

Summary of New York State Department of Health’s Prosecution of Danielle Roberts

In July 2017, Sarah Edmondson (“Edmondson”), a former member DOS¹, filed a complaint with the Office of Professional Medical Conduct (“OPMC”) after receiving a brand from Danielle Roberts (“Danielle”). Danielle, a physician, was a DOS member. The brand was done with an electrocautery pen, similar to tattooing as they both involve the use of heat to alter tissue.

The OPMC dismissed the complaint, stating that the cauterization, branding, “did not occur within the doctor-patient relationship” and “[is] not medical misconduct [by Danielle]” but “should be reported to law enforcement.”²

Notably, Lauren Salzman, a cooperating witness for the government, who recruited Edmondson into DOS, testified in the trial of Keith Raniere that prospective DOS members were informed beforehand that joining would involve receiving a brand.³

On October 17, 2017, a *New York Times* article⁴ revealed DOS' existence, while focusing on Edmondson's claims about forcibly receiving a brand—claims that are demonstrably false.⁵

The article criticized the OPMC for not taking action and cited a text message where a state police investigator told Edmondson and 2 other women that their criminal complaint would not be pursued because the “actions had been **consensual**.”

Two days later, the *New York Times* followed up, quoting Richard Azzopardi, spokesperson for then Governor Andrew Cuomo, “[o]fficials in New York State plan to review why regulators and others did not act.”⁶

Shortly after the *New York Times* articles, the OPMC reversed its dismissal. On or about November 17, 2017, Danielle received an unsigned, undated 70-page Statement of Charges from the Bureau of Professional Medical Conduct (“BPMC”) by its Deputy Counsel .⁷

¹In 2015, Keith Raniere co-founded a private women’s self-empowerment group, a non-collegiate sorority, called DOS.

² See Attachment 1, Letter from OPMC to Ms. Edmondson, dated July 11, 2017.

³ See Trial T. (5/20/19) at 1602:9-1603:17.

⁴ See Barry Meier, Inside a Secretive Group Where Women Are Branded, *N.Y. Times*, October 17, 2017, <https://www.nytimes.com/2017/10/17/nyregion/nxivm-women-branded-albany.html>.

⁵ See Dr. Danielle Roberts’ Statement in Response to the Revocation of Her Medical License, <https://www.drdanielleroberts.com/sovereignty/dr-danielle-roberts-statement-in-response-to-the-revocation-of-her-medical-license>; see also Trial T. (5/20/19) at 1749:1-15 (Lauren Salzman describing the conditions of Ms. Edmondson’s branding ceremony).

⁶ See Complaints About Branding Inside Secretive Group Are Under Review, *N.Y. Times* (Oct. 19, 2017), <https://www.nytimes.com/2017/10/19/nyregion/complaints-by-ex-nxivm-members.html>.

⁷ See Attachment 2, OPMC Statement of Charges.

The Statement of Charges alleged medical misconduct toward 25 individuals, including 2 who had passed away from natural causes long before these allegations were compiled. It also contained other demonstrably false claims, including:

- It claims Danielle gave a brand to Nancy Salzman, the 60+ year-old president of NXIVM, who, in fact, never received a brand.
- The statement accuses Danielle of giving brands to 12 specific women, none of whom received a brand.
- It claims Edmondson repeatedly “requested on multiple occasions that [Danielle] cease performing the branding procedure.”⁸ Video evidence from Edmondson’s own branding session, which she consented to be filmed, shows no such requests to stop.⁹
- It claims “Edmondson believed that she was only having a tattoo applied to her pelvic region.”¹⁰ However, evidence confirms that Edmondson was fully aware and informed she would receive a brand, not a tattoo. She had been told about the brand in advance of joining DOS and even filmed the process of other DOS members receiving a brand before receiving her own.¹¹

On December 1, 2017, Associate Counsel Jeffrey J. Conklin (“Associate Counsel Conklin”) reminded Danielle, through counsel, about “the possibility of separate criminal investigations ongoing” and inquired as to whether Roberts would voluntarily surrender her license.¹²

On January 18, 2018, Associate Counsel Conklin subpoenaed 7 women¹³, including DOS members India Oxenberg (“Oxenberg”) and Allison Mack (“Mack”), (*I took out alleging bc the subpoena doesn’t spell it out directly*) inferring they were victims of medical misconduct by Roberts. Mack was charged by the EDNY months later, and Oxenberg was designated as an “unindicted co-conspirator.”

Danielle herself was a potential key defense witness. She was positioned within DOS under Mack and alongside the EDNY’s primary alleged victim at that time. Roberts’ experience and evidence directly contradicts the government’s narrative of coercion, central to their case.¹⁴

⁸ *Id.* at 1 A(3).

⁹ See GX 441_SE Video_v1, presented in *In re Danielle Roberts*, D.O., N.Y. Dep’t of Health, State Bd. for Prof’l Med. Conduct.

¹⁰ See OPMC Statement of Charges at 2 at A(7).

¹¹ See Trial T. (5/20/19) at 1747:11-20 (Lauren Salzman stating, “I think it was Sarah [Edmondson]” who filmed the first branding ceremony, prior to Edmondson’s own).

¹² See Attachment 3, Email from Associate Counsel Conklin, dated December 1, 2017

¹³ See, e.g., Attachment 4, BPMC Subpoena for Allison Mack

¹⁴ See Attachment 5, Declaration of Danielle Roberts, dated June 15, 2022, which was included in a Rule 33 motion for a new trial, dated June 21, 2022, in *US v. Keith Raniere* (EDNY), 18-cr-204, Doc. 1178.

The subpoenas “commanded” the women to appear at the OPMC office on February 14, 2018, and to bring emails, texts, photos, videos, and any other evidence relating to the cauterizing pen. These women contested the subpoenas¹⁵. Some had not received a brand at all, others received a brand from a tattoo artist, not Danielle, and all who received a brand had consented.

On February 5, 2018, Associate Counsel Conklin invited Roberts to provide information at an OPMC interview.¹⁶ Danielle declined this “offer.”

Under NY State Public Health Law Section 230(10)(iii), the Bureau of Professional Medical Conduct had **90 days** from the date of the interview offer to bring charges against Danielle, but failed to do so.

From March 2018 to June 2019, as the Eastern District pursued its criminal case against Keith Raniere, Allison Mack, and others, there was no further action from BPMC.

However, a week after Raniere’s guilty verdict on June 27, 2019 after the February 2018 offer letter, Associate Counsel Conklin contacted Roberts’ lawyer again, suggesting that Danielle might want to “consider a resolution short of a permanent surrender.”¹⁷

By this time, 400+ days had passed since the interview offer, yet Associate Counsel Conklin had still not brought any charges, despite the legal requirement to do so within 90 days. During this time, Danielle was unable to secure medical employment after being terminated from her prior job or get malpractice insurance in New York due to the pending investigation.

Subsequently, Associate Counsel Conklin pressed Danielle to surrender her license, threatening her with license revocation, “the imposition of maximum monetary fines”, the potential for “separate criminal investigations”, and the possibility of “notifying appropriate law enforcement official or authority.”¹⁸

On September 30, 2021, after a trial, the New York Department of Health revoked Danielle’s license. 2 years later, in 2023, the NYS Supreme Court denied her appeal, and the NYS Court of Appeals declined to review the case.

This timeline of actions can only demonstrate how the OPMC, influenced by media pressure in concert with New York State and DOJ influence, was improperly weaponized to support the federal prosecution of Mr. Raniere.

¹⁵ See, e.g., Attachment 6, Letter on behalf of Allison Mack to OPMC, dated February 2, 2018

¹⁶ See Attachment 7, OPMC Interview Offer, dated February 5, 2018.

¹⁷ See Attachment 8, Email from OPMC Prosecutor Conklin, dated June 27, 2019.

¹⁸ See Attachment 9, Emails from OPMC Prosecutor Conklin from October 2019

ATTACHMENTS

Attachment 1

Letter from OPMC to Ms. Edmondson, dated July 11, 2017.



ANDREW M. CUOMO
Governor

Department of Health

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

July 11, 2017

OPMC # 17-07-4422

Dear Ms. Edmondson:

In accordance with New York State Public Health Law Section 230, the Office of Professional Medical Conduct (OPMC) has reviewed your July 7, 2017 correspondence regarding Danielle Roberts, DO. This office is responsible for investigating allegations of professional misconduct by physicians, physician assistants and special assistants. We assessed the allegations you raised and the physician's actions in the context of New York State Education Law Section 6530 that defines the parameters of medical misconduct.

The issues you describe did not occur within the doctor-patient relationship and should be reported to law enforcement in the area where the incident occurred. The issues you describe are not medical misconduct as defined in New York State Education Law Section 6530. The information that you have supplied will be retained in our confidential files and no further action will be taken.

If you have further questions regarding the processing of your complaint, or this letter, you may contact this office at 1-800-663-6114. Thank you for bringing this matter to our attention.

Sincerely,

A handwritten signature in black ink that reads "R. Soulier".

R. Soulier
Central Intake Unit
Office of Professional Medical Conduct

Attachment 2

OPMC Statement of Charges, dated November 17, 2017.

IN THE MATTER
OF
DANIELLE ROBERTS, D.O.

STATEMENT
OF
CHARGES

DANIELLE ROBERTS, D.O., the Respondent, was authorized to practice medicine in New York State on or about October 5, 2009, by the issuance of license number 255075 by the New York State Education Department.

FACTUAL ALLEGATIONS

- A. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient A, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.

4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.
5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.
10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
12. Respondent failed to provide appropriate medical care and treatment for the patient.
13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.

- B. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient B, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.
 5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
 6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
 7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
 8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
 9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.

10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
 11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
 12. Respondent failed to provide appropriate medical care and treatment for the patient.
 13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.
- C. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient C, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.

5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.
10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
12. Respondent failed to provide appropriate medical care and treatment for the patient.
13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.

- D. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient D, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.
 5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
 6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
 7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
 8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
 9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.

10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
 11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
 12. Respondent failed to provide appropriate medical care and treatment for the patient.
 13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.
- E. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient E, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.

5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.
10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
12. Respondent failed to provide appropriate medical care and treatment for the patient.
13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.

- F. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient F, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.
 5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
 6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
 7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
 8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
 9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.

10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
 11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
 12. Respondent failed to provide appropriate medical care and treatment for the patient.
 13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.
- G. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient G, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.

5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.
10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
12. Respondent failed to provide appropriate medical care and treatment for the patient.
13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.

- H. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient H, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.
 5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
 6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
 7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
 8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
 9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.

10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
 11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
 12. Respondent failed to provide appropriate medical care and treatment for the patient.
 13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.
- I. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient I, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.

5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.
10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
12. Respondent failed to provide appropriate medical care and treatment for the patient.
13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.

- J. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient J, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.
 5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
 6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
 7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
 8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
 9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.

10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
 11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
 12. Respondent failed to provide appropriate medical care and treatment for the patient.
 13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.
- K. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient K, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.

5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.
10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
12. Respondent failed to provide appropriate medical care and treatment for the patient.
13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.

- L. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient L, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.
 5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
 6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
 7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
 8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
 9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.

10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
 11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
 12. Respondent failed to provide appropriate medical care and treatment for the patient.
 13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.
- M. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient M, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.

5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.
10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
12. Respondent failed to provide appropriate medical care and treatment for the patient.
13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.

- N. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient N, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.
 5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
 6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
 7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
 8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
 9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.

10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
 11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
 12. Respondent failed to provide appropriate medical care and treatment for the patient.
 13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.
- O. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient O, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.

5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.
10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
12. Respondent failed to provide appropriate medical care and treatment for the patient.
13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.

- P. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient P, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.
 5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
 6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
 7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
 8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
 9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.

10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
 11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
 12. Respondent failed to provide appropriate medical care and treatment for the patient.
 13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.
- Q. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient Q, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.

5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.
10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
12. Respondent failed to provide appropriate medical care and treatment for the patient.
13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.

- R. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient R, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.
 5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
 6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
 7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
 8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
 9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.

10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
 11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
 12. Respondent failed to provide appropriate medical care and treatment for the patient.
 13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.
- S. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient S, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.

5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.
10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
12. Respondent failed to provide appropriate medical care and treatment for the patient.
13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.

- T. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient T, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.
 5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
 6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
 7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
 8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
 9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.

- 10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
 - 11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
 - 12. Respondent failed to provide appropriate medical care and treatment for the patient.
 - 13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.
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- U. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient U, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
 - 1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 - 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 - 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 - 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.

5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.
10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
12. Respondent failed to provide appropriate medical care and treatment for the patient.
13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.

- V. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient V, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.
 5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
 6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
 7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
 8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
 9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.

10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
 11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
 12. Respondent failed to provide appropriate medical care and treatment for the patient.
 13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.
- W. On or about March, 2017, the Respondent intentionally used a cauterizing iron as part of a branding procedure and/or rite to permanently alter and/or disfigure the skin by branding Patient W, a female patient, hereinafter identified in the attached Appendix "A", with the initials KR/AM in the pelvis region, thereby leaving a permanent scar.
1. Respondent performed the branding procedure and/or rite in an other than appropriately sterile environment and/or without appropriate infection control.
 2. Respondent, while performing the branding procedure and/or rite, caused the patient to suffer excruciating pain for no known medical purpose.
 3. The patient requested on multiple occasions that Respondent cease performing the branding procedure and/or rite, which said Respondent failed to do.
 4. Respondent failed to cease performing the branding procedure and/or rite despite the fact that the patient screamed on multiple occasions because of the excruciating pain she was experiencing.

5. Respondent, during the course of the branding procedure and/or rite, tortured and physically abused the patient.
6. Respondent performed the branding procedure and/or rite upon the patient at the time the patient was naked and while being held down by three other individuals, who were also naked, contrary to any appropriate medical protocol or need.
7. Respondent knowingly performed a branding procedure and/or rite upon the patient when Respondent knew, or should have known, that the patient believed that she was only having a tattoo applied to her pelvic region.
8. Respondent inappropriately performed the branding procedure and/or rite upon the patient while an individual who was also naked utilized a cell phone to video said branding procedure and/or rite without the consent of the patient.
9. Respondent failed to provide appropriate wound care for the patient at the time of the branding procedure and/or rite and thereafter.
10. Respondent failed to refer the patient to a specialist after the branding procedure and/or rite to provide appropriate wound care.
11. Respondent inappropriately advised the patient to take photos of the wound caused by the branding procedure and/or rite on a daily basis for one month and once a week for another month, and to thereafter send such photographs to an individual known as "Lauren Salzman".
12. Respondent failed to provide appropriate medical care and treatment for the patient.
13. Respondent failed to prepare and/or maintain appropriate medical records for the patient which accurately reflected the evaluation and treatment of the patient.

- X. In on or about 2014, the Respondent provided medical care and treatment to Patient X, as identified in the Appendix. The Respondent's medical care of Patient X deviated from accepted standards of care as follows:
1. Respondent failed to prepare and/or maintain appropriate records which accurately reflected the evaluation and treatment of Patient X.
- Y. In on or about 2016, the Respondent provided medical care and treatment to Patient Y, as identified in the Appendix. The Respondent's medical care of Patient Y deviated from accepted standards of care as follows:
1. Respondent failed to prepare and/or maintain appropriate records which accurately reflected the evaluation and treatment of Patient Y.
- Z. During the time from on or about June 2016 through August 2016, NXIVM and/or the Executive Success Program (ESP) conducted a conference and/or meeting at the Silver Bay Conference and Family Retreat Center (Conference Center), located in Silver Bay, New York. The Respondent and approximately 300 to 400 other individuals attended the conference, including 50 to 60 children. During the course of the conference, hundreds of the attendees became severely ill with an undetermined communicable disease. The individuals who became ill suffered inter alia, flu-like symptoms, severe vomiting and diarrhea. The Respondent had knowledge of the fact that many individuals at the conference had become ill. The Respondent knew or should have known that the illness suffered by the attendees at the conference was a communicable disease, outbreak of a communicable disease, and/or an unusual disease or outbreak.
1. Respondent failed to report the suspected or confirmed case of communicable disease, outbreak of communicable disease, and/or the unusual disease or

- outbreak to the city, county, or district health officer as required by Title 10 N.Y.C.R.R. Section 2.10.
2. Respondent failed to report by telephone, facsimile, or other electronic communication, or in person the illness of the attendees at the conference suspected or confirmed to have been caused due to the consumption of spoiled or poisonous food to the city, county, or district health officer, in violation of Title 10 N.Y.C.R.R. Section 2.15.
 3. Upon being made aware of the fact that attendees at the conference might have been suffering from a communicable disease, the Respondent failed to cause such individuals to be isolated in an appropriate environment, pending official action by the health officer, in violation of Title 10 N.Y.C.R.R. Section 2.27.

SPECIFICATIONS OF CHARGES

FIRST THROUGH TWENTY-THIRD SPECIFICATIONS
WILLFULLY ABUSING A PATIENT

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(31) by willfully abusing a patient as alleged in the facts of:

1. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, A and A.10, A and A.11, A and A.12, and/or A and A.13.
2. The facts in paragraphs B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, B and B.10, B and B.11, B and B.12, and/or B and B.13.
3. The facts in paragraphs C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8, C and C.9, C and C.10, C and C.11, C and C.12, and/or C and C.13.
4. The facts in paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, D and D.9, D and D.10, D and D.11, D and D.12, and/or D and D.13.
5. The facts in paragraphs E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, E and E.10, E and E.11, E and E.12, and/or E and E.13.

6. The facts in paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, F and F.8, F and F.9, F and F.10, F and F.11, F and F.12, and/or F and F.13.
7. The facts in paragraphs G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, G and G.7, G and G.8, G and G.9, G and G.10, G and G.11, G and G.12, and/or G and G.13.
8. The facts in paragraphs H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, H and H.6, H and H.7, H and H.8, H and H.9, H and H.10, H and H.11, H and H.12, and/or H and H.13.
9. The facts in paragraphs I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6, I and I.7, I and I.8, I and I.9, I and I.10, I and I.11, I and I.12, and/or I and I.13.
10. The facts in paragraphs J and J.1, J and J.2, J and J.3, J and J.4, J and J.5, J and J.6, J and J.7, J and J.8, J and J.9, J and J.10, J and J.11, J and J.12, and/or J and J.13.
11. The facts in paragraphs K and K.1, K and K.2, K and K.3, K and K.4, K and K.5, K and K.6, K and K.7, K and K.8, K and K.9, K and K.10, K and K.11, K and K.12, and/or K and K.13.
12. The facts in paragraphs L and L.1, L and L.2, L and L.3, L and L.4, L and L.5, L and L.6, L and L.7, L and L.8, L and L.9, L and L.10, L and L.11, L and L.12, and/or L and L.13.

13. The facts in paragraphs M and M.1, M and M.2, M and M.3, M and M.4, M and M.5, M and M.6, M and M.7, M and M.8, M and M.9, M and M.10, M and M.11, M and M.12, and/or M and M.13.
14. The facts in paragraphs N and N.1, N and N.2, N and N.3, N and N.4, N and N.5, N and N.6, N and N.7, N and N.8, N and N.9, N and N.10, N and N.11, N and N.12, and/or N and N.13.
15. The facts in paragraphs O and O.1, O and O.2, O and O.3, O and O.4, O and O.5, O and O.6, O and O.7, O and O.8, O and O.9, O and O.10, O and O.11, O and O.12, and/or O and O.13.
16. The facts in paragraphs P and P.1, P and P.2, P and P.3, P and P.4, P and P.5, P and P.6, P and P.7, P and P.8, P and P.9, P and P.10, P and P.11, P and P.12, and/or P and P.13.
17. The facts in paragraphs Q and Q.1, Q and Q.2, Q and Q.3, Q and Q.4, Q and Q.5, Q and Q.6, Q and Q.7, Q and Q.8, Q and Q.9, Q and Q.10, Q and Q.11, Q and Q.12, and/or Q and Q.13.
18. The facts in paragraphs R and R.1, R and R.2, R and R.3, R and R.4, R and R.5, R and R.6, R and R.7, R and R.8, R and R.9, R and R.10, R and R.11, R and R.12, and/or R and R.13.
19. The facts in paragraphs S and S.1, S and S.2, S and S.3, S and S.4, S and S.5, S and S.6, S and S.7, S and S.8, S and S.9, S and S.10, S and S.11, S and S.12, and/or S and S.13.

20. The facts in paragraphs T and T.1, T and T.2, T and T.3, T and T.4, T and T.5, T and T.6, T and T.7, T and T.8, T and T.9, T and T.10, T and T.11, T and T.12, and/or T and T.13.
21. The facts in paragraphs U and U.1, U and U.2, U and U.3, U and U.4, U and U.5, U and U.6, U and U.7, U and U.8, U and U.9, U and U.10, U and U.11, U and U.12, and/or U and U.13.
22. The facts in paragraphs V and V.1, V and V.2, V and V.3, V and V.4, V and V.5, V and V.6, V and V.7, V and V.8, V and V.9, V and V.10, V and V.11, V and V.12, and/or V and V.13.
23. The facts in paragraphs W and W.1, W and W.2, W and W.3, W and W.4, W and W.5, W and W.6, W and W.7, W and W.8, W and W.9, W and W.10, W and W.11, W and W.12, and/or W and W.13.

**TWENTY-FOURTH THROUGH
FORTY-SIXTH SPECIFICATIONS**

**CONDUCT IN THE PRACTICE OF MEDICINE
WHICH EVIDENCES MORAL UNFITNESS**

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(20)

24. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, A and A.10, A and A.11, A and A.12, and/or A and A.13.

25. The facts in paragraphs B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, B and B.10, B and B.11, B and B.12, and/or B and B.13.
26. The facts in paragraphs C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8, C and C.9, C and C.10, C and C.11, C and C.12, and/or C and C.13.
27. The facts in paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, D and D.9, D and D.10, D and D.11, D and D.12, and/or D and D.13.
28. The facts in paragraphs E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, E and E.10, E and E.11, E and E.12, and/or E and E.13.
29. The facts in paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, F and F.8, F and F.9, F and F.10, F and F.11, F and F.12, and/or F and F.13.
30. The facts in paragraphs G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, G and G.7, G and G.8, G and G.9, G and G.10, G and G.11, G and G.12, and/or G and G.13.
31. The facts in paragraphs H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, H and H.6, H and H.7, H and H.8, H and H.9, H and H.10, H and H.11, H and H.12, and/or H and H.13.

32. The facts in paragraphs I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6, I and I.7, I and I.8, I and I.9, I and I.10, I and I.11, I and I.12, and/or I and I.13.
33. The facts in paragraphs J and J.1, J and J.2, J and J.3, J and J.4, J and J.5, J and J.6, J and J.7, J and J.8, J and J.9, J and J.10, J and J.11, J and J.12, and/or J and J.13.
34. The facts in paragraphs K and K.1, K and K.2, K and K.3, K and K.4, K and K.5, K and K.6, K and K.7, K and K.8, K and K.9, K and K.10, K and K.11, K and K.12, and/or K and K.13.
35. The facts in paragraphs L and L.1, L and L.2, L and L.3, L and L.4, L and L.5, L and L.6, L and L.7, L and L.8, L and L.9, L and L.10, L and L.11, L and L.12, and/or L and L.13.
36. The facts in paragraphs M and M.1, M and M.2, M and M.3, M and M.4, M and M.5, M and M.6, M and M.7, M and M.8, M and M.9, M and M.10, M and M.11, M and M.12, and/or M and M.13.
37. The facts in paragraphs N and N.1, N and N.2, N and N.3, N and N.4, N and N.5, N and N.6, N and N.7, N and N.8, N and N.9, N and N.10, N and N.11, N and N.12, and/or N and N.13.
38. The facts in paragraphs O and O.1, O and O.2, O and O.3, O and O.4, O and O.5, O and O.6, O and O.7, O and O.8, O and O.9, O and O.10, O and O.11, O and O.12, and/or O and O.13.

39. The facts in paragraphs P and P.1, P and P.2, P and P.3, P and P.4, P and P.5, P and P.6, P and P.7, P and P.8, P and P.9, P and P.10, P and P.11, P and P.12, and/or P and P.13.
40. The facts in paragraphs Q and Q.1, Q and Q.2, Q and Q.3, Q and Q.4, Q and Q.5, Q and Q.6, Q and Q.7, Q and Q.8, Q and Q.9, Q and Q.10, Q and Q.11, Q and Q.12, and/or Q and Q.13.
41. The facts in paragraphs R and R.1, R and R.2, R and R.3, R and R.4, R and R.5, R and R.6, R and R.7, R and R.8, R and R.9, R and R.10, R and R.11, R and R.12, and/or R and R.13.
42. The facts in paragraphs S and S.1, S and S.2, S and S.3, S and S.4, S and S.5, S and S.6, S and S.7, S and S.8, S and S.9, S and S.10, S and S.11, S and S.12, and/or S and S.13.
43. The facts in paragraphs T and T.1, T and T.2, T and T.3, T and T.4, T and T.5, T and T.6, T and T.7, T and T.8, T and T.9, T and T.10, T and T.11, T and T.12, and/or T and T.13.
44. The facts in paragraphs U and U.1, U and U.2, U and U.3, U and U.4, U and U.5, U and U.6, U and U.7, U and U.8, U and U.9, U and U.10, U and U.11, U and U.12, and/or U and U.13.
45. The facts in paragraphs V and V.1, V and V.2, V and V.3, V and V.4, V and V.5, V and V.6, V and V.7, V and V.8, V and V.9, V and V.10, V and V.11, V and V.12, and/or V and V.13.

46. The facts in paragraphs W and W.1, W and W.2, W and W.3, W and W.4, W and W.5, W and W.6, W and W.7, W and W.8, W and W.9, W and W.10, W and W.11, W and W.12, and/or W and W.13.

FORTY-SEVENTH THROUGH SIXTY-NINTH SPECIFICATIONS

FAILING TO USE SCIENTIFICALLY ACCEPTED INFECTION CONTROL PRACTICES

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(47)

47. The facts in paragraphs A and A.1, A and A.8, A and A.9, A and A.10, and/or A and A.11.

48. The facts in paragraphs B and B.1, B and B.8, B and B.9, B and B.10, and/or B and B.11.

49. The facts in paragraphs C and C.1, C and C.8, C and C.9, C and C.10, and/or C and C.11.

50. The facts in paragraphs D and D.1, D and D.8, D and D.9, D and D.10, and/or D and D.11.

51. The facts in paragraphs E and E.1, E and E.8, E and E.9, E and E.10, and/or E and E.11.

52. The facts in paragraphs F and F.1, F and F.8, F and F.9, F and F.10, and/or F and F.11.

53. The facts in paragraphs G and G.1, G and G.8, G and G.9, G and G.10, and/or G and G.11.
54. The facts in paragraphs H and H.1, H and H.8, H and H.9, H and H.10, and/or H and H.11.
55. The facts in paragraphs I and I.1, I and I.8, I and I.9, I and I.10, and/or I and I.11.
56. The facts in paragraphs J and J.1, J and J.8, I and J.9, J and J.10, and/or J and J.11.
57. The facts in paragraphs K and K.1, K and K.8, K and K.9, K and K.10, and/or K and K.11.
58. The facts in paragraphs L and L.1, L and L.8, L and L.9, L and L.10, and/or L and L.11.
59. The facts in paragraphs M and M.1, M and M.8, M and M.9, M and M.10, and/or M and M.11.
60. The facts in paragraphs N and N.1, N and N.8, N and N.9, N and N.10, and/or N and N.11.
61. The facts in paragraphs O and O.1, O and O.8, O and O.9, O and O.10, and/or O and O.11.
62. The facts in paragraphs P and P.1, P and P.8, P and P.9, P and P.10, and/or P and P.11.
63. The facts in paragraphs Q and Q.1, Q and Q.8, Q and Q.9, Q and Q.10, and/or Q and Q.11.

64. The facts in paragraphs R and R.1, R and R.8, R and R.9, R and R.10, and/or R and R. 11.
65. The facts in paragraphs S and S.1, S and S.8, S and S.9, S and S.10, and/or S and S.11.
66. The facts in paragraphs T and T.1, T and T.8, T and T.9, T and T.10, and/or T and T.11.
67. The facts in paragraphs U and U.1, U and U.8, U and U.9, U and U.10, and/or U and U.11.
68. The facts in paragraphs V and V.1, V and V.8, V and V.9, V and V.10, and/or V and V.11.
69. The facts in paragraphs W and W.1, W and W.8, W and W.9, W and W.10, and/or W and W.11.

SEVENTIETH THROUGH NINETY-SECOND SPECIFICATIONS

PRACTICING THE PROFESSION FRAUDULENTLY OR BEYOND ITS SCOPE

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(2)

70. The facts in paragraphs A and A.2, A and A.3, A and A.4, and/or A and A.7.
71. The facts in paragraphs B and B.2, B and B.3, B and B.4, and/or B and B.7.
72. The facts in paragraphs C and C.2, C and C.3, C and C.4, and/or C and C.7.
73. The facts in paragraphs D and D.2, D and D.3, D and D.4, and/or D and D.7.

74. The facts in paragraphs E and E.2, E and E.3, E and E.4, and/or E and E.7.
75. The facts in paragraphs F and F.2, F and F.3, F and F.4, and/or F and F.7.
76. The facts in paragraphs G and G.2, G and G.3, G and G.4, and/or G and G.7.
77. The facts in paragraphs H and H.2, H and H.3, H and H.4, and/or H and H.7.
78. The facts in paragraphs I and I.2, I and I.3, I and I.4, and/or I and I.7.
79. The facts in paragraphs J and J.2, J and J.3, J and J.4, and/or J and J.7.
80. The facts in paragraphs K and K.2, K and K.3, K and K.4, and/or K and K.7.
81. The facts in paragraphs L and L.2, L and L.3, L and L.4, and/or L and L.7.
82. The facts in paragraphs M and M.2, M and M.3, M and M.4, and/or M and M.7.
83. The facts in paragraphs N and N.2, N and N.3, N and N.4, and/or N and N.7.
84. The facts in paragraphs O and O.2, O and O.3, O and O.4, and/or O and O.7.
85. The facts in paragraphs P and P.2, P and P.3, P and P.4, and/or P and P.7.
86. The facts in paragraphs Q and Q.2, Q and Q.3, Q and Q.4, and/or Q and Q.7.
87. The facts in paragraphs R and R.2, R and R.3, R and R.4, and/or R and R.7.
88. The facts in paragraphs S and S.2, S and S.3, S and S.4, and/or S and S.7.
89. The facts in paragraphs T and T.2, T and T.3, T and T.4, and/or T and T.7.
90. The facts in paragraphs U and U.2, U and U.3, U and U.4, and/or U and U.7.
91. The facts in paragraphs V and V.2, V and V.3, V and V.4, and/or V and V.7.
92. The facts in paragraphs W and W.2, W and W.3, W and W.4, and/or W and W.7.

NINETY-THIRD THROUGH ONE HUNDRED FIFTEENTH SPECIFICATIONS

PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(4)

93. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, A and A.10, A and A.11, A and A.12, and/or A and A.13.
94. The facts in paragraphs B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, B and B.10, B and B.11, B and B.12, and/or B and B.13.
95. The facts in paragraphs C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8, C and C.9, C and C.10, C and C.11, C and C.12, and/or C and C.13.
96. The facts in paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, D and D.9, D and D.10, D and D.11, D and D.12, and/or D and D.13.
97. The facts in paragraphs E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, E and E.10, E and E.11, E and E.12, and/or E and E.13.
98. The facts in paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, F and F.8, F and F.9, F and F.10, F and F.11, F and F.12, and/or F and F.13.

99. The facts in paragraphs G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, G and G.7, G and G.8, G and G.9, G and G.10, G and G.11, G and G.12, and/or G and G.13.
100. The facts in paragraphs H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, H and H.6, H and H.7, H and H.8, H and H.9, H and H.10, H and H.11, H and H.12, and/or H and H.13.
101. The facts in paragraphs I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6, I and I.7, I and I.8, I and I.9, I and I.10, I and I.11, I and I.12, and/or I and I.13.
102. The facts in paragraphs J and J.1, J and J.2, J and J.3, J and J.4, J and J.5, J and J.6, J and J.7, J and J.8, J and J.9, J and J.10, J and J.11, J and J.12, and/or J and J.13.
103. The facts in paragraphs K and K.1, K and K.2, K and K.3, K and K.4, K and K.5, K and K.6, K and K.7, K and K.8, K and K.9, K and K.10, K and K.11, K and K.12, and/or K and K.13.
104. The facts in paragraphs L and L.1, L and L.2, L and L.3, L and L.4, L and L.5, L and L.6, L and L.7, L and L.8, L and L.9, L and L.10, L and L.11, L and L.12, and/or L and L.13.
105. The facts in paragraphs M and M.1, M and M.2, M and M.3, M and M.4, M and M.5, M and M.6, M and M.7, M and M.8, M and M.9, M and M.10, M and M.11, M and M.12, and/or M and M.13.

106. The facts in paragraphs N and N.1, N and N.2, N and N.3, N and N.4, N and N.5, N and N.6, N and N.7, N and N.8, N and N.9, N and N.10, N and N.11, N and N.11, N and N.12, and/or N and N.13.
107. The facts in paragraphs O and O.1, O and O.2, O and O.3, O and O.4, O and O.5, O and O.6, O and O.7, O and O.8, O and O.9, O and O.10, O and O.11, O and O.12, and/or O and O.13.
108. The facts in paragraphs P and P.1, P and P.2, P and P.3, P and P.4, P and P.5, P and P.6, P and P.7, P and P.8, P and P.9, P and P.10, P and P.11, P and P.12, and/or P and P.13.
109. The facts in paragraphs Q and Q.1, Q and Q.2, Q and Q.3, Q and Q.4, Q and Q.5, Q and Q.6, Q and Q.7, Q and Q.8, Q and Q.9, Q and Q.10, Q and Q.11, Q and Q.12, and/or Q and Q.13.
110. The facts in paragraphs R and R.1, R and R.2, R and R.3, R and R.4, R and R.5, R and R.6, R and R.7, R and R.8, R and R.9, R and R.10, R and R.11, R and R.12, and/or R and R.13.
111. The facts in paragraphs S and S.1, S and S.2, S and S.3, S and S.4, S and S.5, S and S.6, S and S.7, S and S.8, S and S.9, S and S.10, S and S.11, S and S.12, and/or S and S.13.
112. The facts in paragraphs T and T.1, T and T.2, T and T.3, T and T.4, T and T.5, T and T.6, T and T.7, T and T.8, T and T.9, T and T.10, T and T.11, T and T.12, and/or T and T.13.

113. The facts in paragraphs U and U.1, U and U.2, U and U.3, U and U.4, U and U.5, U and U.6, U and U.7, U and U.8, U and U.9, U and U.10, U and U.11, U and U.12, and/or U and U.13.
114. The facts in paragraphs V and V.1, V and V.2, V and V.3, V and V.4, V and V.5, V and V.6, V and V.7, V and V.8, V and V.9, V and V.10, V and V.11, V and V.12, and/or V and V.13.
115. The facts in paragraphs W and W.1, W and W.2, W and W.3, W and W.4, W and W.5, W and W.6, W and W.7, W and W.8, W and W.9, W and W.10, W and W.11, W and W.12, and/or W and W.13.

ONE HUNDRED SIXTEENTH THROUGH ONE HUNDRED THIRTY-NINTH

SPECIFICATIONS

**PRACTICING THE PROFESSION WITH NEGLIGENCE
ON MORE THAN ONE OCCASION**

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(3)

116. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, A and A.10, A and A.11, A and A.12, and/or A and A.13.
117. The facts in paragraphs B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, B and B.10, B and B.11, B and B.12, and/or B and B.13.

118. The facts in paragraphs C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8, C and C.9, C and C.10, C and C.11, C and C.12, and/or C and C.13.
119. The facts in paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, D and D.9, D and D.10, D and D.11, D and D.12, and/or D and D.13.
120. The facts in paragraphs E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, E and E.10, E and E.11, E and E.12, and/or E and E.13.
121. The facts in paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, F and F.8, F and F.9, F and F.10, F and F.11, F and F.12, and/or F and F.13.
122. The facts in paragraphs G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, G and G.7, G and G.8, G and G.9, G and G.10, G and G.11, G and G.12, and/or G and G.13.
123. The facts in paragraphs H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, H and H.6, H and H.7, H and H.8, H and H.9, H and H.10, H and H.11, H and H.12, and/or H and H.13.
124. The facts in paragraphs I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6, I and I.7, I and I.8, I and I.9, I and I.10, I and I.11, I and I.12, and/or I and I.13.

125. The facts in paragraphs J and J.1, J and J.2, J and J.3, J and J.4, J and J.5, J and J.6, J and J.7, J and J.8, J and J.9, J and J.10, J and J.11, J and J.12, and/or J and J.13.
126. The facts in paragraphs K and K.1, K and K.2, K and K.3, K and K.4, K and K.5, K and K.6, K and K.7, K and K.8, K and K.9, K and K.10, K and K.11, K and K.12, and/or K and K.13.
127. The facts in paragraphs L and L.1, L and L.2, L and L.3, L and L.4, L and L.5, L and L.6, L and L.7, L and L.8, L and L.9, L and L.10, L and L.11, L and L.12, and/or L and L.13.
128. The facts in paragraphs M and M.1, M and M.2, M and M.3, M and M.4, M and M.5, M and M.6, M and M.7, M and M.8, M and M.9, M and M.10, M and M.11, M and M.12, and/or M and M.13.
129. The facts in paragraphs N and N.1, N and N.2, N and N.3, N and N.4, N and N.5, N and N.6, N and N.7, N and N.8, N and N.9, N and N.10, N and N.11, N and N.12, and/or N and N.13.
130. The facts in paragraphs O and O.1, O and O.2, O and O.3, O and O.4, O and O.5, O and O.6, O and O.7, O and O.8, O and O.9, O and O.10, O and O.11, O and O.12, and/or O and O.13.
131. The facts in paragraphs P and P.1, P and P.2, P and P.3, P and P.4, P and P.5, P and P.6, P and P.7, P and P.8, P and P.9, P and P.10, P and P.11, P and P.12, and/or P and P.13.

132. The facts in paragraphs Q and Q.1, Q and Q.2, Q and Q.3, Q and Q.4, Q and Q.5, Q and Q.6, Q and Q.7, Q and Q.8, Q and Q.9, Q and Q.10, Q and Q.11, Q and Q.12, and/or Q and Q.13.
133. The facts in paragraphs R and R.1, R and R.2, R and R.3, R and R.4, R and R.5, R and R.6, R and R.7, R and R.8, R and R.9, R and R.10, R and R.11, R and R.12, and/or R and R.13.
134. The facts in paragraphs S and S.1, S and S.2, S and S.3, S and S.4, S and S.5, S and S.6, S and S.7, S and S.8, S and S.9, S and S.10, S and S.11, S and S.12, and/or S and S.13.
135. The facts in paragraphs T and T.1, T and T.2, T and T.3, T and T.4, T and T.5, T and T.6, T and T.7, T and T.8, T and T.9, T and T.10, T and T.11, T and T.12, and/or T and T.13.
136. The facts in paragraphs U and U.1, U and U.2, U and U.3, U and U.4, U and U.5, U and U.6, U and U.7, U and U.8, U and U.9, U and U.10, U and U.11, U and U.12, and/or U and U.13.
137. The facts in paragraphs V and V.1, V and V.2, V and V.3, V and V.4, V and V.5, V and V.6, V and V.7, V and V.8, V and V.9, V and V.10, V and V.11, V and V.12, and/or V and V.13.
138. The facts in paragraphs W and W.1, W and W.2, W and W.3, W and W.4, W and W.5, W and W.6, W and W.7, W and W.8, W and W.9, W and W.10, W and W.11, W and W.12, and/or W and W.13.
139. The facts in paragraphs X and X.1 and/or Y and Y.1.

ONE HUNDRED FORTIETH THROUGH ONE HUNDRED SIXTIETH SPECIFICATIONS

PRACTICING THE PROFESSION WITH GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(6)

140. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, A and A.10, A and A.11, A and A.12, and/or A and A.13.
141. The facts in paragraphs B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, B and B.10, B and B.11, B and B.12, and/or B and B.13.
142. The facts in paragraphs C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8, C and C.9, C and C.10, C and C.11, C and C.12, and/or C and C.13.
143. The facts in paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, D and D.9, D and D.10, D and D.11, D and D.12, and/or D and D.13.
144. The facts in paragraphs E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, E and E.10, E and E.11, E and E.12, and/or E and E.13.
145. The facts in paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, F and F.8, F and F.9, F and F.10, F and F.11, F and F.12, and/or F and F.13.

146. The facts in paragraphs G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, G and G.7, G and G.8, G and G.9, G and G.10, G and G.11, G and G.12, and/or G and G.13.
147. The facts in paragraphs H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, H and H.6, H and H.7, H and H.8, H and H.9, H and H.10, H and H.11, H and H.12, and/or H and H.13.
148. The facts in paragraphs I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6, I and I.7, I and I.8, I and I.9, I and I.10, I and I.11, I and I.12, and/or I and I.13.
149. The facts in paragraphs J and J.1, J and J.2, J and J.3, J and J.4, J and J.5, J and J.6, J and J.7, J and J.8, J and J.9, J and J.10, J and J.11, J and J.12, and/or J and J.13.
150. The facts in paragraphs K and K.1, K and K.2, K and K.3, K and K.4, K and K.5, K and K.6, K and K.7, K and K.8, K and K.9, K and K.10, K and K.11, K and K.12, and/or K and K.13.
151. The facts in paragraphs L and L.1, L and L.2, L and L.3, L and L.4, L and L.5, L and L.6, L and L.7, L and L.8, L and L.9, L and L.10, L and L.11, L and L.12, and/or L and L.13.
152. The facts in paragraphs M and M.1, M and M.2, M and M.3, M and M.4, M and M.5, M and M.6, M and M.7, M and M.8, M and M.9, M and M.10, M and M.11, M and M.12, and/or M and M.13.

153. The facts in paragraphs N and N.1, N and N.2, N and N.3, N and N.4, N and N.5, N and N.6, N and N.7, N and N.8, N and N.9, N and N.10, N and N.11, N and N.12, and/or N and N.13.
154. The facts in paragraphs O and O.1, O and O.2, O and O.3, O and O.4, O and O.5, O and O.6, O and O.7, O and O.8, O and O.9, O and O.10, O and O.11, O and O.12, and/or O and O.13.
155. The facts in paragraphs P and P.1, P and P.2, P and P.3, P and P.4, P and P.5, P and P.6, P and P.7, P and P.8, P and P.9, P and P.10, P and P.11, P and P.12, and/or P and P.13.
156. The facts in paragraphs Q and Q.1, Q and Q.2, Q and Q.3, Q and Q.4, Q and Q.5, Q and Q.6, Q and Q.7, Q and Q.8, Q and Q.9, Q and Q.10, Q and Q.11, Q and Q.12, and/or Q and Q.13.
157. The facts in paragraphs R and R.1, R and R.2, R and R.3, R and R.4, R and R.5, R and R.6, R and R.7, R and R.8, R and R.9, R and R.10, R and R.11, R and R.12, and/or R and R.13.
158. The facts in paragraphs S and S.1, S and S.2, S and S.3, S and S.4, S and S.5, S and S.6, S and S.7, S and S.8, S and S.9, S and S.10, S and S.11, S and S.12, and/or S and S.13.
159. The facts in paragraphs T and T.1, T and T.2, T and T.3, T and T.4, T and T.5, T and T.6, T and T.7, T and T.8, T and T.9, T and T.10, T and T.11, T and T.12, and/or T and T.13.

160. The facts in paragraphs U and U.1, U and U.2, U and U.3, U and U.4, U and U.5, U and U.6, U and U.7, U and U.8, U and U.9, U and U.10, U and U.11, U and U.12, and/or U and U.13.
161. The facts in paragraphs V and V.1, V and V.2, V and V.3, V and V.4, V and V.5, V and V.6, V and V.7, V and V.8, V and V.9, V and V.10, V and V.11, V and V.12, and/or V and V.13.
162. The facts in paragraphs W and W.1, W and W.2, W and W.3, W and W.4, W and W.5, W and W.6, W and W.7, W and W.8, W and W.9, W and W.10, W and W.11, W and W.12, and/or W and W.13.

ONE HUNDRED SIXTY-THIRD THROUGH

ONE HUNDRED EIGHTY-SIXTH SPECIFICATIONS

**PRACTICNG THE PROFESSION WITH INCOMPETENCE
ON MORE THAN ONE OCCASION**

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(5)

163. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, A and A.10, A and A.11, A and A.12, and/or A and A.13.
164. The facts in paragraphs B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, B and B.10, B and B.11, B and B.12, and/or B and B.13.

165. The facts in paragraphs C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8, C and C.9, C and C.10, C and C.11, C and C.12, and/or C and C.13.
166. The facts in paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, D and D.9, D and D.10, D and D.11, D and D.12, and/or D and D.13.
167. The facts in paragraphs E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, E and E.10, E and E.11, E and E.12, and/or E and E.13.
168. The facts in paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, F and F.8, F and F.9, F and F.10, F and F.11, F and F.12, and/or F and F.13.
169. The facts in paragraphs G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, G and G.7, G and G.8, G and G.9, G and G.10, G and G.11, G and G.12, and/or G and G.13.
170. The facts in paragraphs H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, H and H.6, H and H.7, H and H.8, H and H.9, H and H.10, H and H.11, H and H.12, and/or H and H.13.
171. The facts in paragraphs I and I.1, I and I.2, I and I.3, I and I.4, I and I.5, I and I.6, I and I.7, I and I.8, I and I.9, I and I.10, I and I.11, I and I.12, and/or I and I.13.

172. The facts in paragraphs J and J.1, J and J.2, J and J.3, J and J.4, J and J.5, J and J.6, J and J.7, J and J.8, J and J.9, J and J.10, J and J.11, J and J.12, and/or J and J.13.
173. The facts in paragraphs K and K.1, K and K.2, K and K.3, K and K.4, K and K.5, K and K.6, K and K.7, K and K.8, K and K.9, K and K.10, K and K.11, K and K.12, and/or K and K.13.
174. The facts in paragraphs L and L.1, L and L.2, L and L.3, L and L.4, L and L.5, L and L.6, L and L.7, L and L.8, L and L.9, L and L.10, L and L.11, L and L.12, and/or L and L.13.
175. The facts in paragraphs M and M.1, M and M.2, M and M.3, M and M.4, M and M.5, M and M.6, M and M.7, M and M.8, M and M.9, M and M.10, M and M.11, M and M.12, and/or M and M.13.
176. The facts in paragraphs N and N.1, N and N.2, N and N.3, N and N.4, N and N.5, N and N.6, N and N.7, N and N.8, N and N.9, N and N.10, N and N.11, N and N.12, and/or N and N.13.
177. The facts in paragraphs O and O.1, O and O.2, O and O.3, O and O.4, O and O.5, O and O.6, O and O.7, O and O.8, O and O.9, O and O.10, O and O.11, O and O.12, and/or O and O.13.
178. The facts in paragraphs P and P.1, P and P.2, P and P.3, P and P.4, P and P.5, P and P.6, P and P.7, P and P.8, P and P.9, P and P.10, P and P.11, P and P.12, and/or P and P.13.

179. The facts in paragraphs Q and Q.1, Q and Q.2, Q and Q.3, Q and Q.4, Q and Q.5, Q and Q.6, Q and Q.7, Q and Q.8, Q and Q.9, Q and Q.10, Q and Q.11, Q and Q.12, and/or Q and Q.13.
180. The facts in paragraphs R and R.1, R and R.2, R and R.3, R and R.4, R and R.5, R and R.6, R and R.7, R and R.8, R and R.9, R and R.10, R and R.11, R and R.12, and/or R and R.13.
181. The facts in paragraphs S and S.1, S and S.2, S and S.3, S and S.4, S and S.5, S and S.6, S and S.7, S and S.8, S and S.9, S and S.10, S and S.11, S and S.12, and/or S and S.13.
182. The facts in paragraphs T and T.1, T and T.2, T and T.3, T and T.4, T and T.5, T and T.6, T and T.7, T and T.8, T and T.9, T and T.10, T and T.11, T and T.12, and/or T and T.13.
183. The facts in paragraphs U and U.1, U and U.2, U and U.3, U and U.4, U and U.5, U and U.6, U and U.7, U and U.8, U and U.9, U and U.10, U and U.11, U and U.12, and/or U and U.13.
184. The facts in paragraphs V and V.1, V and V.2, V and V.3, V and V.4, V and V.5, V and V.6, V and V.7, V and V.8, V and V.9, V and V.10, V and V.11, V and V.12, and/or V and V.13.
185. The facts in paragraphs W and W.1, W and W.2, W and W.3, W and W.4, W and W.5, W and W.6, W and W.7, W and W.8, W and W.9, W and W.10, W and W.11, W and W.12, and/or W and W.13.
186. The facts in paragraphs X and X.1, and/or Y and Y.1.

**ONE HUNDRED EIGHTY-SEVENTH THROUGH
TWO HUNDRED NINTH SPECIFICATIONS**

EXERCISING UNDUE INFLUENCE ON A PATIENT

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(17)

187. The facts in paragraphs A and A.5, A and A.6, and/or A and A.7.
188. The facts in paragraphs B and B.5, B and B.6, and/or B and B.7.
189. The facts in paragraphs C and C.5, C and C.6, and/or C and C.7.
190. The facts in paragraphs D and D.5, D and D.6, and/or D and D.7.
191. The facts in paragraphs E and E.5, E and E.6, and/or E and E.7.
192. The facts in paragraphs F and F.5, F and F.6, and/or F and F.7.
193. The facts in paragraphs G and G.5, G and G.6, and/or G and G.7.
194. The facts in paragraphs H and H.5, H and H.6, and/or H and H.7.
195. The facts in paragraphs I and I.5, I and I.6, and/or I and I.7.
196. The facts in paragraphs J and J.5, J and J.6, and/or J and J.7.
197. The facts in paragraphs K and K.5, K and K.6, and/or K and K.7.
198. The facts in paragraphs L and L.5, L and L.6, and/or L and L.7.
199. The facts in paragraphs M and M.5, M and M.6, and/or M and M.7.
200. The facts in paragraphs N and N.5, N and N.6, and/or N and N.7.
201. The facts in paragraphs O and O.5, O and O.6, and/or O and O.7.
202. The facts in paragraphs P and P.5, P and P.6, and/or P and P.7.

- 203. The facts in paragraphs Q and Q.5, Q and Q.6, and/or Q and Q.7.
- 204. The facts in paragraphs R and R.5, R and R.6, and/or R and R.7.
- 205. The facts in paragraphs S and S.5, S and S.6, and/or S and S.7.
- 206. The facts in paragraphs T and T.5, T and T.6, and/or T and T.7.
- 207. The facts in paragraphs U and U.5, U and U.6, and/or U and U.7.
- 208. The facts in paragraphs V and V.5, V and V.6, and/or V and V.7.
- 209. The facts in paragraphs W and W.5, W and W.6, and/or W and W.7.

TWO HUNDRED TENTH SPECIFICATION

WILLFULLY FAILING TO FILE A REPORT REQUIRED BY LAW

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(21)

- 210. The facts in paragraphs Z and Z.1, and/or Z and Z.2.

TWO HUNDRED ELEVENTH SPECIFICATION

**WILLFULLY OR GROSSLY FAILING TO COMPLY WITH
FEDERAL, STATE, OR LOCAL LAWS RULES OR
REGULATIONS GOVERNING THE PRACTICE OF MEDICINE**

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(16)

211. The facts in paragraphs Z and Z.1, Z and Z.2, and/or Z and Z.3.

**TWO HUNDRED TWELFTH THROUGH
TWO HUNDRED THIRTY-FOURTH SPECIFICATIONS**

**PERFORMING PROFESSIONAL SERVICES WHICH
HAVE NOT BEEN AUTHORIZED BY THE PATIENT**

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(26)

212. The facts in paragraphs A and A.3, and/or A and A.7.
213. The facts in paragraphs B and B.3, and/or B and B.7.
214. The facts in paragraphs C and C.3, and/or C and C.7.
215. The facts in paragraphs D and D.3, and/or D and D.7.
216. The facts in paragraphs E and E.3, and/or E and E.7.
217. The facts in paragraphs F and F.3, and/or F and F.7.
218. The facts in paragraphs G and G.3, and/or G and G.7.
219. The facts in paragraphs H and H.3, and/or H and H.7.
220. The facts in paragraphs I and I.3, and/or I and I.7.
221. The facts in paragraphs J and J.3, and/or J and J.7.

- 222. The facts in paragraphs K and K.3, and/or K and K.7.
- 223. The facts in paragraphs L and L.3, and/or L and L.7.
- 224. The facts in paragraphs M and M.3, and/or M and M.7.
- 225. The facts in paragraphs N and N.3, and/or N and N.7.
- 226. The facts in paragraphs O and O.3, and/or O and O.7.
- 227. The facts in paragraphs P and P.3, and/or P and P.7.
- 228. The facts in paragraphs Q and Q.3, and/or Q and Q.7
- 229. The facts in paragraphs R and R.3, and/or R and R.7.
- 230. The facts in paragraphs S and S.3, and/or S and S.7.
- 231. The facts in paragraphs T and T.3, and/or T and T.7.
- 232. The facts in paragraphs U and U.3, and/or U and U.7.
- 233. The facts in paragraphs V and V.3, and/or V and V.7.
- 234. The facts in paragraphs W and W.3, and/or W and W.7.

**TWO HUNDRED THIRTY-FIFTH THROUGH
TWO HUNDRED FIFTY-EIGHTH SPECIFICATIONS**

FAILING TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(32)

- 235. The facts in paragraphs A and A.13.
- 236. The facts in paragraphs B and B.13.

237. The facts in paragraphs C and C.13.
238. The facts in paragraphs D and D.13.
239. The facts in paragraphs E and E.13.
240. The facts in paragraphs F and F.13.
241. The facts in paragraphs G and G.13.
242. The facts in paragraphs H and H.13.
243. The facts in paragraphs I and I.13.
244. The facts in paragraphs J and J.13.
245. The facts in paragraphs K and K.13.
246. The facts in paragraphs L and L.13.
247. The facts in paragraphs M and M.13.
248. The facts in paragraphs N and N.13.
249. The facts in paragraphs O and O.13.
250. The facts in paragraphs P and P.13.
251. The facts in paragraphs Q and Q.13.
252. The facts in paragraphs R and R.13.
253. The facts in paragraphs S and S.13.
254. The facts in paragraphs T and T.13.
255. The facts in paragraphs U and U.13.
256. The facts in paragraphs V and V.13.
257. The facts in paragraphs W and W.13.
258. The facts in paragraphs X and X.1, and/or Y and Y.1.

DATE: November , 2017
Albany, New York

MICHAEL A. HISER, ESQ.
Deputy Counsel
Bureau of Professional Medical Conduct

APPENDIX "A"

Patient A	Sarah Edmondson;
Patient B	Amanda Canning;
Patient C	Lauren Salzman;
Patient D	Livia Cohen;
Patient E	Allison Mack;
Patient F	Alicia Novak;
Patient G	Melissa Demmers;
Patient H	Maggie Dou;
Patient I	India Oxenberg;
Patient J	Soukaina Mehdaoui;
Patient K	Michelle Salzman;
Patient L	Audrey McIntyre;
Patient M	Nicki Klein;
Patient N	Sylvie Lloyd;
Patient O	Pam Aristikitis;
Patient P	Nancy Salzman;
Patient Q	Ana-Lea Holland;
Patient R	Sahjo Haertel;
Patient S	Rosa Laura Junco;
Patient T	Jimena Garza;

Patient U	Corolla Garza;
Patient V	Nicole Isbal;
Patient W	Angelica Hinjos;
Patient X	Barbara Jeske; and
Patient Y	Pam Cafritz

Attachment 3

Email from OPMC Prosecutor Conklin, dated December 1,2017

From: Conklin, Jeffrey J (HEALTH) [mailto:jeffrey.conklin@health.ny.gov]
Sent: Friday, December 01, 2017 12:31 PM
To: Michael Kelton <MKelton@Abramslaw.com>
Subject: [REDACTED] and Danielle Roberts, M.D.

Michael: Our investigation has continued, which has resulted in new evidence and confirmation of the charges of professional misconduct against [REDACTED] and Dr. Roberts. With the possibility of separate criminal investigations ongoing, please let me know whether your clients have reconsidered the offers of the voluntary Surrenders with the modest Statements of Charges. If they are willing to voluntarily surrender their licenses, we will seek authority for you to speak to individuals involved with the parallel criminal investigations.

If you are inclined to discuss these matters, you can call me at (518) 473-4219 (direct line) or (518) 275-1178 (cell). I also have access to my work e-mail at all times.

Jeffrey J. Conklin

Associate Counsel

Bureau of Professional Medical Conduct

Division of Legal Affairs

New York State Department of Health

Room 2516, Corning Tower

Empire State Plaza

Albany, New York 12237

(518) 473-4219

Jeffrey.conklin@health.ny.gov

Attachment 4

OPMC Subpoena for Allison Mack, dated January 18, 2018

NEW YORK STATE

DEPARTMENT OF HEALTH

IN THE MATTER
OF
AL-17-07-4422A

SUBPOENA
AD
TESTIFICANDUM
AND
DUCES TECUM

THE PEOPLE OF THE STATE OF NEW YORK

TO: Allison Mack
127 Grenadier Court
Clifton Park, New York 12065-6583

PURSUANT TO THE AUTHORITY OF N.Y. Pub. Health Law § 230(10)(a), the State Board for Professional Medical Conduct (the Board) is conducting an investigation of possible professional misconduct within the meaning of N.Y. Educ. Law §§ 6530 and 6531 by an individual licensed to practice medicine in the State of New York.

The Board is required to conduct this investigation by N.Y. Pub. Health Law § 230(10)(a).

PURSUANT TO N.Y. Pub. Health Law § 230(11)(a), all complaints of possible professional misconduct received by the Board must remain and are kept confidential.

PURSUANT TO THE AUTHORITY OF N.Y. Pub. Health Law §§ 230(10)(k) and (l), on November 1, 2017, a committee on professional conduct (the Committee) reviewed the complaint and investigatory materials in connection with the above-captioned matter. The committee determined that the complaint is authentic and that there is sufficient substance to warrant investigation into the professional conduct of the physician named therein. The Committee, having concluded that the preliminary investigation justifies the issuance of subpoenas in furtherance of the investigation, specifically authorized the issuance of subpoenas in this matter. The instant subpoena requires the production of documents necessary to the proper investigation of the possible professional misconduct.

YOU ARE HEREBY COMMANDED to appear and be examined before the designee(s) of the Director of the Office of Professional Medical Conduct, pursuing an investigation on the authority of the State Board for Professional Medical Conduct, New York State Department of Health, pursuant to Pub. Health Law §§230(10)(a)(i), Empire State Plaza, Corning Tower, Room 2512, Albany, New York 12237, on February 14, 2018, at 10:00 a.m., or at such other adjourned date, time or place as may be directed.

Failure to comply with this Subpoena Ad Testificandum may subject you to such penalties as are provided by the laws of the State of New York.

YOU ARE HEREBY FURTHER COMMANDED to produce before the Office of Professional Medical Conduct at New York State Department of Health, Empire State Plaza, Corning Tower, Room 2512, Albany, New York 12237, on or before the 14th day of February, or at such other adjourned dates, times and places as may be scheduled, the following documents now in your possession or under your control:

- 1) Any and all records, written communications (whether by text messaging or other text or messenger apps, e-mails, social media posts, or correspondence) photographs, movies, videos, and cellphone videos regarding marks (symbols, initials or other letters) made by use of a cauterizing pen (or other medical device) upon you by Danielle Roberts, D.O.
- 2) Any and all records, written communications (whether by text messaging or other text or messenger apps, e-mails, social media posts, or correspondence) photographs, movies, videos, and cellphone videos regarding the disinfectants, bandages, masks and gloves utilized at the times marks (symbols, initials or other letters) were made by use of a cauterizing pen (or other medical device) upon you by Danielle Roberts, D.O.

3) Any and all records, written communications (whether by text messaging or other text or messenger apps, e-mails, social media posts, or correspondence) photographs, movies, videos, and cellphone videos regarding the instructions for wound care given to you at the time marks (symbols, initials, or other letters) were made by use of a cauterizing pen (or other medical device) upon you by Danielle Roberts, D.O., including, but not limited to, the type of bandages to be applied, the frequency when bandages should be changed, the application of Neosporin, ointments, coconut oil, and/or lavender to the wounds, and the frequency of said applications, and taking photographs of the wounds, and the frequency of said photographs.

OR

4) Legible photocopies of the material described in paragraphs (1), (2) and (3), above, certified to be true and complete copies thereof.

AND UPON YOUR FAILURE to produce as required above, you may be held subject to such penalties as are provided by the laws of the State of New York.

WITNESS, Robert Catalano, M.D., Executive Secretary
State Board for Professional Medical Conduct

DATED: January 18, 2018
Albany, New York

Robert Catalano, M.D., Executive Secretary
State Board for Professional Medical Conduct

By: Jeffrey J. Conklin
JEFFREY J. CONKLIN, ESQ.
Associate Counsel/ BPMC

Inquiries to:

Jeffrey J. Conklin, Esq.
Associate Counsel
Bureau of Professional Medical Conduct
(518) 473-4219

Attachment 5

Declaration of Danielle Roberts, dated June 15, 2022

Declaration of Danielle Roberts

1. My name is Danielle Roberts, DO, MS.
2. I currently reside in St. Francis, Wisconsin.
3. I graduated from Binghamton University Cum Laude in 2003 with a degree in Psychobiology. I completed a dual degree as a Doctor of Osteopathic Medicine with a Masters in Clinical Nutrition in 2008. I completed my Family Practice Residency in 2011. Since, I have served our communities as a hospitalist in 4 different hospitals from 2012-2017, as a Medical Director of an Integrative Medical Practice from 2011-2013, and as an entrepreneur creating and developing 4 different movement and wellness systems and certifications for prevention from 2013-2018, one of which was implemented in 3 countries.
4. I was a second-line member of DOS and was invited by Allison Mack.
5. I served as the primary branding artist for those who got a brand.
6. I have key information I could have offered to the defense counsel in Keith Raniere's case to dispel much of the testimony that was given at trial about how DOS worked, its procedures and practices, the branding process, and my experiences in DOS with Allison Mack, and India and Nicole who were in my circle.
7. I could have given direct testimony that would have challenged Nicole's narrative in general, and specifically about her spending a few hours transcribing videos with me, for Pamela Cafritz's memorial service, which the Government argued was "forced labor."
8. As a second-line member of DOS, I directly experienced the processes and protocols being developed and implemented by the first line.
9. My testimony would have attested to the rigorous and thoughtful enrollment process each woman would have undergone who decided to join, and the conditions surrounding the collateral.
10. This would have clearly illustrated that the collateral was used as a tool to back our promises to ourselves, like surety, not as a tool of fear, force, or blackmail as was alleged by the Government and by Nicole.
11. I believe much of my testimony would have helped to dispel, if not completely dismantle, the Government's theory of sex trafficking and forced labor. I was similarly situated to Nicole, both of us being in the same circle of DOS.
12. In addition, I have been a close friend and business partner of Mr. Raniere.
13. I had known him for approximately six years at the time of the trial.
14. I had worked very closely with him for four years building our company exo | eso, and I worked very closely with him and his closest chosen family in caring for Ms. Pamela Cafritz in her two-year struggle with metastatic renal cancer before she passed away in 2016.
15. I cared for Ms. Cafritz in their home and, at the end, around the clock.

16. As such a close friend, I could have offered essential and reliable testimony as to the consistency of Mr. Raniere's character and conduct.
17. I believe my testimony would have strongly contradicted the handful of Government witnesses' narrative of Mr. Raniere's alleged sinister intent.
18. Instead of being afforded an uninfluenced right to testify under oath as to the nature and purpose of DOS and my experience, I was threatened and intimidated into silence by the actions of U.S. Governmental agencies, including the EDNY, which I will describe below, and significant media pressure.
19. In and around Oct. 2017, the time when Mr. Raniere and five others were being indicted, the New York Times published an article that criticized NYS Governor, Andrew Cuomo, for choosing not to investigate my medical license.
20. In the summer of 2017, the Office of Professional Medical Conduct (OPMC), part of the NYS Health Department, had already issued a written decision, in response to a complaint from Ms. Sarah Edmondson, stating that my actions as a branding artist for DOS was NOT the practice of medicine.
21. Two days after the New York Times article, the OPMC, in contravention of their prior decision, launched an investigation into my private and professional life.
22. This decision (to act outside of their jurisdiction) cost me my contract as a hospitalist at Columbia St. Mary's Hospital (which I had served loyally for 5 years) and every other job I tried to pursue over the next 2 years in the medical field. This was the beginning of dismantling my reputation, credibility, and financial stability.
23. The OPMC threatened me with a salacious, highly exaggerated statement of charges to subpoena information from me, and other women (not related to the practice of medicine and quite possibly to try to collect further information in relation to Mr. Raniere's criminal case).
24. These initial allegations are very different from the allegations the Health Dept. finally published against me about three years later. The Health Dept. continually found ways to try to intimidate me to surrender my license, including highlighting their right to use any information I may state as testimony to defend my medical license and livelihood, as grounds for criminal charges. Clearly discouraging me from testifying in any way in relation to the federal case.
25. OPMC prosecutor, Jeffery Conklin indicated that any testimony I gave in my medical hearing could be used to support a criminal indictment, thus inextricably linking the federal case and my medical hearing. Therefore, any evidence uncovered or testimony given by me (or others) in my hearing could have been used in the federal case to challenge the prosecutors narrative.
26. The women that were subpoenaed through my case, also pleaded the 5th amendment for fear of prosecutorial retaliation, reputational damage, and financial consequence.

27. Seeing I was not amendable to surrendering my license (and that I would likely testify at my own hearing), my hearing was held in abeyance for approximately 2 years, until September 2019, when the federal trial was complete (June 2019) and convictions made.
28. It is precatory that the OPMC present a case to the state board no more than 90 days after an initial interview is offered to a physician/defendant. It was 2 years before the OPMC moved my hearing forward. In order to justify their delay, and divergence from their standard, they offered another “initial” interview so that the hearing would be within the “90 day window”. This was a severe deviation from the standard, during which I was unable to work, and timed exactly with the progression of the criminal trial.
29. The consequences of these unjustified tactics and actions led to the loss of my livelihood.
30. I had to sell my home and most of my possessions and eventually had to change careers to support myself and pay legal fees.
31. In addition to the significant intimidation and financial duress I was placed under, the Federal Government invaded and threatened our community, followed us in our cars, sat outside our homes in their vehicles, and raided Ms. Salzman’s home just a few blocks from my home.
32. As a gesture of cooperation, NXIVM had closed their offices and I was sufficiently intimidated that I closed my company, exo | eso™ as well.
33. I sought legal representation and was represented by attorney Michael Kelton, Esq. of Abrams Fensterman, LLP for my matters with the OPMC and attorney Daniel Stein, Esq. of Mayer Brown, LLP for any matters pertaining to possible criminal charges. In April 2018, the prosecutor’s in Mr. Raniere’s case informed Mr. Stein that they wanted to speak with me.
34. Mr. Stein offered that I comply, if they offered me protection from prosecution.
35. Then-Assistant US Attorney Moira Kim Penza, the lead prosecutor, granted limited immunity. The limited protections of the proffer agreement stated that the proffer agreement did not constitute a cooperation agreement. Should there be any criminal exposure for me discovered in the course of the interview, that my participation in the proffer and continued cooperation would be helpful in resolving such issues.
36. However, Ms. Penza stated that she was not making any promises to resolve any matter in any particular fashion.
37. It became clear to me that if I was of help to the prosecution, it would be beneficial to me.
38. There were many moments over the course of the two, full eight-hour-long proffer sessions that Ms. Penza seemed very fixed in her viewpoints about NXIVM and DOS; especially pertaining to my experience and perspectives regarding the collateral I voluntarily gave in exchange for mentorship (however unconventional), and the incorporation of Mr. Raniere’s initials into the meanings of the brand.

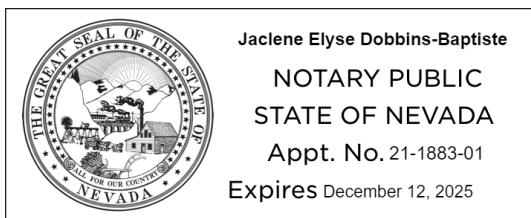
39. When I shared my viewpoints, based on my personal experiences, she often seemed to get visibly upset and perseverated on those specific points and others that offered a different motivation other than coercion.
40. I recall one instance in particular where, for around fifteen minutes, she argued with me about my experience of collateral. I explained that collateral was a tool I chose to use to build self-trust and self-reliance, to back my promises and that it was not, nor was it intended to be, a tool of coercion or extortion. My attorney eventually needed to step in to point out her behavior and redirect her.
41. She displayed the same behavior when discussing the intent and meaning behind what I was told the incorporation of Mr. Raniere's initials meant in the symbol that was created by the 1st line members. She again was insistent the meaning was related to control, possession, and coercion, when that was not my opinion at all.
42. By the end of the interview on May 11, 2018, it became clear to me that Ms. Penza had solely two possible viewpoints: 1) I was a co-conspirator of a massive criminal enterprise, or 2) I was a victim of the situation that had been brainwashed and couldn't think for myself.
43. It did not seem to me that she was open to the possibility, which I believe to be the truth, that this group of people, including Keith Raniere, was innocent and well-intended, even if some mistakes were made.
44. Consistent with my observation, at the end of the first interview she offered me victim support services so that I could be properly treated for the abuse that she decreed that I had undergone, even though I did not, and do not feel, I was abused nor can I measure objectively any destruction of my life or life's work by the practices I engaged in in DOS. In fact, I experienced quite the opposite and I conveyed that in my proffer interviews.
45. Ms. Penza's comments to me at the end of the first interview indicated to me that she had dismissed my testimony, my positive experience, and rendered me incompetent in her mind in order to maintain her theory of the case and the foundation she needed to "win."
46. At the end of the second interview, she threatened to subpoena me to testify in the trial against Mr. Raniere. I made it clear I was not interested in helping her.
47. I also knew that if I were to testify in support of the defense, Mr. Raniere, she may change her mind about me, if it served her, and I could then become a co-conspirator in her assessment, open to indictment, even though I had done nothing wrong or criminal.
48. Based on my initial direct experiences with Ms. Penza, she seemed disinterested in the truth and unwilling to examine any contrary perspective to one of abuse and coercion.
49. I was effectively intimidated from giving crucial testimony to the case.
50. Ms. Penza did not choose to call me to testify.
51. The actions of Ms. Penza were the straw that broke the camel's back and successfully intimidated me from testifying in the criminal proceedings.

52. I declare under penalty of perjury of the laws of the United States of America that the foregoing is true and correct, and of my own personal knowledge, except as to those matters stated upon information and belief. As to those matters, I believe them to be true.

Executed on June 15, 2022 at St. Francis, Wisconsin.

Danielle Roberts

Danielle Roberts



Notarized online using audio-video communication

State of Nevada

County of Clark

Signed and sworn to (or affirmed) before me
on 06/14/2022 by Danielle Roberts.

Jaclene Elyse Dobbins-Baptiste

Attachment 6

Letter on behalf of Allison Mack to OPMC, dated February 2, 2018

ABRAMS AF FENSTERMAN

Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara, Wolf & Carone, LLP

Attorneys at Law
www.abramslaw.com

1 MetroTech Center
Suite 1701
Brooklyn, New York 11201
Phone: (718) 215-5300
Fax: (718) 215-5304
FAX NOT FOR LEGAL SERVICE

FIRM OFFICES

Lake Success
New York
Rochester

February 2, 2018

VIA EMAIL AND FIRST-CLASS MAIL

Jeffrey Conklin, Esq.
New York State Department of Health
Office of Professional Medical Conduct
Riverview Center
150 Broadway, Suite 355
Albany, New York 12204-2719

Re: OPMC # AL-17-07-4422A

Dear Mr. Conklin:

As you know, this office has been retained by Allison Mack in connection with the Administrative Subpoena ad Testificandum and Duces Tecum (“the Administrative Subpoena”) issue to her by BPMC.

Ms. Mack is neither a licensee of the state of New York, nor a holder of a limited permit, medical resident, physician, physician assistant’s or specialist’s assistant subject to the jurisdiction of the Department of Health. As such the Department of Health has no jurisdiction over Ms. Mack, nor any legal authority to compel her to respond to the Administrative Subpoena. See N.Y. Public Health Law §230 generally, and §230(7)(a).

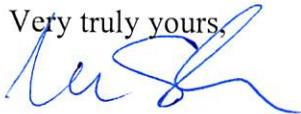
It is Ms. Mack’s position that, inasmuch as she is not subject to the jurisdiction of the Department of Health, the Administrative Subpoena provides no legal compulsion to require her to provide the materials and testimony requested therein. As such, she will not comply with the Administrative Subpoena.

Further, it is Ms. Mack’s position that the Administrative Subpoena is based upon nothing more than an unsubstantiated fishing expedition infringing upon her constitutionally protected personal affiliations and lifestyle choices, and does not satisfy the threshold requirement of a good faith basis by which to compel her response.

In responding to the Administrative Subpoena in the manner set forth herein, Ms. Mack

neither admits nor denies that she has any of the requested items or materials in her possession or under her control, or that she possesses any relevant and material information in connection with BPMC's purported investigation.

Ms. Mack recognizes that BPMC may seek legal redress in the appropriate forum. Should such action be taken, demand is made on behalf of Ms. Mack, that the undersigned be given reasonable advance notice of such action and an opportunity to be heard in connection therewith.

Very truly yours,

Michael S. Kelton

cc: Allison Mack

Attachment 7

OPMC Interview Offer, dated February 5, 2018



Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

February 5, 2018

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

PERSONAL AND CONFIDENTIAL

Danielle Roberts, DO
c/o Michael S. Kelton
Abrams Fensterman
1 MetroTech Center Suite 1701
Brooklyn, New York 11201

RE: OPMC# AL-17-07-4422A

Dear Dr. Roberts:

The Office of Professional Medical Conduct (OPMC) within the New York State Department of Health is authorized to investigate instances or complaints of suspected professional misconduct. OPMC is currently investigating your medical conduct.

Public Health Law Section 230(10)(a)(iii) provides that in all matters referred to an investigation committee of the Board for Professional Medical Conduct, the licensee shall have an opportunity to be interviewed by OPMC in order to provide an explanation of the issues under investigation and to submit written comments or expert opinions to OPMC. You may have legal counsel present during this interview. A copy of the report of interview from OPMC will be provided to you within 30 days of the conclusion of your interview. You may have a stenographer present to transcribe the interview (at your own expense). You must provide a copy of the transcribed interview to this office within 30 days of the conclusion of the interview. After review of the transcript, if there are no inconsistencies, a Memorandum of Investigation will be provided to you within 15 days. Please see the enclosed Information for Licensees as well as information regarding infection control practices.

The matters under investigation are listed below. The questions that will be presented to you during the interview will, for the most part, address these matters. However, the discussion may, if appropriate, cover other areas relevant to the evaluation, diagnosis, treatment, and follow-up provided to the specified individuals during the specified timeframes, as well as other professional conduct, including, but not limited to, medical procedures performed on the individuals, and the circumstances before, during and after such medical procedures.

The issues under investigation are:

- Whether you used a cauterizing pen, or other medical device, to burn letters, initials, symbols or other marks upon the bodies of Sarah Edmondson, Audrey

McIntyre, India Oxenberg, Pamela Arstikaitis, Rosa Laura Junco, Allison Mack, Lauren Salzman, Sylvie Lloyd, Sahajo Haertel, and Nicole Clyne, and/or other individuals, during the period of 2009 to the present.

- Whether before, during and after the times when you used a cauterizing pen or other medical device to burn letters, initials, symbols or other marks upon the bodies of the above referenced individuals, you performed such procedures in an appropriate sterile environment, administered anesthesia, used proper equipment, and took necessary infection control steps.
- Whether you permitted multiple women in a state of nakedness to hold down the limbs of the above referenced individuals (who were also naked) in an unsterile environment, without administering anesthesia, without using proper equipment and taking necessary infection control steps while using a cauterizing pen or other medical device to burn letters, initials, symbols or other marks upon the bodies of such individuals.
- Whether you provided medical care and treatment to the above referenced individuals, and/or advised such individuals as to wound care.
- Whether you maintained medical records for each of the above referenced individuals.
- Whether videos were taken of the above referenced individuals at the time you used a cauterizing pen, or other medical device, to burn letters, initials, symbols, and/or other marks upon their bodies.
- The circumstances under which you used a cauterizing pen, or other medical device, to burn letters, initials, symbols, and/or other marks upon the bodies of the above referenced individuals.
- Whether you failed to report a virus outbreak during a retreat held at the Silver Bay YMCA in August and September 2016 to public authorities.
- Whether your physician profile, which was last updated on January 13, 2010, is presently current and compliant with law.

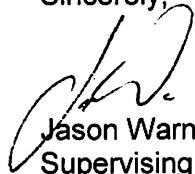
Please note that New York State Public Health Law (NYSPHL) Section 2995 mandates that physicians actively registered to practice medicine in New York State complete a Physician Profile Survey which they are required to update within six months prior to the expiration of each biennial registration period, as a condition of registration renewal. Your profile has *not* been updated as required. You must update your physician profile prior to this interview. The updates can be made on line through your Health Commerce System (HCS) account or by requesting a survey via telephone at 1-888-338-6998. Failure to update your profile as required may result in disciplinary action.

You may provide written comment and/or expert opinion that is directly relevant to the issues identified in this letter or during the interview. In addition, you are directed to provide the following identifying information, which may be provided in the form of a curriculum vitae: full name, date of birth, place of birth, residence address/phone number, office address/phone number, all states where currently or previously licensed, medical school/year graduated, residency location(s)/dates, internship location(s)/dates, current practice type and specialty, current hospital/health maintenance organization affiliations, and past hospital affiliations. Please also provide a list of all professional corporations/businesses in which you are an owner or partner, and a list of all private corporations by which you are employed.

Please telephone me at 518-408-5431 no later than February 26, 2018 to either schedule this interview or decline this opportunity for an interview. This interview must be scheduled no

sooner than 20 days from receipt of this letter, (unless you wish to waive this 20 day period), and no later than March 12, 2018. A declination must be followed up in writing to me at **New York State Department of Health, Office of Professional Medical Conduct, Riverview Center, 150 Broadway, Suite 355, Menands, New York 12204**. Failure to contact this office to schedule an interview or failure to show for the interview on the scheduled date will be considered a declination of your opportunity for an interview. If you or your attorney wish to discuss this matter further, please contact me at your earliest convenience. Thank you.

Sincerely,



Jason Warn
Supervising Medical Conduct Investigator
Office of Professional Medical Conduct

Enclosures

Attachment 8

Email from OPMC Prosecutor Conklin, dated June 27, 2019

From: Conklin, Jeffrey J (HEALTH) <jeffrey.conklin@health.ny.gov>
Sent: Thursday, June 27, 2019 9:06 AM
To: Michael Kelton [REDACTED]
Subject: Matter of Roberts

Michael: As you may recall, we discussed negotiated resolutions of the Porter and Roberts matters back in 2017. With regard to Dr. Porter, the penalty included, among other parameters, a two year suspension dated from October of 2017. Had that offer been accepted, Dr. Porter would be in a position to resume his medical career in 4 months. Of course, we do not have an Order and Decision in the case.

Before completing our investigation and initiating a hearing in the Roberts case, this e-mail is to inquire whether Dr. Roberts is inclined to consider a resolution short of a permanent surrender. I do not have the authority to accept any such offer, but would

discuss the same with my superiors. If Dr. Roberts does not intend to conduct negotiations under any circumstances, please advise.

I hope you are enjoying the summer.

Jeffrey J. Conklin

Associate Counsel

Bureau of Professional Medical Conduct

Division of Legal Affairs

New York State Department of Health

Room 2516, Corning Tower

Empire State Plaza

Albany, New York 12237

(518) 473-4219

Jeffrey.conklin@health.ny.gov



Attachment 9

Emails from OPMC Prosecutor Conklin from October 2019

From: Conklin, Jeffrey J (HEALTH) <jeffrey.conklin@health.ny.gov>
Sent: Thursday, October 10, 2019 3:03 PM
To: Michael Kelton <MKelton@Abramslaw.com>
Subject: Matter of Roberts

Michael: This e-mail is to follow-up on our recent communications regarding the Roberts matter. If at any time in the future your firm is no longer representing Dr. Roberts, please advise. As you know, Dr. Roberts sent a letter which indicated that she would be unable to afford the services of an attorney.

The investigation by OPMC continues. At the time this case is submitted to an Investigation Committee, and if it is voted to hearing, I will advise you immediately. If that occurs, of course, Dr. Roberts will be offered an opportunity to be interviewed.

I would ask that you bring to the attention of Dr. Roberts Public Health Law Section 230 (9-a). Pursuant to this provision, "At any time, if the board or professional medical conduct or the office of professional medical conduct determines that there is a reasonable belief that an act or omission that constitutes a crime under the law of the state of New York, or any other state, or the United States has been committed by the licensee, the board for professional medical conduct shall notify the appropriate law enforcement official or authority."

Thank you.

Jeffrey J. Conklin

Associate Counsel

Bureau of Professional Medical Conduct

Division of Legal Affairs

On Oct 24, 2019, at 12:18 PM, Conklin, Jeffrey J (HEALTH) <jeffrey.conklin@health.ny.gov> wrote:

Michael: Over the course of time, I have advised you of the offer of a license surrender, with a modest Statement of Charges (alleging negligence on more than one occasion regarding the use of a medical device - cautery pen).

I have met with 2 expert witnesses, who are expected to be called as witnesses at the professional misconduct hearing. Additionally, I am in receipt of devastating evidence against Dr. Roberts (through investigation, interviews of witnesses, and evidence from the AUSA involved in the criminal prosecution of Keith Ranieri and other NXIVM semembers.

Based upon the foregoing, the Statement of Charges will include many more Specifications than the draft previously forwarded to you.

If Dr. Roberts had accepted the settlement offer from October of 2017, she would be able to practice medicine at this time. Again, I am reiterating the opportunity for Dr. Roberts to surrender her license, with the less serious allegations. In 3 years, Dr. Roberts can reapply for restoration of her medical license. If this case is voted to hearing, and the testimony and other evidence goes as expected, the Department will seek revocation of Dr. Roberts' license. Additionally, by reason of the egregious nature of her professional misconduct, we will request the imposition of the maximum monetary fines. In the event a Hearing Committee sustains the charges of professional misconduct and revokes Dr. Roberts' medical license, the chances of restoration in the future would be greatly diminished.

I urge Dr. Roberts in the strongest possible terms to accept the offer to resolve this matter.

Please forward this e-mail to Dr. Roberts. Thank you.

Sent from my iPhone