Final Order No. DOH-04-1019- S -MOA
FILED DATE - 9-1-04
Department of Health

By: Heather Coleman
Deputy Agency Clerk

STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOH CASE NOS.: 1998-12206
1999-51810
LICENSE NO.: ME0064073

JASON N. POZNER, M.D.,

Respondent.
_______________________________/

FINAL ORDER

THIS CAUSE came before the BOARD OF MEDICINE (Board) pursuant to Sections 120.569 and 120.57(4), Florida Statutes, on August 6, 2004, in Tallahassee, Florida, for the purpose of considering a Consent Agreement (attached hereto as Exhibit A) entered into between the parties in this cause. Upon consideration of the Consent Agreement, the documents submitted in support thereof, the arguments of the parties, and being otherwise fully advised in the premises, the Board rejected the Consent Agreement and offered a Counter Consent Agreement which Respondent was given 7 days to accept. By letter dated August 23, 2004, counsel for Respondent timely accepted the Board's Counter Consent Agreement on behalf of the Respondent. The Counter Consent Agreement incorporates the original Consent Agreement with the following amendments:

1. The fine set forth in Paragraph 2 of the Stipulated Disposition shall be increased to $20,000.

2. The community service set forth in Paragraph 5 of the Stipulated Disposition shall be increased to require 100 hours of community service.

3. The requirement for a letter of concern shall be deleted.

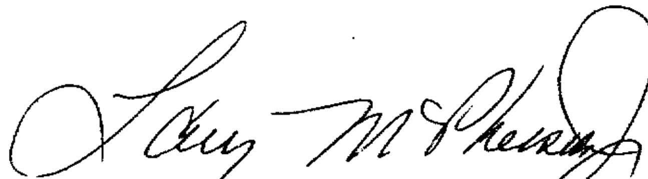
4. Respondent shall be REPRIMANDED by the Board.

IT IS HEREBY ORDERED AND ADJUDGED that the Consent Agreement as submitted be and is hereby approved and adopted in toto and incorporated herein by reference with the amendments set forth above. Accordingly, the parties shall adhere to and abide by all the terms and conditions of the Consent Agreement as amended.

This Final Order shall take effect upon being filed with the Clerk of the Department of Health.

DONE AND ORDERED this 26 day of AUGUST, 2004.

BOARD OF MEDICINE



Larry McPherson, Jr., Executive Director
for Elisabeth Tucker, M.D., Chair

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by U.S. Mail to JASON N. POZNER, M.D., 4800 North Federal Highway, Suite C-101, Boca Raton, Florida 33431; to Allen R. Grossman, Esquire, Gray, Robinson, P.A., 301 S. Bronough Street, Suite 600, Tallahassee, Florida 32301-7721; and by interoffice delivery to Denise O'Brien and Pamela Page, Department of Health, 4052 Bald Cypress Way, Bin #C-65, Tallahassee, Florida 32399-3253 this 1st day of September, 2004.

Erica L. Prine
Deputy Agency Clerk

F:\Users\ADMIN\NANCY\MED\ORD\August-2004\Pozner-POCCA.wpd

STATE OF FLORIDA
DEPARTMENT OF HEALTH
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

v. **DOH CASE NUMBERS 1999-51810 & 1998-12206**

JASON NEAL POZNER, M.D.,

Respondent.
______________________________/

CONSENT AGREEMENT

Jason Neal Pozner, M.D., referred to as the "Respondent," and the Department of Health, referred to as "Department," stipulate and agree to the following Agreement and to the entry of a Final Order of the Board of Medicine, referred to as "Board," incorporating the Stipulated Facts and Stipulated Disposition in this matter.

Petitioner is the state department charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes, and Chapter 458, Florida Statutes.

STIPULATED FACTS

1. At all times material hereto, the Respondent was a licensed physician in the State of Florida having been issued license number ME 64073.

2. The Respondent was charged by an Administrative Complaint filed by the Agency and properly served upon the Respondent with violations of Chapter 458, Florida

14691

Statutes, and the rules enacted pursuant thereto. A true and correct copy of the Administrative Complaint is attached hereto as Exhibit A.

3. Respondent neither admits nor denies the allegations of fact contained in the Administrative Complaint.

STIPULATED CONCLUSIONS OF LAW

1. The Respondent admits that, in his capacity as a licensed physician, he is subject to the provisions of Chapters 456 and 458, Florida Statutes, and the jurisdiction of the Department and the Board.

2. The Respondent admits that the facts set forth in the Administrative Complaint, if proven, would constitute violations of Chapter 458, Florida Statutes, as alleged in the Administrative Complaint.

3. Respondent admits that the Stipulated Disposition in this case is fair, appropriate and acceptable to Respondent.

STIPULATED DISPOSITION

1. **FUTURE CONDUCT.** The Respondent shall not in the future violate Chapters 456, 458 and 893, Florida Statutes, or the rules promulgated pursuant thereto. Prior to signing this agreement, the Respondent shall read Chapters 456, 458, 893 and the Rules of the Board of Medicine, at Section 64B8, Florida Administrative Code.

2. **ADMINISTRATIVE FINE.** The Board shall impose an administrative fine in the amount of ten thousand dollars ($10,000.00) against the Respondent. The fine shall be paid by the Respondent to the Board of Medicine within 30 days of its imposition

by Final Order of the Board. **THE RESPONDENT ACKNOWLEDGES THAT THE TIMELY PAYMENT OF THE FINES IS HIS LEGAL OBLIGATION AND RESPONSIBILITY AND THE RESPONDENT AGREES TO CEASE PRACTICING IF THE FINE IS NOT PAID AS AGREED TO IN THIS CONSENT AGREEMENT, SPECIFICALLY: IF THE RESPONDENT HAS NOT RECEIVED WRITTEN CONFIRMATION THAT THE FULL AMOUNT OF THE FINE HAS BEEN RECEIVED BY THE BOARD OFFICE WITHIN 30 DAYS OF THE FILING OF THIS FINAL ORDER, THE RESPONDENT AGREES TO CEASE PRACTICE UNTIL SUCH WRITTEN CONFIRMATION IS RECEIVED BY THE RESPONDENT FROM THE BOARD. (SEE EXHIBIT B OF THIS CONSENT AGREEMENT FOR BOARD ADDRESS AND STANDARD TERMS).**

3. **REIMBURSEMENT OF COSTS.** In addition to the amount of any fine noted above, the Respondent agrees to reimburse the Department for any administrative costs incurred in the investigation, prosecution, and preparation of this case, including costs assessed by the Division of Administrative Hearings, if applicable, and by the Board of Medicine office. **The agreed upon Agency costs to be reimbursed in this case is five thousand, two hundred forty dollars and eighty-nine cents ($5,240.89).** The costs shall be paid by the Respondent to the Board of Medicine within 30 days of its imposition by Final Order of the Board. **THE RESPONDENT ACKNOWLEDGES THAT THE TIMELY PAYMENT OF THE COSTS IS HIS LEGAL OBLIGATION AND RESPONSIBILITY AND RESPONDENT AGREES TO CEASE PRACTICING IF THE**

COSTS ARE NOT PAID AS AGREED TO IN THIS CONSENT AGREEMENT, SPECIFICALLY: IF THE RESPONDENT HAS NOT RECEIVED WRITTEN CONFIRMATION THAT THE FULL AMOUNT OF THE COSTS NOTED ABOVE HAS BEEN RECEIVED BY THE BOARD OFFICE WITHIN 30 DAYS OF THE FILING OF THIS FINAL ORDER, THE RESPONDENT AGREES TO CEASE PRACTICE UNTIL SUCH WRITTEN CONFIRMATION IS RECEIVED BY THE RESPONDENT FROM THE BOARD. (SEE EXHIBIT B OF THIS CONSENT AGREEMENT FOR BOARD ADDRESS AND STANDARD TERMS).

4. **FMA MEDICAL RECORDS COURSE.** Respondent shall complete the Florida Medical Association course entitled "Quality Medical Record Keeping for Health Care Professionals" within one (1) year of the filing of the Final Order of the Board. In addition, Respondent shall submit documentation in the form of certified copies of the receipts, vouchers, certificates, or other papers, such as physician's recognition awards, documenting completion of this medical education course within one (1) year of the Final Order incorporating this Agreement. All such documentation shall be sent to the Board of Medicine, regardless of whether some or any of such documentation was previously provided during the course of any audit or discussion with counsel for the Department. These hours shall be in addition to those required for renewal of licensure. Unless otherwise approved by the Board, said continuing medical education courses shall consist of a live, lecture format.

5. **COMMUNITY SERVICE**. During the next twelve months following the filing date of a Final Order in this case, Respondent shall perform fifty hours of community service. Community service shall consist of the delivery of medical services directly to patients, without fee or cost to the patient, for the good of the people of the state of Florida. Such community service shall be performed outside the Respondent's regular practice setting. Respondent shall submit a written plan for performance and completion of the community service to the Board for approval prior to performance of said community service. Affidavits detailing the completion of community service requirements shall be filed with the Board quarterly.

6. **LETTER OF CONCERN.** Respondent shall receive a Letter of Concern from the Board of Medicine.

7. Upon consideration of the Board of Medicine at the time of presentation of this agreement the Board shall dismiss subsection (a) in count three and four of the administrative complaint.

8. **MITIGATING FACTORS:** In arriving at this disposition the parties considered the following mitigating factors: Respondent has no prior discipline in this or any other jurisdiction in which he has been licensed to practice medicine; there were no legal restraints on Respondent at the time of the alleged offense; the conduct alleged in these cases took place in 1997 and 1998 respectively; there have been no additional complaints of any kind against Respondent's medical license throughout his more than eleven years of medical practice in Florida; Respondent is a Board Certified

Plastic Surgeon; at the time of these incidents, Respondent was an employed surgeon at the Florida Center for Cosmetic Surgery and shortly after these incidents, Respondent voluntarily left employment at that center and opened his own office which has been inspected and certified by the Department of Health; Respondent has on staff a full time risk manager; and Respondent also currently retains an outside risk manager who periodically re-inspects his office and practice. The investigative file in this matter includes copies of a complete and appropriate medical history contained in Respondent's medical record for Patient PS. All of these factors support a conclusion that the remaining allegations of the Administrative Complaint are not indicative of Respondent's usual practice of medicine and that Respondent has taken appropriate steps to assure that the alleged conduct does not occur in the future.

9. Upon presentation to the Board of Medicine, the board shall dismiss subsection (a) in count three and four of the administrative complaint.

STANDARD PROVISIONS

1. It is expressly understood that this Agreement is subject to the approval of the Board and the Department. In this regard, the foregoing paragraphs (and only the foregoing paragraphs) shall have no force and effect unless a Final Order incorporating the terms of this Agreement is entered by the Board.

2. Respondent is required to appear before the Board at the meeting of the Board where this Agreement is considered.

3. Respondent and the Department fully understand that this joint agreement and subsequent Final Order incorporating same will in no way preclude additional proceedings against Respondent for acts or omissions not specifically set forth in the Administrative Complaint attached as Exhibit "A" herein.

4. Upon the Board's adoption of this Agreement, Respondent expressly waives all further procedural steps, and expressly waives all rights to seek judicial review of or to otherwise challenge or contest the validity of the Agreement and the Final Order of the Board incorporating said Agreement.

5. Respondent waives the right to seek any attorney's fees or costs from the Department in connection with this matter.

6. This agreement is executed by the Respondent for the purpose of avoiding further administrative action with respect to this cause. In this regard, Respondent authorizes the Board to review and examine all investigative file materials concerning Respondent prior to or in conjunction with consideration of the Agreement. Furthermore, should this joint Agreement not be accepted by the Board, it is agreed that presentation to and consideration of this Agreement and other documents and matters by the Board shall not unfairly or illegally prejudice the Board or any of its members from further participation, consideration, or resolution of these proceedings.

EXHIBIT B

STANDARD TERMS APPLICABLE TO CONSENT AGREEMENTS

The following are the standard terms applicable to all Consent Agreements, including supervision and monitoring provisions applicable to licensees on probation.

A. PAYMENT OF FINES. Unless otherwise directed by the Consent Agreement, all fines shall be paid by check or money order and sent to the Board address as set forth in paragraph E, below. The Board office does not have the authority to change terms of payment of any fine imposed by the Board.

B. COMMUNITY SERVICE AND CONTINUING EDUCATION UNITS. Unless other wise directed by the Consent Agreement, all community service requirements, continuing education units/courses must be completed, and documentation of such completion submitted to the Board of Medicine at the address set forth below in paragraph E, WITHIN ONE YEAR OF THE DATE OF THE FINAL ORDER.

C. ADDRESSES. The Respondent must keep current residence and practice addresses on file with the Board. The Respondent shall notify the Board within ten (10) days of any changes of said addresses. Furthermore, if the Respondent's license is on probation, the Respondent shall notify the Board within ten (10) days in the event that the Respondent leaves the active practice of medicine in Florida.

D. COSTS. Pursuant to Section 458.331(2), Florida Statutes, the Respondent shall pay all costs necessary to comply with the terms of this Consent Agreement. Such costs include, but are not limited to, the cost of preparation of Investigative Reports

detailing compliance with the terms of the Consent Agreement, obtaining supervision or monitoring of the practice, the cost of quality assurance reviews, and the Board's administrative cost directly associated with the Respondent's probation.

E. BOARD ADDRESS. Unless otherwise directed by the Board office, all fines/costs shall be sent to Department of Health, HMQAMS/Client Services, P.O. Box 6320, Tallahassee, FL 32314-6320. ATTN: Medical Compliance Officer. All reports, correspondence and inquiries must be sent to Department of Health, HMQAMS/Client Services/Bin C01, 4052 Bald Cypress Way, Tallahassee, FL 32399-3251, ATTN: Medical Compliance Officer.

SIGNED this 2 day of July, 2004.

JASON NEAL POZNER, M.D.

Before me, personally appeared Jason Pozner whose identity is known to me by Personally (type of identification) and who, under oath, acknowledges that his/her signature appears above.

Sworn to and subscribed before me this 2nd day of July, 2004.

NOTARY PUBLIC

My Commission Expires:

Dee L. Doddy
Commission #DD187373
Expires: Feb 24, 2007
Bonded Thru
Atlantic Bonding Co., Inc

APPROVED this 8th day of July, 2004.

John O. Agwunobi, M.D., M.B.A., M.P.H.
Secretary, Department of Health

By: Wings S. Benton
Deputy General Counsel
Department of Health

WSB:pdt

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. CASE NO. 1999-51810
1998-12206

JASON N. POZNER, M.D.,

RESPONDENT.
_______________________________/

ADMINISTRATIVE COMPLAINT

Petitioner, the Department of Health, for its Complaint against Jason N. Pozner, M.D., states as follows:

PARTIES

1. The Department of Health is the state agency charged with regulating the practice of medicine under Florida Law.

2. Respondent, whose address of record is 4800 North Federal Highway, Suite C-101, Boca Raton, Florida 33431, was issued license number ME 0064073 on May 26, 1993, and is board certified in Surgery and Plastic Surgery.

3. At all times material to this Complaint, Respondent was a licensed physician within the State of Florida.

4. Respondent's relationship with the patients described in this complaint arose from his employment as a contract employee for Florida Center for Cosmetic Surgery, Inc. ("FCCS")

14701

5. Respondent was not an owner, shareholder or officer of the FCCS.

FACTS PERTAINING TO PATIENT D.M.

6. On or about January 7, 1998, Patient D.M., a forty-five (45) year-old male, presented to Respondent at FCCS for plastic surgery and for a revision of a previous tummy tuck performed by another surgeon.

7. Patient D.M. signed consent forms for anesthesia services, Blepharoplasty (eyelid surgery), Rhytidectomy (face-lift), chin implant, neck suspension, suction assisted lipectomy (fat suction), abdominoplasty (tummy tuck), and rhinoplasty (nasal lip plasty) (an operation that changes the shape of the nose).

8. On or about January 22, 1998, during the Pre-Surgical and Anesthesia Evaluation, Patient D.M. denied having a history of any disease, denied that he was taking any medication, and acknowledged that he smoked.

9. On or about January 22, 1998, Respondent performed surgery on Patient D.M. including lower eyelid surgery, chin implant, face-lift with neck suspension, nose surgery, ultrasonic assisted lipoplasty (liposuction), and revision of the previous tummy tuck.

10. On a follow-up visit of January 23, 1998, Respondent removed the drains from Patient D.M.'s abdomen and face.

11. On a follow-up visit of January 26, 1998, Respondent drained 60 ccs of fluid from the lower front of Patient D.M.'s neck, and 30 ccs of fluid from the right side of his neck.

12. On a follow-up visit of January 29, 1998, Respondent removed the drains from Patient D.M.'s neck.

13. On a follow-up visit of February 2, 1998, Respondent drained 10 ccs of fluid from Patient D.M.'s neck.

14. On a follow-up visit of February 13, 1998, Respondent described Patient D.M. as "with swelling and scar."

15. On February 13, 1998, Respondent drained 5 ccs of fluid from Patient D.M.'s neck, gave an injection of a steroid in the neck and prescribed Keflex (an antibiotic), Valium and Percocet.

16. On or about February 27, 1998, Patient D.M. presented for follow-up. Respondent drained 10 ccs of fluid from Patient D.M.'s neck.

17. On or about February 27, 1998, Respondent diagnosed infection of the neck area. Respondent performed a surgical procedure on Patient D.M. that afternoon for visual inspection and excision of infected tissue. Respondent forwarded a tissue specimen from this procedure for culture analysis.

18. On or about March 4, 1998, Patient D.M. presented to Respondent for surgery to release some of the scar tissue on his neck and for closure of the wound. During the procedure, Respondent drained a small amount of fluid from Patient D.M.'s neck.

19. On or about March 9, 1998, Respondent received the results of the February 27 culture studies on Patient D.M., which revealed staph aureus.

20. On or about March 13, 1998, Patient D.M. presented for follow-up, and Respondent noted in the medical records that Patient D.M.'s sutures were removed, and patient was doing well.

COUNT ONE – STANDARD OF CARE

21. Petitioner realleges and incorporates paragraphs one (1) through twenty (20) as if fully set forth herein this Count One.

22. Respondent failed to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances, in that Respondent:

(a) By failing in diagnosing the infection in Patient D.M.'s neck, even with the presence of a chin implant and recurring collections of fluid prior to the surgical procedure on February 27, 1998;

(b) By failing to replace the drains in Patient D.M.'s neck or closely monitoring him after he developed recurring collections of fluid in his neck; and

(c) By failing to delay Patient D.M.'s surgical procedure on or about March 4, 1998, to give the patient additional time for settling of the soft tissues after the procedure performed on or about February 27, 1998.

23. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes, by failing to practice medicine with that level of care, skill, and

treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

COUNT TWO - DEFICIENT MEDICAL RECORDS

24. Petitioner realleges and incorporates paragraphs one (1) through twenty (20) as if fully set forth herein this Count Two.

25. Respondent failed to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient, in one or more of the following ways:

(a) By failing to document that he performed a history and physical examination on Patient D.M. before the surgery on January 22, 1998;

(b) By failing to document a history, physical examination or justification for ordering the January 7, 1998 blood test for Patient D.M.;

(c) By failing to have Patient D.M. sign consent forms for the surgical procedures on or about February 27, 1998, and March 4, 1998; or

(d) By failing to document consideration of infection, justification for the prescription of Keflex or instruction to Patient D.M. about possible infection before February 27, 1998.

26. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes, by failing to keep legible medical records that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

FACTS PERTAINING TO PATIENT P.S.

27. On or about November 28, 1997, Patient P.S., a sixty-three (63) year-old female, presented to the Florida Center for Cosmetic Surgery for information on receiving a face-lift, liposuction and breast surgery.

28. On or about November 28, 1997, Patient P.S. presented with a history of smoking, pneumonia, kidney disorder/bladder infections, and bronchitis. Patient P.S. documented on her family history that her father had a heart attack and her mother had hardening of the arteries.

29. On or about November 28, 1997, Patient P.S. filled out a pre-anesthesia evaluation form including information that she had a history of smoking, bronchitis, pneumonia, and kidney/bladder problems.

30. A CBC blood test obtained by the Florida Center for Cosmetic Surgery, on or about November 28, 1997, for Patient P.S. was normal.

31. On or about December 1, 1997, Patient P.S. advised the nurse anesthetist that Patient P.S. had taken a long time to recover from anesthesia related to a prior surgery.

32. On or about December 1, 1997, immediately prior to surgery, the nurse anesthetist advised Respondent of Patient P.S.'s history with regard to anesthesia.

33. On or about December 1, 1997, Respondent performed face lift surgery on Patient P.S. under general anesthesia for 6 hours at the Florida Center for Cosmetic Surgery.

34. Patient P.S. was extubated after the surgery and she was bandaged and monitored by the nursing staff.

35. While Patient P.S. was being prepared to be transferred to the recovery room, she developed trouble breathing and the anesthetist re-intubated her. EKG leads and a blood pressure device revealed she was flatlined and without a pulse. The nursing staff contacted emergency medical services (EMS) and began CPR with chest compression. Patient P.S. was medicated and her pulse and EKG returned; the ventilation was continued.

36. When EMS arrived, they found Patient P.S. unconscious. Patient P.S. was transported to the emergency room at Cleveland Clinic Hospital where she arrived in respiratory arrest.

37. At Cleveland Clinic, Patient P.S. was diagnosed as having suffered hypoxic encephalopathy (brain damage), coma, diabetes mellitus and status post recent facial plastic surgery.

COUNT THREE – STANDARD OF CARE

38. Petitioner realleges and incorporates paragraphs one (1) through five (5) and paragraphs twenty-seven (27) through thirty-seven (37) as if fully set forth herein this Count Three.

39. Respondent failed to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances, in one or more of the following ways:

(a) By failing to obtain a complete medical history of Patient P.S.; or

(b) By failing to perform a physical examination of Patient P.S.

40. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes, by failing to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

COUNT FOUR - DEFICIENT MEDICAL RECORDS

41. Petitioner realleges and incorporates paragraphs one (1) through five (5) paragraphs twenty-seven (27) through thirty-two (37) as if fully set forth herein this Count Four.

42. Respondent failed to keep legible medical records that justify the course of treatment of the patient, in one or more of the following ways:

(a) By failing to document in a complete medical history; or

(b) By failing to document a physical examination;

43. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes, by failing to keep legible medical records that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

COSTS

44. Petitioner has incurred costs related to the investigation and prosecution of this matter.

45. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter on a respondent in addition to any other discipline imposed.

WHEREFORE, Petitioner requests that, in order to protect the health and safety of the People of the State of Florida, Respondent be found responsible for the violations alleged, and each of them, and that one or more of the following disciplines be entered against Respondent:

(A) Permanent Revocation of Respondent's license;

(B) Suspension of Respondent's license for an appropriate period of time;

(C) Restriction of Respondent's practice;

(D) Imposition of an administrative fine;

(E) Issuance of a reprimand;

(F) Placement of Respondent on probation, with appropriate conditions;

(G) Such other and further relief as is appropriate.

SIGNED this 14 day of January, 2003.

John O. Agwunobi, M.D., M.B.A.
Secretary, Department of Health

Bruce A. Campbell
Assistant General Counsel
DOH, Prosecution Services Unit
4052 Bald Cypress Way, Bin C-65
Tallahassee, FL 32399-3265
Florida Bar # 191163
(850) 414-8126 voice
(850) 414-1991 facsimile

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK Vicki R. Kenon
DATE 1/15/03

Reviewed and approved by: DKK (initials) 1/14/03 (date)

PCP: December 20, 2002
PCP Members: El-Bahri, Davies, Beebe

NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with section 120.569 and 120.57, Florida Statutes (2002), to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or her behalf if a hearing is requested.