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**BEFORE THE ARIZONA REGULATORY BOARD
OF PHYSICIAN ASSISTANTS**

In the Matter of:

KEVIN EARLYWINE, P.A.-C,

Holder of License No. 2140
For Practice as a Physician Assistant
in the State of Arizona.
Respondent.

Case No. PA-04-0048A
PA-05-0039A
PA-06-0035A

**CONSENT AGREEMENT FOR LETTER
OF REPRIMAND AND PROBATION**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Regulatory Board of Physician Assistants ("Board") and Kevin Earlywine P.A.-C. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

1 4. The Board may adopt this Consent Agreement of any part thereof.
2 This Consent Agreement, or any part thereof, may be considered in any future
3 disciplinary action against Respondent.

4 5. This Consent Agreement does not constitute a dismissal or resolution of
5 other matters currently pending before the Board, if any, and does not constitute
6 any waiver, express or implied, of the Board's statutory authority or jurisdiction
7 regarding any other pending or future investigation, action or proceeding. The
8 acceptance of this Consent Agreement does not preclude any other agency,
9 subdivision or officer of this State from instituting other civil or criminal proceedings
10 with respect to the conduct that is the subject of this Consent Agreement.

11 6. All admissions made by Respondent are solely for final disposition of this
12 matter and any subsequent related administrative proceedings or civil litigation
13 involving the Board and Respondent. Therefore, said admissions by Respondent
14 are not intended or made for any other use, such as in the context of another state
15 or federal government regulatory agency proceeding, civil or criminal court
16 proceeding, in the State of Arizona or any other state or federal court.

17 7. Upon signing this agreement, and returning this document (or a copy
18 thereof) to the Board's Executive Director, Respondent may not revoke the
19 acceptance of the Consent Agreement. Respondent may not make any
20 modifications to the document. Any modifications to this original document are
21 ineffective and void unless mutually approved by the parties.

22 8. If the Board does not adopt this Consent Agreement, Respondent will not
23 assert as a defense that the Board's consideration of this Consent Agreement
24 constitutes bias, prejudice, prejudgment or other similar defense.
25

1 9. This Consent Agreement, once approved and signed, is a public record
2 that will be publicly disseminated as a formal action of the Board and will be
3 reported to the National Practitioner Data Bank and to the Board's website.

4 10. If any part of the Consent Agreement is later declared void or
5 otherwise unenforceable, the remainder of the Consent Agreement in its entirety
6 shall remain in force and effect.

7 11. Any violation of this Consent Agreement constitutes unprofessional
8 conduct and may result in disciplinary action. A.R.S. § § 32-2501(27)(k) ("[v]iolation
9 of a formal order, probation or stipulation issued by the board") and 32-2551.

10 12. *Respondent has read and understands the condition(s) of*
11 *probation.*

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16 _____
17 Kevin Earlywine, P.A.-C.
18 _____
19 Date 12/30/08
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1 **FINDINGS OF FACT**

2 1. The Board is the duly constituted authority for the regulation and
3 control of the performance of healthcare tasks in the State of Arizona.

4 2. Respondent is the holder of license number 2140 for the performance
5 of healthcare tasks in the State of Arizona.

6 **PA-04-0048A**

7 1. The Board initiated case number PA-04-0048A after receiving an
8 anonymous complaint regarding Respondent's care and treatment of a fifty-one
9 year old female patient CK. On October 21, 2004, Respondent was asked to
10 provide the Board by November 4, 2004, a complete copy of his medical records for
11 CK. On November 11, 2004, Respondent submitted an incomplete record dated
12 from May 3, 2004 to August 12, 2004. The record submitted did not include an
13 October 26, 2004 office visit, a pain management contract, or copies of Schedule III
14 prescriptions written by him. The complete record was not submitted until
15 December 15, 2004.

16 2. A medical consultant review found that Respondent did not follow
17 Board guidelines for prescribing opiates in that he failed to obtain or corroborate
18 patient CK's past medical history with previous physicians. He also failed to obtain
19 any drug screens on the patient.

20 3. In addition, the medical consultant found that Respondent over
21 prescribed the acetaminophen component of a combination drug during one month
22 and did not follow PA prescribing statutes from May 2005 to November 2005.

23 4. The medical consultant found actual harm in that the patient was
24 hospitalized with confusion related to various medications. The medical consultant
25 found that the supervising physician failed to adequately supervise Respondent
calling the relationship haphazard and incomplete.

1 formulate a diagnostic impression of a chronic pain patient and to maintain
2 adequate medical records documenting in the chart diagnostic, therapeutic and
3 laboratory results to support the diagnosis.

4 12. Respondent failed to adequately evaluate CJ. There is no review of
5 previous diagnostic studies or previous interventions or drug history. There is no
6 documentation in the chart of diagnostic, therapeutic and laboratory results to
7 support the diagnoses Respondent lists.

8 13. Patient DJ is a 53 year old man who was seen 16 times by
9 Respondent between May 25, 2004 and February 6, 2006, primarily for treatment of
10 chronic pain. DJ's original diagnoses were numerous and included degenerative
11 disc disease in the spine; degenerative joint disease; phantom limb pain involving
12 the right arm where patient has a below the shoulder right arm amputation; history
13 of multiple surgeries to the left hand; right should and right knee pain and others.

14 14. Respondent failed to conduct an examination of the spine or area of
15 pain, although DJ was there on May 25, 2004 for pain management and pain
16 medications. Respondent did not review previous treatment records or diagnostic
17 tests. He refilled DJ's Lortab prescription, but referred the patient to pain
18 management specialists for other refills.

19 15. At the June 25, 2004 visit, Respondent added a prescription for Soma
20 but there is no documentation as to why this was added or needed.

21 16. The usual reason for DJ's visits was pain medication refills, but notes
22 do not contain any history of present illness. There is no verification as to the
23 severity of DJ's complaints of spine pain.

24 17. On August 4, 2004, Patient DJ called and requested a refill for his MS
25 Contin prescription. He was informed that Respondent did not write prescriptions
for this drug. DJ threatened that he would probably have to check into the hospital
for withdrawal.

1 18. In October, 2004, Respondent decided to have his supervising
2 physician write the prescription for MS Contin. Respondent provided the patient
3 with an emergency script for 72 hours on October 18, 2004. DJ called demanding
4 pain medication and was denied on October 20th. The following day, DJ came to
5 the office to talk about pain meds. There is no documented history of present
6 illness or documentation of the discussion between Respondent and DJ.
7 Respondent provided DJ with 24 hour emergency coverage by giving him Demerol
8 50 mg 1-2 po Q 3-4 hours prn #6. On the following day, Respondent's supervising
9 physician wrote MS Contin 100 mg po Q12 hours #60 along with Lortab and Soma.

10 19. From then on, either Respondent or his supervising physician refilled
11 the pain medications including the MS Contin. DJ's short acting medication was
12 switched to Norco 10/325 to help protect his liver. In the medication log, it is noted
13 that that Respondent wrote his 14 day supply of MS Contin 60 mg i-ii po Q12 hrs
14 #56 while the supervising physician wrote his one month supply of MS Contin 60
15 mg I po Q12 hrs #60. The records are not clear as to how the patient was
16 instructed to take the MS Contin.

17 20. On the first visit, DJ signed a pain contract which required him to
18 pursue other forms of treatment including various specialists as recommended. DJ
19 never saw a pain specialist as recommended by Respondent. The pain contract
20 required Respondent to cease providing narcotics if DJ failed to comply with the
21 agreement. On March 9, 2005, DJ again demanded MS Contin and Respondent
22 refused to do so until DJ scheduled an appointment with a pain specialist. DJ left
the office and did not return until October 12, 2005.

23 21. At that visit, Respondent had begun using an EMR (electronic) format
24 for office notes. The notes document a more extensive musculoskeletal physical
25 exam with decreased range of motion of the spine from the neck to lumbar region
and in the shoulders.

1 22. During subsequent visits DJ continued to receive pain medication refills
2 and medication for upper respiratory symptoms.

3 23. Respondent never adequately evaluated and managed DJ's chronic
4 pain. There is no physical exam of the area of pain on the initial visit. There is no
5 review of previous diagnostic studies or interventions or drug history. There is no
6 discussion of other modalities for management of pain other than trying to get the
7 patient to a pain specialist and providing pain pills. Although there was a pain
8 contract, DJ did not comply with this contract and Respondent continued to supply
9 narcotics.

10 24. Respondent failed to maintain adequate records by providing objective
11 information to support numerous diagnoses or to support the ongoing need for
12 narcotic prescriptions. There is no historical information or MRI or CT to document
13 that the patient ad lumbar spinal stenosis; no history or GI evaluations to support a
14 diagnosis of GERD; and, no historical or objective documentation through x-rays,
15 MRIs or CTs to document a diagnosis of osteoarthritis of the spine with
16 intervertebral disc degenerations although Respondent's records contain them.

17 25. Also, the records are not clear as to the exact dosing DJ was receiving.
18 The records appear to state that both Respondent and his supervising physician
19 were writing prescriptions for MS Contin at the same time and few copies of the
20 prescriptions are contained within the medical records.

21 26. Respondent took over the care of patient DF, a 53 year old wheelchair
22 bound woman with a history of interstitial lung disease, NIDD and motor vehicle
23 accident with a head injury, on January 17, 2005. She had come to the clinic for
24 pain management and had been seen by another provider two times previously.
25 Respondent's notes for the visit do not contain any history of present illness. The
examination notes are not legible although Respondent marks heart, lung, breast,
abdomen, musculoskeletal and skin exams as "abnormal." Although he notes that

1 he reviewed the case with his supervising physician, there is no signature from him
2 on the records. Respondent's prescription for MS Contin 100mg, 2 po Q12 hrs. prn
3 #56 and Morphine IR liquid 20 mg/cc 2-3 cc q 4-6 hrs prn #4 bottles is either an
4 unexplained doubling of the previous dosing for this patient or an attempt to violate
5 the Respondent's 14-day prescribing privilege.

6 27. At DF's January 26, 2005 follow up visit, Respondent records the
7 original dosing amounts, but again writes a prescription for double that amount.

8 28. On February 16, 2005, DF returns for another follow up visit.
9 Respondent records the original dosing amounts, but again writes a prescription for
10 double that amount. An exam records oxygen saturation level to be 85% with lungs
11 noted to be clear. Respondent fails to address this in a patient who has known
12 pulmonary hypertension.

13 29. On March 18, 2005, DF returns for a medication refill. Respondent
14 records the dosage amount as consistent with his last two prescription amounts.
15 Respondent's supervising physician is noted to be sending a prescription.
16 However, the supervising physician has not signed any of the charts as having
17 been reviewed and did not do so for any visits until December 2, 2005. Again, the
18 patient's oxygen saturation level is low at 90%. Respondent provided a short term
19 refill of medications.

20 30. On May 3, 2005, DF returns for refills and a complaint about a lump on
21 the back of her neck. The record shows no history of present illness. A low oxygen
22 saturation level of 85% is noted. Although Respondent noted that he had reviewed
23 this with his supervising physician, there is no signature, there are no
24 accompanying dictations and no discussion or assessment of the low oxygen
25 saturation. Phenergan is added as a prescription.

31. Patient DF returns for visits with Respondent several more times
through March 21, 2006. Although low oxygen saturation is noted throughout, it is

1 never treated or referred to a pulmonologist.

2 32. The standard of care requires a physician assistant to address, assess
3 and appropriately treat low oxygen saturation. Respondent failed to do so despite
4 numerous patient contacts showing low oxygen saturation in the 80 percentile. The
5 patient has a history of interstitial lung disease and is on supplemental oxygen. She
6 also has evidence of pulmonary hypertension documented on an echocardiogram.
7 Low oxygen saturation is repeatedly recorded in the vitals, but not once is it
8 discussed in the history of present illness (HPI) or assessment and there is never
9 an intervention or plan of care outlined for his abnormality. No referral is made to a
10 pulmonologist for opinion.

11 33. Respondent failed to maintain adequate records for this patient. When
12 there is no accompanying dictation to his hand written note, there is no HPI and
13 much of the notes are illegible making it difficult for another practitioner to know
14 what occurred. There are multiple diagnoses listed without supporting
15 documentation that the diagnosis exists. For example, DF is diagnosed with
16 lumbar spinal stenosis yet there are no historical symptoms, MRI, CT or other
17 objective documenting supportive evidence in the chart. Respondent switched to
18 an Electronic Medical Record (EMR) in August 2005. The notes from that point on
19 are basically the same and without substance.

20 34. Respondent failed to verify the diagnoses causing pain in this patient.
21 There is no objective evidence provided to the diagnoses made or complaints.
22 There are no treatment objectives outlined except the noted fact that the patient's
23 medications are refilled routinely. The charts contain conflicting and confusing
24 information about the dosing of MS Contin and how the patient was to take it. The
25 records do not support a finding that the patient received a periodic review of
chronic pain.

35. The potential harm is that the patients are at risk of inadequate

1 management of chronic pain and in the case of DF there may have been a
2 treatment delay in the unrecognized and unaddressed low oxygen saturation. The
3 inadequate medical record keeping makes it difficult to know what doses of
4 medications patients are on and it is difficult to discern what the plan of care is for
5 these patients' chronic pain and DF's low oxygen saturation. Without a directed
6 physical examination, a review of previous diagnostic studies, a review of previous
7 interventions, a drug history, and an assessment of coexisting diseases or
8 conditions, these patients are at risk of being provided medications and doses that
9 are unnecessary or inadequate.

10 36. Patient MF was seen by Respondent on June 8, 2004 with a complaint
11 of constant, increasing neck and shoulder pain associated with headache. She had
12 a history of a C spine fracture at age 11 and also complained of severely
13 debilitating abdominal pain and a history of depression. There was a history of
14 marijuana use. MF had tenderness at C2-4 with limited range of motion due to
15 pain. Respondent made eleven diagnoses in his assessment and his treatment
16 plan was to refill her pain medications and to get her old records and to check labs.

17 37. Respondent's records contain two separate notes for that date.
18 However, the notes contain several dissimilarities. One reflects a drug allergy to
19 Hydrocodone while the other does not. One lists current medications as Oxycontin
20 D 40/20 and a note that patient is intolerant of pill. The other list current
21 medications as Motrin and Hydrocodone. One lists a "soft tissue osteopathic
22 manipulation and orders an MRI of the spine and a CXR, echo and EKG with a
23 referral to a neurologist and pain management. The other mentions only a referral
24 to a gynecologist and no x-rays or imaging studies.

25 38. The next three visits (July 8, and 23, and October 15, 2004) have only
handwritten notes. None contain an adequate history, only stating the patient
needs pain medication refills, needs to change her cholesterol medication or needs

1 to go over test results. No other historical information is documented. The exams
2 show a normal exam except for some loss of motion in ROM of either the neck or
3 lumbar spine and a systolic ejections murmur (SEM). The patient's diagnoses
4 during these three visits consist of DDD, DJD, hyperlipidemia, chronic neck and
5 back pain and depression. On July 8th, Respondent prescribes Lipitor, but on July
6 23rd discontinues it for undocumented reasons and puts her on Advicor.

7 39. According to the medication log, MF is being prescribed Oxy/DE 40/20.
8 The prescription increases from 1-1.5 ml po QID to 1-2 tsp Q4 hrs prn from the
9 June 8th visit to the July 23rd visit. The prescription is changed to Hydrocodone on
10 August 10, 2004 and continues until January 28, 2005, despite the earlier mention
11 of an allergy to Hydrocodone.

12 40. On November 19, 2004, MF reports she is pregnant and Respondent
13 advises she stop pain medications until approved by her OB/GYN. On December
14 6, 2004, MF presents in follow up to an emergency room visit where she had
15 requested narcotics, claiming she had left her prescription in Phoenix. She had
16 been approved for continued use by her OB/GYN. The patient indicated that she
17 did not want to stop narcotic use because of fear of withdrawal. Respondent's
18 supervising physician wrote a prescription for pain medications but there is no
19 documentation that he saw the patient.

20 41. A physician assistant must practice within the same scope of practice
21 as the supervising physician and perform only duties delegated. Respondent
22 documented that he performed a soft tissue osteopathic manipulation. As such a
23 manipulation is not within the training of the supervising physician such a duty
24 cannot be delegated.

25 42. The medical records are inadequate as they do not clearly state the
patient's beginning medications and know drug allergies.

43. Respondent failed to obtain or document objective data such as x-rays

1 or old records to review showing that the patient required the pain medications. He
2 failed to establish a pain contract with the patient even though his records noted
3 several red flags for behaviors indicating inappropriate use of narcotics. He failed
4 to make a referral to an addiction specialist even though he documented this 30
5 year old pregnant patient was addicted to the pain medications. The patient also
6 required early refills, frequent ER visits for narcotics and obtained pain medications
7 from more than one practitioner. He failed to reduce the medications.

8 44. The patient was eventually involved in a motor vehicle accident while
9 on her way to pick up a new prescription for her narcotics from Respondent. She
10 was hospitalized and recognized almost immediately as abusing narcotics.

11 45. The potential harm to the patient was allowing a continuation of the
12 abuse of narcotics and the confusing records that had the potential of placing the
13 patient at risk of a drug reaction by prescribing medication the patient was allergic
14 to.

15 46. Respondent began seeing patient PK, a 49 year old woman, on March
16 9, 2005. On her first visit, she complained of a seven day history of stomach pain
17 and diarrhea and had recently been hospitalized for "ulcerative colitis". The initial
18 visit documents an allergy to Phenergan. She has some intermittent nausea and
19 on exam has some mid epigastric tenderness. Respondent assesses her with 13
20 diagnoses and prescribed Norco 10/325 and Flagyl and plans to obtain previous
21 records. There is no objective data gathered to support the prescribing and
22 ongoing use of Norco for the patient.

23 47. PK returns six times between March 30 and July 18, 2005. There is
24 little to no historical information recorded. The patient has a normal abdominal
25 exam, but is advised to see a GI specialist and prescribed Norco 10/325.
Respondent lists the diagnosis of Crohn's disease, IBS and diverticulitis without any
clarifying data. On July 6, 2005, Respondent adds a prescription for Xanax with no

1 clear reasons given.

2 48. From August 19 to October 19, 2005, PK returns another five times.
3 Respondent had switched to his EMR system for record keeping. For all five of
4 these office visits, the patient's complaint is nausea and vomiting. The patient's
5 complaint of nausea and vomiting is never assessed. Respondent prescribes
6 Phenergan (which he had earlier documented as the patient being allergic to),
7 Keflex, Norco and sleep aids. Four days later, on October 24, 2005, the patient
8 was hospitalized with a subarachnoid hemorrhage and third nerve palsy. Although
9 Respondent had prescribed Keflex seven times to this patient, the record contains
10 no reason for prescribing this antibiotic.

11 49. Respondent fails to document a legitimate medical reason for
12 prescribing Norco. He fails to document objective information about the diagnoses
13 he lists. He failed to evaluate the patient's primary complaint of persistent nausea
14 and vomiting who presents five times in a two month period of time. On the visits of
15 September 28 and October 19, 2005, the patient also complained of a headache.
16 Respondent failed to appreciate the significance of the three complaints together as
17 being potentially related to a central nervous system origin. The patient was
18 subsequently hospitalized with a subarachnoid hemorrhage and third nerve palsy.

19 50. There was actual harm to this patient when Respondent failed to
20 evaluate her consistent complaints of nausea, vomiting and headache resulting in
21 her hospitalization. In addition, there was potential harm by Respondent prescribing
22 Phenergan after indicating an allergy and repeatedly prescribing an antibiotic
23 without indication which may lead to drug resistance to the antibiotic.

24 51. Also, in the above-mentioned patient records, Respondent failed to
25 maintain a medication log for DJ listing Schedule II and III controlled substances for
DJ for prescriptions written for hydrocodone on April 15, 2005 and for MS Contin on
March 9, 2006. Prescriptions were missing from patient records for CJ, DJ, DF and

1 LJ.

2 52. Respondent failed to follow established guidelines for pain
3 management; prescribed medications listed in PK's records as an allergy, and
4 doubled doses of Schedule II and III controlled substances for DJ and DF without
5 documenting any explanation in the records.

6 53. Both Respondent and the supervising physician admitted during
7 interviews with Board staff that they did not meet every week to discuss patient care
8 management and review charts.

9 54. A pharmacy survey from WalMart and Walgreen's indicated that
10 Respondent wrote or authorized prescriptions during April 11 to April 20, 2004 at a
11 time when he did not have a Board-approved supervising physician.

12 55. From July 28, 2005 through October 19, 2005, Respondent billed for
13 same day services and for the same fees for patient PK as did his supervising
14 physician. Respondent billed an insurance company for a "new patient"
15 examination when his dictated notes indicated he saw patient CK for a "follow up"
16 examination.

17 56. On July 5, 2006, Respondent was requested to provide specific
18 records to Board staff no later than July 24, 2006. He failed to provide the records.

19 57. Respondent saw and provided treatment for children at the clinic.
20 However, his supervising physician admitted that he had no training in pediatrics or
21 adolescent medicine. Therefore, he could not delegate duties that were not within
22 the physician assistant's scope of training or within the supervising physician's
23 training or experience.

24 58. Respondent admits to the above listed conduct and acknowledges that
25 this conduct constitutes unprofessional conduct.

CONCLUSIONS OF LAW

1. The Arizona Regulatory Board of Physician Assistants possesses

1 jurisdiction over the subject matter hereof and over Respondent.

2 2. The Board possesses jurisdiction over Kevin Earlywine, P.A.-C., the
3 holder of license number 2140, for the performance of healthcare tasks in the State
4 of Arizona.

5 3. The conduct and circumstances described above constitute
6 unprofessional conduct pursuant to A.R.S. § 32-2501(21)(c) "Performing health
7 care tasks that have not been delegated by the supervising physician."

8 4. The conduct and circumstances described above constitute
9 unprofessional conduct pursuant to A.R.S. § 32-2501(21)(i) "prescribing or
10 dispensing controlled substances or prescription-only drugs for which the physician
11 assistant is not approved or in excess of the amount authorized by this chapter."

12 5. The conduct and circumstances described above constitute
13 unprofessional conduct pursuant to A.R.S. § 32-2501(21)(j) "Any conduct or
14 practice that is harmful or dangerous to the health of a patient or the public."

15 6. The conduct and circumstances described above constitute
16 unprofessional conduct pursuant to A.R.S. § 32-2501(21)(p) "failing or refusing to
17 maintain adequate records on a patient."

18 7. The conduct and circumstances described above constitute
19 unprofessional conduct pursuant to A.R.S. § 32-2501(21)(s) "Prescribing,
20 dispensing or administering any controlled substance or prescription-only drug for
21 other than accepted therapeutic purposes."

22 8. The conduct and circumstances described above constitute
23 unprofessional conduct pursuant to A.R.S. § 32-2501(21)(x) "violating or attempting
24 to violate, directly or indirectly, or assisting in or abetting the violation of or
25 conspiring to violate a provision of this chapter."

 9. The conduct and circumstances described above constitute
unprofessional conduct pursuant to A.R.S. § 32-2501(21)(a) "violation of any

1 federal or state law or rule that applies to the performance of health care tasks as a
2 physician assistant" specifically:

3 a. A.R.S. § 32-2532(C) "unless certified for fourteen day prescription
4 privileges pursuant to § 32-2504 (A), a physician assistant shall not prescribe a
5 schedule II or III controlled substance for a period exceeding seventy-two hours.
6 For each schedule IV or V controlled substance, a physician assistant may not
7 prescribe the controlled substance more than five times in a six month period for
8 each patient."

9 b. A.R.S. § 32-2532(I) "if a physician assistant is approved by the board
10 to prescribe, administer or dispense schedule II and schedule III controlled
11 substances, the physician assistant shall maintain an up-to-date and complete log
12 of all schedule II and schedule III controlled substances he administers or
13 dispenses."

14 c. A.R.S. § 32-2531(D) "a physician assistant shall meet in person with
15 the supervising physician at least once each week to discuss patient management.
16 If the supervising physician is unavailable due to vacation, illness or continuing
17 education programs, a physician assistant may meet with the supervising
18 physician's agent. If the supervising physician is unavailable for any other reason,
19 the fulfillment of this responsibility by the supervising physician's agent is subject to
20 board approval."

21 **ORDER**

22 IT IS HEREBY ORDERED that:

23 Respondent is issued a Letter of Reprimand. Further, Respondent is placed
24 on Probation for three years with the following terms and conditions:

25 A. Scope of Practice

1 Respondent shall not undertake the performance of any health care tasks
2 that have not been delegated by his supervising physician. Respondent's practice
3 may not include patients or areas of practice outside of the supervising physician's
4 area of practice. Respondent shall meet with his supervising physician at least
5 weekly to review patient care. Respondent shall not prescribe controlled
6 substances in violation of the Practice Act as set forth in A.R.S. § 32-2501, et seq.
7 Respondent shall identify himself to patients, on all patient records and in all
8 professional correspondence as a physician assistant by affixing the initials P.A.-C.

9 B. Random Chart Reviews

10 Respondent will submit to random inspection of patient records by Board
11 staff. Staff investigators shall be allowed to examine and copy any patient medical
12 records to ensure compliance with this Order. Staff will be able to select which
13 patient records they will review without interference from Respondent. Respondent
14 shall have the rights to be present personally or through office personnel during the
15 time staff is obtaining the records as is provided in statutes.

16 C. Obey All Laws

17 Respondent shall obey all state, federal and local laws, all rules governing
18 the performance of health care tasks in Arizona, and remain in full compliance with
19 any court ordered criminal probation, payments and other orders.

20 D. Tolling

21 In the event Respondent should leave Arizona to reside or practice outside
22 the State or for any reason should Respondent stop practicing medicine in Arizona,
23 Respondent shall notify the Executive Director in writing within ten days of
24 departure and return or the dates of non-practice within Arizona. Non-practice is
25

1 defined as any period of time exceeding thirty days during which Respondent is not
2 engaging in the practice of medicine. Periods of temporary or permanent residence
3 or practice outside Arizona or of non-practice within Arizona, will not apply to the
4 reduction of the probationary period.

5
6 E. The Board retains jurisdiction and may initiate new action based upon
7 any violation of this Order.

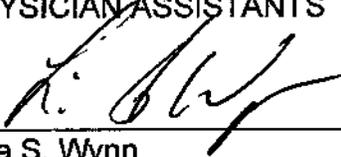
8 F. This Order is the final disposition of case numbers PA-04-0048, PA-05-
9 0039 and PA-06-0035.

10 DATED AND EFFECTIVE this 25TH day of FEBRUARY, 2009.



ARIZONA REGULATORY BOARD
OF PHYSICIAN ASSISTANTS

By



Lisa S. Wynn
Executive Director

17 ORIGINAL of the foregoing filed this
18 25th day of February, 2009 with:

19 Arizona Regulatory Board of Physician Assistants
20 9545 E. Doubletree Ranch Road
21 Scottsdale, AZ 85258

22 EXECUTED COPY of the foregoing mailed
23 this 25th day of February, 2009 to:

24 Andrew Plattner, Esq
25 *Plattner, Schneidman & Schneider, P.C.*
4201 N. 24th Street, Suite 100
Phoenix, Arizona 85016

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Kevin Earlywine, P.A.-C.

Address of Record

Kenneth Corley
Investigational Review

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