



Janice K. Brewer  
Governor

## State Of Arizona Board of Podiatry Examiners

"Protecting the Public's Health"

1400 W. Washington, Ste. 230, Phoenix, AZ 85007; (602) 542-3095; Fax: 542-3093

Barry Kaplan, DPM; Joseph Leonetti, DPM; Barbara Campbell, DPM;  
M. Elizabeth Miles, Public Member; John Rhodes, Public Member; Sarah Penttinen, Executive Director

### **BOARD MEETING MINUTES**

May 8, 2013; 8:30 a.m.  
1400 West Washington St., B1  
Phoenix, AZ 85007

Board Members: Joseph Leonetti, D.P.M, President  
Barry Kaplan, D.P.M., Member  
Barbara Campbell, D.P.M., Member  
M. Elizabeth Miles, Secretary-Treasurer  
John Rhodes, Public Member

Staff: Sarah Penttinen, Executive Director

Assistant Attorney General: Bridget Harrington

#### **I. Call to Order**

Dr. Leonetti called the meeting to order at 8:35 a.m.

#### **II. Roll Call**

Dr. Leonetti noted for the record that all Board members were present as were Ms. Penttinen and Ms. Harrington.

#### **III. Approval of Minutes**

##### **a. April 10, 2013 Regular Session Minutes.**

Dr. Kaplan offered one correction with regard to the Board's discussion of social media advertising and use of lasers in that it was Dr. Campbell and not he who had mentioned laser manufacturers going to nail salons to promote referrals. The other Board members agreed.

MOTION: Dr. Kaplan moved to approve the minutes as amended. Mr. Rhodes seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

##### **b. April 10, 2013 Executive Session Minutes.**

MOTION: Dr. Kaplan moved to approve the minutes as drafted. Dr. Campbell seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

#### **IV. Review, Discussion and Possible Action –Review of Complaints**

##### **a. 11-15-C – Aprajita Nakra, DPM: Practice below the standard of care for improper surgery; improper billing.**

Dr. Nakra was present with attorney Bruce Crawford. Dr. Jerome Cohn was the investigator for the case and was present. Dr. Cohn provided the following summary: the board had previously reviewed this case in October 2012 at which time the board found that there were no concerns regarding the surgery that Dr. Nakra performed. However, the case was tabled at that time to obtain additional billing information and due to complications caused by the civil malpractice case filed by the patient. Dr. Cohn's review at this time addresses the second allegation of improper billing which he feels is substantiated.

Dr. Cohn continued and discussed three specific billing codes. The first code, 99243, was a consult code used for the August 10, 2009 office visit. The problem with this code is that the service provided by Dr. Nakra that day was an evaluation and management, not a consultation. Dr. Cohn agreed with Dr. Leonetti that an appropriate code would have been 99203 or 99204. The second code is 64450 which Dr. Cohn stated should not be used at the same time as a surgical procedure. The third code was 28124. Dr. Nakra had explained to Dr. Cohn that one of her staff had used that code and it was not caught by the billing staff. The service correlated with that code was not performed at all. Dr. Cohn stated his opinion that regardless of who is doing the billing, the doctor needs to be aware of it and responsible for it.

Dr. Cohn also reviewed concerns regarding the number of x-rays that were taken during the post-operative office visits. He stated the patient surgery was a soft tissue procedure and the x-rays were not necessary after the first post-operative visit. Dr. Cohn confirmed for Dr. Leonetti that there was no explanation in the patient's chart as to why so many x-rays were taken. Dr. Cohn stated there was also concern with documentation with regard to whether the patient had been seen by Dr. Nakra or one of the physicians covering for her for various office visits. In addition, the billing code used for the specific office visit on January 27, 2010 is not supported by the documentation in the patient's chart.

Dr. Nakra and Mr. Crawford then addressed the board. Mr. Crawford stated that Dr. Nakra had previously been investigated by the board regarding potential billing problems for the injection code that was used, (64450), and that the patient involved in this particular case preceded the board's review. Dr. Leonetti responded that the podiatry profession as a whole has been advised for many years that that particular code should not be used. Dr. Nakra then spoke with the board members and explained how her documentation and billing procedures work in her office. With regard to the surgical code, (28124), Dr. Nakra stated that it was clearly documented in the operative report that an osseous procedure was not done, so that billing code was simply an administrative mistake and not an attempt to bill for something that was not done. Dr. Leonetti asked Dr. Nakra to explain why there were so many x-rays taken during the post-operative period. Dr. Nakra explained that she has read studies regarding the development of avascular necrosis with a plantar plate repair because the blood supply is being disrupted. Dr. Nakra added that there were additional concerns because this patient was a smoker and had continuous complaints of pain in the surgical area so she took the x-rays to try to determine the cause of that pain. Further, Dr. Nakra stated that the x-rays were taken at appropriate intervals such as when the patient was transferring from a non-weight-bearing status to a cam walker. Dr. Leonetti stated that the reasoning for the x-rays may have been appropriate, but it needed to be documented in the patient's chart. There was also discussion between Dr. Leonetti and Dr. Nakra regarding the appropriateness of the x-rays versus ordering an MRI of the patient's foot. Dr. Kaplan stated that he agreed with Dr. Leonetti's opinion that although the x-rays may have been necessary there was not enough documentation in the chart to demonstrate why. Dr. Nakra confirmed for Dr. Campbell that the patient did not report having any type of trauma or injury to the foot during the post-operative period.

**MOTION:** Dr. Kaplan moved to dismiss this case with a Letter of Concern for lack of documentation to support the billing codes used. Mr. Rhodes seconded the motion.

**DISCUSSION:** There was no discussion on the motion.

**VOTE:** The motion passed unanimously by voice vote.

**b. 11-41-C – Daniel Saunders, DPM: Practice below the standard of care for improper bunion correction; Practice below the standard of care for improper and unnecessary hammertoe corrections.**

Dr. Saunders was not present but was represented by attorney Bruce Crawford. Dr. Dedrie Polakof was the investigator for the case and was present. Dr. Polakof provided the following summary: the patient initially saw Dr. Saunders on May 27, 2010 with a chief complaint of a knot on her left third toe. The patient discussed surgery with Dr. Saunders but told him that she would only allow him to fix it by breaking it. The patient denies that she had any type of hammertoe condition. The patient also had a bunion on the first toe. The patient had also expressed concerns that she did not consent to the surgical procedures done by Dr. Saunders. However, Dr. Polakof stated that she compared the patient's signature on various documents and it does appear consistent with what she signed on Dr. Saunders'

surgical consent form. Dr. Polakof stated that although the outcome of the surgery was not cosmetically pleasing to the patient she does not find that there were any violations in this case.

Dr. Polakof confirmed for Dr. Leonetti that she was not able to speak with the patient and she also did not speak directly with Dr. Saunders. Dr. Leonetti asked her if she was able to decipher from Dr. Saunders's notes whether or not he discussed the surgical procedure with the patient as far as removing portions of the bones and cutting the tendon (hammertoe correction). Dr. Polakof stated she did not. Dr. Leonetti stated there's also some confusion as to whether or not Dr. Saunders performed a fusion of the first MPJ. He stated it appears to him that a Cheilectomy was performed and the patient developed adhesions post-operatively. Dr. Polakof confirmed that there was some shortening of the first toe. Dr. Polakof stated that a screw and a plate were clearly visible on the x-rays on the first toe and a pin on the lesser toe.

Mr. Crawford advised the board that Dr. Saunders had intended to attend today's meeting but was not able to due to family circumstances but he is willing to appear before the board if they would like to discuss the case directly with him.

The board members reviewed with Dr. Polakof a diagram that was in the patient's chart with some markings that are presumed to be indications of where on the foot Dr. Saunders planned to do surgery. There were marks on toes 3, 4 and 5, and a small mark where the Aiken ostectomy would be performed. This diagram does have the patient's signature on it. The board members also reviewed the photocopies of the x-rays that were provided with Dr. Saunders's chart.

The patient was present and addressed the board. She stated that when she saw Dr. Saunders she was only interested in having a knot removed from her third toe. She said she also had developed a corn on the fifth toe and that her first toe was leaning to the left. When she discussed her foot with Dr. Saunders he told her he could fix her toes but did not tell her how he would do that. The patient stated she was not aware that joints in her toes could be removed or fused and she was only interested in a procedure that would involve breaking the toes. She also stated that she did not know her toes would be shortened because Dr. Saunders did not discuss any of the surgical procedure with her. Upon questioning from Dr. Leonetti the patient also stated that she was never advised of any of the risks or complications of the surgery. Following the surgery her toes no longer lay flat and her first toe was completely stiff. The patient added that she also has problems with her second toe in that it curves downward and she has no feeling in it. Because of the curve of the toe she has difficulty walking and finding shoes that fit comfortably. She added that the third, fourth and fifth toes all set up in the air, and fifth toe crosses over the fourth. She did not know that the tendons would be cut in her toes or that she would have pins placed in her toes. The patient offered to show the board members her foot and each of the board members did so.

The patient continued and advised that she transferred her care to Dr. Kerry Zang and eventually required additional surgery on the first toe. Dr. Leonetti asked the patient if she remembered signing the consent form with the diagram on it. The patient stated she only remembered signing one consent form which was at the hospital as she was being wheeled down the hallway to the operating room. (It was noted that on the form with the diagram, there is a sticker from the hospital with the patient's name date of birth and medical record number with the date of July 15, 2010 which was the date of surgery with Dr. Saunders.) Patient stated she has attempted physical therapy but is too difficult because she has trouble balancing in walking. The patient also stated she is going to require additional surgery in the future to try to correct her toes. There was discussion among the board members regarding whether or not all of the necessary documentation, including surgical consent forms, had been submitted. Upon questioning from Dr. Leonetti the patient stated she did not know that Dr. Saunders was going to perform hammertoe corrections and that she did not realize that had been done until she received her explanation of benefits from Medicare. Dr. Leonetti explained to the patient that the billing code, 28285, automatically states "hammertoe correction" even if the toes were not completely contracted. However, Dr. Leonetti added that both consent forms which were signed by the patient, (one in Dr. Saunders's office on May 27th and one at the hospital on the date of surgery), state "correction of hammertoes" so there must've been some discussion of that. The patient stated that was not true. Dr. Leonetti also clarified for the patient that Dr. Saunders did not attempt to fuse her first toe.

Dr. Kaplan suggested that the board subpoena all of the surgical records directly from the hospital where Dr. Saunders performed the surgery because he believes there is a concern with the consent agreement. Mr. Crawford addressed the board and stated that the diagram consent form would have been that Dr. Saunders's form, and that there would be a completely separate consent form that the patient would have signed at the hospital. Mr. Crawford stated he believes that Dr. Saunders took the diagram form to the surgical center to go over it with the patient again prior to the surgery to make sure there were no questions about what he was going to do. Mr. Crawford confirmed for Dr. Leonetti that Dr. Saunders does not have copies of any of the hospital records for this case. The patient again addressed the board and stated that just prior to the surgery Dr. Saunders told her he was going to operate on the first toe, remove the knot from her third toe, and fix her fifth toe. She said Dr. Saunders told her that he could "create more room" if he also operated on the fourth toe and the patient agreed with that but told Dr. Saunders only if he broke the toe. The patient stated again that Dr. Saunders never told her he was going to remove portions of the bone or cut the tendons in her toes, nor did he advised her of the possible complications.

The board members directed Ms. Penttinen to issue a subpoena to the hospital where the surgery was performed to obtain complete copies of all surgical records. The board members also would like to specifically ask Dr. Saunders to appear before the board to discuss this case. The case was tabled for such further action.

**c. 12-03-M – Chad Thompson, DPM: Practice below the standard of care for improper surgery**

Dr. Thompson was present with attorney James Blair. Dr. Dedrie Polakof was the investigator for the case and was present. Dr. Polakof provided the following summary: On July 15, 2008 Dr. Thompson performed a left subtalar joint fusion with a gastroc recession. The patient was discharged from the hospital the next day with a Polar Care Kodiak cold therapy device to help with pain and swelling. On July 21 the patient presented to Dr. Thompson's office and he noted that her dressings were wet. The patient was re-admitted to the hospital that day and subsequently underwent surgery for a left open fasciotomy for compartment syndrome. The patient filed a malpractice claim which was settled in the patient's favor. Dr. Polakof stated that the main concern in this case was the use of the cold therapy device and she finds that this case fell below the standard of care. Dr. Leonetti asked Dr. Polakof her reasoning for her findings. Dr. Polakof stated she considered knowledge of the use of the device, how the device was applied, and instruction given to the patient on proper use. Dr. Polakof clarified for Dr. Leonetti that according to the operative report it was Dr. Thompson who applied the cold therapy device to the patient's foot but, according to the patient, the patient never received instruction on how to use it. Dr. Polakof also stated that the device was found to have a leak in it which caused the freeze burn at the incision site. Dr. Polakof clarified for Dr. Kaplan that the device was not applied properly because the sleeve that came with it was not used and it was applied under the surgical bandages. Dr. Polakof also stated that the patient was unaware of the leak; she was experiencing increased pain and felt a wet/cold feeling but did not know the device was operating improperly until she was re-admitted to the hospital. Dr. Polakof also confirmed that there was no concern about the joint fusion procedure.

Dr. Thompson addressed the board and explained that this particular patient had a low pain threshold and was concerned about postsurgical pain. He stated that he has used this type of cold therapy device many times in the past with success which is why he decided to use it in this case to reduce pain and swelling. Dr. Thompson stated that the hospital dispenses the device to the patient and the nursing staff provides them instructions on its use. He said that he applied approximately 1 inch of cast padding insulation to the patient's foot before applying the cold therapy device in the operating room with a posterior splint placed outside. Dr. Thompson stated the patient contacted him six days post-operatively with complaints of pain. The patient reported she had taken a bath and the dressings were wet. Upon questioning from Dr. Leonetti, Dr. Thompson stated that although the patient stayed in the hospital for approximately 24 hours, the last time he recalled seeing the patient was in the recovery room at which time he spoke extensively with the patient's husband. He also stated that he was uncertain if the nursing staff at the hospital checked the device to make sure it was operating properly but he would assume that they did. Dr. Thompson clarified for Dr. Leonetti that the patient was aware that the cold therapy device would be used following her surgery, but he did not go into specific detail about its use with the patient prior to the surgery. He added that he spoke with the patient's husband in the waiting room following the surgery about the use of the device.

In further discussion with Dr. Leonetti, Dr. Thompson stated that on the patient's first post-operative visit the foot did have small areas of necrosis and some blistering but the incisions were still intact. He also noted a lot of edema which extended slightly proximal to the ankle. He sent the patient back to the emergency room to be admitted to the hospital and believe the patient had developed compartment syndrome. He performed surgery again via a fasciotomy on the dorsal side of the foot. Dr. Thompson also stated that the original fusion healed well and there were no complications from that portion of the surgery. He added that he saw the patient for total of four follow-up visits and at the last visit the wounds from the cold therapy device had not yet completely healed. Upon questioning from Dr. Kaplan, Dr. Thompson stated he is uncertain when the device began leaking, however the dressings were wet all the way up to the proximal end. He also added that he could not be certain whether the bandages were wet due to the device leaking or from the patient taking a bath. There was brief discussion regarding the distribution of liability in the settlement the patient received, and Dr. Campbell added that there was documentation indicating that an engineer found that the device may have not been working properly. Dr. Thompson added that since this incident he no longer uses cold therapy devices because he believes it is too high of a risk.

MOTION: Dr. Leonetti moved to dismiss the case finding no violations. Mr. Rhodes seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

#### **V. Review, Discussion and Possible Action – Probation / Disciplinary Matters**

##### **a. 08-44-C – Alex Bui, DPM: Monthly update.**

Ms. Penttinen advised the board members that she had not yet received Dr. Bui's report for the month of April. The board had previously inquired as to when Dr. Bui's probation will end. Ms. Penttinen advised that Dr. Bui's probation will end on June 28 of this year. Dr. Bui also has a requirement in his consent agreement that he must affirmatively request termination of his probation.

##### **b. 09-17-B – J. David Brown, DPM: Monthly update.**

Ms. Penttinen reviewed with the board members an e-mail from Dr. Sucher's staff which indicates that Dr. Brown is no longer taking narcotic pain medication so it seems there is no longer a need for a pain management evaluation. There was also brief discussion regarding a surgery that Dr. Brown was supposed to have but the board has now been informed that he has not been able to schedule the surgery yet. There was brief discussion among the board members and Ms. Penttinen regarding urine drug screen protocols and the amount of time that various substances can be detected after they have been consumed. Ms. Miles expressed concern that there has been so much delay in obtaining the pain management evaluation along with the circumstances of surgery which seems to have been postponed numerous times. She suggested that the board obtain copies of all of Dr. Brown's drug test results for the months of March, April, May, and any tests in June which occur before the June board meeting. The remaining board members were in agreement with Ms. Miles. Ms. Penttinen stated she will get in touch with Dr. Sucher to obtain those test results.

##### **c. 11-21-M – Robert Fridrich, DPM: Monthly update.**

Dr. Leonetti reviewed a letter submitted by Dr. Fridrich indicating that he did not have any charts to submit for in-office procedures for the month of April.

##### **d. 13-05-B – Kathleen Stone, DPM: Request to amend Consent Agreement.**

The first item discussed was the substance abuse education course which Dr. Stone submitted for approval by the board. The program is through Scottsdale Treatment Institute.

MOTION: Dr. Kaplan moved to approve the course. Ms. Miles seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

The second item discussed was a possible amendment to Dr. Stone's consent agreement with regard to her counseling services. Dr. Stone was not present, but attorney Bruce Crawford was there on her

behalf. Ms. Penttinen had provided the board members with a summary explaining that the counselor with whom Dr. Stone has been working has refused to provide quarterly progress reports as required in Dr. Stone's consent agreement. Dr. Stone had requested additional time to find another counselor who would be able to provide reports as required. Mr. Crawford addressed the board and stated that he has had numerous clients who run into the same problem. He added that Dr. Stone spent a great deal of time trying to find a counselor that she was comfortable with; however, at the time she began working with this particular counselor she was not aware of what the consent agreement requirements would be for the progress reports. Dr. Stone has stated that she does not have any issue with providing reports or records to the board, but it is the counselor who's refusing to do so. The board members reviewed the specific language in Dr. Stone's consent agreement regarding counseling. Following brief discussion among the board members and Mr. Crawford, the board members agreed that Dr. Stone could satisfy the counseling requirement by amending the consent agreement such that rather than quarterly progress reports, Dr. Stone must submit proof of attendance with the counselor by way of showing payment for the counseling services. However, because Dr. Stone is required to continue with counseling for as long as recommended by the counselor, she will need to submit some type of proof to the board at the time that her counseling is no longer needed.

**MOTION:** Ms. Miles moved to offer Dr. Stone and amendments to the consent agreement as discussed above. Dr. Kaplan seconded the motion.

**DISCUSSION:** There was no discussion on the motion.

**VOTE:** The motion passed unanimously by voice vote.

**e. 11-09-M – Kelvin Crezee, DPM: Request from Dr. Crezee and his attorney to reconsider previous Board action.**

The board previously voted to offer a consent agreement for a Decree of Censure. If Dr. Crezee did not accept the agreement then he would be invited to attend an Informal Hearing on this case, and if the Informal Hearing was not accepted then the matter would be referred to a Formal Hearing. The Board is now in receipt of a request from Dr. Crezee to reconsider the board's previous action.

Dr. Crezee was present with attorney Bruce Crawford. Mr. Crawford addressed the board and stated his concern that a Decree of Censure is unduly harsh and is perceived as a severe disciplinary action within the healthcare industry. He and Dr. Crezee would like to resolve this case without the need to proceed to a Formal Hearing. He also explained that Dr. Crezee immediately notified the patient's family of the wrong-site surgery and took responsibility for the mistake. He added that Dr. Crezee has already enacted changes within his pre-operative procedures to prevent a reoccurrence. The surgical center where this occurred has done has also developed new policies and procedures with the same intention. Mr. Crawford suggested that the board could consider a non-disciplinary order for continuing education or a Letter of Concern. Dr. Leonetti clarified with Ms. Harrington that the first thing the board would need to do is decide whether or not to rescind the previous action. It was also clarified for the record that Dr. Crezee has declined to accept both the consent agreement and invitation to attend an Informal Hearing, so at this point the matter would be scheduled for a Formal Hearing.

**MOTION:** Dr. Leonetti moved to rescind the previous board action for the sole purpose of discussing possible settlement of this matter. Dr. Kaplan seconded the motion.

**DISCUSSION:** There was no discussion on the motion.

**VOTE:** The motion passed unanimously by voice vote.

There was discussion among the board members and Mr. Crawford regarding what type of CME would be appropriate in this case if the board were inclined to consider a non-disciplinary order for CME. Dr. Leonetti stated that he does not feel a Letter of Concern is appropriate, but added that he feels this is a good learning opportunity not only for Dr. Crezee but for the medical community as a whole. Dr. Kaplan agreed. After brief additional discussion the board members moved as follows:

**MOTION:** Ms. Miles moved to offer Dr. Crezee a consent agreement for a non-disciplinary order under which he would be required to complete a minimum of one hour instructing the medical profession discussing wrong-site surgery. Dr. Crezee would be required to submit a proposed plan or list of content within 45 days of the effective date of the agreement and the board must pre-approve it. He must then complete the instruction

activity within six months of the effective date of the agreement. Dr. Leonetti seconded the motion

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

## **VI. Review, Discussion and Possible Action on Administrative Matters**

### **a. Discussion regarding podiatrists writing orders for home health care agencies.**

Dr. Leonetti reviewed for the other board members that there have been questions raised as to whether or not a podiatrist can write orders for home healthcare. Technically, according to the laws for home healthcare agencies, orders can only be written by an M.D. or D.O. In the past home healthcare agencies have accepted orders from podiatrists, but occasionally and more recently they have told patients that orders need to be written by their primary care physician or surgeon, etc. Ms. Penttinen reviewed with the board members the specific laws under the Arizona Department Of Health Services which address this matter under the Arizona Administrative Code R9-10-1101(17) and A.A.C. R9-10-1104(C)(1). Ms. Miles stated she would not have any issue with this if the only concern were whether or not a podiatrist was writing orders within their scope of practice; however, the rules for home healthcare agencies are not under the board's jurisdiction. Dr. Leonetti agreed and stated that when podiatrists request information or direction from the board on this issue they should be advised that it is a matter for the Department of Health Services. Ms. Miles suggested that podiatrists or the state association could lobby the Department of Health Services to change the rule to include podiatrists in this manner. Dr. Leonetti agreed and added that under Medicare guidelines podiatrists are considered "physicians." The board members directed Ms. Penttinen to send a letter to Dr. Alan Discont who is currently the president of the state podiatry association advising him of the board's discussion and position on this matter.

### **b. Discussion regarding podiatrists ordering diagnostic studies of body parts not included in the anatomical scope of practice.**

Dr. Leonetti reviewed that a question has been raised as to whether or not a podiatrist can order diagnostic studies for parts of the body which are outside of the anatomical scope of practice. For example, if the patient is having nerve pain in the lower extremities, a podiatrist may want to order an MRI of the lumbar spine to determine if there is any nerve compression in that area which is causing the pain. Dr. Leonetti stated he feels it would not be permissible for podiatrists to order studies on body parts such as upper extremities, but that as long as a diagnostic study is directly related to the treatment and care that a podiatrist is providing within their scope of practice he feels that is acceptable. Dr. Leonetti added that a podiatrist should not interpret or read the studies, such as a lumbar MRI, and would be required to rely on the interpretation provided by the radiologist. The remaining board members were in agreement.

### **c. Discussion regarding the types of medications podiatrists for which podiatrists may write orders within the scope of practice.**

Dr. Leonetti reviewed with the board members that this question arose from a podiatrist who wanted to prescribe a smoking cessation medication to a patient prior to performing surgery. Ms. Miles stated that, as with ordering diagnostic studies, a prescription should be directly related to care and treatment provided within the scope of practice. The other board members agreed. There was brief discussion among the board members that until a specific case is brought before the board there would be no way to make a substantive determination whether the medication was appropriate because there are too many variables to consider. The board members advised Ms. Penttinen that if she receives any further inquiries in this matter she should direct the inquirer to review the scope of practice.

### **d. Review of 2012 license renewal application for Dr. Parker Gennett.**

Ms. Penttinen reviewed for the board that when Dr. Gennett submitted his 2012 license renewal application he had only completed 20 hours of CME. Dr. Gennett had requested a waiver for the other five hours because he stated he did not have time to complete all of the CME. Ms. Penttinen had previously advised him of the criteria under the boards laws for obtaining a waiver for CME which include only disability, military service, or absence from the United States. On October 10, 2012 the board members reviewed the renewal application and request for CME waiver and denied the request. Dr. Gennett was advised this in writing and was given an additional 60 days to complete the five hours of CME. However, Dr. Gennett has not responded or provided any proof of completion of the necessary

CME. There was brief discussion among the board members who were all in agreement that Dr. Gennett did not meet the minimum requirements for license renewal.

MOTION: Dr. Leonetti moved to deny Dr. Gennett's renewal application based on failure to complete the minimum CME requirements. Ms. Miles seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously.

**e. Review of license renewal and/or dispensing registration renewal for the following podiatrists:**

John Charski, DPM

Travis Reber, DPM

M.A. Rosales, DPM

MOTION: Ms. Miles moved to approve the license renewal applications for the three physicians listed above. Dr. Campbell seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

**f. Review of new license applications for the following podiatrists:**

i. Michael Cornfield, DPM

ii. Kenneth Mitchell, DPM

iii. Lindsay Westerhaus, DPM

MOTION: Dr. Leonetti moved to approve Drs. Cornfield and Westerhaus to sit for the oral exam and issue their license if they pass the exam. Dr. Campbell seconded the motion.

DISCUSSION:

VOTE: The motion passed unanimously by voice vote.

MOTION: Ms. Miles moved to approve Dr. Mitchell to sit for the oral exam but to issue a substantive deficiency to obtain additional information regarding the disciplinary action that was taken against his license by the State of Michigan. The specific information requested is a copy of the disciplinary order, discharge from suspension, and an explanation from Dr. Mitchell regarding the circumstances and events which led to the disciplinary action. Dr. Leonetti seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously by voice vote.

**VII. Executive Director's Report – Review, Discussion and Possible Action**

**a. Open complaint status report.**

Ms. Penttinen advised that she has initiated the complaints opened by the board last month regarding social media advertising. There are currently 61 open complaints including those that were on today's agenda.

**b. Malpractice case report. (None at this time.)**

**VIII. Call To The Public**

There were no requests to speak during the Call to the Public.

**IX. Next Board Meeting Date:**

a. June 12, 2013 at 8:00 a.m.

**X. Adjournment**

MOTION: Dr. Campbell moved to adjourn the meeting. Ms. Miles seconded the motion.

DISCUSSION: There was no discussion on the motion.

VOTE: The motion passed unanimously and the meeting was adjourned at 11:27 a.m.