the Defendant's license to practice as a physician assistant in the State of Oklahoma, the assessment of costs and fees incurred in this action, and any other appropriate action with respect to Defendant's license to practice as a physician assistant in the State of Oklahoma.

Dated this 2nd day of January, 2013 at 9:00 a.m.

Respectfully submitted,

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Oklahoma State Board of Medical
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