STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

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| DEPARTMENT OF HEALTH, | ) | |
| | ) | |
| Petitioner, | ) | |
| | ) | |
| vs. | ) | Case No. 04-3643PL |
| | ) | |
| SANDRA BLANKENSHIP, | ) | |
| | ) | |
| Respondent. | ) | |
| _____ | ) | |

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this case before Larry J. Sartin, an Administrative Law Judge of the Division of Administrative Hearings, on December 8, 2004, in Stuart, Florida, and on December 20, 2004, by conference telephone call.

APPEARANCES

For Petitioner: Robert E. Fricke, Esquire
Diane K. Kiesling, Esquire
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For Respondent: Sandra Blankenship, pro se
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STATEMENT OF THE ISSUE

The issue in this case is whether Respondent, Sandra Blankenship, committed the violations alleged in an Amended Administrative Complaint issued by Petitioner, the Department of

Health, and, if so, what disciplinary action should be taken against her.

## PRELIMINARY STATEMENT

In a two-count Amended Administrative Complaint[1] dated June 15, 2001, the Department of Health (hereinafter referred to as the "Department") charged Sandra Blankenship with having violated statutory and rule provisions governing the conduct of midwifery in Florida. Ms. Blankenship disputed the factual allegations in the Amended Administrative Complaint by executing an Election of Rights form in which she requested a formal administrative hearing before the Division of Administrative Hearings.[2]

Ms. Blankenship's request for hearing was filed with the Division of Administrative Hearings on October 6, 2004,[3] for the assignment of an administrative law judge to conduct an evidentiary hearing. The matter was designated DOAH Case No. 04-3643PL and was assigned to the undersigned.

By Notice of Hearing entered October 19, 2004, the final hearing of this case was scheduled to commence December 8, 2004, in Stuart, Florida.

On November 30, 2004, a Joint Witness List, Joint Records Stipulation,[4] and Motion on Facts Agreed Upon were filed. In the Motion on Facts Agreed Upon, which was granted at the commencement of the final hearing, the parties made certain

stipulations concerning Count I of the Amended Administrative Complaint. Essentially, Ms. Blankenship withdrew her assertion that she disputed the facts concerning Count I. Her stipulation concerning Count I is hereby incorporated into this Recommended Order by reference.

On December 6, 2004, the Department filed a corrected Amended Administrative Complaint.[5]

At the portion of the final hearing conducted on December 8, 2004, the Department presented the testimony of S.B., a former patient of Ms. Blankenship (hereinafter referred to as "Patient S.B."); Jannie Gichia, Ph.D., C.N.M. (accepted as an expert in midwifery); and Neil Carter Boland, M.D. (accepted as an expert in obstetrics and gynecology). The Department also had admitted 12 exhibits and had judicial notice taken of the pertinent statute and rule governing this matter. Ms. Blankenship testified on her own behalf and had one exhibit admitted.

At the conclusion of the portion of the hearing conducted on December 8, 2004, Ms. Blankenship requested leave to present the testimony of Tammy Livak. With the agreement that the Department would be allowed to call a rebuttal witness, Ms. Blankenship's request was granted.

On December 20, 2004, the hearing was reconvened by telephone conference. Ms. Blankenship presented the testimony

of Ms. Livak, and the Department presented in rebuttal the testimony of Cathy Griffin, R.N., C.N.M., concluding the final hearing. A Transcript of this portion of the hearing was filed on January 3, 2005.

By Notice of Filing of Transcript issued January 14, 2005, the parties were informed that the Transcript of the portion of the final hearing conducted on December 8, 2004, had been filed. The parties were also informed that they had until January 24, 2005, to file proposed recommended orders. Both parties filed post-hearing argument, which has been fully considered in entering this Recommended Order.

## FINDINGS OF FACT

A. The Parties.

1. The Department is the agency in Florida responsible for regulating the practice of midwifery pursuant to Chapters 20, 456, and 467, Florida Statutes (2004).[6]

2. Ms. Blankenship is and has been at all times material hereto a licensed midwife in the State of Florida, having been issued license number MW 0091. Ms. Blankenship finished her training in May 1998 and received her Florida midwifery license effective July 7, 1998.

B. Patient S.B.

3. Patient S.B., who was 34 years of age, having been born on January 22, 1964, visited Ms. Blankenship, who was then

practicing midwifery at Tree of Life Maternity Services, Inc. (hereinafter referred to as "Tree of Life"), in late December 1998. Patient S.B. went to Tree of Life because she was pregnant and was highly motivated to have an out-of-hospital vaginal birth. The purpose of her visit to Tree of Life was to arrange for prenatal and delivery services.

4. This was not Patient S.B.'s first pregnancy. She had given birth to a son on September 28, 1995. That delivery was made by cesarean section (hereinafter referred to as "C-Section") after a long attempt at vaginal delivery. Patient S.B. was in labor between 24 and 30 hours before the C-Section was performed.

5. Patient S.B. and Ms. Blankenship discussed at length the services Patient S.B. would receive. Patient S.B. was asked questions about her medical history, regular and obstetrical, which she answered. In particular, Patient S.B. informed Ms. Blankenship of the difficult birth of her son, including the fact that he had been delivered by C-Section.[7]

6. Following her initial visit, Patient S.B. began receiving prenatal care at Tree of Life on a monthly basis initially and, as her "due date" for her baby's birth approached, more frequently.

7. During the early morning hours of July 9, 1999, Patient S.B. began having labor pains. Accompanied by her husband,

Patient S.B. arrived at Tree of Life at approximately 6:00 a.m. She was having moderate contractions, four to five minutes apart, and her cervix was dilated five centimeters.

8. Patient S.B. was monitored every hour after her arrival.

9. From approximately 12:45 p.m. until 3:00 p.m., Patient S.B. relaxed in a tub of water. Part of that time she was noted to be sleeping. Her contractions continued to be moderate. At 3:00 p.m., Patient S.B. exited the tub.

10. Between her arrival at 6:00 a.m. and 7:45 p.m., S.B.'s cervix had dilated as follows:

| | |
|---|---|
| 6:00 a.m. | 5 to 6 centimeters |
| 11:00 a.m. | 7 centimeters |
| 12:30 p.m. | 8 centimeters |
| 3:00 p.m. | 9 centimeters |
| 7:30 p.m. | 9 centimeters |
| 7:45 p.m. | 9 centimeters |

11. In order for delivery to occur, the mother's cervix must be dilated ten centimeters, which is referred to as being "complete." Once the mother becomes complete, the baby's head, absent obstruction, should be able to move past the mid-point of the pelvis.

12. A baby's progress is measured, both before and after the mother becomes complete, from the mid-point of the pelvis, which is the narrowest part of the mother's cervix. The location of the baby's head above the mid-point of the pelvis is

measured in centimeters and is referred to as "minus stations." Therefore, if the baby's head is two centimeters above the mid-point, it is said to be at "minus-two station." The location of the baby's head below the mid-point of the pelvis is also measured in centimeters and is referred to as "plus stations." Therefore, if the baby's head is two centimeters below the mid-point, it is said to be at "plus-two station."

13. When Patient S.B. became complete is not specifically noted on the Labor Sheet or Progress Notes kept by Ms. Blankenship during Patient S.B.'s attempted delivery. Nowhere did Ms. Blankenship note specifically that Patient S.B. was "complete" or dilated ten centimeters.

14. Neither party proved precisely when Patient S.B. was dilated to ten centimeters, or complete. Dr. Gichia believed that Patient S.B. was complete at approximately 8:00 p.m. Dr. Gichia's opinion was based, in part, upon a note indicating that Patient S.B. was at plus-one station at 7:25 p.m. Dr. Griffin's reliance upon the note, however, is misplaced.

15. It is doubtful how accurate Ms. Blankenship's estimates of the stations reached by the baby were, based upon the fact that she noted that the baby's head had reached a plus-three or plus-four station by 11:30 p.m., but the baby's head was only at a plus-one station when Patient S.B. was later examined in the hospital by Dr. Neil Boland.

16. Dr. Gichia also based her opinion on a note that Ms. Blankenship had had Patient S.B. start pushing at 8:00 p.m. Dr. Gichia concluded that Patient S.B., if she were pushing, was complete and had, therefore, entered what is referred to as "second stage labor." Again, Dr. Gichia's reliance on the 8:00 p.m. note is misplaced.

17. As explained by Ms. Blankenship, Patient S.B. had indicated at approximately 8:00 p.m. that she had the urge to start pushing. Accordingly to Ms. Blankenship, Patient S.B. was still dilated to only nine centimeters, but she believed that, with pushing, she would become complete.

18. After allowing Patient S.B. to make some effort to push, Ms. Blankenship determined that her effort was poor and, therefore, instructed her to stop for a while. While she wrote on her Labor Sheet that she was having Patient S.B. rest for "20 minutes," in fact, Patient S.B. rested much longer, not beginning to actively push again until 9:30 p.m.

19. Although the precise point in time when Patient S.B. became complete was not proved, it can be said that it did take place at some point after 7:25 p.m. and before, or at, 9:30 p.m. This conclusion is supported by Dr. Boland, who assumed that Patient S.B. began second stage labor at 9:30 p.m. rather than attempt to identify a precise earlier point in time.[8]

20. Although the accuracy of the stations of the baby's location noted by Ms. Blankenship are questionable and not supported by the weight of the evidence,[9] Ms. Blankenship genuinely believed that the baby was at the following stations at the noted times:

| | |
|---|---|
| 7:25 p.m. | plus-one station |
| 9:30 p.m. | plus-two station |
| 11:30 p.m. | plus-three/four station "with pushes" |

21. At midnight Ms. Blankenship informed Patient S.B. that, if she did not deliver by 12:30 a.m., July 10th, she would have her transported to a hospital due to maternal exhaustion. Patient S.B. agreed.

22. At 12:25 a.m. a "911 call" was made to arrange to have Patient S.B. transported to a local hospital. She was picked up at 12:30 a.m.

23. Patient S.B. was not attended to by a physician until 1:30 a.m., an hour after leaving Ms. Blankenship's care.

C. Failure to Progress in Descent.

24. Although testimony was offered at the final hearing concerning whether Patient S.B. should have delivered within two hours of beginning stage two labor, the only alleged deficiency in Ms. Blankenship's treatment of Patient S.B. contained in the Administrative Complaint is that "Patient S.B.'s second stage of labor exceeded two (2) hours without progress in descent (the

downward movement of the baby)." Due to this alleged deficiency, the Department concluded that Ms. Blankenship violated Florida Administrative Code Rule 64B24-7.008(4)(i)1, when she failed to consult with, or refer or transfer Patient S.B. to, a physician.

25. Ms. Blankenship believed that, based upon her conclusion that the baby had moved from plus-two station at 9:30 p.m. to a plus-three or plus-four station at 11:30 p.m., Patient S.B., after beginning second stage labor, had progressed in descent and, therefore, her referral to a physician was timely.

26. The term "progress in descent," however, is a technical term which in the practice of midwifery requires more than just the movement of the baby which Ms. Blankenship mistakenly believed she was witnessing.

27. Based upon standards established by the American College of Obstetricians and Gynecologists (hereinafter referred to as the "ACOG"), for, among other things, the practice of midwifery, progress in descent after two hours contemplates that, once a mother becomes complete, the baby should be born within two hours or, if not, that the midwife will consult with, or refer or transfer the mother to, a physician.

28. Ms. Blankenship failed to comply with the ACOG acceptable definition of progress in descent. Assuming that

Patient S.B. became complete as late as 9:30 p.m., she was not transferred to the hospital until 12:30 p.m., three hours later, and was not seen by a physician until 1:30 p.m., four hours later. While Ms. Blankenship believed that the baby's head was moving downward during this time, that perceived movement did not constitute "progress in descent."

D. Malpractice Insurance.

29. The parties stipulated that Ms. Blankenship did not have malpractice insurance from February 24, 1999, to July 10, 1999, and that she did not inform Patient S.B. that she did not have malpractice insurance while Patient S.B. was in her care.

30. Ms. Blankenship did not, however, intentionally deceive Patient S.B. Rather, she had incorrectly believed that her malpractice insurance had been maintained by a business associate.

## CONCLUSIONS OF LAW

A. Jurisdiction.

31. The Division of Administrative Hearings has jurisdiction over the subject matter of this proceeding and of the parties thereto pursuant to Sections 120.569 and 120.57(1), Florida Statutes (2004).

B. The Burden and Standard of Proof.

32. In the Amended Administrative Complaint, the Department is seeking the imposition of, among other penalties,

the revocation or suspension of Ms. Blankenship's license to practice midwifery in Florida. Therefore, the Department has the burden of proving the allegations in the Amended Administrative Complaint by clear and convincing evidence. See Department of Banking and Finance, Division of Securities and Investor Protection v. Osborne Stern and Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987); and McKinney v. Castor, 667 So. 2d 387 (Fla. 1st DCA 1995).

33. Clear and Convincing evidence has been defined as evidence which:

> requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

C. The Charges Against Ms. Blankenship; Section 467.203(1)(f), Florida Statutes.

34. The grounds proven in support of the Department's assertion that Ms. Blankenship's license should be revoked or suspended must be those specifically alleged in the Administrative Complaint. See, e.g., Cottrill v. Department of Insurance, 685 So. 2d 1371 (Fla. 1st DCA 1996); Kinney v.

Department of State, 501 So. 2d 129 (Fla. 5th DCA 1987); and Hunter v. Department of Professional Regulation, 458 So. 2d 842 (Fla. 2nd DCA 1984). Due process prohibits the Department from taking disciplinary action against a licensee based on matters not specifically alleged in the charging instrument, unless those matters have been tried by consent. See Shore Village Property Owners' Association, Inc. v. Department of Environmental Protection, 824 So. 2d 208, 210 (Fla. 4th DCA 2002); and Delk v. Department of Professional Regulation, 595 So. 2d 966, 967 (Fla. 5th DCA 1992).

35. The specific charges contained in the Amended Administrative Complaint are based upon alleged violations of Section 467.203(1)(f), Florida Statutes, which provides authority for the Department to take disciplinary action against the midwifery license of any person who commits the following proscribed pertinent act:

> (f) Engaging in unprofessional conduct, which includes, but is not limited to, any departure from, or the failure to conform to, the standards of practice of midwifery as established by the department, in which case actual injury need not be established.

36. In particular, the Department alleged in Count I of the Amended Administrative Complaint that Ms. Blankenship violated Section 467.203(1)(f), Florida Statutes, by treating Patient S.B. "without first advising Patient S.B. of the lack of

malpractice insurance, thereby depriving Patient S.B. with the opportunity to reconsider continuing the use of Respondent's midwifery services . . . ."

37. In Count II of the Amended Administrative Complaint, the Department alleged that Ms. Blankenship violated Section 467.203(1)(f), Florida Statutes, because she allowed Patient S.B. to continue in the second stage of labor for in excess of two hours without progress in descent and without consulting with, or referring or transferring Patient S.B. to, a physician.

D. Count I; Failure to Advise of the Lack of Malpractice Insurance.

38. In support of the allegation that Ms. Blankenship violated Section 467.203(1)(f), Florida Statutes, contained in Count I of the Amended Administrative Complaint, the Department has argued that the "standard[] of practice of midwifery as established by the department" which she violated by not informing Patient S.B. of her lack of malpractice insurance, is found in Section 467.014, Florida Statutes. That statutory provision provides the following:

> A licensed midwife shall include in the informed consent plan presented to the parents the status of the midwife's malpractice insurance, including the amount of malpractice insurance, if any.

39. Ms. Blankenship did not dispute the allegation of the Amended Administrative Complaint that, at the time of her treatment of Patient S.B., she did not have malpractice insurance and that she did not so inform Patient S.B. Therefore, Ms. Blankenship, clearly and convincingly failed to comply with Section 467.014, Florida Statutes.

40. The foregoing conclusion, however, does not support a conclusion that Ms. Blankenship thereby violated Section 467.203(1)(f), Florida Statutes, as alleged in the Amended Administrative Complaint. In order to conclude that Ms. Blankenship violated Section 467.203(1)(f), Florida Statutes, the Department was required to prove that she "engaged in unprofessional conduct." In order to show that she engaged in unprofessional conduct, it was necessary that the Department prove that Ms. Blankenship "depart[ed] from, or . . . fail[ed] to conform to, the standards of practice of midwifery as established by the department . . . ." This the Department did not do.

41. What the Department proved was that Ms. Blankenship had failed to follow a statutory directive; it did not prove that that statutory directive constitutes a "standard of practice . . . established by the department" as intended by the Legislature.

42. This conclusion is supported by the fact that the Legislature has defined the following act in Section 467.203, Florida Statutes, as an act for which the Department may take disciplinary action: "Willfully or repeatedly violating any provision of this chapter . . . ." §467.203(1)(i), Fla. Stat. The Legislature has, therefore, concluded that only willful and repeated violations of the general provisions of Chapter 467, Florida Statutes, are disciplinable and not an isolated violation like the one the Department proved Ms. Blankenship committed.

43. Based upon the foregoing, it is concluded that the Department failed to prove clearly and convincingly that Ms. Blankenship committed the violation alleged in Count I of the Amended Administrative Complaint.

E. Count II; Failure to Refer.

44. In support of the allegation that Ms. Blankenship violated Section 467.203(1)(f), Florida Statutes, contained in Count II of the Amended Administrative Complaint, the Department has argued that the "standard[] of practice of midwifery as established by the department" which she violated is contained in Florida Administrative Code Rule 64B24-7.008(4)(i)2). That rule provides the following:

> (4) Risk factors shall be assessed throughout labor to determine the need for physician consultation or emergency

> transport. The midwife shall consult, refer or transfer to a physician if the following occur during labor, deliver, or immediately thereafter:
>
> . . . .
>
> (i) Failure to profess in active labor:
>
> . . . .
>
> 2. Second stage: more than 2 hours without progress in descent.

45. The term "progress in descent" is a technical term which in the practice of midwifery requires more than just the movement of the baby.

46. Based upon standards established by the ACOG, more than two hours without progress in descent contemplates that, once a mother becomes complete, the baby should be born within two hours or, if not, that the midwife will consult with, or refer or transfer the mother to, a physician.

47. While Ms. Blankenship argued that she was in compliance with the standard of practice established in the rule, she failed to comply with the ACOG acceptable definition of progress in descent. At least three hours after Patient S.B. became complete, delivery had not occurred and Ms. Blankenship had not referred her to a physician.

48. Based upon the foregoing, it is concluded that the Department proved clearly and convincingly that Ms. Blankenship

committed the violation alleged in Count II of the Amended Administrative Complaint.

F. Appropriate Disciplinary Action.

49. The Department is authorized, upon finding a violation of Section 467.203(1), Florida Statutes, to impose the discipline specified in Section 467.203(2), Florida Statutes, which ranges from revocation to a reprimand.

50. Florida Administrative Code Rule 64B24-8.002 sets forth the following guidelines concerning violations related to standards of practice:

> (4) The following guidelines shall be used for the disposition of disciplinary cases involving specific types of violations:
>
> . . . .
>
> (c) For violations related to standards of practice regarding:
>
> . . . .
>
> 3. Any act of negligence or departure from standards of practice established by law or rule.
>
> . . . .
>
> For a first offense, a reprimand, a fine up to $200, probation or suspension; for a second offense, probation and a fine up to $400 per offense, a requirement to work under the supervision of a preceptor during probationary period until deemed safe to practice alone or revocation, or any combination thereof; for a third offense, a fine up to $1000 and revocation.

51. Florida Administrative Code Rule 64B24-8.002(1), requires that the Department take into consideration the following factors:

> (a) The severity of the offense;
> (b) The danger to the public;
> (c) The number of repetitions of offenses;
> (d) The length of time since date of violation;
> (e) The number of disciplinary actions taken against the licensee;
> (f) The length of time licensee has practiced;
> (g) The actual damage, physical or otherwise, to the patient;
> (h) The deterrent effect of the penalty imposed;
> (i) Any efforts for rehabilitation;
> (j) Any other mitigating or aggravating circumstances.

52. Based upon the foregoing, the suggested penalty for Ms. Blankenship's violation of the standards of practice, a first offense, is "a reprimand, a fine up to $200, probation or suspension," absent consideration of the factors specified in Florida Administrative Code Rule 64B24-8.002(1). Taking into account those factors, a suspension of one year, followed by probation for two years is an appropriate penalty in this case, not revocation, which the Department has suggested without explanation.

53. Although the evidence failed to prove that Ms. Blankenship was responsible for the baby's death in this

case, there was harm caused to Patient S.B. in that she was allowed to reach maternal exhaustion before being transported to the hospital. In mitigation, Ms. Blankenship's care of Patient S.B. took place almost six years ago, she had just obtained her license, and there is no evidence that she has had any other violation of the standards of practice.

## RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that a final order be entered by the Department:

1. Dismissing Count I of the Amended Administrative Complaint;

2. Finding that Sandra Blankenship violated Section 467.203(f), Florida Statutes, as alleged in Count II of the Amended Administrative Complaint; and

3. Suspending Ms. Blankenship's midwifery license for a period of one year from the date the final order and placing her license on probation for two years thereafter.

DONE AND ENTERED this 18th day of February, 2005, in Tallahassee, Leon County, Florida.

LARRY J. SARTIN
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 18th day of February, 2005.

## ENDNOTES

[1]/ Assuming that the Amended Administrative Complaint replaced an original Administrative Complaint, no explanation of when the original Administrative Complaint was issued or the extent to which it was amended was given by the parties.

[2]/ Ms. Blankenship executed her request for an evidentiary hearing on January 5, 2004. No explanation was given as to why it took until January 5, 2004, for Ms. Blankenship to execute her request for hearing when the Amended Administrative Complaint had been signed June 15, 2001. Nor did either party raise any issue concerning this lapse.

[3]/ Again, no explanation of what took place between January 5, 2004, when Ms. Blankenship requested an evidentiary hearing, and the date the matter was filed with the Division of Administrative Hearings, October 6, 2004, was given by the parties.

[4]/ The parties stipulated to the entry into evidence of: (a) all medical records regarding S.B. (the patient who is the focus of this matter) from Ms. Blankenship's various offices and/or relocations; (b) medical records regarding S.B. from Columbia Medical Center regarding delivery records of Neil C. Boland, M.D.; (c) fetal heart tracings printed July 10, 1999, at Columbia Medical Center; and (d) Ms. Blankenship's response to the Department's complaint.

[5]/ The only correction made by the Department was to include a copy of page 3 of the Amended Administrative Complaint, which had not been included with the Amended Administrative Complaint filed with the Division of Administrative Hearings on October 6, 2004.

[6]/ The statutes and rules relevant to this matter are those in existence in 1999. Therefore, all further references to statutes or rules in this Recommended Order shall be to the 1999 version unless otherwise indicated.

[7]/ Dr. Gichia found fault in her review of this matter with the amount of information Ms. Blankenship obtained about S.B.'s C-Section. She described her concerns in a written opinion she provided to the Department (Petitioner's Exhibit 3) and gave some testimony on the subject at the final hearing. Dr. Neil Boland also gave testimony concerning whether Ms. Blankenship properly reviewed Patient S.B.'s medical records of her C-Section. Those suggested shortcomings were not alleged in the Amended Administrative Complaint and, therefore, are not relevant to this matter. See Shore Village Property Owners' Association, Inc. v. Department of Environmental Protection, 824 So. 2d 208, 210 (Fla. 4th DCA 2002); Cottrill v. Department of Insurance, 685 So. 2d 1371, 1372 (Fla. 1st DCA 1996); and Delk v. Department of Professional Regulation, 595 So. 2d 966, 967 (Fla. 5th DCA 1992). Nor was the testimony of Dr. Gichia or Dr. Boland concerning this matter credited.

[8]/ While Dr. Boland also indicated that he assumed that Patient S.B. was complete at 8:00 p.m., he, like Dr. Gichia, based this testimony on his incomplete understanding of Ms. Blankenship's Labor Sheet notes.

[9]/ Based upon Dr. Boland's testimony and his examination of Patient S.B., the baby did not progress beyond a plus-one station.

COPIES FURNISHED:

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## NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.