

- a) Defendant is the subject of a Complaint and Citation, Case No. 11-08-4376. That case was originally filed on June 1, 2012. Additionally, a First Amended Complaint was filed in this case on January 2, 2013. Finally, a Second Amended Complaint was filed in this case on August 29, 2013.
- b) On August 16, 2013, board investigators received information regarding the deaths of three (3) of Defendant's patients, Patients LHR, SRR and BPR. Initially, the information received consisted of autopsy reports from the Office of the Chief Medical Examiner for the State of Oklahoma ("M.E.")
- c) As a result of obtaining these M.E. reports, board investigators obtained medical records regarding Patients LHR, SRR and BPR. Those records were obtained on August 20, 2013. Records from the M.E. and the medical records obtained clearly indicate that all three patients died from an overdose of CDS including the specific drugs prescribed by Defendant to them.
- d) According to the report of the M.E., Patient SRR died on November 9, 2011, as a result of acute Hydrocodone intoxication. Patient SRR had last seen the Defendant as a patient only two (2) days earlier on November 7, 2011. On that visit Defendant prescribed 120 dosage units of Soma, 120 dosage units of Xanax, and 180 dosage units of Lortab.
- e) Patient LHR died on November 2, 2012. According to the report of the M.E. she died from acute Alprazolam, Methamphetamine and Hydrocodone toxicity. Patient LHR had last seen Defendant as a patient on October 31, 2012, only two (2) days before her death. On that visit Defendant prescribed 180 dosage units of Hydrocodone 10 mg as well as 120 dosage units of Xanax. Defendant's supervising physician, Dr. Valuck, prescribed 90 dosage units of Oxycodone to Patient LHR on the same date. Defendant either knew or should have known of Dr. Valuck's prescription of Oxycodone on the same date he prescribed Xanax and Lortab to Patient LHR.
- f) Patient BPR died on September 30, 2012. According to the report of the M.E. Patient BPR died as a result of acute combined intoxication with Hydrocodone and Alprazolam. Patient BPR was last seen by Defendant as a patient in his clinic on September 12, 2012, only eighteen (18) days prior to his death. On his final visit to Defendant's clinic prior to his death, Patient BPR was prescribed 140 dosage units of Hydrocodone, an increase over the prior prescription of 120 dosage units. On the same office visit of September 12, 2012, Defendant prescribed 90 dosage units of Soma. On that same office visit Defendant prescribed 120 dosage units of Xanax, an increase over the 90 dosage units previously prescribed.
- g) Defendant's charts on all three (3) deceased patients reveal that he failed to perform a complete and adequate physical examination on those patients, 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 he prescribed, and that he did not maintain an office record which sufficiently and accurately reflects the evaluation, treatment and medical necessity of the treatment and prescriptions for any of the three (3) deceased patients.

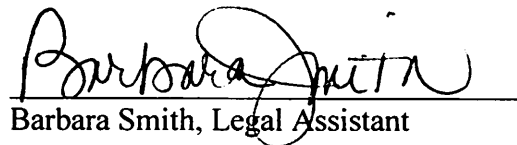
4. Effective Friday, September 6, 2013 at 2:05 p.m. Defendant's physician's assistant license is hereby **SUSPENDED** pending a full hearing before the Board en banc at the meeting scheduled for November 7, 2013.
5. All of the charges against Defendant will be heard before the Board en banc at the meeting scheduled for November 7, 2013.
6. The emergency suspension shall be reported to the National Practitioner Data Bank and all other appropriate groups.



GERALD C. ZUMWALT, M.D.
Secretary/Medical Advisor
Oklahoma State Board of Medical
Licensure and Supervision

CERTIFICATE OF SERVICE

I certify that on the 6th day of September, 2013, I provided a true and correct copy of the Order of Emergency Suspension to Mr. Todd Riddles via email at triddles@cheeklaw.com.



Barbara Smith, Legal Assistant