STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF DENTISTRY,	)	
Petitioner,	)	
vs.	)	Case No. 12-4024PL
STEVEN COURTEN, D.D.S.,	)	
Respondent.	)	

RECOMMENDED ORDER

This case came before Administrative Law Judge Todd P. Resavage for final hearing by video teleconference on February 5, 2013, at sites in Tallahassee and Lauderdale Lakes, Florida.

APPEARANCES

For Petitioner: Adrienne C. Rodgers, Esquire
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For Respondent: Archie J. Ryan, Esquire
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STATEMENT OF THE ISSUES

The issues in this case are whether Respondent, a dentist, failed to maintain adequate records regarding his treatment of patient M.C. and/or provided M.C. dental care, including root

canal therapy, that fell below minimum standards of performance, as Petitioner alleges; if so, whether (and what) disciplinary action should be taken as a result.

PRELIMINARY STATEMENT

Prior to June 1, 2011, the Department of Health issued an Administrative Complaint against Respondent, Steven Courten, D.D.S. [1/] On or about June 1, 2011, Respondent filed an election of rights disputing the material facts alleged in the Administrative Complaint and requesting an administrative hearing. On December 14, 2012, the Department of Health issued an Amended Administrative Complaint ("Complaint") against Respondent. On December 17, 2012, the Department referred the matter to the Division of Administrative hearings.

Administrative Law Judge John G. Van Laningham was assigned to the matter and the final hearing was scheduled for February 5, 2013. On January 30, 2013, this case was transferred to the undersigned for all further hearings.

Both parties were represented by counsel at the hearing, which went forward as planned. The Department's witnesses were Odette Hershkowitz, Enrique Torres, Patient M.C., Dr. Thomas Shields, II, and Respondent. Received in evidence during the Department's case were Petitioner's Exhibits 1-5, 7, 8(a), 8(b), and 12. Respondent testified on his own behalf.[2/]

The final hearing transcript, comprising two volumes, was filed on February 22, 2013. Petitioner timely filed a Proposed Recommended Order and Respondent timely filed a Proposed Final Order, which were considered in preparing this Recommended Order.

Unless otherwise indicated, all rule and statutory references are to the versions in effect at the time of the alleged misconduct.

FINDINGS OF FACT

Introduction

1. At all times relevant to this case, Respondent Steven Courten, D.D.S., was licensed to practice dentistry in the state of Florida.

2. Petitioner Department of Health (the "Department") has regulatory jurisdiction over licensed dentists such as Dr. Courten. In particular, the Department is authorized to file and prosecute an administrative complaint against a dentist, as it has done in this instance, when a panel of the Board of Dentistry has found that probable cause exists to suspect that the dentist has committed a disciplinable offense.

3. Here, the Department alleges that Dr. Courten committed two such offenses. In Count I of the Complaint, the Department charged Dr. Courten with the offense defined in section 466.028(1)(m), alleging that he failed to keep written dental

records justifying the course of treatment of a patient named M.C. In Count II, Dr. Courten was charged with incompetence or negligence—again vis-à-vis M.C.—allegedly by failing to meet the minimum standards of performance in diagnosis and treatment when measured against generally prevailing peer performance, an offense under section 466.028(1)(x).

The Material Historical Facts

4. M.C. and Respondent have known each other personally since the 1960s, when they attending grade school together. In 1992, Respondent began providing dental services to M.C. Respondent performed dental services for M.C. during two time periods, from 1992-1995 and again from 2001-2009. The Complaint specifically limits the allegations against Respondent to the care and treatment provided to M.C. from April 30, 2005 through 2009.

5. Respondent treated M.C. under a financial arrangement whereby Respondent would receive payment from M.C.'s dental insurance, when such coverage was available. Although M.C. had a co-pay obligation that varied over the years, Respondent would forgive the same.

6. The primary, but uncharged, event giving rise to this case occurred on November 15, 2009. On that occasion, M.C. presented to Respondent and a dispute arose over tooth number 2, which was no longer in M.C.'s mouth and was composed of 18 karat

gold. Respondent proposed a course of treatment to include re-cementing the same. M.C. expressed his desire to simply take possession of the tooth and Respondent refused.

7. Thereafter, M.C. submitted a handwritten, unsigned complaint to the Department of Health alleging that Respondent was practicing dentistry out of his home, in unsanitary conditions, and in a manner that was below the standard of care.

8. As part of the subsequent investigation, on or about January 21, 2010, a subpoena with an accompanying certificate of completeness of records was served on Respondent. In response, Respondent provided the Department with M.C.'s records and the executed certificate of completeness on or about February 8, 2010.

9. A dispute exists between the parties regarding whether Respondent, in response to the subpoena and as attested by Respondent in the certificate of completeness, provided to the Department all of the records comprising M.C.'s chart. Respondent was not charged, however, with failing to make available to the Department copies of documents in the possession of Respondent which related to M.C., a separate disciplinable offense pursuant to section 466.028(1)(n). Therefore, he is not subject to discipline in this case for any shortcoming concerning said dispute.

The Charges

10. A thorough dissection of the instant Complaint is a required exercise in this case. Paragraph 5 provides that, "[t]he Respondent's continuing care from April 30, 2005 onward is the subject of this Amended Administrative Complaint."

11. Consistent with that limitation, Paragraphs 6 through 9 allege that Respondent performed root canals and crownwork on October 15, 2005; January 15, 2009; and February 20, 2009, concerning teeth numbers 5, 7, and 20, respectively.

12. Paragraph 20 alleges that Respondent did not use a rubber dam for isolation during the root canal treatments of teeth numbers 5, 7, and/or 20.

13. Paragraph 24 alleges that Respondent did not obtain sufficient radiographs for evaluation of the root canal treatments of teeth numbers 5, 7, or 20.

14. Paragraph 11 is interpreted by the undersigned as an attempt to allege that Respondent did not document radiographs or radiographic results in the written treatment record concerning teeth numbers 2 and 10 on the visit of November 15, 2009.

15. The balance of the factual allegations contained within the Complaint under the headings of "Medical History," "Radiograph Sufficiency and Margin Evaluation," "Radiographic

Examination Documentation," "Periodontal and Soft Tissue Care," and "Statements in the Alternative" fail to refer to a specific treatment, examination, date, or tooth. The undersigned has interpreted said allegations to apply exclusively to the course of treatment contained within the time limitation consistent with paragraph 5.

16. As noted above, the charges against Respondent are set forth in the Complaint under two counts. In Count I, the Department accused Respondent of failing to keep adequate dental records, an offense disciplinable pursuant to section 466.028(1)(m). The Department alleged that, in the course of treating M.C., Respondent violated the recordkeeping requirements in six particulars, which are identified in paragraph 47, subparagraphs a) through f) of the Complaint. In Count II, the Department charged Respondent with dental malpractice, which is punishable under section 466.028(1)(x). Seven particulars of alleged incompetence or negligence in the treatment of M.C. are set forth in paragraph 51, subparagraphs a) through g).

17. Several of the allegations in paragraphs 47 and 51 are parallel to one another, so that, when aligned side-by-side, they can be examined in logical pairs. Generally speaking, the Department's theory in relation to each allegation-pair can be expressed as follows: Where the circumstances required that the

dental act "X" be done for M.C. to meet the minimum standards of performance as measured against generally prevailing peer performance, Respondent failed to do X, thereby violating the standard of care. Respondent also failed to record doing X in the patient's record, thereby violating the recordkeeping requirements.

18. The parallel propositions comprising each allegation-pair are mutually exclusive. For example, if Respondent did not, in fact, do X, then he might be found to have violated the standard of care, if the Department were successful in proving, additionally, that, under the circumstances, X was required to be done to meet the minimum standards of performance. If Respondent did not do X, however, he obviously could not be disciplined for not recording in M.C.'s chart that he actually performed X. (If a dentist were to write in a patient's chart that he performed X when in fact he had not performed X, he would be making a false record; that would be a recordkeeping violation, but it is not the sort of misconduct with which the Department has charged Respondent.)

19. Conversely, if Respondent in fact did X and failed to note in M.C.'s chart having done X, then—if the law required Respondent to document the performance of X—he would be guilty of a recordkeeping violation.

20. The specific charges against Respondent are reproduced in the table below, which places the corresponding allegation-pairs side-by-side in separate rows. For ease of presentation, the undersigned has reordered the allegations to some extent. An empty cell denotes the absence of a corresponding allegation.

21. The Department charges Respondent as follows:

	Count II, ¶ 51: Alleged Standard-of-Care Violations	**Count I, ¶ 47: Alleged Recordkeeping Violations**
1	a) [F]ail[ing] to perform a comprehensive periodontal examination	b) Respondent's notes do not include a comprehensive periodontal examination
2	b) [F]ail[ing] to perform sufficient, if any, soft tissue examination	c) Respondent's notes do not include the results of a soft tissue examination
3	c) [F]ail[ing] to provide for, adequately document, and/or receive, informed consent for the multiple root canal treatments provided to Patient M.C.	
4	d) [F]ail[ing] to use a rubber dam and/or provide adequate justification for not using a rubber dam	
5	e) [F]ail[ing] to properly evaluate the obturation of his root canal treatments on one or more occasions	
6	f) [F]ail[ing] to properly evaluate the margins of his crown placements	
7	g) [F]ail[ing] to take adequate diagnostic comprehensive radiographs necessary to properly diagnose, treatment plan and/or perform the necessary treatments.	d) [F]ail[ing] to maintain labels or mounting for the radiographic records; e) [F]ail[ing] to document findings, interpretations, or diagnostic results of his radiographic examinations; f) [F]ail[ing] to take or maintain adequate diagnostic comprehensive radiographs necessary to justify the treatment that was performed

8		a) Respondent's notes do not include an appropriate medical history

Radiographs

22. The Department presented the testimony of Thomas Shields, D.D.S., on issues relating to the standard of care and record keeping. Dr. Shields was shown to have formulated his opinions based upon the review of information provided him by the Department. Included within the Department's information was an envelope that contained 51 individual radiographs. The radiographs appeared to be originals that were not mounted, labeled, or dated.

23. As a result, it was not possible for Dr. Shields to follow the treatment sequence provided by Respondent to M.C. Dr. Shields, in turn, opined that Respondent failed to meet the minimum standards for the profession of dentistry because 1) he could not discern evidence of full mouth radiographs; and 2) he could not discern that the radiographs were sufficient to adequately treat M.C. He further opined, based upon the loose radiographs received, that Respondent failed to meet standards for record-keeping because, although there are many radiographs, same are not described in the records.

24. A pivotal dispute exists, however, concerning whether the radiographs used for the diagnosis and treatment of M.C., and the cardboard mounts in which they were originally placed, were provided by Respondent and/or received by the Department.

25. Respondent credibly maintains that the subject radiographs were submitted to the Department on four cardboard mounts that included the dates of exposure, as well as minimal descriptions. Respondent further credibly avers that when the same were returned to him, after having been copied by a third-party copying service utilized by the Department, the mounts were absent and the order and sequencing of the radiographs were altered.

26. The evidence presented with regard to the standard of care violations contained in paragraphs 51(e) and (g) and the record-keeping violations contained in paragraphs 47(d), (e), and (f) does not clearly and convincingly demonstrate that Respondent failed to 1) take radiographs to properly evaluate the obturation of M.C.'s root canal treatments; or 2) take adequate diagnostic comprehensive radiographs necessary to properly diagnose, treatment plan and/or perform the necessary treatments.

27. The evidence further fails to prove clearly and convincingly that Respondent failed to 1) maintain labels or mounting for the radiographic records; 2) document findings, interpretations, or diagnostic results of his radiographic examinations; or 3) take or maintain adequate diagnostic comprehensive radiographs necessary to justify the treatment that was performed. Respondent is, therefore, not guilty of the

charges as alleged in paragraphs 51(e) and (g) or paragraphs 47(d), (e), and (f).

Comprehensive periodontal examination

28. Dr. Shields, from review of the available records, opined that Respondent failed to perform a proper periodontal examination. The basis for this opinion is, again, exclusively premised upon the lack of documentation contained in M.C.'s medical chart. The evidence does not clearly and convincingly establish any minimum standards of performance that Respondent failed to meet, under the facts of this case, in examining or addressing M.C.'s periodontal condition. As a result, Respondent is not guilty of the standard-of-care violation alleged in paragraph 51(a).

29. The evidence does, however, clearly and convincingly establish that Respondent failed to maintain the results of any such periodontal examination, and, therefore, Respondent is guilty of the record-keeping violation as set forth in paragraph 47(b).

Soft tissue/oral pathology

30. Dr. Shields, from review of the available records, opined that there was no evidence that Respondent performed a soft tissue or oral cancer examination. The basis for this opinion is, again, exclusively premised upon the lack of documentation contained in M.C.'s medical chart. The evidence

does not clearly and convincingly establish any minimum standards of performance that Respondent failed to meet, under the facts of this case, in examining M.C. As a result, Respondent is not guilty of the standard-of-care violation alleged in paragraph 51(b).

31. The evidence does, however, clearly and convincingly establish that Respondent failed to maintain the results of a soft tissue analysis and cancer screening. Indeed, Respondent conceded that while he performed a soft tissue analysis and conducted an oral cancer screening, he did not chart the results because there were no findings.[3/] Accordingly, Respondent is guilty of the record-keeping violation as set forth in paragraph 47(c).

Informed consent

32. With regard to paragraph 51(c), the evidence is insufficient to prove clearly and convincingly that Respondent failed to provide for, adequately document, and/or receive, informed consent for the multiple root canal treatments provided to M.C. The patient, whose testimony was often disjointed, conceded that he was adequately informed of the root canal treatments:

> Q. Did Dr. Courten always explain what he was going to do and the procedure prior to the work with you? Did he sit down and explain to you what your problem was and how to correct it?

* * *

> A. I understand. The way things went it wasn't an issue of what he was going to do as to how much time we had to do it. Are you comfortable with this? You know, these are our options, you know, for this one.

33. The undersigned finds that Respondent provided sufficient informed consent to M.C. regarding the treatment provided. For that reason alone, Respondent is not guilty of this alleged standard-of-care violation. Further, the failure to obtain informed consent is a disciplinable offense under section 466.028(1)(o) and thus is not punishable under section 466.028(1)(x), which states the offense Respondent has been accused of committing. For this additional and independent reason, Respondent cannot be found guilty of the standard-of-care violation alleged in paragraph 51(c).

Rubber dam utilization

34. Dr. Shield opined that Respondent failed to meet the minimum standard of dental care in Respondent's failure to use a rubber dam when performing root canals on M.C. As Dr. Shield testified, a rubber dam has three functions: 1) to prevent any objects from entering the airway or being aspirated or swallowed; 2) to protect the tissue surrounding the subject tooth from the adverse materials used such as hypochlorite; and 3) to keep the operating field as sterile as possible.

35. Dr. Shield testified that the utilization of a rubber dam is the minimal standard of care. Respondent conceded that a rubber dam is mandatory, is within the standard of care, and to be used whenever possible. Respondent testified, however, that in four or five instances he did not use a rubber dam, because in those particular instances, it was contra-indicated. He further testified that he used a rubber dam "probably, only, maybe two times, possibly, in the ten or so root canals because there were situations where the root was too small or the decay was too far sub-gingival." In the balance of occasions, Respondent employed an alternate aseptic protocol, called Isolite. Respondent's alternate aseptic protocol caveat to the standard of care—utilizing a rubber dam—is rejected and Dr. Shield's opinion is accepted.

36. With regard to the standard-of-care allegation set forth in paragraph 51(d), the evidence is sufficient that Petitioner proved by clear and convincing evidence that Respondent failed to meet the minimum standard of dental care in failing to use a rubber dam when performing root canals on M.C.

Appropriate medical history

37. The Complaint alleges, in paragraph 47 (a), that Respondent's notes do not include an appropriate medical history. In support of this allegation, Petitioner avers that although a medical history was partially obtained in August 20,

1992 (outside the time limitation established by the Complaint), Respondent never updated the medical history.

38. While a review of the chart reveals a limited initial medical history, from the perspective of the undersigned, the same is insufficient to establish a finding that it was not an "appropriate medical history." This conclusion is buttressed by the fact that no evidence was submitted, outside of the chart itself, to support Petitioner's position that it was inappropriate. Thus, Petitioner has not established by clear and convincing evidence the record keeping violation as stated in paragraph 47(a).

CONCLUSIONS OF LAW

39. The Division of Administrative Hearings has personal and subject matter jurisdiction in this proceeding pursuant to sections 120.569, and 120.57(1), Florida Statutes.

40. A proceeding, such as this one, to suspend, revoke, or impose other discipline upon a license is penal in nature. State ex rel. Vining v. Fla. Real Estate Comm'n, 281 So. 2d 487, 491 (Fla. 1973). Accordingly, to impose discipline, the Department must prove the charges against Respondent by clear and convincing evidence. Dep't of Banking & Fin., Div. of Sec. & Investor Prot. v. Osborne Stern & Co., 670 So. 2d 932, 933-34 (Fla. 1996)(citing Ferris v. Turlington, 510 So. 2d 292, 294-95

(Fla. 1987)); Nair v. Dep't of Bus. & Prof'l Reg., Bd. of Medicine, 654 So. 2d 205, 207 (Fla. 1st DCA 1995).

41. Regarding the standard of proof, in Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983), the court developed a "workable definition of clear and convincing evidence" and found that of necessity such a definition would need to contain "both qualitative and quantitative standards." The court held that:

> clear and convincing evidence 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.

Id. The Florida Supreme Court later adopted the Slomowitz court's description of clear and convincing evidence. See In re Davey, 645 So. 2d 398, 404 (Fla. 1994). The First District Court of Appeal also has followed the Slomowitz test, adding the interpretive comment that "[a]lthough this standard of proof may be met where the evidence is in conflict, . . . it seems to preclude evidence that is ambiguous." Westinghouse Elec. Corp. v. Shuler Bros., Inc., 590 So. 2d 986, 988 (Fla. 1st DCA 1991), rev. denied, 599 So. 2d 1279 (Fla. 1992)(citation omitted).

42. Disciplinary statutes and rules "must be construed strictly, in favor of the one against whom the penalty would be imposed." Munch v. Dep't of Prof'l Reg., Div. of Real Estate, 592 So. 2d 1136, 1143 (Fla. 1st DCA 1992); see Camejo v. Dep't of Bus. & Prof'l Reg., 812 So. 2d 583, 583-84 (Fla. 3d DCA 2002); McClung v. Crim. Just. Stds. & Training Comm'n, 458 So. 2d 887, 888 (Fla. 5th DCA 1984)("[W]here a statute provides for revocation of a license the grounds must be strictly construed because the statute is penal in nature. No conduct is to be regarded as included within a penal statute that is not reasonably proscribed by it; if there are any ambiguities included, they must be construed in favor of the licensee."); see also Griffis v. Fish & Wildlife Conserv. Comm'n, 57 So. 3d 929 (Fla. 1st DCA 2011)(statutes imposing a penalty must never be extended by construction).

43. Due process prohibits an agency from taking disciplinary action against a licensee based on matters not specifically alleged in the charging instrument. See § 30 120.60(5), Fla. Stat. ("No revocation, suspension, annulment, or withdrawal of any license is lawful unless, prior to the entry of a final order, the agency has served, by personal service or certified mail, an administrative complaint which affords reasonable notice to the licensee of facts or conduct which warrant the intended action . . . ."); see also Trevisani

v. Dep't of Health, 908 So. 2d 1108, 1109 (Fla. 1st DCA 2005)("A physician may not be disciplined for an offense not charged in the complaint."); Marcelin v. Dep't of Bus. & Prof'l Reg., 753 So. 2d 745, 746-747 (Fla. 3d DCA 2000); Delk v. Dep't of Prof'l Reg., 595 So. 2d 966, 967 (Fla. 5th DCA 1992)("[T]he conduct proved must legally fall within the statute or rule claimed [in the administrative complaint] to have been violated.").

44. In Count I of the Complaint, the Department charged Respondent under section 466.028(1)(m), which provides in pertinent part as follows:

> (1) The following acts constitute grounds for denial of a license or disciplinary action . . . :
>
> * * *
>
> (m) Failing to keep written dental records and medical history records justifying the course of treatment of the patient including, but not limited to, patient histories, examination results, test results, and X rays, if taken.

45. In connection with this charge, the Department alleged further that Respondent had not complied with rule 64B5-17.002, which provides, in relevant part, as follows:

> **64B5-17.002 Written Dental Records; Minimum Content; Retention.** (1) For the purpose of implementing the provisions of subsection 466.028(1)(m), F.S., a dentist shall maintain written records on each patient which written records shall contain, at a minimum, the following information about the patient:

(a) Appropriate medical history;

(b) Results of clinical examination and tests conducted, including the identification, or lack thereof, of any oral pathology or diseases;

(c) Any radiographs used for the diagnosis or treatment of the patient;

(d) Treatment plan proposed by the dentist; and

(e) Treatment rendered to the patient.

46. As found above, the undersigned has determined that Respondent failed to keep written dental records that conform to the requirements of section 466.028(1)(m) in failing to maintain written records of M.C. that contain 1) the results of periodontal examinations and 2) soft tissue analysis or oral pathology results.

47. In Count II of the Complaint, the Department charged Respondent under section 466.028(1)(x), which provides in pertinent part as follows:

(1) The following acts constitute grounds for denial of a license or disciplinary action . . . :

* * *

(x) Being guilty of incompetence or negligence by failing to meet the minimum standards of performance in diagnosis and treatment when measured against generally prevailing peer performance, including, but not limited to, the undertaking of diagnosis and treatment for which the dentist is not

> qualified by training or experience or being guilty of dental malpractice.

48. As found above, the Department succeeded in proving by clear and convincing evidence that Respondent failed to meet the minimum standards of performance in treating M.C., by the failure to utilize a rubber dam when performing root canals.

49. The Board of Dentistry imposes penalties upon licensees in accordance with the disciplinary guidelines prescribed in Florida Administrative Code Rule 64B5-13.005. The range of penalties for a first offense involving section 466.028(1)(m), which is set forth in rule 64B5-13.005(1)(m), is from a $500 fine to probation with conditions and a $7500 fine.

50. The range of penalties for a first offense involving section 466.028(1)(x), which is set forth in rule 64B5-13.005(1)(x), is from a $500 fine to probation with conditions and a $10,000 fine.

51. Rule 64B5-13.005(2) provides that, in applying the penalty guidelines, the following aggravating and mitigating circumstances are to be taken into account:

> (a) The danger to the public;
>
> (b) The number of specific offenses, other than the offense for which the licensee is being punished;
>
> (c) Prior discipline that has been imposed on the licensee;

(d) The length of time the licensee has practiced;

(e) The actual damage, physical or otherwise, caused by the violation and the reversibility of the damage;

(f) The deterrent effect of the penalty imposed;

(g) The effect of the penalty upon the licensee;

(h) Efforts by the licensee towards rehabilitation;

(i) The actual knowledge of the licensee pertaining to the violation;

(j) Attempts by the licensee to correct or stop the violation or refusal by the licensee to correct or stop violation;

(k) Any other relevant mitigating or aggravating facto under the circumstances.

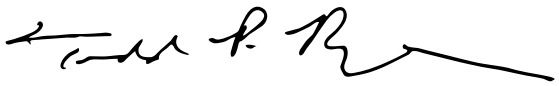
52. Having considered the potential aggravating and mitigating factors, the undersigned does not find compelling reasons to deviate from the guidelines, and, therefore, recommends that the Board of Dentistry impose a penalty that falls within the recommended range.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Board of Dentistry enter a final order finding Respondent guilty of the record-keeping violations alleged in paragraphs 47(b) and (c) of the Complaint (failure to record periodontal, soft tissue, and oral pathology

examinations) and the standard-of-care violation alleged in paragraph 51(d) of the Complaint (failure to utilize a rubber dam); finding Respondent not guilty of the remaining violations; and imposing the following penalties: issuance of a letter of concern; remedial education reasonably related to the topics of recordkeeping, endodontics, and ethics; and a fine of $2500.00.

DONE AND ENTERED this 26th day of March, 2013, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 26th day of March, 2013.

ENDNOTES

[1/] The record is silent concerning the date of issuance of the Administrative Complaint.

[2/] Respondent did not offer any exhibits during the Final Hearing. On February 6, 2013, Respondent filed a Verified Motion to Reopen Hearing for the purpose of allowing the introduction of Respondent's "written patient records" into evidence. On February 13, 2015, the undersigned issued an order denying said motion.

[3/] Rule 64B5-17.002(1)(b) provides that a dentist shall maintain written records on each patient that contain the results of clinical examinations and tests conducted, including the identification, or lack thereof, of any oral pathology or diseases.

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.