



1           4. On December 21, 2010, the Board issued a Complaint and Notice of Hearing,  
2 setting forth certain factual allegations, charging Respondent with unprofessional  
3 conduct as defined by A.R.S. § 32-1854(6), (25), (34), (36), (38), and (44), and  
4 scheduling a hearing on January 27 and 28, 2011, at 8:00 a.m.

5           5. The Board sent copies of the Complaint and Notice of Hearing to Respondent  
6 at his address of record and to his attorney, Frederick M. Cummings, Esq.

7           6. On December 22, 2010, Mr. Cummings informed the Board that he no longer  
8 represented Respondent.

9           7. The Board's attorney, but not Respondent, appeared for the scheduled  
10 hearing on January 27, 2011, at 8:00 a.m. The Board's attorney provided a new  
11 current address for Respondent to the Administrative Law Judge ("ALJ") and requested  
12 that the ALJ schedule a continued hearing because Respondent may not have received  
13 notice of the January 27, 2011 hearing.

14           8. On January 27, 2011, the ALJ issued an order, setting a continued hearing  
15 on April 4 and 5, 2011, beginning at 8:00 a.m. on both dates. The OAH mailed a copy  
16 of the order setting a continued hearing to Respondent at the new address of record  
17 that the Board's attorney had provided.

18           9. On February 3, 2011, the United States Postal Service returned as "not  
19 deliverable as addressed, unable to forward" the copy of the January 27, 2011 OAH  
20 order setting a continued hearing that OAH staff had mailed to Respondent's new  
21 address of record. According to the docket of the OAH, staff contacted the Board,  
22 confirmed Respondent's new address, and obtained an e-mail address and telephone  
23 number for Respondent. OAH staff called the telephone number and received the  
24 message, "Voicemail full, unable to leave a message." OAH staff sent a copy of the  
25 order to Respondent at the e-mail address, but the e-mail came back as undeliverable.

26           10. A hearing was held on April 4, 2011, between 8:00 a.m. and 10:15 a.m.  
27 The Board submitted 21 exhibits and presented the testimony of three witnesses: (1)  
28 Barbara Meyer, the Board's Deputy Director; (2) Elaine LeTarte, the Board's Executive  
29 Director; and (3) Barbara Prah-Wix, D.O., the Board's medical consultant.

30           11. Although the hearing did not conclude for more than two hours, Respondent  
did not appear, personally or through an attorney, and did not contact the OAH to

1 request another continuance or that the start of the hearing be further delayed.  
2 Respondent did not present any evidence to defend his license.

3  
4 **HEARING EVIDENCE**  
5 **Case No. DO-09-0117**

6 12. Ms. Meyer oversees the Board's monitoring of licensees. She first had  
7 contact with Respondent in 2006, when a complaint was made against him involving  
8 Respondent's possible abuse of prescription pain medications, impairment at work, and  
9 failure to comply with a Board order for biological fluid testing in January 2007. The  
10 Board designated this complaint as Case No. 3834.

11 13. Days after Respondent failed to comply with the Board's order in Case No.  
12 3834, the Board received a complaint involving Respondent's prescription of an  
13 "atypical amount of methadone" to his patients. The Board designated this complaint  
14 as Case No. 4018. The investigation of Case No. 4018 produced an additional  
15 allegation of poor record-keeping against Respondent.

16 **The May 2008 Verbal Agreement and the November 2008 Agreement**

17 14. In May 2008, Respondent and his attorney verbally agreed to enter a non-  
18 confidential agreement for the Board to monitor him for a period of one year as partial  
19 resolution of Case No. 3834. Respondent agreed to do the following: (1) To enroll in  
20 the Board's Monitored Aftercare Program ("MAP") for substance abuse; (2) To obtain a  
21 Board-approved primary care physician ("PCP") to provide medical care and treatment,  
22 to refer Respondent to health care specialists, and to coordinate his care; (3) To take  
23 only those medications that his PCP and specialists prescribed and disclosed to the  
24 Board; (4) To maintain a medication log; and (5) To submit biological fluids for random  
25 drug testing. On November 7, 2008, Respondent signed the agreement and on  
26 November 12, 2008, Ms. Meyer signed the agreement on behalf of the Board ("the  
27 November 2008 Agreement").

28 15. Respondent informed the Board that he was under the care of PCP Clevis  
29 Parker, M.D. and Asim Khan, M.D., a pain management specialist.  
30

1 16. Dr. Prah-Wix testified that she had reviewed Dr. Parker's and Dr. Kahn's  
2 records of their treatment of Respondent. Dr. Kahn prescribed Lyrica, 120 tablets with  
3 six refills to Respondent.

4 17. A pharmacy survey of prescriptions filled nationally at Walgreen's stores  
5 showed that on November 21, 2008, Respondent filled a prescription for Lyrica in Utah,  
6 and that Respondent's brother, a physician in Utah, had written the prescription. The  
7 Board did not approve Respondent's brother to be his PCP.

8 18. Dr. Prah-Wix testified that it was concerning that Respondent chose to  
9 receive Lyrica from his brother, even though Dr. Khan had written a refillable  
10 prescription for Lyrica.

11 19. On January 23, 2009, Respondent submitted a biological fluid sample that  
12 later tested positive for Tramadol, a drug that was not listed on his medication log.  
13 Respondent initially informed the Board that Dr. Khan prescribed Tramadol on an as-  
14 needed or p.r.n. basis, but Respondent stated on the monthly medication log that he  
15 submitted to the Board on February 13, 2009, that Dr. Parker prescribed the Tramadol.

16 20. Dr. Parker's and Dr. Khan's medical records did not contain any Tramadol  
17 prescription or any report from Respondent that he was taking Tramadol that another  
18 physician prescribed to him.

19 21. Ms. Meyer testified that although Tramadol is not a narcotic controlled  
20 substance, it acts similarly to a narcotic. Ms. Meyer testified that when the Board  
21 informed Respondent that his medical records did not include a prescription for  
22 Tramadol, he said that Dr. Khan had prescribed the Tramadol, but that he did not  
23 realize that he was required to report to the Board the prescription of non-narcotic or  
24 over-the-counter medications.

25 22. Dr. Prah-Wix testified that normally people are compliant with consent  
26 agreements and that only their prescribed medications show up on drug tests. Dr.  
27 Prah-Wix testified that although Respondent had chronic pain and needed to be on  
28 medication, his failure to comply with the November 2008 Agreement raised questions  
29 about whether he could be regulated.

### 30 **The March 2009 Agreement**

1           23. On March 3, 2009, Respondent and his attorney signed a Consent  
2 Agreement and Amended Order of Probation with Terms ("the March 2009 Agreement")  
3 to resolve the outstanding issues in Case No. 3834 and the entirety of Case No. 4018.  
4 The Board approved the March 2009 Agreement effective March 14, 2009.

5           24. The March 2009 Agreement included among its requirements the following:  
6 (1) Respondent was to have stopped treating chronic pain patients by May 19, 2008,  
7 and was to have sent written notification dismissing all such patients from his practice  
8 within thirty days;<sup>1</sup> (2) Respondent was to have stopped prescribing methadone as of  
9 June 19, 2008; (3) Respondent was to complete ten hours of Board-approved  
10 continuing medical education ("CME") in pain management and ten hours of Board-  
11 approved CME in recordkeeping within six months of the effective date of the March  
12 2009 Agreement; and (5) Respondent was to provide the Board with copies of all  
13 prescriptions written for scheduled drugs and to submit to quarterly random chart  
14 reviews of ten patient charts by Board staff.

15           25. An audit of pharmacy records showed that Respondent last wrote a  
16 prescription for methadone to patient K.E. on June 10, 2008, but Respondent's records  
17 did not show an office visit for K.E. on June 10, 2008. K.E.'s last recorded office visit  
18 was on May 22, 2008.

19           26. Respondent provided copies of prescriptions that he wrote for scheduled  
20 drugs during the months of March and April 2009, but did not provide copies of any  
21 prescriptions that he wrote for scheduled drugs in May 2009. When the Board  
22 compared Respondent's reported prescriptions to reports that the Board obtained from  
23 the Arizona Board of Pharmacy, the Board discovered that during March, April, and  
24 May 2009, Respondent had written an additional 60 prescriptions of scheduled drugs to  
25 55 patients that he did not report to the Board, and that Respondent had written  
26 prescriptions for Schedule II drugs to seven of the patients.

27           27. On May 15, 2009, Respondent notified Board staff that he was ceasing to  
28 practice medicine in Arizona, selling his practice, and moving out of the state.  
29 Respondent's last drug test was performed on June 23, 2009. When Respondent left

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30 <sup>1</sup> The record does not explain why the March 2009 Agreement included Respondent's present promises to refrain from committing past acts.

1 Arizona, he had completed approximately seven months of the year of monitoring to  
2 which he had agreed in the November 2008 Agreement.

3 28. Board staff selected ten of Respondent's patients for the chart reviews that  
4 the March 2009 Agreement required, including five patients to whom Respondent had  
5 prescribed scheduled drugs and five patients to whom he had not prescribed scheduled  
6 drugs.

7 29. On September 18, 2009, the new owners of Respondent's practice provided  
8 eight of the ten patient records and on October 6, 2009, the new owners located a ninth  
9 record in storage and provided it to the Board. The new owners could not locate any  
10 records for the tenth patient, T.K. Dr. Prah-Wix testified that she spoke to "Christi," an  
11 employee who had worked for Respondent and continued working for the new owners,  
12 and "Christi" stated that Respondent did not maintain a medical record for T.K. but,  
13 instead, Respondent saw T.K. "through the back door." Dr. Prah-Wix testified that  
14 "Christi" stated that T.K. was now a patient of the new owners but had never been a  
15 patient of Respondent's.

16 30. Dr. Prah-Wix testified that the Board of Pharmacy records showed that  
17 Respondent prescribed Adderall and amphetamine salts to treat T.K.'s attention deficit  
18 disorder on May 21, 2009, six days after he had informed the Board that he had  
19 stopped practicing, and that the prescription was filled on June 3, 2009.

20 31. Dr. Prah-Wix testified that Respondent's records showed that he last saw  
21 patient K.K. in his office on March 31, 2008, when he wrote a refill prescription for a  
22 three-month supply of dextroamphetamine and a new prescription for a three-month  
23 supply of Concerta and instructed the patient to return to his office in three months.  
24 These prescriptions did not appear in Respondent's medication log or in the Board's  
25 pharmacy query.

26 32. Dr. Prah-Wix testified that Respondent's medication log included  
27 prescriptions for dextroamphetamine and Phenergan VC with codeine cough syrup to  
28 K.K. on March 2, 2009, but that that his records showed no corresponding office visit for  
29 K.K. on this date and these medications were not documented in K.K.'s chart.

30 33. Dr. Prah-Wix testified that even though Respondent's medical records did  
not show that he saw K.K. after March 31, 2008, the Board of Pharmacy records

1 showed that Respondent had written prescriptions to K.K. for dextroamphetamine and  
2 Concerta on May 21, 2009, six days after Respondent told the Board that he had  
3 stopped practicing, and that K.K. filled the prescriptions on June 1, 2009.

4 34. Dr. Prah-Wix testified that Respondent's medical records showed that he  
5 last saw patient L.C. on July 1, 2008, for chronic pain and Lyme disease. Respondent's  
6 chart and medication log showed that he wrote a prescription for Dilaudid for L.C. on  
7 April 23, 2009, and that L.C.'s chart showed no corresponding office visit on that date.

8 35. Dr. Prah-Wix testified that Respondent's medical records indicated that he  
9 saw patient G.M. on a regular basis and that on March 18, 2009, Respondent received  
10 notification from G.M.'s health care provider, Phoenix Health Plan, that it was  
11 monitoring prescriptions for controlled substances to G.M. Although Respondent  
12 signed Phoenix Health Plan's notification on March 26, 2009, Respondent prescribed  
13 the controlled substance Percocet to G.M. for abdominal pain on April 16, 2009.

14 36. Dr. Prah-Wix testified that the standard of care for an osteopathic physician  
15 dictates that he should maintain adequate medical records at the time of each office  
16 visit or patient encounter, and that a physician should not prescribe a controlled  
17 substance unless he has performed a documented examination of the patient. Dr.  
18 Prah-Wix testified that Respondent fell below these standards of care in that he failed  
19 to maintain medical records on patients T.K., K.K., L.C., and G.M.

20 37. On July 21, 2009, Respondent submitted documentation that he had  
21 completed courses for 27 hours in CME in pain management in April 2008, prior to both  
22 the May 2008 verbal agreement and the effective date of the March 2009 Agreement.  
23 Respondent did not submit documentation of having taken any CME in the six-month  
24 period defined in the March 2009 agreement, and did not submit documentation of  
25 having taken any CME in recordkeeping at any time.

26 38. The Board combined Case Nos. 3834 and 4018 for hearing, and  
27 redesignated them as Case No. DO-19-0117.

28 **Case No. DO-19-0115**

29 39. On June 19, 2009, Board staff received notification pursuant to A.R.S. §§  
30 12-570 and 32-3203 that Respondent had settled a malpractice claim filed by the  
surviving parents of V.W., a 45-year-old woman whom Respondent had treated in 2006

1 for chronic pain and who had died on August 19, 2006, as a result of overdosing on  
2 methadone that Respondent had prescribed to her.

3 40. The Board opened an investigation and obtained Respondent's medical  
4 records, as well as police and autopsy reports, for V.W.

5 41. V.W. first presented at Respondent's office on April 4, 2006, for  
6 management of chronic pain related to bilateral sciatica. At that first visit, Respondent  
7 increased V.W.'s Neortonin (gabapentin) prescription from 900 mg three times a day to  
8 800 mg four times a day, and also refilled a prescription for Vicodin 10/500 three times  
9 a day for 100 tablets and one refill.

10 42. On June 9, 2006, Respondent saw V.W. again and she told him the Vicodin  
11 was not relieving her pain. Respondent increased V.W.'s Vicodin prescription to 150  
12 tablets per refill, to be taken five times a day. Respondent's medical records for V.W.  
13 do not reflect that he conducted a physical evaluation or that he ordered any laboratory  
14 work to evaluate her condition.

15 43. On August 2, 2006, Respondent saw V.W. again and she told him that she  
16 continued to be in pain. Respondent changed V.W.'s medications to OxyContin and  
17 Oxycodone. Because V.W.'s insurance would not pay for both medications, she only  
18 partially filled Respondent's prescriptions, and obtained 20 of the Oxycodone pills.  
19 V.W. then called Respondent to advise him she could not afford the medication that he  
20 prescribed.

21 44. On August 9, 2006, Respondent saw V.W. again. Although V.W.'s records  
22 do not indicate any prior usage of methadone, Respondent wrote a prescription for 360  
23 10 mg tablets of methadone to V.W., to be taken 3 tablets every three hours.  
24 Respondent's medical records indicate that he instructed V.W. to "slowly titrate," but  
25 contain no other instructions for titrating or instructions about the use of methadone.

26 45. On August 9, 2006, Respondent also wrote a second prescription for 100 30  
27 mg tablets of Morphine Sulphate Immediate Release ("MSIR") to V.W., to be taken ½ to  
28 2 tablets every 4 to 6 hours, as needed. V.W.'s records also do not indicate any prior  
29 usage of morphine or MSIR. Respondent's medical records for V.W. indicate he  
30 prescribed the MSIR if the methadone was too expensive, but do not document that he  
cautioned V.W. against taking both the methadone and the MSIR at the same time.

1 46. Dr. Prah-Wix testified that the standard of care dictates a physician to give  
2 instruction on the amount of the medication and frequency it should be taken both  
3 verbally to the patient or caregiver and in writing on the prescription. The standard of  
4 care also dictates that the physician document in the medical record the instructions  
5 that he gave to the patient. Respondent fell below this standard of care in that he did  
6 not document any instructions in the medical record on how V.W. should have taken  
7 the methadone and MSIR, and there is no evidence that he gave specific instructions to  
8 V.W.

9 47. Dr. Prah-Wix testified that the standard of care for prescription of  
10 methadone dictates that physicians take an individualized approach. Respondent did  
11 not seem to realize that V.W. was not opioid-tolerant, and prescribed unusually large  
12 dosages of narcotics to V.W., even though she had never taken any narcotic other than  
13 the Vicodin. The standard of care requires a physician to consider patient variability in  
14 the drug's absorption, metabolism, and analgesic potency, especially in an opioid-naïve  
15 patient. Respondent fell below the standard of care in his prescription of methadone to  
16 V.W.

17 48. V.W. filled both prescriptions. Dr. Prah-Wix testified that methadone and  
18 MSIR taken together can potentiate the effects of the drugs on a patient's central  
19 nervous system ("CNS"), which means the cumulative effect of both drugs may be far  
20 greater than the effect of either drug taken alone, especially if the patient also  
21 consumes alcohol. Respondent fell below the standard of care by failing to instruct  
22 V.W. on how to use the medications and by failing to instruct V.W. not to use  
23 methadone and MSIR concomitantly. Respondent also did not instruct V.W. to avoid  
24 alcohol when she was taking methadone or MSIR.

25 49. On August 17, 2006, V.W. contacted Respondent's office, complaining of  
26 nausea. Despite Respondent's recent prescription to V.W. of methadone and MSIR,  
27 Respondent's staff did not ask V.W. to come in for an evaluation, did not ask whether  
28 she had filled both prescriptions for methadone and MSIR, and did not ask how much  
29 or how often she was taking the medications. Instead, Respondent's staff called in a  
30 prescription of promethazien for V.W.

1 50. On August 18, 2006, V.W. presented at Respondent's office, complaining  
2 about having difficulty with urination. Respondent's staff performed an in-office  
3 urinalysis. Despite the recent prescriptions for methadone and MSIR and V.W.'s  
4 previous complaint of nausea, neither Respondent nor any licensed health care  
5 practitioner personally examined or consulted V.W. or asked her what pain medications  
6 she was taking. Instead, Respondent's medical assistant called in a prescription for  
7 Bactrim for V.W., and Respondent signed the prescription at the direction of his medical  
8 assistant.

9 51. Dr. Prah-Wix testified that because methadone accumulates in the CNS, the  
10 standard of care requires a physician who has recently started a patient on methadone  
11 to follow-up with the patient in three to five days to adjust the dose to prevent CNS  
12 depressive effects. The physician or physician extender should examine the patient  
13 and question her about any side effects of the medication. Respondent's care of V.W.  
14 fell below this standard.

15 52. On August 19, 2006, V.W. was found dead at the house of some friends  
16 with whom she had been staying, with the drugs that Respondent had prescribed.  
17 V.W.'s friends called the City of Gilbert Police Department.

18 53. Because Respondent's name was on the prescriptions that he had written  
19 for V.W. and officers found Respondent's business card among V.W.'s belongings,  
20 Gilbert police contacted Respondent. According to the police report, Respondent  
21 stated that he could not remember treating V.W., but offered to sign her death  
22 certificate.

23 54. Gilbert police instead contacted the Maricopa County Office of the Medical  
24 Examiner ("the Medical Examiner"), and it took V.W.'s body. The Medical Examiner  
25 subsequently performed an autopsy and determined that V.W. had a toxic methadone  
26 concentration and a therapeutic morphine concentration in her body. V.W.'s death was  
27 ruled an accident.

### 28 CONCLUSIONS OF LAW

29 1. This matter lies within the Board's jurisdiction.<sup>2</sup>

30 <sup>2</sup> See A.R.S. §§ 32-1803(A)(1) and (13); 32-1855.

1           2. The Complaint and Notice of Hearing that the Board mailed to Respondent at  
2 his address of record was reasonable, and Respondent is deemed to have received the  
3 Complaint and Notice of Hearing.<sup>3</sup> The OAH's January 27, 2011 order setting a  
4 continued hearing that the OAH sent to Respondent at his updated address of record  
5 was also reasonable, and he is deemed to have received notice of the continued  
6 hearing.

7           3. The Board bears the burden of proof and must establish cause to discipline  
8 Respondent's license by a preponderance of the evidence.<sup>4</sup> "A preponderance of the  
9 evidence is such proof as convinces the trier of fact that the contention is more probably  
10 true than not."<sup>5</sup>

11           4. The Board established that Respondent committed unprofessional conduct  
12 as defined by applicable statutes in the following respects:

13           4.1 A.R.S. § 32-1854(25)<sup>6</sup> by failing to submit to drug tests for 12 months and  
14 by taking medications that were not prescribed by his Board-approved PCP or  
15 specialist, in violation of the November 2008 Agreement, and by failing to provide all the  
16 prescriptions that he wrote for controlled medications and by failing to complete the  
17 requisite CME in the time allowed, in violation of the March 2009 Agreement;

18           4.2 A.R.S. § 32-1854(36)<sup>7</sup> by failing to keep adequate records of his  
19 prescriptions of controlled substances to patients V.W., K.E., T.K., K.K., L.C., and G.M.;

20           4.3 A.R.S. § 32-1154(34)<sup>8</sup> by failing to examine V.W. when she presented at  
21 his office on August 18, 2006, complaining of difficult urination, and allowing his medical  
22 assistant instead to write her a prescription for Bactrim;

23  
24  
25 <sup>3</sup> See A.R.S. §§ 41-1092.04; 41-1092.05(D).

26 <sup>4</sup> See A.R.S. § 41-1092.07(G)(2); A.A.C. R2-19-119; *see also Vazanno v. Superior Court*, 74 Ariz. 369, 372,  
27 249 P.2d 837 (1952).

28 <sup>5</sup> Morris K. Udall, ARIZONA LAW OF EVIDENCE § 5 (1960).

29 <sup>6</sup> A.R.S. § 32-1854(25) defines "unprofessional conduct" as "[v]iolating a formal order, probation or a  
30 stipulation issued by the board under this chapter."

<sup>7</sup> A.R.S. § 32-1854(36) defines "unprofessional conduct" as "[p]rescribing or dispensing controlled  
substances or prescription-only medications without establishing and maintaining adequate patient  
records."

<sup>8</sup> A.R.S. § 32-1854(34) defines "unprofessional conduct" as "[l]ack of or inappropriate direction,  
collaboration or supervision of a licensed, certified or registered health care provider or office personnel  
employed by or assigned to the physician in the medical care of patients."

1 4.4 A.R.S. § 32-1854(6) and (38)<sup>9</sup> in his personal use of undisclosed  
2 medications from unapproved providers, inadequate medical records regarding his  
3 treatment of patients T.K., K.K., L.C., and G.M., and his treatment of V.W.; and

4 4.5 A.R.S. § 32-1854(44)<sup>10</sup> in his repeated failure to meet the standard of care  
5 in his treatment of V.W.

6 5. The Board also has established that Respondent cannot be regulated at this  
7 time. Therefore, the Board has established that the appropriate discipline for  
8 Respondent's proven unprofessional conduct is revocation of his license under A.R.S. §  
9 32-1855(I).

10 **ORDER**

11 Based on the foregoing Findings of Fact and Conclusions of Law, **IT IS**  
12 **HEREBY ORDERED** that License 3452, previously issued to Erol LeBlanc, D.O. is  
13 **REVOKED**.

14 **NOTICE OF RIGHT TO REQUEST REVIEW OR REHEARING**

15 Any party may request a rehearing or review of this matter pursuant to A.R.S. §  
16 41-1092.09. The motion for rehearing or review must be filed with the Arizona Board of  
17 Osteopathic Examiners within thirty (30) days. If a party files a motion for review or  
18 rehearing, that motion must be based on at least one of the eight grounds for review or  
19 rehearing that are allowed under A.A.C. R4-22-106(D). Failure to file a motion for  
20 rehearing or review within 30 days has the effect of prohibiting judicial review of the  
21  
22  
23

24 <sup>9</sup> A.R.S. § 32-1854(6) and (38) define "unprofessional conduct" as follows:

25 6. Engaging in the practice of medicine in a manner that harms or  
26 may harm a patient or that the board determines falls below the  
27 community standard.

28 . . . .

29 38. Any conduct or practice that endangers a patient's or the public's  
30 health or may reasonably be expected to do so.

<sup>10</sup> A.R.S. § 32-1854(44) defines "unprofessional conduct" as "[c]onduct that the Board determines constitutes gross negligence, repeated negligence or negligence that results in harm or death of a patient."

1 Board's decision. Service of this order is effective five (5) days after date of mailing.  
2 A.R.S. § 41-1092.09(C). If a motion for rehearing or review is not filed, the Board's  
3 Order becomes effective thirty-five (35) days after it is mailed to Respondent.  
4

5 ISSUED THIS 3<sup>rd</sup> DAY OF August, 2011.



6 STATE OF ARIZONA  
7 BOARD OF OSTEOPATHIC EXAMINERS  
8 IN MEDICINE AND SURGERY

9 By: Elaine LeTarte  
10 Elaine LeTarte, Executive Director  
11

12  
13 Original filed this 3<sup>rd</sup> day of August, 2011 with the:

14  
15 Arizona Board of Osteopathic Examiners  
16 In Medicine and Surgery  
17 9535 East Doubletree Ranch Road  
18 Scottsdale AZ 85258-5539

19 Copy of the foregoing sent via certified mail,  
20 return receipt requested this 3<sup>rd</sup> day of August, 2011 to:

21 Erol LeBlanc, DO  
22 Address of Record

23 Copy of the foregoing sent via electronic and USPS Mail this 3<sup>rd</sup>  
24 day of August 2011 to:

25 Erol LeBlanc, DO  
26 Address of Record and alternate addresses on file

27 Copy of the foregoing sent via electronic mail  
28 this 3<sup>rd</sup> day of August, 2011 to:

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