IN THE MATTER OF	*	**BEFORE THE**
ROBERT D. DOWD, P.T.	*	**STATE BOARD**
LICENSE NO. 16871	*	**OF PHYSICAL THERAPY**
Respondent	*	**EXAMINERS**

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FINAL CONSENT ORDER

Based on information received and a subsequent investigation by the State Board of Physical Therapy Examiners (the "Board"), and subject to Md. Health Occ. Ann. § 13-101, et seq., (2000 Repl. Vol.) (the "Act"), the Board charged Robert D. Dowd, P.T., (the "Respondent"), with violations of the Act. Specifically, the Board charged the Respondent with violation of the following provisions of § 13-316:

> Subject to the hearing provisions of § 13-317[1] of this subtitle, the Board may deny a license, temporary license, or restricted license to any applicant, reprimand any licensee or holder of a temporary license or restricted license, place any licensee or holder of a temporary license or restricted license on probation, or suspend or revoke a license, temporary license, or restricted license if the applicant, licensee or holder:
>
> (14) Willfully fails to file or record any report as required by law, willfully impedes or obstructs the filing or recording of the report, or induces another to fail to file or record the report;
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> (16) Violates any rule or regulation adopted by the Board;
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> (18) Is professionally, physical, or mentally incompetent;

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1 In addition to imposing the aforecited sanctions, the Board may, under certain circumstances, impose a monetary penalty, pursuant to § 13-407.1 of the Act. § 13-407.1 states: If, after a hearing under § 13-317 of this title, the Board finds that there are grounds under § 13-316 of this title to suspend or revoke a license to practice physical therapy or limited physical therapy, to reprimand a licensee, or to refuse to license an applicant, the Board may impose a penalty not exceeding $5,000 in addition to suspending or revoking the license or reprimanding the licensee.

(20) Commits an act of unprofessional conduct in the practice of physical therapy;

(26) Fails to meet accepted standards in delivering physical therapy care.

The Board further charged the Respondent with violations of the following regulations, adopted as its Code of Ethics, pursuant to Code of Maryland Regulations (COMAR), tit. 10.38.02:

.02.A. A physical therapist...may not engage in sexual misconduct.

B. (1) Sexual behavior with a client or patient in the context of a professional evaluation, treatment, procedure, or service to the client or patient, regardless of the setting in which the professional service is rendered;

(3) Solicitation of a sexual relationship, whether consensual or nonconsensual, with a patient;

(4) Sexual advances requesting sexual favors;

(5) Therapeutically inappropriate or intentional touching of a sexual nature;

(6) A verbal comment of a sexual nature; and

(7) Physical contact of a sexual nature with a patient.

The Board further charges the Respondent with a violation of its Standards of Practice, pursuant to Code of Maryland Regulations (COMAR) tit. 10.38.03:

.02A The physical therapist shall exercise sound professional judgment in the use of the evaluation and treatment procedures.

.02L At least once in every ten visits or every 60 calendar days, whichever comes first, there shall be a joint on-site visit with treatment rendered by the physical therapist assistant under

the direct supervision of the physical therapist. At this visit the physical therapist is to assess the treatment performed by the physical therapist assistant, reevaluate the patient's program, and document the treatment program.

The Board also charges the Respondent with a violation of its requirements for Documentation, pursuant to Code of Maryland Regulations tit. 10.38.02-1:

.02-1 Requirements for Documentation.

A. As established by the American Physical Therapy Association of Maryland, and as approved by the Board, the physical therapist shall document the patient's chart as follows:

(1) For initial visit:
- (a) Date,
- (b) Condition/diagnosis for which physical therapy is being rendered,
- (c) Onset,
- (d) History, if not previously recorded,
- (e) Evaluation and results of tests (measurable and objective data),
- (f) Interpretation,
- (g) Goals,
- (h) Plan of care, and
- (i) Signature, title (PT), and license number;

(2) For subsequent visits:
- (a) Date,
- (b) Modalities, procedures, etc.,
- (c) Cancellations, no-shows,
- (d) Response to treatment,
- (e) Signature and title (PT), with identifying signatures appearing on the patient's chart, although the flow chart may be initialed,
- (f) Weekly progress or lack of it,
- (g) Unusual incident/unusual response,
- (h) Change in plan of care,
- (i) Temporary discontinuation or interruption of services and reasons,

(j) Reevaluation, and
(k) If there is a physical therapist assistant, reevaluate and document as required by Regulation .02L of this chapter;

(3) For discharge or last visit:
(a) Date,
(b) Reason for discharge,
(c) Status at discharge,
(d) Recommendations for follow-up, and
(e) Signature and title.

The Respondent was given notice of the issues underlying the Board's charges by a letter dated October 16, 2001. Accordingly, a Case Resolution Conference was held on December 6, 2001, and was attended by Natalie McIntyre, P.T., Board member, Ann Tyminski, Executive Director of the Board, and Linda Bethman, Staff Attorney, Co-Counsel to the Board. Also in attendance were the Respondent and his attorney, Randall Lutz, and the Administrative Prosecutor, Roberta Gill.

Following the Case Resolution Conference, the parties and the Board agreed to resolve the matter by way of settlement. The parties and the Board agreed to the following:

FINDINGS OF FACT

1. At all times relevant herein, the Respondent was licensed to practice physical therapy in Maryland. The Respondent was initially licensed on December 10, 1990. The Respondent last renewed his license on May 25, 2001. The Respondent's license expires on May 31, 2003.

2. From on or about July 1997 through September 15, 2000, the Respondent was employed by Shore Health System, which consists, in part, of Memorial Hospital (the "Hospital") in Easton, Maryland, and two outpatient centers, known as Shore Rehab; one office was located in Stevensville, Maryland and other office was located in Denton, Maryland. The Respondent provided physical therapy at Shore Rehab, where he was assisted by a Physical Therapist Assistant (PTA).

3. Shore Rehab submitted billing to the Hospital for patients seen at Shore Rehab. In turn, the Hospital would do the billing. When a patient came to Shore Rehab for services, the patient signed in on an attendance sheet. The patient would then receive physical therapy treatments, which physical therapy services were to be documented in the patient's treatment file or patient record. A "superbill" would be marked by the physical therapist, indicating services rendered at that visit. The superbill would then be inputted into the computer system for billing purposes.

FINDINGS REGARDING COMPLAINANT

4. On or about April 17, 2000, the Board received a complaint from one of the Respondent's former patients, hereinafter, the Complainant. The Board began an investigation of the complaint which disclosed the following:

A. The Respondent rendered physical therapy to the Complainant at Shore Rehab, beginning March 16, 1999.

B. The Respondent documented providing treatment for the Complainant at Shore Rehab on nine occasions until May 4, 1999, at which time, he

documented in his medical records that the patient was discharged because "...PT appears ineffective at this time...D/C secondary to lack of progress."

C. Despite "discharging" the patient, the Respondent continued to treat the Complainant at Shore Rehab after May 4, 1999, until approximately June 30, 1999, informing her that she no longer needed to sign in on the attendance sheets, because her "insurance did not cover more visits." The Respondent did not document any treatment rendered to the Complainant after May 4, 1999.

D. In early June 1999, while the Respondent was providing physical therapy care to the Complainant at Shore Rehab, the Respondent accompanied the Complainant to Ocean City with the Complainant's children. One evening, the Respondent became inebriated and tried to physically assault the Complainant. The Respondent apologized the next day and the Respondent and the Complainant then entered into a consensual sexual relationship.

E. Thereafter, the Respondent provided treatment to the Complainant at Shore Rehab and then discontinued treatment near the end of June 1999, at Shore Rehab. However, the Respondent continued to provide physical therapy treatments to the Complainant at her home, but he failed to document any treatment or a discharge from treatment.

F. The Respondent and the Complainant and her husband lived in the same neighborhood, and the Respondent started spending considerable time with

them. At the end of June 1999, the Respondent informed the Complainant that he would treat her at home with electrode equipment.

G. During the summer of 1999, the Respondent and the Complainant and her husband engaged in a three-way consensual sexual relationship. In August 1999, the Respondent traveled to Las Vegas with the Complainant and her husband. This three-way sexual relationship continued until October 1999.[2]

5. During the time period in which these sexual encounters with the Complainant and her husband occurred, the Respondent would, from time to time, provide physical therapy treatment to the Complainant's husband. The Respondent failed to document that he performed an evaluation prior to instituting treatment. The Respondent failed to keep contemporaneous session notes of the treatment rendered to the Complainant's husband. The Respondent failed to properly document that he discharged the Complainants husband from therapy.

FINDINGS REGARDING OTHER PATIENTS

6. In addition to the Complainant, the Board's investigation disclosed that the Respondent violated the Act and regulations thereunder with regard to the following patients:[3]

A. Patient A is employed by the Maryland Primary Care Physicians, which is located in the same building as Shore Rehab in Stevensville. Patient A was referred to the Respondent by a Physician's Assistant in the office where she is employed

2 Although the Complainant filed a complaint in April 2000, she, her husband and the Respondent

for a neck problem. Patient A's first appointment with the Respondent was August 24, 2000; and the Respondent saw her three or four times thereafter for therapy. According to Patient A, the Physical Therapist Assistant (PTA) provided ultrasound on one occasion. On other occasions, the Respondent provided ultrasound, electrical stimulation, manipulation, massage and cold packs. The Respondent failed to document an evaluation, treatment notes or discharge summary. The Respondent further failed to render a superbill; consequently, there was no billing for his services to Patient A. In addition, the Respondent instructed Patient A not to sign in when she received services.

The Respondent signed and documented only an initial evaluation for Patient A, part of which is not legible. The evaluation is not dated and contains no onset date. The Respondent failed to write session notes for his treatment of Patient A or to document a discharge.

The Respondent socialized with Patient A and her husband. The Respondent hugged Patient A in his office while he was seated, so that his face was at her chest.

B. Patient B began treatment with the Respondent on February 10, 2000. Patient B stated that he continued treatment with the Respondent until September 7, 2000. However, June 22, 2000 was the last date that the Respondent required Patient B to sign in when he arrived for therapy at Shore Rehab. The last recorded physical therapy treatment in the medical record, however, is dated June 1, 2000.

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traveled to Dover, Delaware for another overnight sexual encounter in May 2000.
3 Patients' names are not disclosed herein.

The Respondent failed to document that he reevaluated Patient B, as required. A note dated March 27, 2000 indicated "Re-eval" in the "Plan" section, but there is no reevaluation for that date. The Respondent failed to date the discharge note. The Respondent further failed to record the status of Patient B at discharge, the reason for discharge, and recommendations for follow-up.

C. Patient C was also employed by Maryland Primary Care Physicians. The Respondent first saw Patient C on August 10, 1999, as a result of a shoulder injury sustained at work. Patient C's last date of treatment was January 6, 2000. She had a total of 29 physical therapy visits. The Respondent failed to document an initial evaluation or reevaluations. The Respondent further failed to document any joint onsite visits with the PTA, as required.

D. Patient D was employed at Shore Pediatrics, which is across the parking lot from the Respondent's Denton office. Patient D was in a motor vehicle accident and was referred to the Respondent for outpatient physical therapy for treatment of multiple injuries, including a fractured pelvis. Patient D's initial visit with the Respondent was June 21, 1999, and she was treated until September 3, 1999. There were 22 documented visits in the medical record.

The Respondent's initial evaluation is very difficult to read, as are many of the other entries. There is no evidence of reevaluations or joint on-site visits with the PTA, as required.

On the 10th visit, July 14, 1999, Patient D received only a hot pack, provided by the PTA, in contravention of the standards of practice.

On July 19, 1999, there is no entry in the record. There is, however, documentation for July 3, 1999 on a separate sheet, which is out of order from the other notes. Patient C did not sign in on July 3, but did sign in on July 19.

Patient D stated that she and the Respondent remained friendly after her formal discharge and she started dating him approximately one month after discharge, with the relationship progressing to be sexual. During the time that the Respondent dated Patient D, he would treat her back, rub her neck and apply heat in his office during Patient D's lunch hour. Patient D also indicated that the Respondent would treat her at his home, by "cracking" her back. The Respondent failed to maintain any treatment notes for these occasions.

E. Patient E is employed by Memorial Hospital. Her office is in front of the same building as the Respondent's office. Patient E sometimes volunteered to assist the Respondent as a secretary if he needed more support staff. While assisting in this capacity, the Respondent would rub Patient E's shoulders and "crack" her back. On one occasion the Respondent instructed an aide to apply heat treatment to Patient E, in contravention of the standards of care.

During the entire time that Patient E received treatments from the Respondent, the Respondent never required her to sign in as a patient. The only medical records that the Respondent maintained for Patient E were obtained by the Board directly

8. As a result of this information, Ms. Blem reviewed the Complainant's treatment file and confronted the Respondent with these allegations, which he admitted, in part. Consequently, Ms. Blem terminated the Respondent from employment at Shore Rehab.

9. After the Respondent was terminated, Ms. Blem was informed about other patients for whom therapy had been rendered but for whom the Respondent had failed to maintain treatment notes, conduct evaluations/reevaluations, write discharge summaries and/or superbills. As a result, Ms. Blem instructed the staff to assemble all files of patients that the Respondent had treated, and to mark where notes were missing. Thereafter, Ms. Blem requested that the Respondent come to Memorial Hospital to complete documentation for the patients he had treated.

10. On September 26, 2000, the Respondent wrote treatment notes and discharge summaries for patients he had seen prior to his termination.

11. The Board investigators reviewed 174 records. Of those, they took into possession 22 records, as a representative sample. The following was disclosed in those 22 records:

A. Patient G's initial evaluation on August 16, 2000 is signed by the Respondent. Patient G was seen for five visits at Shore Rehab. The Respondent signed, but failed to date, the discharge summary, as required.

B. The Respondent failed to put a name or date on Patient H's initial evaluation; however, the billing statement indicates that the initial date was May 26, 2000.

The patient signed in on three occasions between May 26, 2000 and June 9, 2000. The Respondent signed the discharge summary, but failed to date it.

C. The Respondent documented an initial evaluation for Patient I, but failed to date it. However, it appears from the sign-in sheet that she was in therapy on September 12 and September 14, 2000. Although the Respondent noted under the "S" (subjective) part of the SOAP notes on September 14, 2000 that the patient had a "Complete resolution of symptoms," the Respondent still provided hot pack, electrical stimulation, ultrasound and myofascial release for her on that date. Neither Shore Rehab nor Memorial Hospital was able to locate any billing records for this patient.

D. Patient J appears to be an O.T. patient. There are no P.T. notes for Patient J except the discharge summary dated and signed by the Respondent on August 4, 2000; however Respondent did not actually write the discharge summary until September 26, 2000.

E. The Respondent conducted Patient K's initial evaluation on July 14, 2000. The patient was seen 17 times, with the last visit on September 22, 2000. The Respondent failed to conduct a joint on-site visit with the PTA, as required. The Respondent failed to document any reevaluations. The discharge was done in handwriting other than the Respondent's, although the Respondent signed and dated the discharge for September 22, 2000—after he was terminated.

F. The Respondent treated Patient L on 55 occasions between her initial evaluation on December 9, 1999 and her last visit of September 21, 2000. The

8. As a result of this information, Ms. Blem reviewed the Complainant's treatment file and confronted the Respondent with these allegations, which he admitted, in part. Consequently, Ms. Blem terminated the Respondent from employment at Shore Rehab.

9. After the Respondent was terminated, Ms. Blem was informed about other patients for whom therapy had been rendered but for whom the Respondent had failed to maintain treatment notes, conduct evaluations/reevaluations, write discharge summaries and/or superbills. As a result, Ms. Blem instructed the staff to assemble all files of patients that the Respondent had treated, and to mark where notes were missing. Thereafter, Ms. Blem requested that the Respondent come to Memorial Hospital to complete documentation for the patients he had treated.

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A. Patient G's initial evaluation on August 16, 2000 is signed by the Respondent. Patient G was seen for five visits at Shore Rehab. The Respondent signed, but failed to date, the discharge summary, as required.

B. The Respondent failed to put a name or date on Patient H's initial evaluation; however, the billing statement indicates that the initial date was May 26, 2000.

Respondent failed to conduct reevaluations. The Respondent failed to conduct joint on-site visits with the PTA, as required. The Respondent recorded under "plan" of the June 8, 2000 notes "plan for discharge," but kept treating the patient.

G. Patient M was referred to the Respondent from a physician on June 20, 2000. The billing statement indicated that the Respondent conducted the physical therapy evaluation on June 13, 2000. The Respondent signed the evaluation, but it has no patient name or date of service. The clinic sign-in sheet has a signature for this patient, but no dates. Patient M appears to have been treated six times, with the last date of service on July 18, 2000. The Respondent's discharge notation, purportedly dated July 18, 2000, notes that "pt did not return and will be D/C'd." However, according to the Respondent's entry into the medical record for that date, and the billing, the patient was treated on that date.

H. The Respondent conducted an initial evaluation of Patient N, but failed to date it or provide a diagnosis. The billing indicates that the evaluation was conducted on August 15, 2000. The sign-in sheet has no dates. There is no additional billing. The Respondent failed to date the discharge summary.

I. The Respondent failed to date Patient O's initial evaluation, although the billing indicated that the date was September 12, 2000.

J. The Respondent failed to date the initial evaluation conducted on Patient P; however, the billing indicates that that date was August 29, 2000. The Respondent indicated on the discharge note, purportedly dated August 31, 2000 that the

"Patient did not return." However, there were daily entry notes for August 31 and September 5, 2000 by another provider.

K. The Respondent conducted an initial evaluation for Patient Q, which he failed to date. The first date of service appears to be July 8, 2000. There were eight entries on the sign-in sheet for Patient Q, but no dates are noted, except for the entry of September 5, 2000. Patient Q was treated until September 15, 2000. The Respondent's daily note of that date states, under "Plan" in the SOAP note "Con't (continued)." However, the Respondent wrote in the discharge note, purportedly dated on September 15, 2000, "Patient did not return for PT. D/C to IHEP (independent home exercise program)."

L. The Respondent signed and dated Patient R's initial evaluation of February 25, 2000, but failed to list a diagnosis. There were eleven visits noted on the sign-in sheet but 13 visits in the notes. The Respondent failed to perform a reevaluation. The patient was not seen between March 21, 2000 and May 9, 2000, but the Respondent failed to perform a reevaluation when she returned. Nor did the Respondent perform a reevaluation for the patient's absence between May 16, 2000 and June 20, 2000. "Cont" was noted under the "Plan" section of the SOAP notes, without any indication that the program was modified. Although the daily entry of June 20, 2000 indicates "cont" in the "Plan" section, the discharge notation, dated June 20, 2000, indicated that the patient was discharged to an independent home exercise program. Moreover, the discharge was not actually written until September 28, 2000.

M. The Respondent conducted an initial evaluation of Patient S on April 4, 2000. Patient S was seen for six more visits, until May 9, 2000, when the Respondent purportedly signed a discharge notation.

N. The Respondent failed to date the initial evaluation conducted on Patient T. He also failed to include a treatment plan or goals. The billing statement indicates that the date of the initial evaluation was August 22, 2000.

O. The Respondent failed to date the initial evaluation conducted on Patient U. However, billing records indicate that that date was August 11, 2000. The patient signed in three times, with the last visit occurring on August 23, 2000. The Respondent purportedly dated a discharge notation for August 23, 2000 and noted that "Patient did not return after August 23, 2000."

P. The Respondent failed to date Patient V's initial evaluation. The sign-in sheet has four visits, from September 5 to September 14, 2000. (The Center failed to bill for the September 14, 2000 date.)

Q. The Respondent failed to put a name or date on Patient W's initial evaluation form. The Respondent failed to document any treatment given. There were no patient sign-ins, nor billings. The Respondent failed to date the discharge notation.

R. The Respondent failed to put a name or date on Patient X's initial evaluation. The patient was billed for July 18, 2000. The Respondent failed to sign or date Patient X's discharge summary.

S. The Respondent failed to put a name on or date Patient Y's initial evaluation. There were six progress notes for Patient Y, who signed in on seven occasions from May 26 to June 16, 2000. The Respondent failed to record a discharge summary.

T. The Respondent conducted an initial evaluation on Patient Z on August 3, 2000. Patient Z signed in on 10 visits. The patient signed in on September 7 and was billed for this date. However, the Respondent dated his treatment note for September 8, 2000.

U. The Respondent signed and dated Patient AA's initial evaluation on September 11, 2000, but the notes are illegible and there is no diagnosis. The Respondent failed to record a discharge summary.

V. The Respondent signed Patient BB's initial evaluation but failed to record a patient name, date or diagnosis. Patient BB signed in 34 times between March 22 and September 14, 2000; however, the Respondent failed to document any reevaluations or joint on-site visits with the PTA, as required. The daily entry, purportedly dated April 20, 2000 is out of order. The Respondent purportedly noted in the daily entry for September 14, 2000 "Con't," however, the discharge, also signed by the Respondent, is dated that same date.

12. Overall, the Respondent was deficient in documenting in the following manner:

A. Many records were illegible and abbreviations are not standard.

B. There were instances when evaluations were absent or did not include dates, names, diagnoses or complete evaluation findings.

C. Daily entries were completed in the SOAP format, however there was rarely an assessment of the patient's status, notation of progress or lack thereof, change in plan of care, if appropriate, flow sheet of specific exercises that were given, or plan for future care, other than "con't".

D. Many charts did not have reevaluations after 10 visits or when the patient had not returned to therapy after a lengthy hiatus.

E. There was no documentation of joint on-site visits with the PTA.

F. In many instances, discharge notes were missing, not dated or incomplete, including the status at discharge or recommendations for follow-up.

G. In multiple cases, the Respondent dated the discharge note the same date as the last patient visit and information in the notes is conflicting.

H. There is evidence of documentation completed at a date after the service was rendered and after the Respondent was terminated.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the Board finds that Respondent violated §13-316 (14), (16), (18), (20), and (26). The Board finds that the Respondent also violated its Code of Ethics, pursuant to Code of Maryland Regulations (COMAR), tit. 10.38.02.02.A. and B. (1), (3), (4), (5), (6) and (7). The Board further finds that the Respondent violated its Standards of Practice, pursuant to Code of Maryland Regulations

(COMAR) tit. 10.38.03.02A. and L. The Board further finds that the Respondent violated its requirements for Documentation, pursuant to Code of Maryland Regulations tit. 10.38.02-1.02-1A. (1)(a), (b), (c), (d), (e), (f), (g), (h), and (i); (2) (a), (b), (c), (d), (e), (f), (g), (h), (i), (j), and (k); (3) (a), (b), (c), (d), and (e).

ORDER

Based on the foregoing Findings of Fact, Conclusions of Law and agreement of the parties, it is this 19th day of February, 2002 by a majority of a quorum of the Board:

ORDERED that the Respondent's license to practice physical therapy is hereby **SUSPENDED** for twelve (12) months with all twelve months **STAYED**; and be it further

ORDERED that the Respondent shall be placed immediately on two years' Probation, subject to the following conditions:

A. During the first year of Probation, the Respondent shall enroll in and successfully complete:

1. A Board-pre-approved law course; attended 6/27/02

2. A Board-pre-approved documentation course; and, done 7/09/02

3. A Board-approved ethics course. The Board may waive this requirement if the Respondent submits to the Board a syllabus of the ethics course taken last year and the Board determines that this condition has been satisfied. 9/11/02

B. The Respondent shall enter into therapy with a Board-pre-approved psychologist or psychiatrist and cooperate with the therapist in his treatment. The Respondent shall remain in therapy until the therapist recommends that he be discharged.

The therapist shall report to the Board, upon the Board's request, upon the Respondent's progress and cooperation in treatment.

C. During the Probationary period, the Respondent shall submit, on a quarterly basis, six random patient charts for the Board's review and the Respondent shall follow any recommendations regarding any deficiencies in his record keeping.

ORDERED that the Consent Order is effective as of the date of its signing by the Board; and be it further

ORDERED that should the Board receive a report that the Respondent's practice is a threat to the public health, welfare or safety, or if the Respondent commits any violations of the Order during the first twelve months of the probationary period, the Board may take summary action against the Respondent, including lifting the Stay of Suspension, providing notice and an opportunity to be heard are provided to the Respondent in a reasonable time thereafter. After the first twelve months of probation, should the Board receive in good faith information that the Respondent has substantially violated the Act or if the Respondent violates any conditions of this Order or of Probation, after providing the Respondent with notice and an opportunity for a hearing, the Board may take further

disciplinary action against the Respondent, including suspension or revocation. The burden of proof for any action brought against the Respondent as a result of a breach of the conditions of the Order or of Probation shall be on the Respondent to demonstrate compliance with the Order or conditions; and be it further

ORDERED that the Respondent shall practice in accordance with the laws and regulations governing the practice of physical therapy in Maryland and in a competent manner; and be it further

ORDERED that, at the end of the Probationary period, the Respondent may petition the Board to be reinstated without any conditions or restrictions on his license, provided that he can demonstrate compliance with the conditions of this Order. Should the Respondent fail to demonstrate compliance, the Board may impose additional terms and conditions of Probation, as it deems necessary. Should the Respondent fail to petition the Board, the conditions of Probation shall remain in effect;

ORDERED that for purposes of public disclosure, as permitted by Md. State Govt. Code Ann. §10-617(h) (Repl. Vol. 1999), this document consists of the contents of the foregoing Findings of Fact, Conclusions of Law and Order and that the Board may also disclose same to any national reporting data bank that it is mandated to report to.

Mindy Sacks, PT

Mindy Sacks, P.T.A., Chairperson