IN THE MATTER OF	*	**BEFORE THE MARYLAND BOARD**
FREDERICK AARON, D.C.	*	**OF CHIROPRACTIC EXAMINERS**
LICENSE NUMBER: 01919	*	**CASE NUMBER: 05-02C**
Respondent	*	**OAG NO.: 05-BP-122**

* * * * * * * * * * * * *

CONSENT ORDER

The Maryland Board of Chiropractic Examiners (the "Board"), charged **Frederick Aaron, D.C., License Number 01919,** (the "Respondent") under the Maryland Chiropractic Act (the "Act") codified at Md. Health Occ. Code Ann. ("Health Occ.") §§ 3-101 *et seq.* (2005).

The pertinent provisions of the Act under which the Respondent was charged provide:

Health Occ. § 3-313 Denials, reprimands, suspensions, and revocations.

Subject to the hearing provisions of § 3-315 of this subtitle, the Board may deny a license to any applicant, reprimand any licensee, place any licensee on probation, with or without conditions, or suspend or revoke a license, or any combination thereof, if the applicant or licensee:

(9) Is professionally incompetent;

(18) Practices chiropractic with an unauthorized person or supervises or aids an unauthorized person in the practice of chiropractic;

(19) Violates any rule or regulation adopted by the Board;

(21) Commits an act of unprofessional conduct in the practice of chiropractic;

(28) Violates any provision of this title.

The statutory provision underlying ground §3-313 (28) is:

§ 3-304. Delegation of duties to assistant; qualifications for assistant.
A licensed chiropractor may delegate duties to an assistant to the extent permitted by the rules and regulations of the Board if the assigned duties do not require the professional skill and judgment of a licensed chiropractor. The rules and regulations shall also establish qualifications for the position of chiropractic assistant.

The Regulations underlying § 3-313(19) are:

C. A chiropractor and chiropractic assistant shall:
(2) Be professional in conduct

COMAR 10.43.14.04 Relationship with Patient.

A. A chiropractor shall:
(1) Use professional judgment in the use of evaluation and treatment procedures.

COMAR 10.43.14.05 Professional Boundaries.

A. A chiropractor and chiropractic assistant shall:
(2) Respect and maintain professional boundaries and respect the patient's reasonable expectation of professional conduct.
B. A chiropractor and chiropractic assistant may not:
(1) Exploit a relationship with a patient for the chiropractor's or chiropractic assistant's personal advantage including, but not limited to, a personal, sexual, romantic, or financial relationship;

COMAR 10.43.15.03 Record Keeping.

A. The chiropractor shall maintain accurate, detailed, legible, and organized records, documenting all data collected pertaining to the patient's health status.
B. The chiropractor may not erase or alter patient records but shall initial and date any changes made in the corresponding margin.
C. The Patient Record.
(1) The chiropractor shall create a record for each patient.
(2) The chiropractor shall state the patient's name or identification number on each document contained in the patient record.
(3) The chiropractor shall include the following information in the patient record:
(a) Chiropractor and clinic name and identification;
(b) Patient history;
(c) Examination findings;
(d) Diagnoses;
(e) Treatment plan;
(f) SOAP notes;
(g) Financial records;
(h) Records of telephone conversations;
(i) Copies of correspondence and reports sent to other health care providers, diagnostic facilities, and legal representatives;
(j) Records and reports provided by other health care providers and diagnostic facilities; and
(k) The signed consent of the patient or the parent or guardian of a minor patient or incompetent patient.

COMAR 10.43.15.05 Patient History.

The chiropractor shall include the following in the patient history;
A. Personal data, including:

(1) Name,
(2) Address,
(3) Telephone number,
(4) Date of Birth,
(5) Race,
(6) Sex, and
(7) Current occupation;

B. Complaint or complaints, including:
(1) Description of the complaint or complaints,
(2) Quality and character of the complaint or complaints,
(3) Intensity,
(4) Frequency,
(5) Location,
(6) Radiation,
(7) Onset,
(8) Duration,
(9) Palliative and provocative factors, and
(10) History of present complaint or complaints;

C. Family health history;

D. Past health history, including:
(1) General state of health,
(2) Previous illnesses,
(3) Surgical history,
(4) Previous injuries,
(5) Hospitalizations,
(6) Previous treatment and diagnostic testing,
(7) Prescribed and nonprescribed medications and supplements,
(8) Allergies, and
(9) Mental illness;

E. Systems review, including:
(1) Musculoskeletal,
(2) Cardiovascular,
(3) Respiratory,
(4) Gastrointestinal,
(5) Neurological,
(6) Opthalmological,
(7) Otolaryngological,
(8) Endocrine,
(9) Peripheral vascular, and
(10) Psychiatric; and

F. Personal history, including:
(1) Occupational,
(2) Activities,
(3) Exercise, and
(4) Health habits.

COMAR 10.43.07 Chiropractic Assistants.

.01 Definitions.

B. Terms Defined.

(3) "Chiropractic assistant" means an individual who is registered by the Board to perform the duties authorized under this chapter.

(4) "Direct Supervision" means supervision provided by a supervising chiropractor who is personally present and immediately available in the treatment area where the procedures are performed to give aid, direction, and instruction when certain procedures or activities are performed.

(5) "Supervising chiropractor" means a chiropractor licensed by the Board in chiropractic with the right to practice physical therapy as set forth in Health Occupations Article, § 3-301(c), Annotated Code of Maryland, and approved as a supervising chiropractor by the Board.

.02 Board Approval Required.

A. A supervising chiropractor shall apply for and receive approval from the Board before undertaking to train or supervise a new applicant or chiropractic assistant.

.06 Responsibilities of the Supervising Chiropractor.

A. The supervising chiropractor is responsible for:

(1) The safe and competent performance of the assigned duties of the applicant and the chiropractic assistant[.]

As a result of negotiations between the Office of the Attorney General, by Alice L. Tayman, Assistant Attorney General, the Respondent, through his attorney Paul Weber, Esq., and the Board, the parties agree to enter into this Consent Order consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

The Board finds that the following facts are true:

Background

1. At all times relevant to these charges, the Respondent was and is licensed to practice chiropractic in the State of Maryland, having been issued license number 01919 on or about May 10, 1999.
2. The Respondent was employed at several chiropractic offices in Montgomery County, Maryland in 2005.
3. On or around March 14, 2005, the Board received a complaint regarding the Respondent from one of his former employers alleging that the Respondent was behaving erratically and that he had been absent or tardy for work on numerous occasions, resulting in his being terminated from employment at the Complainant's chiropractic office ("Office A").
4. As a result of this complaint, the Board opened an investigation into the Respondent's professional conduct which revealed the following allegations:

Miscellaneous Unprofessional Conduct Allegations

5. The Respondent was employed part-time by Office A from January to March 10, 2005 when he was terminated for failure to report for work on multiple occasions and erratic behavior.
6. The Respondent was also employed on a part-time basis by another chiropractic office ("Office B") in January and February 2005. He was terminated from Office B for failure to report for work on multiple occasions.
7. He was then employed at a third chiropractic office ("Office C") from March 14 to August 22, 2005 where he was terminated for unprofessional conduct including absenteeism, tardiness, unsatisfactory working relationships, unsatisfactory performance, and borrowing $868 from a patient.

8. From approximately September 5, 2005 to December 7, 2005, the Respondent was employed by a fourth chiropractic office ("Office D"). The Respondent was terminated from Office D for chronic lateness and failing to report for work entirely on two (2) occasions.

Supervision of Unauthorized Practice

9. On several occasions between March 14, 2005 and August 22, 2005, while employed at Office C as a chiropractor, the Respondent supervised a chiropractic assistant who provided physical therapy, including electrical stimulation and heat therapy to the Respondent's patients. The Respondent was not approved by the Board to be a Supervising Chiropractor as defined in COMAR 10.43.07.01[1]. The Respondent typically had the assistant provide physical therapy to patients when "it was busy in the office."

10. After August 22, 2005, while employed at Office D, the Respondent supervised an individual who was an applicant to be a chiropractic assistant.

Patient Care/Documentation Issues

11. On several occasions between January and March 2005, the Respondent left the premises of the Office A where he worked for five (5) to twenty-five (25) minutes at a time while a patient was receiving electrical stimulation therapy. During the Respondent's absences, there was no other licensed staff on the premises to assist the patients.

12. On numerous occasions, while working at Office B, the Respondent left the premises for several minutes at a time while patients were receiving electrical stimulation and there was no other licensed staff in the office.

[1] The Respondent has never been approved to be a supervising chiropractor by the Board.

13. As part of its investigation of the allegations in the complaint, the Board submitted several patient files for review by an independent chiropractor (the "Reviewer") who noted numerous problems with the Respondent's patient care and documentation thereof.

14. Generally, the Reviewer made the following comments regarding the records he reviewed:

- **Patient intake form**: The patient history section was often incomplete or ignored as it related to the chief complaint. Some of the histories were written in Spanish and it is is not clear from the record whether the Respondent understands Spanish.
- **Chief Complaint**: The records generally do not have an accurate, detailed, description of how the injury occurred, what makes it worse or better, what kind of pain, severity of pain, or whether it is on the patient's left or right.
- **Exams & Re-exams**: The examination reports lack specific palpatory findings. They are unclear with respect to whether the injury or pain is on the patient's left and/or right. The orthopedic examinations are incomplete and vague. The range of motion findings appear to be estimates and vague with regard to pain. Deep tendon reflexes lack information as to which were done, left or right. There is no documentation of the patient's vital signs.
- **X-rays**: X-rays are often ordered but the patient files contain no report as to what was on them.
- **Treatment**: Daily notes are not readable in most cases. The documentation does not specify where the therapies were applied and often mentions joint dysfunction but does not mention a level of involvement.
- **Prognosis**: There are two "canned" statements that are hard to defend in some cases based on the lack of information given in the exam and the chief complaint sections.

Patient A

15. In January 2005, Patient A was a thirty (30) year old male who sought chiropractic services at the office where the Respondent was employed as a staff chiropractor for injuries resulting from a car accident.

16. The Respondent provided chiropractic treatment to Patient A on January 17, 18, 19, 20, 21, 24, 25, 26, and 29 of 2005.

17. The Respondent documented the care he provided to Patient A on a form which prompted "SOAP" (Subjective findings, Objective findings, Assessment, and Plan) notes.

18. On each of the above treatment days, the Respondent circled billing codes for chiropractic manipulative treatment, electrical stimulation, massage, and hot and cold packs. The Respondent did not indicate where on the patient any of these treatments were applied.

19. On January 19, 2005, Soto Hall is described as positive but does not provide any indication as to the location of the pain.

20. Several of the notes for the treatment dates listed above are entirely illegible.

21. On January 26, 2005, the Respondent appears to have written in the objective findings section of the notes that the patient has segmental joint dysfunction, however, the location of the dysfunction is not noted.

Patient B

22. Patient B, a then thirty-seven (37) year old male, presented to the Respondent on January 18, 2005 for an initial evaluation after being hit by a car as a pedestrian. The Respondent obtained a limited description of the accident which was documented as "MVA Pt. pedestrian, walking, [illegible] Pt. L Hip." The Respondent did not document the location or speed of the accident or any other details including how the patient was hit e.g. head on or from the side or rear.

23. The Respondent did not document anything in the family history or past history section whatsoever.

24. The Respondent circled "neck pain" and "low back pain" as being the patient's complaints but does not mention any hip pain as described in the description of the accident. There is no description of the nature of the pain or what makes it better or worse.

25. The Respondent circled "upper trapezius, levator scapulae, and lumbar paraspinal" as having revealed "tenderness, hypertonicity, and swelling" upon palpatory examination. There is no indication as to whether these findings refer to the left or the right side.

26. The Respondent circled various sections describing the orthopedic examination he performed but did not clearly indicate which of the examinations caused pain or where the pain was located.

27. The Respondent appears to have ordered x-rays but does not document what part of the body was x-rayed or what the x-rays showed.

28. On the January 20, 2005 SOAP note, the Respondent mentions that the x-ray showed that there is "[illegible] scoliosis no fracture" but does not provide any further description.

29. On the "History of Accident" form completed by the Respondent on January 18, 2005, the Respondent documents the following findings under the category of lumbar range of motion:

ROM[2]	EXAM	PAIN
Flex/90	30	Line[3]
Ext/30	10	Line
RLF/20	10	Line
LLF/20	10	Line
RR/45	10	Line
LR/45	10	Line

[2] ROM appears to be an abbreviation for Range of Motion.

[3] The Respondent simply drew a vertical line through the pain column.

30. The Respondent did not provide any clarification as to whether the numbers in the "EXAM" column are referring to symptoms observed in the patient's left or right nor did he provide any explanation of the significance of the line he drew through the "PAIN" column.

31. On the "Initial Exam Form" which was also dated January 18, 2005, the Respondent documented the following findings under the category of Lumbar Examination:

ROM	R	L	Pain
Flex/90	60	60	[blank[4]]
Ext/30	20	20	[blank]
RLF/20	10	10	[blank]
LLF/20	10	10	[blank]
RR/45	30	30	[blank]
LR/45	30	[illegible]	[blank]

32. The Respondent appears to have documented both of these range-of-motion examinations on the same day but did not provide any explanation whatsoever for the apparently inconsistent results from the same examination or why the examination was repeated.

Patient C

33. Patient C, a then twenty-three (23) year old female, sought treatment from the chiropractic office where the Respondent was employed in November 2004 for injuries resulting from a work accident.

34. The Respondent provided chiropractic treatment to Patient C on January 13, 14, 17, 19, 21, 24, 26, 28, 31, February 1, 8, 11, 22, and March 1, 2005.

[4] The Respondent did not write anything in the "pain" category.

35. The Respondent did not document his treatment with SOAP notes.

36. The Respondent's treatment notes are largely illegible.

37. X-rays appear to have been taken at the hospital after the injury and also ordered during the patient's initial evaluation but there is no report in the patient's record.

38. On the treatment dates listed above, the Respondent documented that he performed one or more of the following therapies: chiropractic manipulation,[5] electrical stimulation, massage, and traction. He did not indicate where these therapies were applied.

Patient D

39. Patient D, a then thirty-one (31) year old female, presented to the Respondent on January 21, 2005 for an evaluation and treatment after an automobile accident.

40. On the "History of Accident and Physical Examination" form, the Respondent simply wrote "Pt. was hit from behind, stopped in traffic" under the *History of the accident* section. He did not provide any additional information as to whether air bags were deployed, the speed of the accident or any other detail.

41. The Respondent left the *Family or past history* section entirely blank.

42. The Respondent indicated on the form that Patient D had complaints of neck and right arm pain. There is no description of the pain or what aggravates it or alleviates it.

43. The cervical spine range of motion results do not include any indication of whether they cause pain or not. Lumbar range of motions were not measured.

44. The examination is incomplete and the documentation provides no indication of whether it is referring to right or left.

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[5] The form used by the Respondent to document his patient care listed Current Procedural Terminology ("CPT") code 97260 which had been the code for chiropractic manipulation until 1999 when the code was deleted from the CPT and replaced with 98940.

45. The Respondent noted in the initial evaluation that he had ordered x-rays but did not document any x-ray findings in the patient's chart.

46. In the initial evaluation, the Respondent indicated that deep tendon reflexes were normal but did not specify to which deep tendon reflexes he was referring.

47. After the initial evaluation, the Respondent provided treatment to Patient D on January 22, 24, 25, 26, and 28 of 2005. Many of the SOAP notes documenting these treatment dates are illegible. On each of these treatment dates the Respondent circled billing codes indicating that he provided chiropractic manipulative treatment, electrical stimulation, massage, and hot and cold packs but in none of the notes did he indicate where he applied these therapies.

48. On January 25, the Respondent documented segmental joint dysfunction but did not specify on what level the dysfunction was located.

Patient E

49. Patient E, a then forty (40) year old male, sought treatment from the chiropractic office where the Respondent was employed in January 2005 for injuries resulting from an auto accident.

50. The initial evaluation and History form completed on January 31, 2005 is unsigned and almost entirely left blank except that it mentioned that the patient complained of neck pain, headaches and "side.[6]" The handwriting on the January 31, 2005 History form appears not to have been the Respondent's.

51. On the day after the initial evaluation, February 1, 2005 and on February 2, 3, 8, 10, 15, 17, 22, 24, 31 and March 8, 2005, the Respondent treated Patient E. At no time were

[6] The evaluator wrote "side" as one of the patient's complaints but provided no explanation whatsoever what he or she was describing, which side, whether the patient was complaining about pain, stiffness, bruising etc.

any of the details of the patient's prior medical history, history of the accident, and evaluation of injury which should have been documented in the History form during the initial evaluation, documented in Patient E's record.

52. In addition, on the day after the initial evaluation and for the remainder of Patient E's treatment, the Respondent documented subjective findings of "low back pain" which was not one of the complaints mentioned on the initial evaluation.

53. The Respondent's treatment notes are largely illegible.

54. The Respondent's notes mention segmental joint dysfunction, but do not specify what level the dysfunction was located.

55. On the treatment dates listed above, the Respondent documented that he performed one or more of the following therapies: chiropractic manipulation, electrical stimulation, traction, massage, and traction. He did not indicate where these therapies were applied.

Patient F

56. Patient F, a then thirty-four (34) year old female, presented to the Respondent on February 11, 2005 for an evaluation and treatment after an automobile accident.

57. On the "History of Accident and Physical Examination" form, the Respondent simply wrote "MVA" under the *History of the accident* section and circled "rear." He did not provide any additional information as to whether air bags were deployed, the speed of the accident or any other detail.

58. The Respondent documented that the patient's past medical history was "N/A" however, the patient had apparently misunderstood the form and had checked <u>all</u> of the boxes inquiring about her prior medical history. The Respondent did not clarify the patient's statements to assure that the patient's chart accurately reflected the patient's past medical history.

59. The Respondent circled on the form that Patient F had complaints of neck pain and headaches. There is no description of the pain or what aggravates it or alleviates it.

60. Although the patient complained of headaches, the Responded did not conduct a CNS[7] or a cranial nerve exam.

61. The Respondent's documentation does not uniformly specify right or left.

62. The Respondent documented that the patient's deep tendon reflexes were normal but did not specify which reflexes he tested.

63. The Respondent appears to have ordered x-rays but did not document what was x-rayed or any findings from the x-rays.

64. The cervical spine range of motion results do not include any indication of whether they cause pain or not.

65. After the initial evaluation, the Respondent provided treatment to Patient F on February 16 and March 1, 2005. The SOAP notes documenting these treatment dates are largely illegible.

66. On each of these treatment dates the Respondent circled billing codes indicating that he provided chiropractic manipulative treatment, electrical stimulation, massage, and hot and cold packs but he did not indicate where he applied those therapies.

67. The Respondent's notes mention segmental joint dysfunction, but do not specify at what level the dysfunction was located.

Patient G

68. Patient G, a then forty-seven (47) year old female, presented to the Respondent on February 10, 2005 for an evaluation and treatment after an automobile accident.

[7] Central Nervous System

69. On the "History of Accident and Physical Examination" form, the Respondent simply wrote "MVA" under the *History of the accident* section. He did not provide any additional information as to whether the angle of impact was rear, head-on, right or left, whether air bags were deployed, the speed of the accident or any other detail.

70. The Respondent documented that the patient had a history of "MVA-Previous year" but did not provide any other description of the previous accident or whether the patient had incurred any injuries as a result thereof but indicates that "prior to this accident [the patient] was having pain due to: MVA."

71. The Respondent circled on the form that Patient G had complaints of neck pain, low back pain and chest pain. There is no description of the pain or what aggravates it or alleviates it.

72. In the "diagnosis" section of the History form, the Respondent indicates that Patient G has "Post Traumatic Headaches" despite the fact that the patient had not mentioned, or the Respondent had failed to document, that she complained of headaches during the initial examination.

73. The cervical spine range of motion results does not include any indication of whether they cause pain or not. Lumbar range of motions were not measured.

74. The Respondent noted that the deep tendon reflexes were "normal" but did not specify which reflexes he tested.

75. The Respondent noted in the initial evaluation that an x-ray had been taken by the hospital but did not document any x-ray findings in the patient's chart.

76. After the initial evaluation, the Respondent provided treatment to Patient G on February 10, 11, 15, 17, 22, and March 1, and 3 of 2005.

77. Many of the SOAP notes documenting these treatment dates are illegible.

78. On each of these treatment dates the Respondent circled billing codes indicating that he provided chiropractic manipulative treatment, electrical stimulation, massage, and hot and cold packs but in none of the notes did he indicate where he had applied these therapies.

Patient H

79. Patient H, a then twenty-seven (27) year old male, sought treatment in November 2004 from the chiropractic office where the Respondent was employed for injuries resulting from a work accident. Patient H initially complained of pain in his neck and right shoulder and was diagnosed with cervical strain and right shoulder strain.

80. The Respondent provided chiropractic treatment to Patient H on January 6, 10*, 13*, 19*, 21, 24, 26, 28, February 1, 2, 3, 8, 11, 22 and March 3, 2005.[8]

81. The Respondent did not document his treatment with SOAP notes.

82. The Respondent's treatment notes are largely illegible.

83. On the treatment dates listed above, the Respondent documented that he performed one or more of the following therapies: chiropractic manipulation,[9] electrical stimulation, massage and traction. He did not indicate where the therapy was applied.

84. On February 8, 2005, the Respondent appears to document that the patient has segmental joint dysfunction but did not document the level.

85. On January 28, and February 1, 2, 3, 8, 11, and 22, 2005, the Respondent treated Patient H for low back pain however the patient initially complained of neck and right shoulder

[8] The asterisked treatment dates were documented by the Respondent on a separate sheet of paper and appear to be written out of sequence.

[9] The form used by the Respondent to document his patient care listed Current Procedural Terminology ("CPT") code 97260 which had been the code for chiropractic manipulation until 1999 when the code was deleted from the CPT and replaced with 98940.

pain. There is no evaluation of Patient H's low back pain in the patient's record to explain its source.

Patient I

86. Patient I, a then thirty-one (31) year old female, presented to the Respondent on February 8, 2005 for an evaluation and treatment after an automobile accident.

87. In the "History of Accident and Physical Examination" form, the Respondent simply wrote "Motor Vehicle Accident [left] rear" under the *History of the accident* section. He did not provide any additional information as to whether air bags were deployed, the speed of the accident or any other detail.

88. The Respondent wrote "N/A" in the *Family or past history* section.

89. The Respondent indicated on the form that Patient I had complaints of neck, low back, and right arm pain. There is no description of the pain or what aggravates it or alleviates it.

90. The cervical spine range of motion results do not include any indication of whether they cause pain or not.

91. The examination is incomplete and the documentation provides no indication of whether it is referring to right or left.

92. Patient I complained of hand symptoms but there were no tests performed to determine the source of the hand symptoms.

93. In the initial evaluation, the Respondent indicated that deep tendon reflexes were normal but did not specify which deep tendon reflexes he tested.

94. After the initial evaluation, the Respondent provided treatment to Patient I on February 8, 10, 22, 24 and March 3 of 2005. Many of the SOAP notes documenting these treatment dates are illegible. On each of these treatment dates the Respondent circled billing

codes indicating that he provided chiropractic manipulative treatment, electrical stimulation, massage, and hot and cold packs but in none of the notes did he indicate where he applied these therapies.

Patient J

95. Patient J, a then thirty-three (33) year old male, initially sought chiropractic treatment in March 2004 for injuries resulting from a box that fell on his head at work. Patient J complained of neck pains, headaches and dizziness.

96. The Respondent provided treatment to Patient J on January 24, 26, February 8, and March 3, 2005.

97. The Respondent's treatment notes are largely illegible.

98. On the treatment dates listed above, the Respondent documented that he performed one or more of the following therapies: chiropractic manipulation, traction, and massage. He did not indicate where these therapies were applied.

Patient Boundary Violations

99. The Respondent was, in part, terminated from employment at a chiropractic office ("Office C") on or around August 22, 2005 because a patient ("H.K.") reported that the Respondent had borrowed and not repaid a loan of approximately $856.00. The Respondent allegedly borrowed the money from H.K. because he could not afford to pay the tuition for his continuing education courses which the Respondent needed to renew his license.

100. The Respondent procured this loan from H.K. by using the patient's credit card and address to pay for continuing education credits on or about July 16, 2005.

101. In May 2005, the Respondent also enlisted H.K. to sign a lease on an apartment in which the Respondent resided. H.K. did not reside in the apartment.

102. In or around January 2006, the landlord of the apartment began eviction proceedings against the patient, H.K., because the Respondent had failed to pay several thousand dollars in rent.

CONCLUSIONS OF LAW

The Board finds that the Respondent violated the following provisions of the Act and the regulations thereunder Health Occ. § 3-313(9), (18), (19), (21), (28), Health Occ. § 3-304, COMAR 10.43.14.03, COMAR 10.43.14.04, COMAR 10.43.14.05, COMAR 10.43.15.03, COMAR 10.43.15.05, COMAR 10.43.07.01, 10.43.07.02, and COMAR 10.43.07.06.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 21 day of Sept, 2006 by a majority of a quorum of the Board, hereby:

ORDERED that the Respondent shall be **SUSPENDED** for sixty (60) days; and it is further

ORDERED that the Respondent may not petition for a stay of the suspension prior to sixty (60) days from the date of this Order; and it is further

ORDERED that BEFORE the Board terminates the suspension the Respondent must complete the following:

i The Respondent shall undergo a psychological and substance abuse evaluation by a Board-approved evaluator to assess his competence to practice chiropractic in a safe manner which is consistent with the Act;

ii The Respondent shall provide releases of his medical, psychiatric, and substance abuse records to evaluator;

iii The evaluator shall submit a report regarding the Respondent's competence to practice to the Board which is satisfactory in the estimation of the Board; and

iv The Respondent shall demonstrate compliance with any treatment and/or supervision regimen recommended by the evaluator; and it is further

ORDERED that after the Respondent has complied with the terms above, the Board shall, at its discretion, reinstate the Respondent's license and place the Respondent on Probation or schedule a case resolution conference to determine terms for his reinstatement consistent with the recommendations of the evaluator; and it is further

ORDERED that once the Respondent's license is reinstated, he shall be placed on **PROBATION** for at two (2) years during which he shall comply with the following terms:

i. The Respondent shall submit bi-monthly reports from his treating mental health and/or substance abuse treatment providers indicating his compliance with any and all aspects of the prescribed treatment regimen;

ii. The Respondent shall provide quarterly reports from his employer indicating that his work performance is satisfactory;

iii. The Respondent shall provide the name and address of his employer(s) to the Board and must provide an update to the Board within three (3) days in the event that his place of employment changes;

iv. The Respondent shall satisfactorily complete a Board-approved ethics course; and

v. The Respondent shall satisfactorily complete a Board approved documentation course; and it is further

ORDERED that if the Respondent fails to comply with the terms and conditions of this Consent Order, such failure shall be deemed a Violation of Probation and of this Consent Order and the Board may take any action it deems appropriate under the Act, including, but not limited

to, charging the Respondent and/or immediately suspending the Respondent's license, provided the Respondent is given the opportunity for a show cause hearing at the next regularly scheduled meeting of the Board; and it is further

ORDERED that unless the Board is satisfied that the Respondent has shown just cause why his license should not have been or should not be suspended under the provision set out in the previous paragraph of this Consent Order, his license shall remain suspended unless and until he complies with the terms of this Consent Order and any other requirement the Board deems appropriate to ensure the public protection; and it is further

ORDERED that in the event that the Respondent's license remains suspended for two (2) years and sixty (60) days, his license shall be revoked after notice and a show cause hearing; and it is further

ORDERED that the Respondent shall practice chiropractic in accordance with the Maryland Medical Chiropractic Act, and in a competent manner, and it is further

ORDERED that for purposes of public disclosure, as permitted by Md. State Gov't. Code Ann. § 10-617(h) (2004) this document consists of the foregoing Findings of Fact, Conclusions of Law, and Order and that the Board may disclose to any national reporting bank or other entity to whom the Board is mandated to report; and it is further

ORDERED that the Respondent shall pay all costs associated with this order, and it is further

ORDERED that the conditions of this Consent Order are effective as of the date of this Order; and it is further

ORDERED that this Consent Order is a **FINAL ORDER** and, as such, is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't. Code Ann. §§ 10-611 *et seq.* (2004).

IT IS SO ORDERED THIS 21ST **DAY OF** September, **2006**

SEPTEMBER 21, 2006
Date

Marc M. Gamerman, DC
Marc M. Gamerman, D.C., President
Board of Chiropractic Examiners

CONSENT OF FREDERICK AARON, D.C.

I, affixing my signature hereto, acknowledge that:

1. I **Frederick Aaron, D.C., License Number 01919** am represented by counsel and I have reviewed this Consent Order with my attorney.

2. I am aware that I am entitled to a formal evidentiary hearing before the Board, pursuant to Md. Health Occ. Code Ann. § 3-315 (2005) and Md. State Gov't. Code Ann. §§10-201 *et seq.* (2004) I waive any right to contest the terms and findings herein, and I waive my right to a full evidentiary hearing and any right to appeal this Consent Order as set forth in § 3-316 of the Act and Md. State Gov't. Code Ann. §§10-201 *et seq.*

3. I acknowledge the validity of this Consent Order as if entered after a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by law.

4. I voluntarily admit to the foregoing Findings of Fact, Conclusions of Law and Order and submit to the terms and conditions set-forth herein as a resolution of the Charges against me. I acknowledge that by failing to abide by the conditions set forth in this Consent Order, and, following proper procedures, I may suffer disciplinary action, which may include revocation of my license to practice chiropractic in the State of Maryland.

5. I sign this Consent Order without reservation as my voluntary act and deed. I acknowledge that I fully understand and comprehend the language, meaning, and terms of this Consent Order.

2 Oct. 2006
Date

Frederick Aaron, D.C.

Approved by: _____
Paul Weber, Esq.

NOTARY

STATE OF Maryland

CITY/COUNTY OF Anne Arundel

I HEREBY CERTIFY THAT on this 2nd day of October, 2006, before me, a Notary Public for the State of Maryland and the City/County aforesaid, personally appeared Frederick Aaron, D.C. and made oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS my hand and Notarial Seal.

Notary Public

My Commission Expires: 4/1/08