Texas Medical Board Press Release

FOR IMMEDIATE RELEASE
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TMB disciplines 29 physicians at April meeting, adopts rule changes

At its April 9-10, 2015 meeting, the Texas Medical Board disciplined 29 licensed physicians and issued three cease and desist orders. The disciplinary actions included six orders related to quality of care violations, two orders related to unprofessional conduct, two revocations, six voluntary surrenders, one order related to criminal activity, one order related to peer review actions, three orders related to other states’ actions, one order related to improper prescribing, two orders related to impairment, two orders related to violation of prior Board order, two orders related to advertising violations, and one order related to inadequate medical records.

The Board issued 161 physician licenses at the April meeting, bringing the total number of physician licenses issued in FY15 to 2,280.

RULE CHANGES ADOPTED

CHAPTER 161. GENERAL PROVISIONS

§161.3, Organization and Structure
The Amendments to §161.3, relating to Organization and Structure, clarify the process for reporting potential grounds for removal of a board member, and adds a potential ground that must be reported related to both disciplinary and non-disciplinary action against a physician board member under subsection (f). The amendments also add new subsection (g), providing that the validity of an action of the board is not affected by the fact that the action is taken when a ground for removal of a board member exists. Remaining amendments represent general cleanup of the rule.

CHAPTER 163. LICENSURE

§163.1, Definitions
The Amendments to §163.1, relating to Definitions, added new subsection 163.1(9)(D), relating to “one-year training program” and 163.1(13)(D), relating to “two-year training program” to include a domestic training program that subsequently received accreditation by the Accreditation Council for Graduate Medical Education, American Osteopathic Association or Royal College of Physicians, and was accepted by a specialty board that is a member of the American Board of Medical Specialties, the Bureau of Osteopathic Specialists, or the Royal College of Physicians for Board certification purposes. Additional amendments to Rule 163.1(13)(B), relating to “two-year training program” adds clarifying language that describes the board approved program under which a Faulty Temporary License was issued and cites to corresponding rules relating to Faculty Temporary Licenses. This amendment will provide applicants a mechanism to meet training requirements when such training was not accredited by the ACGME or AOA, at the time of such training, but was subsequently accredited by the ACGME or AOA, and was accepted by one of the accepted specialty boards for board certification purposes. An additional benefit will be to avoid confusion and to have rules that are clear and accurate.

§163.7, Ten Year Rule
The Amendment to §163.7, relating to Ten Year Rule, revise paragraph (1) to add the Royal College of Physicians and Surgeons of Canada to the list of specialty boards from which an applicant can present evidence of current competence and updates the list of requirements to clarify that proof of initial certification through passage of all exams or
subsequent passage of a monitored written, specialty certification examination will meet the Ten Year Rule. This amendment will expand the potential pool of qualified applicants by adding the Royal College of Physicians and Surgeons of Canada, and to clarify the standards required of those applicants to satisfy the Ten Year Rule.

§163.11, Active Practice of Medicine
The Amendment to §163.11, relating to Active Practice of Medicine, revise subsection (c)(1)(A) to clarify that proof of initial certification through passage of all exams or subsequent passage of a monitored written, specialty certification examination will meet requirements for purposes of active practice. In addition, the Royal College of Physicians and Surgeons of Canada is added to the list of acceptable specialty boards. The amendment will align the Active Practice rule with other relevant rules in order to have consistency and parity among the rules.

CHAPTER 165. MEDICAL RECORDS

§165.1, Medical Records
The Amendments to §165.1, relating to Medical Records, adds language to subsection 165.1(a), contents of Medical Record, to provide that such requirements pertain to all medical records regardless of the medium in which they are made and maintained. Section 165.1(a)(7) is amended to correct a grammatical error by inserting the word “include.” The rule is further amended to include new subsection 165.1(a)(8) which clarifies the requirement that a physician document any communication made or received by the physician regarding a patient, about which the physician makes a medical decision. The rule is further amended to include new subsection 165.1(a)(10) which further clarifies the requirement that electronic patient medical records contain only accurate pre-populated data, described as data that is based on actual findings from assessments, evaluations, examinations, or diagnostic results. The amendments to Rule 165.1(a) will result in: 1) having medical records that consistently contain required elements, regardless of method used to make such records; 2) helping ensure that a patient’s medical record contains complete and accurate information relating to physician-patient communications; and 3) helping to ensure that electronic patient medical records contain accurate information and data.

CHAPTER 172. TEMPORARY AND LIMITED LICENSES

§172.8, Faculty Temporary Licenses
The Amendment to §172.8, relating to Faculty Temporary License, corrects a typographical error in Rule 172.8(a)(3) by changing the reference to the Medical Practice Act to the correct Section number. The rule is further amended in Rule 172.8(a)(4)(A) and (B) to correct a grammatical error relating to the incorrect use of an article preceding a noun. The amendment corrects an error thereby resulting in accurate and grammatically correct rules that contain correct citations to other laws.

CHAPTER 174. TELEMEDICINE

§§174.2, Definitions; 174.5, Notice to Patients; 174.6, Telemedicine Services Provided at an Established Medical Site; 174.8, Evaluation and Treatment of the Patient
Note: These rules are not being immediately submitted for publication and will go into effect June 3, 2015. A rule summary will be available following submission with the Texas Register.

CHAPTER 176. HEALTH CARE LIABILITY LAWSUITS AND SETTLEMENTS

§176.1, Definitions
The Amendment to §176.1, relating to Definitions, corrects a spelling error in Rule 176.1(6) by changing the word “x-rays” to “x-rays.” The amendment corrects a spelling error thereby resulting in correct, clear and accurate words within the rules.

CHAPTER 190. DISCIPLINARY GUIDELINES

§190.8, Violation Guidelines
DISCIPLINARY ACTIONS

QUALITY OF CARE

Caruth, Jeffrey Chandler, M.D., Lic. No. H6102, Plano
On April 10, 2015, the Board and Jeffrey Chandler Caruth, M.D., entered into an Agreed Order requiring Dr. Caruth to within one year complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The Board found Dr. Caruth failed to document he was using Accolate for off-label purposes and failed to document that he appropriately counseled the patient regarding the risks, benefits, and possible side effects of Accolate.

Connolly, John Robert, Jr., M.D., Lic. No. J0752, Allen
On April 10, 2015, the Board and John Robert Connolly, Jr., M.D., entered into an Agreed Order requiring Dr. Connolly to within one year complete at least 16 hours of CME, divided as follows: eight hours in psychopharmacology and eight hours in treating headaches; and within one year complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The Board found Dr. Connolly violated the standard of care in his treatment of a patient that died by failing to adequately document relevant history regarding treatment of depression, anxiety and Attention Deficit Disorder (ADD); review of depression symptoms; and by prescribing multiple psychiatric medications concurrently without properly monitoring or documenting. The care and treatment provided to the remaining patients was addressed and the Board found Dr. Connolly failed to meet the standard of care in some instances by failing to properly evaluate, document prior history, failing to maintain adequate medical records, and failing to document justification for some of his prescriptions.

Dharma, Kalamani Rachel, M.D., Lic. No. G3289, Dallas
On April 10, 2015, the Board and Kalamani Rachel Dharma, M.D., entered into an Agreed Order requiring Dr. Dharma to within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least four hours of in-person CME in risk management; within 60 days submit in writing revised protocols; and pay an administrative penalty of $3,000 within 90 days. The Board found Dr. Dharma’s physician assistant prescribed phentermine to patients pursuant to protocols that were inadequate given the length of ongoing medication therapy and that Dr. Dharma’s delegate’s prescribing of phentermine for intermittent periods in excess of the maximum FDA approved labeling use of the drug was inappropriate because the medical records and protocols were inadequate to support or justify the long-term use.

On April 10, 2015, the Board and Sameer Andoni Fino, M.D., entered into an Agreed Order requiring Dr. Fino’s practice to be monitored by another physician for 12 consecutive monitoring cycles; within one year complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year complete at least 28 hours of CME, divided as follows: eight hours in coding and billing, eight hours in risk management, eight hours in identifying drug seeking behavior and four hours in ethics; within 30 days Dr. Fino shall develop, implement and submit to the Board a pain management contract with specific provisions for termination of the physician-patient relationship; and pay an administrative penalty of $3,000 within 60 days. The Board found Dr. Fino failed to meet the standard of care with respect to multiple patients because he failed to adequately document focus physical examinations and his rationale for treatment of the patients; and failed to adequately document his counseling of patients with abnormal urine toxicology tests. The Board further found Dr. Fino failed to have set policies regarding positive tests in his pain management contract; and failed to implement and document adequate treatment plans for the patients.

Marotta, Joseph Andrew, M.D., Lic. No. J8310, San Antonio
On April 10, 2015, the Board and Joseph Andrew Marotta, M.D., entered into an Agreed Order requiring Dr. Marotta to within one year successfully complete the physician prescribing course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year and three attempts pass the Medical
Jurisprudence Exam; and within one year complete at least 12 hours of CME, divided as follows: four hours in medical recordkeeping, four hours in ethics and four hours in risk management. The Board found Dr. Marotta failed to meet the standard of care for one patient by failing to adequately document his rationale for the treatment of the patient’s chronic pain, failed to follow Board guidelines for treatment of chronic pain and post-dated Schedule II narcotic prescriptions for the patient.

Sarabosing, Luciano Jo, Jr., M.D., Lic. No. J7177, Victoria
On April 10, 2015, the Board and Luciano Jo Sarabosing, Jr., M.D., entered into an Agreed Order requiring Dr. Sarabosing to have his practice monitored by another physician for 12 consecutive monitoring cycles; within one year complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and pay an administrative penalty of $5,000 within 60 days. The Board found Dr. Sarabosing violated the standard of care in his treatment by allowing potentially inaccurate test results and blood results to remain in patient charts.

UNPROFESSIONAL CONDUCT
Briones, Fermin, Jr., M.D., Lic. No. N0660, San Antonio
On April 10, 2015, the Board and Fermin Briones, Jr., M.D., entered into an Agreed Order publicly reprimanding Dr. Briones and requiring him to within 30 days undergo an independent medical evaluation and follow all recommendations for care and treatment; within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 16 hours of in-person CME, divided as follows: eight hours in ethics and eight hours in HIPAA compliance; and pay an administrative penalty of $5,000 within 90 days. The Board found Dr. Briones engaged in unprofessional conduct by having a sexual relationship with a patient and continuing to have inappropriate contact with the patient after the filing of the complaint alleging a sexual relationship had occurred with the patient; and violated state and federal patient confidentiality laws through his filing of a lawsuit seeking a restraining order against the patient.

Summa, James Angelo, M.D., Lic. No. J8387, Dallas
On April 10, 2015, the Board and James Angelo Summa, M.D., entered into an Agreed Order requiring Dr. Summa to obtain a three-day, out-patient psychiatric evaluation and follow all recommendations for care and treatment; within one year complete at least 12 hours of CME, divided as follows: eight hours in recordkeeping and four hours in risk management; Dr. Summa shall not treat or otherwise serve as a physician for his immediate family and shall not prescribe, dispense, administer, or authorize controlled substances or dangerous drugs with addictive potential or potential for abuse to himself or his immediate family; and pay an administrative penalty of $2,000 within 120 days. The Board found Dr. Summa admitted to inappropriately self-prescribing prescription medications and was arrested for unprofessional conduct at a high school football game, however the charges were dismissed.

REVOCATION
Khuu, Chau Doan, M.D., Lic. No. M4838, Houston
On April 10, 2015, the Board entered a Final Order against Chau Doan Khuu, M.D., which revoked his Texas medical license. The Board found Dr. Khuu illegally operated seven pain management clinics; prescribed controlled substances at unregistered pain management clinics; failed to meet the standard of care with respect to multiple patients being treated for chronic pain; failed to follow Board rules for pain management; failed to properly supervise midlevels; and failed to maintain or properly transfer medical records. The action was based on the findings of two administrative law judges at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Khuu has 20 days from the service of the order to file a motion for rehearing.

Koeneman, Kenneth Scott, M.D., Lic. No. K9826, Irving
On April 10, 2015, the Board entered a Default Order against Kenneth Scott Koeneman, M.D., which revoked his Texas medical license. On September 23, 2014 the Board filed a Complaint with the State Office of Administrative Hearings
The Complaint against Dr. Koeneman involved allegations related to convictions for misdemeanors for violating restraining orders and allegations of impairment. Dr. Koeneman was served notice of the Complaint but did not respond at State Office of Administrative Hearings. All other deadlines passed without any response from Dr. Koeneman, therefore the Board granted a Determination of Default and Dr. Koeneman’s Texas medical license was revoked by Default Order. This order resolves a formal complaint filed at SOAH.

VOLUNTARY SURRENDER

Baker, Laura Kyle, M.D., Lic. No. F9160, Lubbock
On April 10, 2015, the Board and Laura Kyle Baker, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Baker agreed to voluntarily surrender her Texas medical license in lieu of further disciplinary proceedings. The Board found that Dr. Baker has a physical condition that prevents her from continuing to practice medicine.

Edwards, Michael Charles, M.D., Lic. No. L2873, Westminster, CA
On April 10, 2015, the Board and Michael Charles Edwards, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Edwards agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. The Board found Dr. Edwards was subject to an investigation by the Medical Board of California (MBC), which suspended Dr. Edwards’ license as a result of evidence of self-prescribing of controlled substances, and violations of the standard of care in his treatment of patients.

Ramanathan, Subramaniam V., M.D., Lic. No. M0624, Sugar Land
On April 10, 2015, the Board and Subramaniam V. Ramanathan, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Ramanathan agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. Dr. Ramanathan was the subject of a formal complaint at the State Office of Administrative Hearings involving allegations that he illegally operated pain management clinics, failed to adequately supervise mid-level providers, prescribed controlled substances in a nontherapeutic manner to 12 patients, and failed to comply with a Board order. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

Taylor, Thomas Vincent, M.D., Lic. No. K2297, Houston
On April 10, 2015, the Board and Thomas Vincent Taylor, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Taylor agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. Dr. Taylor had been under investigation by the Board for allegedly providing two patients, a couple, with prescriptions for controlled substances in exchange for sexual favors. Dr. Taylor has denied the allegations.

Truong, Tich Ngoc, M.D., Lic. No. G2867, Garland
On April 10, 2015, the Board and Tich Ngoc Truong, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Truong agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. Dr. Truong was under investigation by the Board concerning allegations of a violation of the standard of care by his treatment of one patient and a violation of the privacy rights of two patients.

White, Robert Frank, M.D., Lic. No. C7159, Mount Vernon
On April 10, 2015, the Board and Robert Frank White, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. White agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. The Board found Dr. White was under investigation regarding his care and treatment of 11 patients.

CRIMINAL ACTIVITY

On April 10, 2015, the Board and Jeffrey S. Krantz, D.O., entered in a Modified Agreed Order, modifying Dr. Krantz’ 2014 Order to include the following terms and conditions: a public reprimand; requiring Dr. Krantz to comply with all terms
and conditions associated with his April 16, 2014, Order of Deferred Adjudication; and pay an administrative penalty of $2,000 within 90 days. The Board found an Order of Deferred Adjudication was entered against Dr. Krantz. A Board panel found that, when recommending the 2014 Order, the representatives were aware of the pending felony charge and considered it when issuing the order. All other terms of the Order, as modified, remain in full force.

**PEER REVIEW ACTIONS**

**Khan, Zubeida, M.D., Lic. No. BP10041633, Houston**
On April 10, 2015, the Board and Zubeida Khan, M.D., entered into an Agreed Order requiring Dr. Khan to pay an administrative penalty of $500 within 60 days. The Board found Dr. Khan was disciplined by her residency program because of poor communications and unprofessional conduct with patients and medical staff.

**OTHER STATES’ ACTIONS**

**Dallas, Anthony V., Jr., M.D., Lic. No. N9036, Hendersonville, TN**
On April 10, 2015, the Board and Anthony V. Dallas, Jr., M.D., entered into an Agreed Order requiring Dr. Dallas to complete all terms as required by the Consent Order issued by the Mississippi State Board of Medical Licensure (MSBML) and provide proof of compliance with the MSBML Consent Order to the Board. The Board found that on September 3, 2014, a disciplinary order was imposed on Dr. Dallas by the MSBML regarding his ordering of medications and delegation of prescriptive authority.

**Smith, Bruce D., M.D., Lic. No. E5941, Dallas**
On April 10, 2015, the Board and Bruce D. Smith, M.D., entered into an Agreed Order publicly reprimanding Dr. Smith and requiring Dr. Smith to surrender his DEA/DPS controlled substances registration certificates if he has not already done so and prohibiting Dr. Smith from owning or working in any weight loss clinics in Texas. The Board found Dr. Smith was disciplined by the Mississippi State Board of Medical Licensees (MSBML) regarding violations as to administering, dispensing, or prescribing drugs that have addiction-forming or addiction sustaining liability otherwise than in the course of legitimate professional practice.

**Zarate, Enrique, M.D., Lic. No. G4763, Tracy, CA**
On April 10, 2015, the Board and Enrique Zarate, M.D., entered into an Agreed Order requiring Dr. Zarate to complete all terms as required by the Disciplinary Order issued by the Medical Board of California (MBC) and provide proof of compliance to the Board. The Board found Dr. Zarate was the subject of a disciplinary action by the MBC as a result of an investigation into his care and prescribing to four patients.

**IMPROPER PRESCRIBING**

**Lin, Nicholas, M.D., Lic. No. N6911, Victoria**
On April 10, 2015, the Board and Nicholas Lin, M.D., entered into an Agreed Order requiring Dr. Lin to within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 24 hours of CME, divided as follows: four hours in risk management, four hours in medical recordkeeping, eight hours in ethics and eight hours in physician-patient boundaries; and pay an administrative penalty of $2,000 within 60 days. The Board found Dr. Lin admitted to treating someone with whom he had a close personal relationship and self-prescribed for minor medical problems.

**IMPAIRMENT**

**Stevens, Joshua Alan, M.D., Lic. No. BP10043938, San Antonio**
On April 16, 2015, the Board and Joshua Alan Stevens, M.D., entered into an Agreed Order publicly reprimanding Dr. Stevens. The Board found Dr. Stevens was hospitalized following a police intervention related to a mental health issue.
Dr. Stevens took a medical leave of absence from his residency program shortly before the incident, and resigned from his program on June 5, 2014. He subsequently received counseling for approximately eight weeks.

Wyder, Holly Jo, M.D., Lic. No. M8441, San Antonio
On April 10, 2015, the Board and Holly Jo Wyder, M.D., entered into an Agreed Order publicly reprimanding Dr. Wyder and requiring Dr. Wyder for a period of 10 years to abstain from the consumption of prohibited substances as defined in the Order; participate in the Board’s drug testing program; participate in Alcoholics Anonymous no less than three times a week; within 30 days obtain an independent medical evaluation and follow all recommendations for care and treatment. The Board found Dr. Wyder was diagnosed with Alcoholic Abuse Disorder and other co-morbidities in March 2014 and has previous alcohol-related arrests.

VIOLATION OF PRIOR BOARD ORDER
Final Order – Violation of Prior Order
Roby, Russell, M.D., Lic. No. E1255, Austin
On April 10, 2015, the Board entered a Final Order against Russell Roby, M.D., requiring Dr. Roby to provide certain disclosure information to the public in all advertisements and printed material; keep a copy in the medical record of each patient verifying they have received and were given detailed disclosure regarding content of printed material; maintain a logbook of all antigen injections given to the patient; provide copies of all proposed clinical studies, IRB proposals, phase 1 and 2 studies/results, and any on-going or proposed research projects; that he not treat any patient with thyroid therapy; continue his treatment for bipolar disorder; have his practice monitored by another physician for consecutive chart monitoring cycles on a quarterly basis; within one year and three attempts pass the Special Purpose Exam (SPEX); and within one year complete at least 12 hours of CME in endocrinology; and shall not be permitted to supervise and delegate prescriptive authority to midlevels. Dr. Roby’s failure to substantially comply with any terms of the Order may allow Board representatives to direct the Executive Director to immediately suspend his medical license. The Board found Dr. Roby failed to comply with provisions of the 2007 Order, in that he did not comply with the recommendations of the chart monitor and he did not include the disclaimer on all printed materials released or distributed by him or the Roby Institute. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Roby has 20 days from the service of the order to file a motion for rehearing.

On April 10, 2015, the Board and Daniel Eric Rousch, D.O., entered into an Agreed Order Modifying Prior Order, modifying his February 2013 Order to require Dr. Rousch to make current all chart monitor payments and present proof within 60 days; require Dr. Rousch to complete an additional six cycles of chart monitoring; and within one year complete at least 40 hours in CME, divided as follows: 20 hours in evaluation and treatment of bipolar disorder in adults and children, 10 hours in evaluation and treatment of Attention Deficit Hyperactive Disorder and 10 hours in psychopharmacology. The Board found Dr. Rousch is not in compliance with his 2013 Order, as he has failed to comply with and implement the recommendations for the chart monitor and has failed to pay required chart monitor fees. All other provisions of the Order, as modified, remain in full force.

ADVERTISING VIOLATION
De Wet, Pieter Juan, M.D., Lic. No. J0470, Tyler
On April 10, 2015, the Board and Pieter Juan De Wet, M.D., entered into an Agreed Order publicly reprimanding Dr. De Wet and requiring him to within one year complete at least 12 hours of CME, divided as follows: eight hours in risk management and four hours in ethics; and pay an administrative penalty of $3,000 within 180 days. The Board found Dr. De Wet’s website contained statements that were false and/or misleading.

On April 10, 2015, the Board and Jill Taylor, D.O., entered into an Agreed Order requiring Dr. Taylor to within one year and three attempts complete the Medical Jurisprudence Exam; within one year complete at least four hours of CME in
ethics; and pay an administrative penalty of $2,500 within 60 days. The Board found Dr. Taylor’s board certification had expired; however, her website and another internet advertisement improperly stated that she was board certified in Family Practice and Emergency Medicine.

**INADEQUATE MEDICAL RECORDS**

**Olivieri, Julio Cesar, M.D., Lic. No. K2549, Dallas**

On April 10, 2015, the Board and Julio Cesar Olivieri, M.D., entered into an Agreed Order requiring Dr. Olivieri to within one year complete at least 24 hours of CME, divided as follows: 16 hours in medical recordkeeping, four hours in ethics and four hours in risk management; and pay an administrative penalty of $3,000 within 60 days. The Board found that Dr. Olivieri admitted that he failed to adequately document medical records for approximately 11 visits and admitted to making late entries without indicating the amendments were not made contemporaneously with original notations.

**CEASE AND DESIST**

**Acosta, Frank Garcia, No License, Odessa**

On April 10, 2015, the Board and Frank Garcia Acosta entered into an Agreed Cease and Desist Order prohibiting Mr. Acosta from practicing medicine in Texas without a license issued by the Texas Medical Board. Mr. Acosta shall refrain from practicing outside the scope of his license. The Board found Mr. Acosta has engaged in the unlicensed practice of medicine by practicing outside the scope of massage therapy beginning in June 2012 and continuing through the present day. Mr. Acosta has been administering vitamin and/or pain injections and diagnosing medical conditions, as well as administering IV vitamins and nutritional supplements.

**Snell, Debra, No License, Austin**

On April 10, 2015, the Board and Debra Snell entered into an Agreed Cease and Desist Order requiring Ms. Snell to cease and desist practicing medicine in the state of Texas. The Board found Ms. Snell was alleged to have engaged in the unlicensed practice of medicine by administering Botox and Voluma injections to a patient in Austin, Texas, without a contract to do so by a supervising physician.

**Southerland, Dale, No License, Pearland**

On April 10, 2015, the Board and Dale Southerland entered into an Agreed Cease and Desist Order prohibiting Mr. Southerland from practicing medicine in the state of Texas and requiring him to cease and desist any unlicensed practice of medicine in the state of Texas. The Board found Mr. Southerland, who is a licensed chiropractor, made offers to treat patients for conditions beyond the scope of practice of chiropractic through his website, social medial and other public written means. Furthermore, Mr. Southerland used the title “doctor” without designating the authority under which he used the title.

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To view disciplinary orders, visit the TMB website, click on "Look Up A License," accept the usage terms, then type in a licensee’s name. Click on the name shown in the search results to view the licensee’s full profile. Within that profile is a button that says "View Board Actions."

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