

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **WILLIAM E. MORA, M.D.**

4 Holder of License No. **13088**  
5 For the Practice of Allopathic Medicine  
6 In the State of Arizona.

Board Case No. MD-03-0239A

**FINDINGS OF FACT,  
CONCLUSIONS OF LAW AND ORDER**

(Letter of Reprimand and Probation)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting  
8 on December 7, 2005. William E. Mora, M.D., ("Respondent") appeared before the  
9 Board with legal counsel Michael Bradford for a formal interview pursuant to the authority  
10 vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following  
11 Findings of Fact, Conclusions of Law and Order after due consideration of the facts and  
12 law applicable to this matter.

13 **FINDINGS OF FACT**

- 14
- 15 1. The Board is the duly constituted authority for the regulation and control of  
16 the practice of allopathic medicine in the State of Arizona.
  - 17 2. Respondent is the holder of License No. 13088 for the practice of allopathic  
18 medicine in the State of Arizona.
  - 19 3. The Board initiated case number MD-03-0239A after receiving a complaint  
20 that Respondent performed and billed for repeated and excessive testing and procedures  
21 on a forty-one year-old male patient ("IR") who sustained a workplace "crush" injury to his  
22 left hand. The complaint expressed concerns regarding Respondent's upper extremity  
23 muscle testing, strong muscle testing, and head and neck muscle testing all prior to  
24 anesthesia and the use of a pulse oximeter and osteopathic manipulations of carpal  
25 ligament, as well as a Body Logic analyzer to determine the patient's body fat.

1           4.       IR sustained a crush injury to his left hand with circumferential wounds to  
2 the long and ring fingers of the left hand and a fracture of the middle phalanx of the ring  
3 finger. Respondent performed five surgical procedures on IR, including a closed  
4 reduction in K wire fixation of the fracture of the ring finger with exploration of the digital  
5 nerves of the long and ring fingers and repair of the flexor tendon to the ring finger; a  
6 second surgery with the removal of the K wires; a manipulation of the fingers on two  
7 occasions under anesthesia; and a capsulectomy and tenolysis of the tendons of the  
8 fingers. Respondent's records document he performed preoperative head and neck  
9 muscle testing, jaw muscle testing, and upper extremity muscle testing on six occasions  
10 and billed IR for the testing. Respondent's records reflect separate upper extremity  
11 muscle testing and associated billing on twenty occasions, range of motion  
12 measurements and associated billing on eighteen occasions, manipulation of the carpal  
13 ligament and associated billing on seven occasions, pulse oximetry in the office and  
14 associated billing on three occasions, and body fat analysis and associated billing on two  
15 occasions.

16           5.       Respondent testified he was trained in plastic surgery at the University of  
17 California, San Francisco and spent nine months at San Francisco General Hospital  
18 running the hand service. Respondent was asked if he was taught during training that  
19 determining pulse oximetry and body mass index is normal and customary to properly  
20 evaluate a patient's hand. Respondent testified he uses a variety of different methods to  
21 evaluate patients and he was strongly encouraged to use history, examination, and  
22 whatever tools he had rather than doing extraordinary testing like MRI. Respondent  
23 testified he could not say how long pulse oximetry has been around, but it is just basically  
24 a fancy Allen's test. Respondent testified body fat measurement testing is not something  
25 that was utilized at the time of his training and had come along in his practice over the

1 last ten years. Respondent was asked if it was his training during fellowship that body  
2 mass index ("BMI") is part of an examination of a hand patient. Respondent testified it  
3 was part of an examination to determine the patient's status in terms of whether or not  
4 they are obese and the use of the tool is just an extension of that. Respondent testified  
5 he was trained to assess the patient's status (whether the patient is overweight or  
6 diabetic) in terms of the patient's ability to tolerate anesthesia.

7 6. Respondent was asked if he was taught in his fellowship to use pulse  
8 oximetry as a tool to evaluate a patient's hand. Respondent testified it was one of many  
9 tools. Respondent was asked if such teaching was standard in textbooks for hand  
10 surgery. Respondent testified he could not answer specifically because he had not  
11 reviewed every textbook on hand surgery. Respondent was asked to answer the  
12 question in reference to those textbooks he was familiar with. Respondent testified he  
13 could not. Respondent was asked if it was the normal standard practice for hand  
14 surgeons in this community to test for BMI and pulse oximetry when evaluating a hand.  
15 Respondent testified he did not think it was out of the standard of care and was the  
16 standard for those who choose to do so.

17 7. Respondent was asked if he was familiar with other hand surgeons in the  
18 community who perform BMI in evaluating the hand. Respondent testified he could not  
19 say because he did not have access to other physicians' records and he does not talk to  
20 them. Respondent noted he was a solo practitioner and does not meet with other  
21 surgeons and discuss such things. Respondent testified his doing so has never been an  
22 issue except for one particular physician who may have an adversarial position about it.  
23 Respondent testified that physicians across the country he has spoken to about the idea  
24 do not find it unusual. Respondent was asked if it was his testimony that it was the  
25 standard of care in the community, but yet he also stated he was not familiar with people

1 in the community. Respondent testified the community would be across the United  
2 States and, across the United States, it is not unusual. Respondent testified he did not  
3 know if it was the local standard of care, but he does not think it is unusual that BMI or  
4 pulse oximetry is used across the United States. Respondent was asked to name  
5 physicians in other states who do such testing. Respondent named one physician in  
6 Detroit, Michigan and stated he was the only physician Respondent had spoken to about  
7 it.

8           8. Respondent testified he sees anywhere from forty to sixty patients per day  
9 and does pulse oximetry maybe once or twice a month. Respondent was asked why he  
10 does pulse oximetry only once or twice per month when he testified it was the standard of  
11 care to do pulse oximetry. Respondent testified it was standard of care to do pulse  
12 oximetry depending on the problem he was looking at. Respondent was asked what  
13 problems pulse oximetry is used for. Respondent testified he uses it for crush injuries,  
14 crush in the vascularity, thrombosed ulnar arteries, and spontaneous thrombosis of the  
15 ulnar artery. Respondent was asked if he performed an Allen's test on his patients on a  
16 routine basis. Respondent testified sometimes he does and sometimes he does not.  
17 Respondent was asked how many times a day he performed an Allen's test. Respondent  
18 testified he did so twenty-five percent of the time, depending on the patient. Respondent  
19 was asked how pulse oximetry was superior to the Allen's test. Respondent testified it  
20 was superior because it gives more information – he can tell particular patients with  
21 scleroderma or other vascular diseases (when they have sores or non-healing wounds)  
22 whether or not the flow is coming from radial or ulnar arteries or whether or not they have  
23 no flow from either artery and they just have collateral flow.

24           9. Respondent was asked how this would be different in terms of radial versus  
25 ulnar arteries in a patient who he just uses an Allen's test. Respondent testified there

1 was sometimes more information because he can actually include a digital artery on  
2 either side of the finger and the Allen's test would not tell him anything about that.  
3 Respondent testified he can check each digit by occluding the vessels in the finger and  
4 the Allen's test does not do that. Respondent was asked how many patients per year  
5 have positive tests that determine one digital artery is abnormal. Respondent testified it  
6 was a small number, maybe six and this information has allowed him to provide the  
7 patient information as to whether the patient needs an arteriogram. Respondent noted  
8 this is information he would not otherwise be able to provide.

9       10. Respondent was asked how he determined BMI. Respondent testified he  
10 has a body fat measuring machine that enters data – height, weight, age, male or female  
11 – and it registers numbers that tell the body fat, the BMI. Respondent testified he has  
12 patients who claim they cannot do things, and claim they cannot work, but actually gain  
13 weight, and their BMI goes up and this correlates with sedentary status. Respondent  
14 testified in one case he reviewed video of a patient and his information and was able to  
15 conclude the patient was fraudulent. Respondent testified he performed BMI on one or  
16 two patients per month. Respondent was asked how his fees are generated with these  
17 two examinations – the pulse oximetry and BMI. Respondent testified he used the  
18 physician's fee index. Respondent testified he did not know the exact fee, just the codes.  
19 Respondent was asked, since it is part of the normal examination, what the code would  
20 be – should it be billed separately or as part of his global fee that occurs during that visit,  
21 the normal NM code. Respondent testified he just follows the rules of the physician fee  
22 schedule that says the things you do, such as range of motion, is a separate test, just a  
23 different code. Respondent testified the physician's fee schedule says that he should  
24 code what he does and put a number with it so he just follows the schedule.

25

1           11. Respondent was asked his chief concerns for IR at the first visit.  
2 Respondent testified IR had wounds and fractures that needed surgery and his problem  
3 was complicated because he had fractures and tendon injuries. Respondent testified it is  
4 tough when there is a fracture with an associated flexion tendon wound because you  
5 have to worry about getting the bones healed first and then getting the tendon healed.  
6 Respondent testified over the course of treatment IR had gotten better compared to when  
7 Respondent first saw him. Respondent was asked if he was concerned about any  
8 circulation compromise at the beginning of IR's care. Respondent testified he thought he  
9 became concerned later on, but did not recall whether he was concerned at the  
10 beginning. Respondent was asked what happened in IR's course of treatment when  
11 Respondent said he was getting better that required him to get pulse oximetry to his  
12 hand. Respondent testified he thought there was a point in time when he was concerned  
13 about IR's crush and whether or not IR's stiffness was related to blood flow, whether he  
14 was getting enough nourishment.

15           12. Respondent was asked to explain manipulation of the transverse carpal  
16 ligament. Respondent testified he forgot the name of the physician who has tapes and  
17 literature to support that with MRI's you can enlarge the transverse carpal ligament by  
18 stretching it and also by doing certain exercises. Respondent testified he has a device –  
19 a platform - that he puts the hand in to stretch the thumb and small finger apart and the  
20 transverse carpal ligament is stretched by hyperextending the wrist and taking the thumb  
21 and small finger and pressing across where the transverse carpal ligament is.  
22 Respondent noted this physician has published reports with MRI showing the transverse  
23 carpal ligament actually enlarges with that movement as well as with the stretching  
24 exercises the patient is taught.

25

1           13.     Respondent was asked on which patients he performed the muscle testing.  
2 Respondent testified he does not do it on every patient on every visit, but on patients that  
3 he is particularly concerned about when their grip strength measurements do not match  
4 up with muscle tests. Respondent testified there is another physician in town who does  
5 exactly the same thing, but reports what he calls his "break-away testing." Respondent  
6 was asked what the normal portion of his physical examination would include for an  
7 average patient who comes into his office with a hand problem. Respondent testified for  
8 most patients he checks to see if they have simple things and checks to see if they have  
9 carpal tunnel, even though much of this is in the history. Respondent testified he checks  
10 to see if they have problems associated with the basilar joints – depending on their age,  
11 checks to see if they have good pulses, and if their finger sensation is intact.  
12 Respondent testified depending on the patient, if there is a vascular problem, he will use  
13 a pulse oximeter and if there is a question of strength, he will use muscle testing.  
14 Respondent noted he sometimes measures grip strength, particularly for those patients  
15 who have problems with range of motion.

16           14.     Respondent was asked to describe muscle testing. Respondent testified it  
17 was asking the patient to perform activities against resistance, but this was not part of a  
18 normal hand examination. Respondent was asked if sensory examination was part of the  
19 normal examination. Respondent testified pinhole sensation was – a pinwheel that is a  
20 gross examination of the patient's sensation. Respondent noted there are other ways to  
21 measure sensation, such as monofilament testing and two-point discrimination testing.  
22 Respondent testified there is a code for testing using the pinwheel, but he does not use it  
23 all the time. Respondent was asked to differentiate how his motor testing is different from  
24 that of other physicians who do not bill separately for this testing. Respondent testified  
25 he did not know what other physicians did in terms of motor testing, but for him motor

1 testing on the hand is usually related to the intrinsics of the hand and that is not what he  
2 calls muscle testing.

3 15. Respondent was asked if he was familiar with the EMM code of 99214.  
4 Respondent testified he was not. The Board noted this was the code Respondent billed  
5 IR on the July 10, 2002 visit. Respondent was asked how much time he thought he  
6 spent with IR during that visit. Respondent referred to his notes and testified the visit  
7 took quite a bit of time because checking range of motion and all the digits takes time.  
8 Respondent noted on that date it looked like there was a screening nerve conduction test  
9 done and that takes twenty or thirty minutes, so IR was Probably there for forty-five  
10 minutes or longer.

11 16. Respondent was asked how an abstract of a paper he submitted to the  
12 Board entitled "Journal of Clinical Monitoring and Computing" related to his use of pulse  
13 oximetry in his practice. Respondent testified the article had to do with cannulation, but is  
14 saying that they are concerned about collateral circulation with cannulation of the radial  
15 artery. Respondent testified the article is saying pulse oximetry has value and this tells  
16 him a patient does not necessarily need to have the radial artery cannulated to use the  
17 pulse oximeter and just says the pulse oximeter is a useful tool in patients who have the  
18 artery cannulated. Respondent was asked if he has found any other abstracts or papers  
19 in a peer review journal that support his use of the pulse oximeter to evaluate palmar  
20 circulation. Respondent testified he had not looked. Respondent was asked how then  
21 he submitted this article because it is dated in 1988 and is not a peer-reviewed journal.  
22 Respondent testified he pulled it off the internet. Respondent testified he could not say  
23 he was not aware of any other articles in a peer review journal that would support pulse  
24 oximetry, but he would also say in terms of textbooks that they are not considered  
25 anything more than information and are not considered authoritative. Respondent

1 testified whether or not something is in a textbook does not mean it does not happen.  
2 Respondent was asked what he would consider an authoritative source in terms of what  
3 would be acceptable in the medical community. Respondent testified opinions of other  
4 physicians and support of the community would be authoritative.

5 17. Respondent was asked how measurement of the artifact to assess the total  
6 evaluation of the patient would help with the examination of a finger status post injury,  
7 multiple trauma. Respondent testified he did not think the reference was to a finger per  
8 se, but to people who use their hands to work and it is an assessment usually as a  
9 baseline for a first measurement he may check along the way if the patient is not working  
10 after two or three months. Respondent was asked if it is obvious if a patient is obese is  
11 measuring body mass fat required to evaluate a hand injury to see what the progression  
12 of the hand injury would be. Respondent testified he does not just treat the hand, he  
13 treats the whole patient. Respondent was asked what he treated in IR other than his  
14 hand. Respondent testified measuring body fat is useful in a hand injury because some  
15 of the patients are working and it is a useful measurement to get as a baseline so you  
16 can compare it later and it is a cheap method of surveillance of what the patients are  
17 doing on the outside – whether or not they are active. Respondent testified when he  
18 takes a patient's history he asks if they are working, where they working, and have they  
19 been working and, even though the finger of the hand is the injury, the assessment is  
20 whether they are working and usually the recommendation is the patient can return to  
21 work.

22 18. Respondent was asked if pulse oximetry to determine blood circulation of  
23 the fingers is a procedure he can bill for because it is usually part of the examination after  
24 a procedure is done. Respondent testified there was a billing code for it. The Board  
25 noted it is a billable item when a physician is looking at whether a surgery did or did not

1 compromise the vasculature, basically a follow-up on the procedure that is a part of the  
2 procedure. Respondent was asked if he could charge for every step of the activity he  
3 did. Respondent testified it would be like saying doing an x-ray is part of the procedure,  
4 but x-rays are charged for or if you are a cardiologist and order an EKG, the EKG is  
5 charged for. The Board noted Respondent was not comparing apples to apples.  
6 Respondent testified pulse oximetry is a procedure that is commonly dictated on. The  
7 Board asked if putting a clip on a finger to see if there is a reading on it was a procedure.  
8 Respondent testified it was not just one finger, it is usually checking all digits to make  
9 sure if there is swelling, usually on both hands.

10 19. Respondent was asked how he splinted IR's finger the first time he  
11 operated on him, how he immobilized it. Respondent testified to the best of his  
12 recollection he had pins in place, but he would probably have to look at the records. The  
13 Board noted it reviewed the operating notes, but could not find how Respondent  
14 immobilized IR. Respondent was asked how he immobilized the finger and what position  
15 he had the fingers in. Respondent testified that normally with finger fractures he puts  
16 patients in a volar splint and extends it to the fingers. Respondent was asked if the  
17 fingers were fully extended. Respondent testified they were not and he usually tries to  
18 put it in a position of function, either MCT flex, PIP, DIP extended, or holding a cup. The  
19 Board noted Respondent did not document on his second operative note that he had IR  
20 in function of the flex or the MP, PIP at 30, 32 degrees. Respondent was asked if his  
21 immobilization was a cause of his having to bring IR back because of adhesions.  
22 Respondent testified it was not because IR had fractures and tendon injuries and the  
23 problem is that he is running against the clock with such injuries. Respondent testified  
24 there is a fine line between when you can have the patient move their fingers with a  
25 fracture and not have the fracture be dislodged.

1           20.     Respondent was asked what he believed was the correct splint – dorsal or  
2 volar – for a finger fracture and tendon injury. Respondent testified it depends, if you do  
3 tendon injuries a dorsal splint is acceptable and if you have fractures and tendon injuries  
4 he did not think it mattered as long as the fingers do not move. Respondent was asked if  
5 he would want some kind of passive movement flexion-wise to prevent adhesions.  
6 Respondent testified this is the problem you have with a fracture and a tendon – you do  
7 not want the finger moving with a fracture and you have to wait. Respondent testified in  
8 his experience using pins is not as stable as plates and he is reluctant to have patients  
9 move their fingers with pins because he has seen too many people referred to him from  
10 other surgeons that developed problems because their fractures moved and were  
11 displaced. Respondent testified when you have a fracture with a tendon you are  
12 probably obligated and looking towards future surgery. The Board noted Respondent  
13 also did some exploration of a capsule to relieve contracture and asked if Respondent  
14 thought moving important so it would not go into contracture again. Respondent testified  
15 the fracture is probably healed by that time and he agreed that you do anything intended  
16 to help improve motion and the first thing is to get the patient moving their fingers.

17           21.     Respondent was asked if he performed the manipulation of IR under local  
18 anesthesia at his office. Respondent testified it was probably done in his office.  
19 Respondent was asked what he was trying to do when he says “manipulation under  
20 anesthesia” – was he trying to translate the motion. Respondent testified he was not and  
21 was usually trying to break up scar adhesions. The Board noted this was the second  
22 time in eight months he broke up scar adhesions in IR and asked Respondent how much  
23 scar tissue he can break up after eight months. Respondent testified he has had patients  
24 come to his office with stiff fingers one and two years after being treated by another  
25 surgeon and he has been able to break scar adhesions and avoid the operating room.

1           22.     Respondent was directed to a letter he wrote the State Compensation Fund  
2 listing that he performed "jaw muscle testing – quality assurance" and that "[q]uality  
3 assurance requires jaw muscle testing . . . to assess the patient with a potential of  
4 requiring a general anesthetic." Respondent was asked to explain the reason for jaw  
5 muscle testing. Respondent testified for a time he did this testing for every patient who  
6 underwent jaw anesthesia. Respondent was asked if the purpose of the test was to see  
7 if a patient can open their mouth so an anesthesiologist can put an endotracheal tube in.  
8 Respondent testified it was not and was intended to see if they can get their neck off the  
9 table, if they can move side to side. Respondent was asked if it was the standard of care  
10 in 2002 at the hospital where he worked that doctors who wanted to put patients under  
11 general anesthesia were required to do jaw muscle testing. Respondent testified it was  
12 for this one particular anesthesiologist.

13           23.     Respondent was asked if his billing person used a template. Respondent  
14 testified the billing secretary only looks at the records. Respondent was again directed to  
15 a specific record from July 10, 2002 where he charged the code 99214 and was asked  
16 what services the patient received, what exactly did Respondent do. Respondent  
17 testified he evaluated IR and measured range of motion for all his fingers. The Board  
18 stopped Respondent and noted he had separately billed for range of motion so range of  
19 motion could not have been included in the 99214. Respondent testified he thought  
20 when he looked at IR he was coordinating the use of the CPM machine and more likely  
21 than not he talked to the therapist IR was working with and also assessed whether or not  
22 he needed further studies and recommended further studies. The Board noted 99214  
23 says "a detailed examination" and asked what kind of examination IR got for the 99214  
24 Respondent charged for, especially since Respondent charged him "ala carte" for other  
25 things on the same date – specifically, 95832, muscle testing; 95852, range of motion;

1 95900, nerve conduction; and a number of other tests. Respondent was asked if he  
2 unbundled and charged "ala carte" for things that should have been billed under the  
3 99214 examination.

4 24. Respondent testified he did not unbundle and when he sees a patient he  
5 has a super bill that does not have prices and he checks a box and sometimes the box  
6 checked may be nebulous. The Board noted Respondent checked 99214, 95852, 95832,  
7 95900, 95903, 95904, and 93720 for that day and asked what Respondent did to  
8 substantiate the CPT code 99214 in the examination of the musculoskeletal system.  
9 Respondent testified as he understand CPT code 99214 it does not say anything about  
10 doing other things that you do not charge for. So, within the scope of what he did that  
11 day, after spending forty-five minutes with IR, it did require him to do other things, but  
12 those other things got covered. The Board noted it believed Respondent was not  
13 understanding the question and repeated the question was what Respondent did for  
14 99214 because he charged separately for range of motion or sensory examinations.  
15 Respondent testified he did not know what box he checked on the super bill and what his  
16 billing person saw or whether the charge is nebulous or not and he would have to look at  
17 the super bill. The Board noted that when looking at other billing Respondent started off  
18 every day with 99214 and then supplemented with 95832 for muscle testing and 95852  
19 for range of motion.

20 25. Respondent was asked to explain how he came up with the billing codes for  
21 the July 10 visit, specifically, a sensory examination under 95904, a nerve conduction  
22 examination, 95900 – one for nerve conduction, one for sensory, and one for motor with  
23 F wave in the same visit that he had 99214. Respondent testified the fees came right  
24 from the physician fee schedule that has sensory testing, motor testing, and F wave  
25 testing. Respondent was asked how he did this testing. Respondent testified he used a

1 Brevio nerve conduction study by applying a Brevio machine to the extremity and passing  
2 electricity through the sensors. Respondent testified he usually sets the machine to get  
3 one reading and then after that, he tries to get the maximum amount of juice that you can  
4 get a reading for and then the machine interprets it and gives you information.  
5 Respondent was asked if the nerve conduction billed under 95900 was done for the  
6 whole arm or just the finger. Respondent testified IR had a history of carpal tunnel, so it  
7 was not a finger examination. Respondent was asked if he did this test every time the  
8 patient came in. Respondent stated he did not. The Board noted however, that on later  
9 visits Respondent billed for muscle testing on the hand and for nerve conduction.  
10 Respondent testified it may have been done at separate times and he thought he saw IR  
11 every six months.

12 26. Respondent was asked what he did for the nerve, did he repair the nerve or  
13 just release the pressure or tension around it when he first saw IR. Respondent testified  
14 he would have to look at the operative note because he did not recall. The Board noted it  
15 did not believe there was nerve laceration and the Respondent just did neurolysis.  
16 Respondent testified he did not recall and did not recall IR having a nerve injury. The  
17 Board noted the mere fact that Respondent was doing nerve testing every time IR came  
18 in, at least twice, was because all Respondent did was neurolysis and he was doing  
19 nerve conduction, but he just stated there was no nerve laceration. Respondent noted in  
20 the July 10 note under "impression" it says IR had previously had carpal tunnel  
21 diagnosed in August of 2001 and he was trying to follow up on the carpal tunnel.  
22 Respondent was asked if the carpal tunnel was part of the industrial injury. Respondent  
23 testified at the time he did not think it had been accepted and one of the problems was  
24 trying to get studies authorized by the insurance companies and showing the test was  
25 abnormal sort of documented his part for the patient to show he had a problem.





1 rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days  
2 after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not  
3 filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to  
4 Respondent.

5 Respondent is further notified that the filing of a motion for rehearing or review is  
6 required to preserve any rights of appeal to the Superior Court.

7 DATED this 10<sup>th</sup> day of February, 2006.



8 THE ARIZONA MEDICAL BOARD

9  
10  
11 By   
12 TIMOTHY C. MILLER, J.D.  
13 Executive Director

14 ORIGINAL of the foregoing filed this  
10<sup>th</sup> day of February, 2006 with:

15 Arizona Medical Board  
16 9545 East Doubletree Ranch Road  
17 Scottsdale, Arizona 85258

18 Executed copy of the foregoing  
19 mailed by U.S. ~~Certified~~ Mail this  
10<sup>th</sup> day of February, 2006, to:

20 Michael Bradford  
21 Bradford Law Offices, P.L.L.C.  
22 4131 North 24<sup>th</sup> Street – Suite C-201  
23 Phoenix, Arizona 85016

24 Executed copy of the foregoing  
25 mailed by U.S. Mail this  
10<sup>th</sup> day of February, 2006, to:

1 William E. Mora, M.D.  
2 Address of Record

3  
4  A horizontal line extends from the end of the signature across the page.

- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21
- 22
- 23
- 24
- 25