Adverse Actions Report May 2022 – June 2022

The digital edition of the *Forum* presents a two-month report of recent adverse actions. This report does not include non-adverse action such as reentry agreements or relief of consent order obligations. To view all public actions, visit www.ncmedboard.org/BoardActions.

Name/license #/location	Date of action	Cause of action	Board action
ANNULMENTS			
MCMILLION, Virgil Waid, DO (202101535) Morgantown, WV	06/29/2022	In February 2020, DO was issued a "Letter of Qualification" (LOQ) for an expedited license from the West Virginia Board of Osteopathic Medicine through the Interstate Medical Licensure Compact. To be eligible for an LOQ, an applicant must not be under investigation by any licensing agency or federal or state law enforcement authority. In March 2021, DO applied to renew his LOQ, with DO reporting that he was not under active investigation. The LOQ was issued in June 2021. However DO had, in fact, been under active investigation by virtue of the fact that a search warrant for his DNA was served on him by the Weston, WV, Police Department in December 2020. This misrepresentation by DO led the West Virginia Board to issue an order in February 2022 that rendered DO's June 2021 LOQ null and void. The West Virginia Board also reprimanded and fined DO $1000.00 for violating the West Virginia Board's rules. In	NC medical license Annulled

		March 2021, DO submitted an application for expedited license to NCMB. In that application DO made the same misrepresentation he did to the West Virginia Board. In response to the expedited application question that asked, "Are you aware of any complaint or investigation or inquiry, ever, regarding you that has been received or conducted by any of the following:... Local, state, federal, or other governmental agency" DO responded "No." On May 3, 2021, NCMB issued DO an expedited license based upon this misrepresentation. On December 2, 2021, DO inactivated his license by request.	
SUMMARY SUSPENSIONS			
NONE			
REVOCATIONS			
BOYER, Patricia Kimberly, MD (009300426) Charlotte, NC	05/23/2022	MD practiced psychiatry and geriatric psychiatry in Charlotte, North Carolina. Patient presented to MD in late 1999. Patient reported being in an abusive marriage in addition to experiencing other psychological stressors. MD provided psychotherapy and medication management. After several years of treating Patient, MD and Patient entered into a	Revocation of NC medical license

		consensual relationship and that relationship continued until 2017. MD reports that she discussed ending her physician-patient relationship with Patient because of a lack of therapeutic progress. MD further reports that this conversation occurred prior to her and Patient entering into a personal relationship. As a board-certified psychiatrist, MD knew or should have known, that the ethics of the psychiatric profession forbid intimate relationships between not only psychiatrists and current patients, but also former patients. Over the course of her relationship with Patient, MD continued to treat Patient "off the books", This care included writing multiple prescriptions for Patient, including controlled substances, none of which were documented in any patient chart. MD has expressed remorse for her actions and has fully cooperated with the investigation conducted by the Board.	
SUSPENSIONS			
FOLUKE, Alfred Kwasi, MD (000023899)	05 /20/2022	MD is a Board-Certified psychiatrist who, since 2010, operated Diagnosis and Assessment of Emotions-Health Services, PLLC (DAE), where he	Indefinite suspension

		primarily practiced addiction psychiatry. In addition, MD also owns and operates Select Properties, a property management company. MD treated a patient for opioid use disorder from March 2020 until February 2021, during which time he prescribed her Suboxone, a Schedule III Controlled Substance, along with other medications. In late 2020, MD offered Patient a job at his property management company. Patient was employed by MD for several months during which time MD continued to treat Patient. While treating and employing Patient, MD rented a single-family house that he owned to Patient. During the time Patient resided at the house owned by MD, he stayed overnight on two occasions. MD stayed at the house because he and Patient, had concerns about her safety. For several months, MD was Patient's treating physician, employer, and landlord, demonstrating a failure by MD to maintain appropriate personal and professional boundaries.	
RICE, James Edwin, MD (000029028) Southern Pines, NC	05/26/2022	In September 2021, MD was convicted on felony charges of Conspiracy to Defraud the United	Indefinite Suspension

		States, Tax Evasion, and two counts of Failure to Pay Trust Fund Taxes. In January 2022, MD was sentenced to five years in prison, with three years of supervised release and $2.4 million in restitution to the United States. MD timely filed a notice of appeal of his convictions in February 2022.	
LIMITATIONS/CONDITIONS			
HILL, Sherry Leigh, MD (200100696) Asheville, NC	06/03/2022	In June 2020, while on duty at a Tennessee hospital, MD was observed by hospital staff in what appeared to be an impaired state. The Tennessee Board of Medical Examiners investigated and summarily suspended MD's Tennessee medical license in October 2020. These actions by the Tennessee Board caused NCMB to open an investigation. In October 2020, MD voluntarily went to the North Carolina Professionals Health Program (NCPHP). NCPHP conducted an initial evaluation, determined it could not support MD as safe to practice medicine at that time, and recommended further evaluation related to substance use and mental health concerns. In October 2020, MD inactivated her North Carolina medical license. In December	License reinstated; MD to maintain her current agreement with NCPHP

		2020, she entered into a Monitoring Agreement with NCPHP. In June 2021, she applied for reinstatement of her license to practice medicine in North Carolina. In December 2021, MD entered into a Consent Order with the Board that indefinitely suspended her inactive North Carolina license, retroactive to the date she made it inactive, which was October 29, 2020. This retroactive indefinite suspension resolved the NCMB case. MD is an ongoing, compliant participant with NCPHP, which now supports her as safe to practice.	
KRISHNARAJ, Ramesh Loganathan, MD (009901228) Lenoir, NC	06/01/2022	MD has a history of alcohol use disorder more specifically described in Consent Orders issued September 2015, and June 2021. In March 2021, after a relapse, MD inactivated his North Carolina medical license at the request of NCMB. MD has not practiced medicine since that time. After MD's most recent relapse, he completed inpatient treatment and upon his discharge resided in a Sober Living facility for six months. In March 2021, he signed a new five-year monitoring agreement with the North Carolina Professionals Health	License reinstated with terms and conditions

		Program (NCPHP). In June 2021, MD and the Board entered into a Consent Order in which his license was indefinitely suspended. In December 2021, MD applied for reinstatement of his NC medical license. MD is currently in compliance with his NCPHP.	
MCGRATH, Timothy John, MD (200200571) Burlington, NC	06 /13/2022	MD has a history of substance use disorder more specifically described in Consent Orders issued in July 2014, December 2015, August 2017, and December 2017. In June 2020, after testing positive for a controlled substance in violation of his North Carolina Professionals Health Program (NCPHP) agreement and December 2017 Consent Order, MD, through counsel, requested that his license be made inactive. MD has not practiced medicine since that time. MD has been a participant with NCPHP since December 2010. In August 2020, MD signed a new five-year monitoring agreement with NCPHP. In November 2020, MD and the Board entered into a Consent Order in which his license was indefinitely suspended. In September 2021, MD applied for reinstatement of his NC	License reinstated via consent order; MD shall maintain his current agreement with NCPHP

		medical license. MD is in compliance with his NCPHP agreement.	
OKWARA, Benedict Onwukwe, MD (000033878) Monroe, NC	06/17/2022	In September 2016, MD entered into a Non Disciplinary Consent Order with the Board. The 2016 Order issued a Public Letter of Concern and required, among other things, that MD complete comprehensive professional assessment in internal medicine and complete all resulting recommendations. This action was based on findings that MD failed to properly treat one of his patients, as detailed in the 2016 Order. In December 2016, MD obtained a professional assessment from The Center for Personalized Education for Professionals (CPEP). CPEP found areas of educational need and developed a remedial plan to enhance MD's medical knowledge (CPEP Plan). The Board thereafter received five progress reports on an approximately quarterly basis from July 2017 to March 2020, detailing MD's educational activities. These reports showed that MD actively participated and engaged in the CPEP Plan. CPEP authored a Summary Report in March 2020 and noted that while MD had made significant progress with	Consent Order; MD shall ensure that an NC licensed PA or NP work with and assist him with all clinical patient encounters

		the CPEP Plan, he ultimately did not successfully complete the entire plan. Based on the CPEP Summary Report, the Board had the care of eight of MD's patients reviewed by an independent medical expert who opined that the care rendered by MD was below the standard of care in NC in seven of the eight patients. The Board notes that the focus of the independent medical expert's criticisms surrounded MD's lack of thorough and detailed medical record documentation.	
ULSTAD, Richard Douglas, PA (000103434) Wilmington, NC	05/13/2022	In February 2021, the Board received a complaint from a patient regarding PA. The patient alleged that, while examining her abdomen and administrating a steroid injection to address pain in her right hip and knee during an unchaperoned medical visit, PA unnecessarily lifted and later lowered her shorts and underwear. PA admits he was previously cautioned about the risks of unchaperoned examinations. PA denies the allegations made against him by the patient; however, he acknowledges that by not having a chaperone present, he placed himself at risk of such allegations. PA complied	Indefinite suspension immediately stayed with conditions

		with all requests from the Board and has voluntarily ensured to have a chaperone present for all patients and procedures, including injections, since this complaint was filed to protect himself and the public. In March 2021, PA submitted to an examination at the North Carolina Professionals Health Program (NCPHP). NCPHP recommended that PA obtain a comprehensive in-person evaluation at a NCPHP-approved assessment facility specializing in assessing providers accused of inappropriate behavior in the workplace. At his employer's suggestion, PA completed the Vanderbilt University Medical Center's course on Maintaining Proper Boundaries. PA was evaluated by the Pine Grove Behavioral Health & Addiction Services in July 2021. Pine Grove suggested that PA complete an in-person program for professionals designed to address professional and boundary issues. PA completed eight weeks of an outpatient program at Pine Grove in November 2021. Substance abuse and alcohol disorders were ruled out, and PA passed all polygraph	

		examinations administered to him. At the time of his discharge, Pine Grove made several recommendations including, but not limited to: (1) monitoring by NCPHP; (2) workplace limitations, including chaperones during all female patient encounters; (3) biannual polygraphs; (4) individual therapy. In November 2021, PA entered into a five-year monitoring agreement with NCPHP. He is in compliance with his NCPHP agreement and Pine Grove and NCPHP are of the opinion that he is safe to practice.	
REPRIMANDS			
HEROMAN, James Wesley, MD (201301462)	06/17/2022	In 2013, MD bought Carolina Retina and Vitreous Consultants (CRVC) from another physician. MD continued a medication-ordering practice at CRVC that had been established by the prior owner. MD thought this practice was appropriate and lawful. He ordered and received prescription medications that were not approved by the U.S. Food and Drug Administration (FDA) for use within the United States. This practice was, in fact, illegal. MD and CRVC were investigated by the FDA and the United States Department of Justice. These	Reprimand

		investigations have recently resolved. MD pled guilty to a Class A Misdemeanor in violation of Title 21 prohibiting, receipt in interstate commerce of misbranded drugs, and the delivery or proffered delivery thereof for pay or otherwise. CRVC shall pay $450,000 in restitution in a separate civil case settlement. MD's North Carolina medical license was made inactive by request during the Board's investigation.	
JAH, Fatimah Omar, MD (2014-00175) Orlando, FL	06/27/2022	Action based on another state Board's action related to MD's practice of family medicine via telemedicine. In October 2021, MD entered into a Consent Order with Rhode Island Board of Medical Licensure and Discipline in which she was reprimanded, assessed a $1,300.00 administrative fee, and required to complete 21 hours of Continuing Medical Education related to the care of patients by telemedicine and maintaining appropriate medical record documentation. The Rhode Island Board's Consent Order was based on MD's failure to properly document patient care provided during telemedicine visits for two patients.	Reprimand
DENIALS OF LICENSE/APPROVAL			

YANK, Glenn Russell, MD (YANK-CQZ9OI) Chapel Hill, NC	06/24/2022	Acton based on another state Board's action. MD previously practiced psychiatry in Tennessee. In July 2021, he applied for a North Carolina medical license. In March 2022, the Board notified MD that the Board had denied his application and notified him that he was entitled to a formal hearing before the Board. The Board based its decision to deny MD's application on the grounds that: In November 2016, he entered into a Consent Order with the Tennessee Board of Medical Examiners in which he was reprimanded, restricted from prescribing opioids and other medications, and required to be monitored for a period of three years; in July 2020, MD entered into a Consent Order of Modification of Prior Order with the Tennessee Board that indicated MD had failed to satisfy the monitoring requirement imposed by the 2016 Consent Order, had retired from the practice of medicine in April 2020, and stated certain restrictions and conditions that would be placed on his Tennessee medical license should he apply to reactivate his Tennessee license.	Denial of licensure
SURRENDERS			

NONE			
PUBLIC LETTERS OF CONCERN			
ANDREWS, David William, PA-C (001012351) Charlotte, NC	06/16/2022	The Board is concerned that PA failed to disclose information in his license application in the Regulatory Action section that asks about other regulatory entity investigations. In 2016 The Indiana Physician Assistant Committee denied PA's physician assistant renewal because he failed to tell the Committee about an April 2016 Wisconsin Medical Examining Board Final Decision and Order that imposed a reprimand and required that he pay $798.00 in costs for practicing outside the scope of his physician assistant license and failing to cooperate in a timely manner with the Wisconsin Board investigation. In 2017 The Indiana Committee issued a Decision Following Personal Appearance that reinstated PA's Indiana physician assistant license subject to a minimum two-year probation. In 2017 The Michigan Department of Licensing and Regulatory Affairs Bureau of Professional Licensing Task Force on Physician's Assistants Disciplinary Subcommittee filed an Administrative Complaint against PA	Public Letter of Concern; $2,500 fine

		alleging that he failed to timely report the April 2016 Wisconsin Board Final Decision and Order to the Michigan Subcommittee. In 2018 PA entered into a Consent Order with the Michigan Subcommittee that resolved the November 2017 Administrative Complaint. In 2019 The Indiana Committee issued an Order that indefinitely suspended PA's Indiana physician assistant license for failing to comply with the June 2017 Indiana Committee Decision Following Personal Appearance. In 2019 The Wisconsin Board issued a Final Decision and Order that imposed a reprimand and required PA to pay $310.00 in costs because he failed to report the 2018 Michigan Subcommittee Consent Order to the Wisconsin Board.	
CARO, Maricelina Doreley, MD (200201346) Chapel Hill, NC	05/12/2022	Action based on another state Board action. The Board is concerned that in September 2021 MD entered into a Consent Order with the Virginia Board, in which she was reprimanded. Additionally, in December 2021 MD entered into a Consent Order and Agreement with the Pennsylvania Board in which she was issued a reprimand and	Public Letter of Concern

		required to complete five hours of remedial education on the topic of ethics. Both Boards' actions were based on MD's failure to disclose on her initial applications for licensure that she was suspended by her employer for five days in March 2018 due to unacceptable personal conduct. MD has now reported the suspension to all state boards in which she is licensed and has been forthcoming to this Board about any action taken by other licensing boards related to this matter.	
COLON-GARCIA, Patricia, MD (201702571) Fort Myers, FL		The Board is concerned that MD's care of a patient may have failed to conform to the standards of acceptable and prevailing medical practice in North Carolina. In February 2019, a sixty-seven-year-old male (Patient) was transported from his home to a nearby hospital by EMS after demonstrating signs of a possible stroke, including slurred speech, left facial droop, and weakness on his left side. The attending physician evaluated Patient and assigned a 3 out of 42 on the National Institutes of Health Stroke Scale based mainly on Patient's left leg weakness. The attending physician then ordered a	Public Letter of Concern

		noncontrast CT which was negative for hemorrhage. MD was called in for a tele-neurology consult approximately 1.5 hours after onset of Patient's symptoms. MD's impression was that Patient was suffering from an acute stroke, but that Patient's presentation was not suggestive of a large vessel occlusion. Therefore, she did not recommend a CT angiogram (CTA) of Patient's head at the time. Patient was admitted to the hospital for observation and a subsequent CTA of Patient's head revealed a large vessel occlusion. In March 2019, Patient was discharged to a rehabilitation facility secondary to cognitive impairment and need for assistance with all activities of daily life. The Board is concerned that MD failed to consider that Patient may have had an impending large vessel occlusion in progress and did not recommend a CTA. Had she recommended a CTA at the time of consultation, she may have identified the impending large vessel occlusion and intervention measures could have been taken before Patient	

		developed permanent and severe disabilities.	
HAGER, Shelton Philip, MD (009901190) Kingsport, TN	06/02/2022	Action based on another state Board action. The Board notes that MD is a family medicine physician with specialty certification who has practiced for several years in a community that has experienced a shortage of pain management specialists. As a result, MD treated patients for chronic pain management. The Board is concerned that the Tennessee Board investigated MD's medical practice and reviewed medical records of patients that he provided chronic pain management care to from January 2018 to September 2020. The Tennessee Board had concerns related to MD's chronic pain management, controlled substance prescribing and documentation. As a result, MD entered into a Consent Order with the Tennessee Board in January 2022, which placed his license on probation, restricted prescribing, required practice monitoring, CME and a fine. MD's North Carolina medical license became inactive in December 2021. He may apply for reinstatement of his NC license at any time.	Public Letter of Concern
HSU, Wesley, MD (201101177)	05/05/2022	The Board is concerned	Public Letter of Concern

Winston-Salem, NC		that MD's care of a patient may have failed to conform to the standards of acceptable and prevailing medical practice in North Carolina. In June 2017, MD evaluated a seventy-two-year-old male (Patient) with thoracic and lumbar stenosis. An MRI of the lumbar showed severe stenosis at thoracic vertebras (T10/11) and stenosis and spondylolistheses of the fourth and fifth lumbar vertebras (L4/5). A dedicated thoracic MRI also showed stenosis at T10/11 but was interpreted and documented by an independent radiologist to be at T11/12. In August 2017, MD performed decompression and fusion surgery on Patient at levels T11/12 and L4/L5. The Board is concerned MD relied on the thoracic MRI which incorrectly labeled the stenosis at T11/12 without reconciling the thoracic MRI with the lumbar MRI, which correctly labeled the stenosis at T10/11. This failure to reconcile the two conflicting MRI reports led to incorrectly diagnosing stenosis at T11/12.	
JABARI, Jawanza Nyahuma, MD (202003599) Whiteville, NC	06/13/2022	In September of 2020, a thirty-five-year-old male (Patient) presented to	Public Letter of Concern

		the hospital where MD was the attending anesthesiologist for an elective toe amputation. Induction of anesthesia was performed by a Certified Registered Nurse Anesthetist (CRNA) and approximately 15 minutes into the procedure Patient went into cardiac arrest. Resuscitation attempts were successfully performed, but Patient suffered hypoxic brain injury and was placed on life-support. Patient was then transferred to a tertiary care center for further care and evaluation. Patient's condition continued to deteriorate, and he was given a poor prognosis for recovery. Approximately two weeks after the initial procedure, Patient's family withdrew life-sustaining care, at which time Patient died. The Board had MD's treatment of Patient reviewed by an outside medical expert. The reviewing expert opined that there were issues with respect to the documentation of MD's overall care, including whether or not MD was present at the time of induction. There were also concerns regarding the documentation of the resuscitation efforts.	

KHANDANI, Amir Hossein, MD (200700163) Chapel Hill, NC	06/13/2022	The Board is concerned that MD's care of a Patient may have failed to conform to the standards of acceptable and prevailing medical practice in North Carolina. Patient is a 49-year-old male with a history of inflammatory bowel disease (Crohn's Disease), including multiple surgical procedures and related complications. In January 2018, Patient had an abdominal and pelvic positron emission tomography (PET) scan to evaluate for a fever of unknown origin with concerns of a possible infection. MD interpreted Patient's PET scan as compatible with multiple intraabdominal abscesses. Because Patient recently had a "normal" colonoscopy and several negative computerized tomography (CT) scans, he did not include the possibility of cancer in his differential diagnosis. In June 2018, approximately six months later, Patient was diagnosed with rectal cancer. The Board had MD's interpretation of Patient's PET scan reviewed by an independent medical expert. The reviewing expert opined that MD's care of Patient may have fallen below the	Public Letter of Concern

		standard of care in North Carolina. Specifically, the reviewing expert criticized MD's failure to recognize the abnormality that could be visualized below the area noted during his interpretation. The reviewing expert opined that the standard practice in North Carolina would be to "identify this large abnormality during the initial interpretation of the study, to provide a differential diagnosis of active inflammation versus tumor, and to recommend further investigation with proctoscopy/sigmoidoscopy." The Board recognizes that MD's original diagnosis was influenced by his concern for the consequence of a false positive cancer diagnosis for a severely ill individual. The Board further recognizes that he has implemented changes to his standard practice to include a broader differential diagnosis in his interpretation.	
LEWIS, Kristine Rene, PA-C (000101600)	06/17/2022	The Board is concerned that from May 2019 to May 2021, PA prescribed numerous medications, including multiple controlled substances, for her own use. Administrative Rules prohibit licensees from	Public Letter of Concern

		prescribing controlled substances for personal use. Further, from August 2019 to January 2021, PA prescribed multiple non-controlled substances to an immediate family member. PA did not prepare any documentation or medical charting for the prescriptions in writing on the patient's record, including the medication name and dosage, amount prescribed, directions for use, and number of refills. PA's self-prescribing and prescribing to an immediate family was in conflict with the Board rules and with Board Position Statements entitled, "Writing of Prescriptions" and "Self-Treatment and Treatment of Family Members".	
PILATI, David Michael, MD (009901289) Cary, NC	06/21/2022	In October 2018, a patient presented to MD and underwent a revision of a previous Roux-en-Y gastric bypass after experiencing weight recidivism resulting in a body mass index of 60. Patient's revision surgery was complicated by postoperative compartment syndrome, bowel obstruction, omental ischemia, bowel leaks iatrogenic colotomy, and fistulae. Management of these	Public Letter of Concern

		postoperative complications prolonged Patient's recovery and hospital stay. The Board is concerned the Roux-en-Y revisional procedure may have failed to conform to the standards of acceptable and prevailing medical practice in North Carolina.	
SEBASTIEN, Joel Larry, MD (201801526) Lenoir, NC	05/18/2022	The Board is concerned that MD's care of a patient may have failed to conform to the standards of acceptable and prevailing medical practice in North Carolina. The Board is concerned that after performing a laparoscopic vertical sleeve gastrectomy on Patient in December 2017, MD did not give proper postoperative care. MD failed to recognize that Patient was experiencing a postoperative bleed, did not recognize the severity of that bleed, and failed to return to the operating room in a timely manner, all of which resulted in Patient's death. Despite being called multiple times with updates on Patient's condition, including updates that indicated Patient was unstable, persistently hypotensive, acidotic, and under resuscitated, MD was unavailable for 18 hours after the	Public Letter of Concern

		surgery and relied on other intensivists to manage Patient's postoperative complications. The Board is also concerned that MD failed to keep adequate postoperative progress notes.	
SPENNETTA, Joseph Donald, MD (200601207) McComb, IL	05/24/2022	Action based on another state Board action. In September 2020, while practicing in Wisconsin, MD treated a patient who had been assaulted, had a blood alcohol level of 0.277 and had admitted to using marijuana. During MD's examination of Patient, a physical altercation ensued. MD maintained that his actions were defensive, but witness accounts questioned whether MD used excessive force. The hospital where this occurred investigated, concluded that there was unprofessional conduct on MD's part and discharged him. The Wisconsin Board investigated this incident and, in August 2021, issued a Final Decision and Order which Reprimanded MD and required a fitness for practice evaluation with a preapproved psychiatrist or psychologist. The Board notes that this was done in September and October 2021 and that	Public Letter of Concern

		MD was found fit to practice, with recommendations to obtain psychotherapy and coaching. Finally, the Wisconsin Order required MD to show a copy of the action to supervisory personnel at all work settings and also required MD to complete continuing medical education in patient safety, conflict de-escalation and professional interactions. The Board notes that this has been completed. In January 2022, the Wisconsin Board reviewed the fitness to practice evaluation report and entered an Order wherein MD agreed to complete training and continue therapy.	
WASHBURN, Ronald Lee, MD (000021732) Virginia Beach, VA	05/24/2022	The Board is concerned regarding MD's involvement in October 2015, in an incident where an 18-year-old male patient was brought to an emergency department following a motor vehicle accident. MD was a radiologist who treated Patient on this day and interpreted a non-contrast abdominal and pelvic CT scan based on a report of abdominal pain. MD's report notes a "small amount of free intraperitoneal fluid noted within the pelvis." Patient was later	Public Letter of Concern

		discharged by the emergency medicine physician after MD's CT scan report was reviewed. Three days later, Patient returned to an emergency department and a follow up CT scan identified a large amount of bloody intraperitoneal fluid and a large amount of free air. Patient was taken to surgery and a bowel perforation was found and repaired. The Board had MD's CT scan interpretation reviewed by an independent medical expert. The reviewing expert was critical of MD's interpretation. Specifically, the reviewer opined that MD failed to identify a left lateral abdominal wall contusion. Furthermore, the reviewer indicated that MD failed to identify multiple findings of mesenteric injury and recommend emergent surgical consultation.	
MISCELLANEOUS ACTIONS			
NONE			
CONSENT ORDERS AMENDED			
NONE			
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
BARTUV, Noam Eliashiv, MD (202101384) Chapel Hill, NC	06/28/2022	MD was initially issued a Special Purpose License dated April 21, 2021. MD's Special Purpose License permitted him to be a clinical fellow at the	Amended Special Purpose License Agreement

		Duke University Medical Center, Department of Head and Neck Surgery and Communication Sciences, Division of Otolaryngology, beginning July 1, 2021, and ending on June 30, 2022. Duke University Medical Center, Department of Head and Neck Surgery and Communication Sciences, Division of Otolaryngology has extended MD's fellowship training to end on June 30, 2023. The Board shall extend the timeframe of MD's Special Purpose License. So that it shall come into effect at 12:01 a.m., June 30, 2022, and shall expire at midnight on June 30, 2023, at which time MD's Special Purpose License shall become inactive.	
COURT APPEALS/STAYS			
NONE			
DISMISSALS			
NONE			