

## **Texas Medical Board**

### **Press Release**

#### **FOR IMMEDIATE RELEASE**

**Thursday, June 8, 2006**

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#### **32 Doctors Disciplined**

Since its last Board meeting in April, the Texas Medical Board has taken disciplinary action against 32 licensed physicians. Actions included 14 violations based on quality of care; three actions based on unprofessional conduct; two actions based on nontherapeutic prescribing; one action based on inappropriate conduct involving physician-patient relationships; three actions based on inadequate medical records; two actions based on impairment due to alcohol or drugs; two actions based on violations of probation or prior orders; one action based on other state board actions; one action based on a criminal conviction; one action based on a peer review action; and two minimal statutory violations. Administrative penalties totaling \$76,000 were assessed. At its May 19 board meeting, the Texas Physician Assistant Board took disciplinary action against one physician assistant.

#### **New Licenses Issued**

During its June 1-2 Board meeting, the Board approved the licensure applications of 376 physicians.

#### **Rule Changes**

The Board adopted the following proposed rule changes that were published in the *Texas Register*:

**Chapter 163, Licensure**, to include a limit on Texas medical jurisprudence examination attempts, delegated authority to staff to issue licenses, alternative requirements for graduates of unapproved medical schools, and general rule cleanup.

**Chapter 166, Physician Registration**, to include the addition of continuing medical education in forensic evidence collection, modifications to voluntary charity care practice by retired physicians, and general rule cleanup.

**Chapter 171, Postgraduate Training Permits**, to include clarification of reporting requirements, modifications to requirements for board-approved postgraduate fellowship training programs, and general rule cleanup.

**Chapter 172, Temporary and Limited Licenses**, to include the addition of section 172.13 relating to Conceded Eminence Licenses and general rule cleanup.

**Chapter 174, Telemedicine** to include amendments to [§174.2, Definitions](#) and [§174.6 Delegation to and Supervision of Telepresenters](#) regarding delegation of tasks and activities by a physician to a telepresenter.

**Chapter 178, Complaints**, to include amendments to [§178.8, Appeals](#) regarding the deletion of the deadline for filing an appeal.

**Chapter 185, Physician Assistants**, relating to changes mandated by SB419.

**Chapter 192, Office Based Anesthesia** to include amendments to [§192.1](#), to include amendments to the chapter title, [§192.1, Definitions](#), [§192.2, Provision of Anesthesia in Outpatient Settings](#), [§192.3, Compliance with Office-Based Anesthesia Rules](#), [§192.4, Registration](#), [§192.5, Inspections](#), [§192.6, Requests for Inspection and Advisory Opinion](#).

**Chapter 199, Public Information** to include new [§199.5, Notice of Ownership Interest in a Niche Hospital](#) regarding requirements of physicians to notify the Department of State Health Services of an ownership interest in a niche hospital.

#### **Proposed Rule Changes Not Adopted**

Proposed **Chapter 165, Medical Records**, to include amendments to 165.1 Medical Records and the addition of 165.6, Medical Records Regarding an Abortion on an Unemancipated Minor was withdrawn for changes and re-publication in the *Register*.

Repeal of **Chapter 170, Authority of Physician to Prescribe for the Treatment of Pain** and new **Chapter 170, Pain Management** were withdrawn for an ad hoc committee to meet with stakeholders to reach consensus before the August 24-25 board meeting.

### **Proposed Rule Changes**

The following rule changes will be published in the *Texas Register* for comment:

Proposed amendments and a proposed new section to **Chapter 165, Medical Records**, regarding maintaining a copy of consent forms in the medical records and rules and a form for parental consent for an abortion to be performed on an unemancipated minor.

Proposed new section to **Chapter 179, Investigations**, to provide a procedure for initiation of voluntary alcohol and drug screening pending the completion of an investigation of impairment.

Proposed amendment to **Chapter 193, Standing Orders**, new **§193.12, Immunizations of Elderly**.

### **Disciplinary Actions**

The following are summaries of the Board actions and were taken based on the types of violations listed. The full text of the Board orders will be available on the Board's web site at [www.tmb.state.tx.us](http://www.tmb.state.tx.us) about 10 days after the Board meeting. The orders provide all information that is public regarding the facts of the case and violations of the law.

**Open records** requests for orders may be made to [openrecords@tmb.state.tx.us](mailto:openrecords@tmb.state.tx.us). **Media** contact Jill Wiggins at (512) 305-7018 or [jill.wiggins@tmb.state.tx.us](mailto:jill.wiggins@tmb.state.tx.us).

### **QUALITY OF CARE VIOLATIONS:**

1. **ARMSTRONG, DAVILL, M.D., HOUSTON, TX, Lic. #F3025**  
On June 2, 2006, the Board and Dr. Armstrong entered into an Agreed Order of Suspension whereby Dr. Armstrong's license was suspended until such time as he provides information, including a psychological and neuropsychiatric evaluation, to the Board demonstrating that he is physically, mentally, and otherwise competent to safely practice medicine. The action was based on allegations that Dr. Armstrong violated the standard of care in treating 15 patients by treating only specific patient complaints at each office appointment without completing a history and physical and without monitoring chronic medical conditions, and on an Assessment Report from the Center for Personalized Education for Physicians that found Dr. Armstrong's judgment and reasoning below acceptable standards, with significant gaps in his medical knowledge.
2. **ARREDONDO, ADAM GALLARDO, M.D., WAXAHACHIE, TX, Lic. #K7648**  
On June 2, 2006, the Board and Dr. Arredondo entered into an Agreed Order publicly reprimanding Dr. Arredondo and placing him on probation for five years with the following requirements: monitoring of his practice by another physician; modification of his Drug Enforcement Administration Controlled Substances Registration Certificate and his Texas Department of Public Safety Controlled Substances Registration Certificate to eliminate his authority to prescribe Schedules II and III; completing 50 hours per year of continuing medical education in pain management; no supervising or teaching residents or supervising or delegating prescriptive authority to a physician assistant or advanced practice nurse; and assessing an administrative penalty of \$20,000. The action was based on allegations that Dr. Arredondo failed to meet the standard of care in treating 10 patients for the following reasons: failure to review past records; inadequate assessments prior to starting opioid therapy; failure to perform behavior evaluation prior to starting therapy; failure to perform drug screens prior to starting therapy; failure to perform a trial of physical therapy and/or non-opioids; failure to document a treatment plan; inadequate

monitoring of patient responses to therapy; prescribing excessive and nontherapeutic doses of schedule II drugs; inappropriate follow up; prescribing inappropriate dose escalation; lack of attention to red flags for abuse; and performing procedures that were not indicated.

1. **COOK, ROBERT LEE, M.D., TOMBALL, TX, Lic. #L0101**  
On June 2, 2006, the Board and Dr. Cook entered into an Agreed Order assessing an administrative penalty of \$1,000. Dr. Cook was unexpectedly called to assist in the dissection of pelvic lymph nodes when the surgeon scheduled to perform the procedure did not report to the operating room. The action was based on allegations that, after Dr. Cook was consulted intraoperatively, he should have discussed the case with the patient's family members present at the hospital before doing surgery.
3. **DECKER, DOUGLAS CAMPBELL, M.D., FORT WORTH, TX, Lic. #F6561**  
On June 2, 2006, the Board and Dr. Decker entered into an Agreed Order publicly reprimanding Dr. Decker, requiring him to attend at least 16 hours of continuing medical education in each of the areas of risk management and medical records, and assessing an administrative penalty of \$10,000. The action was based on allegations that Dr. Decker failed to meet the standard of care in his treatment of one patient because he failed to order a pregnancy test prior to his performance of a bladder suspension surgery and a hysterectomy. After surgery, the pathology report confirmed an eight week fetus in the uterus.
4. **DRAKE, CASSIUS MARCELLUS, M.D., ROYAL OAK, MI, Lic. #L0141**  
On June 2, the Board and Dr. Drake entered into an Agreed Order requiring Dr. Drake to complete 12 hours of continuing medical education in the area of managing infectious disease. The Order was based on allegations that Dr. Drake prescribed the wrong antibiotic for treating a urinary tract infection, in part because he relied on information from the patient that he had been successfully treated with that antibiotic previously.
5. **GARCIA, ALFREDO T, M.D., HOUSTON, TX, Lic. #F3468**  
On June 2, 2006, the Board and Dr. Garcia entered into an Agreed Order requiring Dr. Garcia to complete continuing medical education courses of at least eight hours in each of the areas of medical records and hematology/interpreting laboratory values. The action was based on allegations that Dr. Garcia failed to meet the standard of care by discharging a patient without ordering a blood count following a second transfusion to determine that the patient was not at substantial risk and not documenting the reason for the discharge.
6. **KUHL, PETER VAN DOREN, M.D., SAN ANTONIO, TX, Lic. #E6462**  
On June 2, 2006, the Board and Dr. Kuhl entered into an Agreed Order requiring Dr. Kuhl's practice to be monitored by another physician for 12 months; requiring that he complete a course of at least 10 hours in the area of the use of laboratory results in treating pregnant patients; and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Kuhl failed to obtain a complete blood count upon the admission of a pregnant patient to the hospital. Obtaining a complete blood count on admission may have identified the patient as developing the HELLP Syndrome. Mitigating factors include that the patient's blood pressure readings continued to be within normal limits and, therefore, preeclampsia, a precursor of the HELLP Syndrome, was not readily identifiable.
7. **NETSCHER, DAVID T., M.D., HOUSTON, TX, Lic. #H0091**  
On June 2, 2006, the Board and Dr. Netscher entered into an Agreed Order assessing an administrative penalty of \$2,500. The action was based on allegations that Dr. Netscher operated for degenerative arthritis on a patient's left ring finger, which did have

significant osteoarthritis, rather than the left index finger as planned, with such wrong site surgery being a violation of the standard of care

8. **NOVAK, JACOB JOHN, M.D., FLOWER MOUND, TX, Lic. #K2766**  
On June 2, 2006, the Board and Dr. Novak entered into an Agreed Order requiring Dr. Novak to complete a course in the area of acute care pediatrics of at least 10 hours and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Novak failed to meet the standard of care in treating a patient's ear infection by prescribing the wrong dosage of one of two antibiotics administered/prescribed, not recording the prescribed antibiotics in the patient's medical record and failing to take a full set of vital signs.
9. **SERRANO, JUAN HERNAN, M.D., HOUSTON, TX, Lic. #E3766**  
On June 2, 2006, the Board and Dr. Serrano entered into a three-year Agreed Order publicly reprimanding Dr. Serrano; requiring his practice to be monitored by another physician; requiring that he complete at least 10 hours of courses in each of gynecological surgical complications and medical records; and assessing an administrative penalty of \$3,000. The action was based on allegations that Dr. Serrano failed to meet the standard of care in evaluating and treating two patients, one of whom was determined during surgery to be pregnant, before performing hysterectomies.
10. **SHAHAR, JULIO, M.D., HOUSTON, TX, Lic. #H6954**  
On June 2, 2006, the Board and Dr. Shahar entered into an Agreed Order requiring Dr. Shahar to complete courses in pulmonology, radiology, and intensive care of at least 20 total hours in duration. The action was based on allegations that Dr. Shahar failed to meet the standard of care because of his delay in diagnosing and correcting a pneumothorax.
11. **SPANN, SCOTT WEAVER, M.D., AUSTIN, TX, Lic. #K1685**  
On June 2, 2006, the Board and Dr. Spann entered into an Agreed Order requiring Dr. Spann to complete 10 hours of continuing medical education in risk management and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Spann performed arthroscopic surgery on the wrong knee, thereby violating the standard of care.
12. **TALMAGE, EDWARD ARTHUR, M.D., HOUSTON, TX, Lic. #D2722**  
On June 2, 2006, the Board and Dr. Talmage entered into an Agreed Order whereby the Board accepted the voluntary and permanent surrender of Dr. Talmage's medical license. During the pendency of two board investigations involving allegations that Dr. Talmage had not met the standard of care in caring for several patients with complaints of chronic pain, Dr. Talmage permanently retired from the practice of medicine and has no desire to contest the Board's allegations, preferring to voluntarily surrender his medical license.
13. **WADE, DEAN EDWARD, M.D., DALLAS, TX, Lic. #F5789**  
On June 2, 2006, the Board and Dr. Wade entered into an Agreed Order requiring Dr. Wade to complete a course in interventional anesthetic techniques of at least 15 hours, and assessing an administrative penalty of \$5,000. The action was based on allegations that Dr. Wade failed to meet the standard of care by failing to confirm preoperatively the placement of a central venous line.

#### **UNPROFESSIONAL CONDUCT VIOLATIONS:**

2. **JOHNSON, BILL J., M.D., GRAPEVINE, TX, Lic. #F9623**  
On June 2, 2006, the Board and Dr. Johnson entered into an Agreed Order assessing an administrative penalty of \$3000. The Order was based on allegations that Dr. Johnson's office manager sent out about 40 letters to other office managers and doctors stating that

each person who referred someone to the esthetic practice Dr. Johnson had established in his internal medicine clinic would receive a \$50 discount on a future esthetic treatment. Such an offer constitutes a reward to a person for referring patients to Dr. Johnson's practice, which violates the Medical Practice Act. In mitigation, an advertising firm that works with physicians recommended the use of the letter.

3. **LEON, MILTIADIS N, M.D., SAN ANGELO, TX, Lic. #K0890**  
On June 2, 2006, the Board and Dr. Leon entered into a two-year Mediated Agreed Order requiring Dr. Leon to continue the practice of having female patients who are unaccompanied in the office examined with another person in attendance, to complete a maintaining proper boundaries course sponsored either by Sant or the Center for Professional Health at Vanderbilt University Medical Center and to obtain 10 hours of ethics courses each year for two years. The action was based on unspecified allegations relating to disruptive behavior toward hospital personnel that may be reasonably expected to adversely impact the quality of care rendered to patients.
4. **REYES, JOSE, M.D., SAN ANTONIO, TX, Lic. #H6540**  
On June 2, 2006, the Board and Dr. Reyes entered into an Agreed Order assessing a \$1,000 administrative penalty. The action was based on allegations that Dr. Reyes distributed an advertisement that included a photograph of an individual who was not identified as a model or an actual patient and also incorrectly referred to cosmetics as a field of medicine, thereby violating board rules relating to false, misleading or deceptive advertising.

#### **NONTHERAPEUTIC PRESCRIBING VIOLATIONS:**

1. **HEATH, GARY L., M.D., ABILENE, TX, Lic. #F1632**  
On June 2, 2006, the Board and Dr. Heath entered into a five-year Agreed Order requiring his practice to be monitored by another physician; requiring Dr. Heath to complete the Medical Review Officer certification; requiring him to maintain a file for all prescriptions written for controlled substances and dangerous drugs with addictive potential or potential for abuse; and assessing an administrative penalty of \$15,000. The action was based on allegations that Dr. Heath engaged in nontherapeutic prescribing of opioids to three patients.
2. **MORENO, KILLEEN MOSS, M.D., BALLINGER, TX, Lic. #H0653**  
On June 2, 2006, the Board and Dr. Moreno entered into a three-year Agreed Order requiring Dr. Moreno's practice to be monitored by another physician and requiring Dr. Moreno to obtain 10 hours of continuing medical education each year in the area of prescribing narcotics and drug seeking patient behaviors and 10 hours in medical records. The action was based on allegations that Dr. Moreno violated the Medical Practice Act through her prescribing practice for hydrocodone cough syrup over a period of one year to one patient she knew or should have known was an abuser of narcotics or was a drug seeker.

#### **INAPPROPRIATE CONDUCT INVOLVING PHYSICIAN-PATIENT RELATIONSHIP VIOLATIONS:**

1. **HELLER, CARL STUART, M.D., KINGWOOD, TX, Lic. #F8154**  
On June 2, the Board and Dr. Heller entered into a 10-year Mediated Agreed Order publicly reprimanding Dr. Heller and requiring that he complete courses of at least 20 hours each in pain management and risk management and 10 hours in medical records; prohibiting him from engaging in the practice of pain management, requiring that he complete the Maintaining Proper Boundaries course presented by the Center for

Professional Health at the Vanderbilt Medical Center or a similar course approved by the executive director of the board; requiring that he maintain adequate medical records on all patient office visits; requiring that his practice be monitored by another physician for a period of five years; requiring that he take and pass the Medical Jurisprudence Examination; prohibiting him from prescribing to family members or other persons with whom he has a personal relationship outside the physician-patient relationship; and assessing an administrative penalty of \$3,000. Additionally, Dr. Heller's license may be immediately suspended if he fails to comply with the terms of the order. The action was based on allegations that Dr. Heller treated a young man, previously homeless, who came to live with him and for whom he became an informal guardian, for complaints including anxiety, depression and chronic pain due to an accident, but did not meet the standard of care in keeping medical records for this treatment. Additional allegations were that Dr. Heller prescribed medications to the young man, who drank alcohol, that were dangerous to use concurrently with alcohol, and wrote prescriptions for excessive amounts of habit-forming medications and was refilling them early, even though the young man was a known abuser of medications. Dr. Heller also prescribed Fentanyl for the young man for the treatment of pain following dental surgery. The young man was later found dead in Dr. Heller's home from an overdose of Fentanyl. No criminal charges were filed.

#### **INADEQUATE MEDICAL RECORDS VIOLATIONS:**

1. **◆PADILLA, MARLON DAYMOND, M.D., DALLAS, TX, Lic. #K2254**  
On June 2, 2006, the Board and Dr. Padilla entered into an Agreed Order requiring Dr. Padilla to complete at least 20 hours in ethics courses and assessing an administrative penalty of \$6,000.◆ The action was based on allegations that Dr. Padilla failed to properly document follow-up care he provided to patients referred to him by various health care providers.
2. **◆SHAIKH, MUHAMMAD YAQOUB, M.D., HOUSTON, TX, Lic. #K4240**  
On June 2, 2006, the Board and Dr. Shaikh entered into a three-year Mediated Agreed Order requiring that Dr. Shaikh's practice be monitored by another physician; requiring that Dr. Shaikh attend 10 hours of additional continuing medical education in each of the areas of medical record-keeping and pain management; and requiring that he maintain a logbook of prescriptions written for schedule II controlled substances. The action was based on allegations that Dr. Shaikh failed to maintain adequate medical records on five pain management patients.
3. **◆SRUNGARAM, RAMESH K, M.D., SUGAR LAND, TX, Lic. #H1845**  
On June 2, 2006, the Board and Dr. Srungaram entered into an Agreed Order whereby Dr. Srungaram voluntarily and permanently surrendered his Texas medical license. The action followed allegations that Dr. Srungaram's documentation of patients' medical records did not support that he met the standard of care in determining whether patients were appropriate candidates for bariatric surgery. Dr. Srungaram no longer resides in the United States and does not intend to return to Texas.

#### **IMPAIRMENT DUE TO ALCOHOL OR DRUGS VIOLATIONS:**

1. **◆CHO, PAUL HENRY, M.D., FORT WORTH, TX, Lic. #L1292**  
On June 2, 2006, the Board and Dr. Cho entered into an Agreed Order requiring Dr. Cho to abstain from consuming prohibited substances, including alcohol and drugs not prescribed for him; to participate in the Board's program for testing for drugs and alcohol; to continue receiving care from his psychiatrist and psychotherapist; and to participate in the activities of Alcoholics Anonymous and/or Narcotics Anonymous. Additionally, Dr. Cho may not reapply for a controlled substance registration from the

Drug Enforcement Administration for at least six months and until he obtains approval to reapply from a panel of Board representatives. The action was based on allegations Dr. Cho abused and was addicted to Hycodan/hydrocodone cough syrup and had written fraudulent prescriptions to obtain this drug.

2. **KOPECKY, CRAIG TINDALL, M.D., SAN ANTONIO, TX, Lic. #K7177**  
On June 2, the Board and Dr. Kopecky entered into an Agreed Order suspending Dr. Kopecky's medical license until such time as he appears before the Board and demonstrates he is physically, mentally and otherwise competent to safely practice medicine. The action was based on Dr. Kopecky's admission of prior alcohol and drug abuse, including self-prescribing of hydrocodone, and that while his sobriety date is March 17, 2005, he is still struggling with his recovery.

#### **VIOLATIONS OF PROBATION OR PRIOR ORDER:**

1. **HUFF, JOHN DAVID SR., M.D., FAIRFIELD, IA, Lic. #D7993**  
On June 2, 2006, the Board and Dr. Huff entered into an Agreed Order accepting the voluntary and permanent surrender of his medical license. The action was based on Dr. Huff's inability to comply with a previous final order of the Board due to financial hardship because he is not currently practicing medicine. The final order followed a hearing at the State Office of Administrative Hearings and prohibited Dr. Huff from practicing ophthalmology or surgery in any form until certain conditions were met, including the payment of a \$29,000 administrative penalty. The final order was based on allegations that Dr. Huff failed to meet the standard of care in performing cataract surgery on four patients.
2. **SMITH, FRANK EDWARD, M.D., HOUSTON, TX, Lic. #D1811**  
On June 2, 2006, the Board and Dr. Smith entered into an Agreed Order making public Dr. Smith's prior confidential non-public rehabilitation order and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Smith had violated his prior order by ingesting alcohol, as evidenced by a positive test for EtG, a derivative of alcohol.

#### **OTHER STATES BOARD ACTIONS:**

1. **HUFFMAN, MICHAEL STEWART, M.D., HOLLIS, NH, Lic. #G8187**  
On June 2, 2006, the Board and Dr. Huffman entered into an Agreed Order requiring Dr. Huffman to appear before a panel of board representatives to demonstrate his safety and competency to practice medicine before he may practice medicine in Texas. The action was based on action by the New Hampshire Board of Medicine reprimanding Dr. Huffman and requiring him to have his medical care monitored and to participate in continuing medical education. The action of the New Hampshire Board was based on Dr. Huffman's health, his conduct during office visits and his failure to timely provide medical records.

#### **ACTIONS BASED ON CRIMINAL CONVICTIONS:**

2. **MAUSKAR, ANANT NILKANTH, M.D., HOUSTON, TX, Lic. #E9300**  
On June 2, 2006, the Board and Dr. Mauskar entered into an Agreed Order suspending Dr. Mauskar's license indefinitely, staying the suspension and placing him on probation under the following terms and conditions: monitoring of his practice by another physician; monitoring of his billing practices by a person experienced in medical billing; no prescribing durable medical equipment or physical therapy; a limit of 50 patients per day. If Dr. Mauskar is incarcerated his license shall be permanently revoked. The action

was based on Dr. Mauskar's conviction in federal court of conspiracy to commit health care fraud and of health care fraud, which conviction is now on appeal.

**PEER REVIEW ACTIONS:**

3. **VANDERLEE, MARGARET GAIL, M.D., ODESSA, TX, Lic. #F7254**  
On June 2, 2006, the Board and Dr. Vanderlee entered into an Agreed Order requiring Dr. Vanderlee to comply with Texas Tech's action plan and assessing an administrative penalty of \$2,000. The action was based on allegations of inappropriate statements and inappropriate conduct, relating to a faulty telephone system in the consultation room at Texas Tech University Health Science Center's Obstetrics and Gynecology Clinic, for which Texas Tech took disciplinary action against Dr. Vanderlee.

**MINIMAL STATUTORY VIOLATIONS:**

The following licensees agreed to enter into orders with the Board for minimal statutory violations such as failure to send medical records within 15 business days or failure to complete required continuing medical education.

Meng, Jianhuan, M.D., Plano, TX, Lic. #K6151

Pilumeli Di Blasi, Tina, M.D., Del Rio, TX, Lic. #L7952

**Physician Assistant**

**WELBORN, TRACY BRANT, GALVESTON, TX, Lic. #PA02947**

On May 19, 2006, the Physician Assistant Board and Tracy Welborn, P.A., entered into an Agreed Rehabilitation Order requiring Mr. Welborn to participate in the Board's drug screening program; to continue psychiatric treatment; requiring him to attend Alcoholics Anonymous or Narcotics Anonymous; limiting his practice to a primary practice site where his supervising physician is present; and prohibiting him from having prescriptive authority. The action was based on Mr. Welborn's abuse of hydrocodone and other drugs, his forging of his supervising physician's signature on stolen prescription pads to obtain the drugs and his placement on deferred adjudication for the felony charge of possession of a controlled substance by fraud.

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The Texas Medical Board, the state agency that regulates physicians, physician assistants, surgical assistants and acupuncturists, provides consumer protection through licensure, investigation and disciplinary action. The Board, under President Roberta M. Kalafut, D.O., and Executive Director Donald W. Patrick, M.D., J.D., and mandated by Senate Bill 104 of the 78th Legislature and S.B. 419 of the 79th Legislature, is strengthening and accelerating the disciplinary process for licensees who fail to meet the required standards of professional proficiency and behavior. Information on filing a complaint is on the agency web site at [www.tmb.state.tx.us](http://www.tmb.state.tx.us) or by calling (800) 201-9353.