

**MINUTES**  
**Monthly Meeting**  
**MEDICAL LICENSURE COMMISSION OF ALABAMA**  
**Meeting Location: 848 Washington Avenue**  
**Montgomery, Alabama 36104**

**May 28, 2025**

**MEMBERS PRESENT IN PERSON**

Jorge Alsip, M.D., Chairman  
Paul M. Nagrodzki, M.D., Vice-Chairman  
Kenneth W. Aldridge, M.D.  
Craig H. Christopher, M.D.  
Howard J. Falgout, M.D.  
Nina Nelson-Garrett, M.D.  
Pamela Varner, M.D.

**MEMBERS NOT PRESENT**

L. Daniel Morris, Esq

**MLC STAFF**

Aaron Dettling, General Counsel, MLC  
Rebecca Robbins, Operations Director (Recording)  
Nicole Roque, Administrative Assistant (Recording)  
Heather Lindemann, Licensure Assistant

**OTHERS PRESENT**

Jim Debardelaben, Esq.  
Patrick Pulliam  
Brian E. Richardson, M.D.

**BME STAFF**

Anthony Crenshaw, Investigator  
Rebecca Daniels, Investigator  
Randy Dixon, Investigator  
Amy Dorminey, Director of Operations  
Alicia Harrison, Associate General Counsel  
Chris Hart, Technology  
Effie Hawthorne, Associate General Counsel  
Wilson Hunter, General Counsel  
Roland Johnson, Physician Monitoring  
Sally Knight, Physician Monitoring  
William Perkins, Executive Director  
Ben Schlemmer, Investigator  
Tiffany Seamon, Director of Credentialing  
Scott Sides, Investigator



Call to Order: 9:00 a.m.

Prior notice having been given in accordance with the Alabama Open Meetings Act, and with a quorum of seven members present, Commission Chairman, Jorge Alsip, M.D. convened the monthly meeting of the Alabama Medical Licensure Commission.

**OLD BUSINESS**

**Minutes April 16, 2025**

Commissioner Christopher made a motion that the Minutes of April 16, 2025, be approved. A second was made by Commissioner Nelson-Garrett. The motion was approved by unanimous vote.

**NEW BUSINESS**

**Full License Applicants**

<b><u>Name</u></b>	<b><u>Medical School</u></b>	<b><u>Endorsement</u></b>
1. Sam David Abdehou	LSU Medical Center in Shreveport	USMLE/LA
2. Christopher Jordan Adams	Lincoln Memorial Univ Debusk College of Osteopathic Medicine	COMLEX
3. Kamardeen Diekola Alabi	Ahmadu Bello University	USMLE/GA
4. Saud Abdulelah O Alsaleh	King Saud University, Riyadh	USMLE/SC
5. Fernando Alvarez, Jr.	Edward Via College of Osteopathic Medicine Auburn	COMLEX
6. Farah Anees	Sindh Medical College	USMLE/KY
7. Alexis Preston Aranda	University of Medicine and Health Sciences St. Kitts	USMLE
8. Subhan Ata	American University of the Caribbean	USMLE
9. Julianna Betbeze	University of South Florida	USMLE/VA
10. Melanie E Bourgeau	Western Michigan Univ Homer Stryker M.D. School of Medicine	USMLE/GA
11. Duncan Lee Bralts	Alabama College of Osteopathic Medicine	COMLEX/MO
12. Michael Robert Brunner	University of Tennessee Memphis College of Medicine	USMLE/TN
13. Martha Christine Carlough	Sidney Kimmel Medical College at Thomas Jefferson University	NBME/NY
14. Thomas Alexander Cato	William Carey University College of Osteopathic Medicine	COMLEX/OH
15. Stephanie Cheifet	UCLA, David Geffen School of Medicine	USMLE/CA
16. Jessica A Clark	Edward Via College of Osteopathic Medicine Auburn	COMLEX
17. Philip William Dockery	University of Alabama School of Medicine Birmingham	USMLE
18. Rana Khan Fowlkes	Cornell University	USMLE
19. Caroline Self Fulwyler	Louisiana State University	USMLE
20. Donald William Furman	Lincoln Memorial Univ Debusk College of Osteopathic Medicine	COMLEX/TN
21. Antonino Germana	Uniformed Services University of the Health Sciences	USMLE/NC
22. Gracie Sanders Gibbs	Edward Via College of Osteopathic Medicine Auburn	COMLEX
23. Alois Edwin Gross-Lesch	Edward Via College of Osteopathic Medicine Auburn	COMLEX/MI
24. Stephen Timothy Hantus	Augusta University	USMLE/OH

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<u>Name</u>	<u>Medical School</u>	<u>Endorsement</u>
25. Jonathan Leslie Harper	Indiana University School of Medicine Indianapolis	USMLE/KY
26. Shawn Wesley Haynes	Ross University	USMLE/FL
27. Brittany Nicole Hegde	University of Tennessee Memphis College of Medicine	USMLE/TX
28. Jamie Michelle Hennigan	University of South Alabama College of Medicine	USMLE/OH
29. Robert Hamilton Hermann	University of Texas Southwestern	USMLE/OR
30. Stephen Todd Hollingsworth	American University of the Caribbean	USMLE
31. Brittany Marie Huynh	Indiana University School of Medicine Indianapolis	USMLE/IN
32. Victoria Dung Huynh	Texas A & M University	USMLE/CO
33. Paul Louis Hyman	Harvard Medical School	USMLE/MA
34. Zohaib Mohammad Ijaz	University of South Alabama College of Medicine	USMLE
35. Alexandria Cool Jager	University of South Alabama College of Medicine	USMLE
36. Shaquana Clark James	Meharry Medical College	USMLE/VA
37. Hannah Virginia Jarvis	Indiana University School of Medicine Indianapolis	USMLE/KY
38. Jonathan Daniel Joiner	Alabama College of Osteopathic Medicine	COMLEX/MI
39. Scott David Robert Jossart	Medical College of Wisconsin	USMLE
40. Jody Watson Joynt	University of Alabama School of Medicine Birmingham	USMLE/VA
41. David Eric Kantrowitz	Columbia University	USMLE/DE
42. Ebrahim Hasan Khan	Aga Khan Medical College, Aga Khan University	USMLE/MN
43. Usman Ayub Khan	University of Peshawar Khyber Medical College	USMLE/TX
44. Glorivel M Koury De Ramos	Santo Domingo Institute of Technology	USMLE/OH
45. Justin Alan Kreuze	Michigan State University College of Osteopathic Medicine	COMLEX/MI
46. Maria Emma Laughlin	Mayo Medical School	USMLE/TN
47. Brandon Thomas Leding	University of Arkansas College of Medicine	USMLE/WI
48. Sally Lee	Rutgers New Jersey Medical School	USMLE/NY
49. Vikas Le-Kumar	St. Georges University	USMLE/MN
50. Joshua Nathan Maher	Edward Via College of Osteopathic Medicine Auburn	COMLEX
51. Meenakumari Manoharan	Volgograd Medical Academy	USMLE/GA
52. Sully Mariel Marquez Flores	National Autonomous University of Honduras	USMLE
53. Robert Ewing McAlister III	LSU School of Medicine New Orleans	USMLE/FL
54. Matthew Coleman McCurdy	Alabama College of Osteopathic Medicine	COMLEX/KY
55. Raynia Letitia McGee	Meharry Medical College	USMLE/SC
56. Brian Young McLean	UCLA, David Geffen School of Medicine	NBME/CA
57. Victoria I Moncada Castro	National Autonomous University of Honduras	USMLE
58. Shirlene Tolbert Moten	Rutgers New Jersey Medical School	NBME/NJ
59. Lillian Tiana Murphy	University of South Alabama College of Medicine	USMLE/LA
60. Michaela Renee Myers	University of South Carolina School of Medicine	USMLE
61. Conner Alexander Patrick	University of Texas Houston Medical School	USMLE/OK
62. Taylor Robert Payne	Augusta University	USMLE/GA
63. Maha Raslan	Philadelphia College of Osteopathic Medicine	COMLEX
64. Jacob Richard Romm	University of Washington School of Medicine	USMLE
65. Estefania Ruiz Perez	University of Puerto Rico School of Medicine	USMLE
66. Matthew Saunders	Eastern Virginia Medical School	USMLE
67. Tiffany Schwasinger-Schmidt	University of Kansas School of Medicine Wichita	USMLE/KS
68. Joseph Steven Snooks, II	Mercer University School of Medicine	USMLE/SC

<u>Name</u>	<u>Medical School</u>	<u>Endorsement</u>
69. Benjamin Joseph Sommer	New York College of Osteopathic Medicine	COMLEX/NY
70. Corey Wayne Speers	Baylor College of Medicine	USMLE/MI
71. Hugo St. Hilaire	Icahn Som at Mount Sinai	USMLE/LA
72. Alexandra Nicole Stedke	University of North Texas Health Science Center	COMLEX
73. Kyra Nikole Stepney	Ohio University Heritage College of Osteopathic Medicine	COMLEX/GA
74. William McKinley Steward	LSU School of Medicine New Orleans	USMLE/MS
75. Zachary Taylor	Elson S. Floyd College of Medicine, Washington State University	USMLE
76. Michael David Tenison	Oregon Health and Science University School of Medicine	USMLE/PA
77. Gregory Lamar Thompson	University of Tennessee Memphis College of Medicine	NBME/TN
78. Asra Toobaie	McGill University Faculty of Medicine	LMCC/CA
79. Melissa Anne Trevelline	Ross University	USMLE/PA
80. Madeline Marie Lear Tucker	University of South Alabama College of Medicine	USMLE
81. Katherine Anne Turner	University of Colorado School of Medicine	USMLE/IL
82. Blake Philip Van Court	LSU School of Medicine New Orleans	USMLE
83. Rachel Anne Ward	Florida State University College of Medicine	USMLE/TN
84. Amber T Watts	Edward Via College of Osteopathic Medicine Auburn	COMLEX
85. Mary Frances Weeks	University of Mississippi School of Medicine	USMLE
86. Zachary R Wood	Edward Via College of Osteopathic Medicine Auburn	COMLEX
87. Denise Marie Young Ajose	Howard University College of Medicine	USMLE/NJ
88. Maad M Alhudairy	King Saud University. Riyadh	USMLE
89. Sonia I Alicea	Iberoamericana University	USMLE
90. Victoria Badia	Wayne State University School of Medicine	USMLE
91. Firas Baidoun	University of Aleppo	USMLE/FL
92. Elyssa Blissenbach	SUNY at Buffalo School of Medicine & Biomedical Science	NBME/SC
93. *Rebekah Bowie	University of South Carolina School of Medicine – Greenville	USMLE/MI
94. *Philip J Cato	University of South Alabama College of Medicine	USMLE/TN
95. *Schae E Hanson	University of South Dakota Sanford School of Medicine	USMLE/NE
96. Muhammad Munawar	Services Institute of Medical Sciences	USMLE/OH
97. *Patricia L Nuse	West Virginia University	USMLE/NC
98. Rachel N Rendon	University of Central Florida College of Medicine	USMLE
99. *Ankur K Singh	University of South Alabama College of Medicine	USMLE/NC
100.*Jessie A Walker	Indiana University School of Medicine Indianapolis	USMLE

*\*Approved pending acceptance and payment of NDC issued by the BME.*

A motion was made by Commissioner Nagrodzki with a second by Commissioner Aldridge to approve applicant numbers one through one hundred (1-100) for full licensure. The motion was approved by unanimous vote.

## Limited License Applicants

	<u>Name</u>	<u>Medical School</u>	<u>Endorsement</u>	<u>Location</u>	<u>License</u>
1.	Sabah Ambreen	Jahurul Islam Medical College	Jackson Hospital FM	LL/AL	R
2.	Juan E Borja Ceballos	Pontifical Catholic Univ of Ecuador	USA Surgery	LL/AL	R
3.	Ryan S Sanchez Briones	Univ of East Ramon Magsaysay Memorial	USA Pediatrics	LL/AL	R
4.	Maria A Chilo Bejarano	G.R. Moreno Autonomous University	Cahaba FM	LL/AL	R
5.	Herandenny Giraldo	Autonomous Univ of Guadalajara	Gadsden Regional FM	LL/AL	R
6.	Yoseph Legesse Herpo	Hayat Medical College	Southeast Health IM	LL/AL	R
7.	Shristi Joshi	Sun Yat-Sen University	Jackson Hospital FM	LL/AL	R
8.	Kollin Travis Kahler	American University of the Caribbean	UAB Rheumatology	LL/AL	R
9.	Xin Zhi Lim	National Univ of Malaysia	Gadsden Regional FM	LL/AL	R
10.	Mahmoud A Mohamed	Ain-Shams University	Crestwood IM	LL/AL	R
11.	Maria J Moreno Leigue	Bolivian Catholic Univ San Pablo	USA Pediatrics	LL/AL	R
12.	Khudija Nayab	Khyber Medical University	Crestwood IM	LL/AL	R
13.	Brian Hoang Nguyen	Poznan Univ of Medical Sciences	Gadsden Regional FM	LL/AL	R
14.	Persis Susan Soman	Basaveshward Medical College	Gadsden Regional FM	LL/AL	R
15.	Chithra Sreenivasan	Government Med College Ernakulam	Jackson Hospital FM	LL/AL	R
16.	Rupesh Timilsina	Kathmandu University	Jackson Hospital FM	LL/AL	R
17.	Davies E Toluhi	Obafemi Awolowo University	Gadsden Regional FM	LL/AL	R

A motion was made by Commissioner Aldridge with a second by Commissioner Christopher to approve applicant numbers one through seventeen (1-17) for limited licensure. The motion was approved by unanimous vote.

### IMLCC Report

The Commission received as information a report of the licenses that were issued via the Interstate Medical Licensure Compact from April 1, 2025, through April 30, 2025. A copy of this report is attached as Exhibit "A".

### REPORTS

#### Physician Monitoring Report

The Commission received as information the physician monitoring report dated May 21, 2025. A copy of the report is attached as Exhibit "B".

Janie Teschner, M.D.

The Commission considered a request filed by Dr. Teschner to accept alternative continuing education courses in lieu of the courses with PBI Education required in a previous Consent Decree. A motion was made by Commissioner Christopher with a second by Commissioner Nagrodzki to enter an order accepting the alternative courses. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "C".

**APPLICANTS FOR REVIEW**

Austin Broussard, M.D.

A motion was made by Commissioner Nagrodzki with a second by Commissioner Nelson-Garrett to invite Dr. Broussard to the June 25, 2025, Commission meeting for an informal interview. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "D".

Ashley Cainion, M.D.

A motion was made by Commissioner Christopher with a second by Commissioner Nelson-Garrett to approve Dr. Cainion's application for full licensure. The motion was approved by unanimous vote.

Vladimir J. Dinolov, M.D.

A motion was made by Commissioner Nelson-Garrett with a second by Commissioner Christopher to approve Dr. Dinolov's application for full licensure. The motion was approved by unanimous vote.

Mehdi Khaleghi, M.D.

A motion was made by Commissioner Christopher with a second by Commissioner Aldridge to approve Dr. Khaleghi's application for limited licensure. The motion was approved by unanimous vote.

Theresa Long, M.D.

A motion was made by Commissioner Christopher with a second by Commissioner Aldridge to approve Dr. Long's application for full licensure. The motion was approved by unanimous vote.

Uyen Phuong Nguyen, M.D.

A motion was made by Commissioner Christopher with a second by Commissioner Varner to defer any action on Dr. Nguyen's application for licensure until a COQ has been issued. The motion was approved by unanimous vote.

Jayunkumar Shah, M.D.

A motion was made by Commissioner Nagrodzki with a second by Commissioner Nelson-Garrett to approve Dr. Shah's application for limited licensure. The motion was approved by unanimous vote.

**DISCUSSION ITEMS**

James C. Dilday, M.D.

A motion was made by Commissioner Aldridge with a second by Commissioner Nelson-Garrett to enter an order setting a hearing for no later than August 27, 2025. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "E".

2025 Meeting Calendar

The October 22, 2025, meeting date was changed to October 29, 2025. A copy of the updated calendar is attached as Exhibit "F".

Advisory Council on Additional Licensing Models – Draft Guidance

Draft guidance from the Federation of State Medical Boards, Intealth, and the ACGME's Advisory Council on Additional Licensing Models was received as information. A copy of the draft is attached as Exhibit "G".

**REQUESTS**

Daniel Morgan, D.O.

The Commission considered a request filed by Dr. Morgan to participate in a professional boundaries program other than Acumen or Pine Grove. A motion was made by Commissioner Christopher with a second by Commissioner Nagrodzki to deny Dr. Morgan's request. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "H".

**ADMINISTRATIVE FILINGS**

**Eric R. Beck, M.D.**

The Commission received a proposed practice plan on behalf of Dr. Beck for consideration. A motion was made by Commissioner Christopher with a second by Commissioner Nelson-Garrett to approve Dr. Beck's practice plan. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "I".

**Steve Norman, M.D.**

The Commission received a Motion to Dismiss the Administrative Complaint filed by the Alabama State Board of Medical Examiners. A motion was made by Commissioner Nagrodzki with a second by Commissioner Varner to dismiss the Administrative Complaint without prejudice. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "J".

**Alan J. Wayne, M.D.**

The Commission received a Voluntary Surrender and a Motion to Dismiss the Administrative Complaint filed by the Alabama State Board of Medical Examiners. A motion was made by Commissioner Nagrodzki with a second by Commissioner Aldridge to accept the voluntary surrender and dismiss the Administrative Complaint without prejudice. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "K".

**CLOSED SESSION UNDER ALA. CODE 34-24-361.1**

At 10:25 a.m., the Commission entered closed session pursuant to Alabama Code § 34-24-361.1 to hear and consider the following matters:

**David Halvorson, M.D.**

At the conclusion of the hearing, a motion was made by Commissioner Nelson-Garrett with a second by Commissioner Christopher to issue an order revoking Dr. Halvorson's Alabama medical license and assessing an administrative fine in the amount of \$10,000. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "L".

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Mohamed A.H. Khalaf, M.D.

At the conclusion of the hearing, a motion was made by Commissioner Aldridge with a second by Commissioner Nelson-Garrett to deny Dr. Khalaf's application for reinstatement. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "M".


Brian E. Richardson, M.D.


The Commission received a Motion to Immediately Suspend filed by the Alabama State Board of Medical Examiners. A motion was made by Commissioner Christopher with a second by Commissioner Falgout to enter an order immediately suspending Dr. Richardson's license to practice medicine in Alabama. The motion was approved by unanimous vote.

A second motion was made by Commissioner Christopher with a second by Commissioner Varner to continue the previously scheduled hearing indefinitely. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "N".

Meeting adjourned at 4:40 p.m.

**PUBLIC MEETING NOTICE:** The next meeting of the Alabama Medical Licensure Commission was announced for Wednesday, June 25, 2025, beginning at 9:00 a.m.

  
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JORGE ALSIS, M.D., Chairman  
Alabama Medical Licensure Commission

  
\_\_\_\_\_  
Rebecca Robbins, Director of Operations  
Recording Secretary  
Alabama Medical Licensure Commission

  
\_\_\_\_\_  
Date Signed

EXHIBIT

A

## IMLCC Licenses Issued April 1, 2025 - April 30, 2025 (27)

Name	License Type	License Number	Status	Issue Date	Expiration Date	State of Principal Licensure
Tushar Menon	MD	51085	Active	4/2/2025	12/31/2025	Arizona
Mary Katherine Grady	MD	51086	Active	4/2/2025	12/31/2025	District of Columbia
Deanna Alicia Oleske	MD	51092	Active	4/2/2025	12/31/2025	Florida
Brandon Hamm	DO	4104	Active	4/1/2025	12/31/2025	Georgia
Cristina Mullins Whitley	MD	51069	Active	4/1/2025	12/31/2025	Georgia
Gaurav Dutta	MD	51081	Active	4/2/2025	12/31/2025	Georgia
Aditi Gulab Gulabani	MD	51065	Active	4/1/2025	12/31/2025	Illinois
Manuel Bienvenido Montes de Oca Jr.	MD	51075	Active	4/1/2025	12/31/2025	Illinois
Christine Marie Davis	MD	51066	Active	4/1/2025	12/31/2025	Indiana
Agyingi Kimbong	MD	51137	Active	4/30/2025	12/31/2025	Kentucky
Jonathan Gary Hodor	DO	4106	Active	4/2/2025	12/31/2025	Maryland
Jodi Bayley Baptiste	MD	51087	Active	4/2/2025	12/31/2025	Maryland
Agam Dhawan	MD	51071	Active	4/1/2025	12/31/2025	Michigan
Edna Siew Wong McKinstry	MD	51070	Active	4/1/2025	12/31/2025	Missouri
Sahar Azim	MD	51068	Active	4/1/2025	12/31/2025	Nevada
Joshua Cameron MacDavid	MD	51067	Active	4/1/2025	12/31/2025	Nevada
Stephen Louis Demeter Jr.	MD	41101	Active	4/25/2025	12/31/2025	Nevada
Nicholas James Nissen	MD	51072	Active	4/1/2025	12/31/2025	North Dakota
Gerard Myers	DO	4103	Active	4/1/2025	12/31/2025	Ohio
Srinivasa Chakravarthi Chekuri	MD	51082	Active	4/2/2025	12/31/2025	Ohio
Yang Lu	MD	51074	Active	4/1/2025	12/31/2025	Texas
Qasim Ali Butt	MD	51090	Active	4/2/2025	12/31/2025	Texas
Gerard Chaaya	MD	51089	Active	4/2/2025	12/31/2025	Texas
Prashanth Nallu Reddy	MD	51088	Active	4/2/2025	12/31/2025	Texas
James William Nelson	MD	51073	Active	4/1/2025	12/31/2025	Washington
Kelly Kuo	MD	51083	Active	4/2/2025	12/31/2025	Washington
Sharon Antoinette Watkins	MD	51084	Active	4/2/2025	12/31/2025	West Virginia

\*Total licenses issued April 2017 - 5,496



EXHIBIT  
B

STATE of ALABAMA  
MEDICAL LICENSURE COMMISSION

**To:** Medical Licensure Commission  
**From:** Nicole Roque  
**Subject:** May Physician Monitoring Report  
**Date:** 5/21/2025

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**The physicians listed below are currently being monitored by the MLC.**

**Physician:** Robert Bolling, M.D.  
**Order Type:** MLC  
**Due Date:** Other  
**Order Date:** 12/18/2024  
**License Status:** Active-Probation  
**Requirements:** APHP Report  
Polygraph  
Therapist Report  
**Received:** Report from Rob Hunt with supporting documents  
Polygraph results  
Report from Deborah Schiller

**Physician:** Scott Hull Boswell, M.D.  
**Order Type:** MLC  
**Due Date:** Quarterly  
**Order Date:** 12/1/2014  
**License Status:** Active  
**Requirements:** Therapist Report  
**Received:** Therapist Report

**Physician:** Ronald Edwin Calhoun, M.D.  
**Order Type:** BME/MLC  
**Due Date:** Quarterly  
**Order Date:** 3/25/2014  
**License Status:** Active  
**Requirements:** APHP Report  
**Received:** Report from Rob Hunt with supporting documents

**Physician:** Kristin J. Dobay, M.D.  
**Order Type:** MLC  
**Due Date:** Other  
**Order Date:** 5/3/2024  
**License Status:** Active-Restricted  
**Requirements:** Limited Practice  
Therapist Report  
Worksite Report  
**Received:** Report from Rob Hunt with supporting documents

**Physician:** Richard E. Jones, M.D.  
**Order Type:** MLC  
**Due Date:** Other  
**Order Date:** 3/27/2024  
**License Status:** Active-Probation  
**Requirements:** Site visit to ensure compliance with Commission Order  
**Received:** Compliance memo from RK Johnson

**Physician:** Shakir Raza Meghani, M.D.  
**Order Type:** BME/MLC  
**Due Date:** Monthly  
**Order Date:** 11/20/2023  
**License Status:** Active  
**Requirements:** Check PDMP Monthly  
Site visit to verify dispensing records  
**Received:** PDMP Compliant  
Site visit conducted and Dr. Meghani was found to be in compliance

**Physician:** Farhaad Riyaz, M.D.  
**Order Type:** MLC  
**Due Date:** Other  
**Order Date:** 8/24/2022  
**License Status:** Active-Probation  
**Requirements:** APHP Report  
**Received:** Report from Rob Hunt with supporting documents

**Physician:** Kenneth Eugene Roberts, M.D.  
**Order Type:** BME/MLC  
**Due Date:** Quarterly  
**Order Date:** 2/6/2014  
**License Status:** Active  
**Requirements:** Chaperon  
Staff/Patient Surveys  
Limited Practice  
**Received:** Compliance Memo from RK Johnson

**Physician:** Frances Delaine Salter, M.D.  
**Order Type:** MLC  
**Due Date:** Quarterly  
**Order Date:** 10/4/2005  
**License Status:** Active  
**Requirements:** APHP Report  
**Received:** Report from Rob Hunt with supporting documents

**Physician:** Janie T. Bush Teschner, M.D.  
**Order Type:** BME/MLC  
**Due Date:** Other  
**Order Date:** 4/19/2023  
**License Status:** Active-Probation  
**Requirements:** APHP Report  
Practice Plan  
Limited Practice  
Therapist Report  
AA/NA Meetings  
Polygraph  
CME  
**Received:** Report from Rob Hunt with supporting documents

**EXHIBIT**

**C**

**ALABAMA STATE BOARD OF  
MEDICAL EXAMINERS,**

**Complainant,**

**vs.**

**JANIE T. BUSH TESCHNER, M.D.,**

**Respondent.**

**BEFORE THE MEDICAL  
LICENSURE COMMISSION OF  
ALABAMA**

**CASE NO. 2020-324**

**ORDER**

This matter comes before the Medical Licensure Commission of Alabama on Respondent's request for approval of alternative continuing education courses to satisfy the requirements of the Consent Decree entered on April 19, 2023. Specifically, Respondent demonstrates that she completed the three-hour "PBI Best Practice Prescribing: Opioids, Pain Management, and Addiction" course offered by PBI Education, and has completed the "Documentation and Provider Standards Training 4.5" and "Mastering Healthcare Documentation Training 5.0" courses, each for 0.75 hours of credit, offered by American Medical Compliance. Upon consideration by the full Commission, Respondent's request is granted, and Respondent's completion of the aforementioned courses is deemed by the Commission to satisfy the continuing education requirements imposed by Section 3(v) of the Consent Decree.

**EXHIBIT**

**D**

**In re: the matter of**  
**AUSTIN J. BROUSSARD, M.D.**

**BEFORE THE MEDICAL  
LICENSURE COMMISSION  
OF ALABAMA**

**ORDER**

This matter is before the Medical Licensure Commission of Alabama on Dr. Broussard's application for licensure. This matter is set for an informal interview, to be held on Wednesday, June 25, 2025, at 10:00 a.m., at 848 Washington Avenue, Montgomery, Alabama, 36104.

DONE on this the 3rd day of June, 2025.

**THE MEDICAL LICENSURE  
COMMISSION OF ALABAMA**

**By:**

**E-SIGNED by Jorge Alsip, M.D.  
on 2025-06-03 08:26:08 CDT**

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**Jorge A. Alsip, M.D.**  
**its Chairman**

**DONE on this the 3rd day of June, 2025.**

**THE MEDICAL LICENSURE  
COMMISSION OF ALABAMA**

**By:**

**E-SIGNED by Jorge Alsip, M.D.  
on 2025-06-03 08:25:22 CDT**

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**Jorge A. Alsip, M.D.  
its Chairman**

**EXHIBIT  
E**

**ALABAMA STATE BOARD OF  
MEDICAL EXAMINERS,**

**Complainant,**

**v.**

**JAMES CURTIS DILDAY, M.D.,**

**Respondent.**

**BEFORE THE MEDICAL  
LICENSURE COMMISSION OF  
ALABAMA**

**CASE NO. 2023-118**

**ORDER**

On October 31, 2024, we entered an Order continuing this matter generally. It is now ordered that the final contested case hearing in this matter, originally set for Monday, November 25, 2024, is set to be held on Wednesday, August 27, 2025, at 10:00 a.m., at 848 Washington Avenue, Montgomery, Alabama, 36104.

DONE on this the 3rd day of June, 2025.

**THE MEDICAL LICENSURE  
COMMISSION OF ALABAMA**

**By:**

**E-SIGNED by Jorge Alsip, M.D.  
on 2025-06-03 08:24:33 CDT**

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**Jorge A. Alsip, M.D.  
its Chairman**

EXHIBIT

# F Alabama Medical Licensure Commission

# 2025

## Important Dates

MLC Meeting Days

BME Meeting Days

Agency Holidays

Annual Session/FSMB

Fall Meeting/Point Clear

Meetings of the Medical Licensure Commission are held in the Montgomery office at 9:00 a.m. Meeting dates are subject to change with advance notice.

*Adopted September 25, 2024  
Revised May 28, 2025*

January						
S	M	T	W	T	F	S
			1	2	3	4
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## Advisory Commission on Additional Licensing Models DRAFT GUIDANCE DOCUMENT

EXHIBIT

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### Introduction

The Advisory Commission on Additional Licensing Models was established in December 2023 to guide and advise state medical boards, state legislators, policymakers and others, to inform their development and/or implementation of laws specific to the licensing of physicians who have already trained and practiced medicine outside the United States. It is co-chaired by the Federation of State Medical Boards (FSMB), the Accreditation Council for Graduate Medical Education (ACGME) and Intealth™ (which oversees the Educational Commission for Foreign Medical Graduates - ECFMG). In February 2025, the commission released its first set of recommendations, focused principally on eligibility requirements and related entry considerations for internationally-trained physicians (ITPs) seeking medical licensure under a new, additional licensure pathway.<sup>1</sup> In this document, the commission offers its second set of recommendations, for consideration by state medical boards and potential employers, related to the assessment and supervision of ITPs during their provisional licensure period before they become eligible for a full and unrestricted license to practice medicine.

Internationally-trained physicians, as described in some of the state laws enacted since 2023 to streamline medical licensure to increase access to care in underserved and rural communities, are generally defined as physicians educated and trained abroad who are licensed and have practiced medicine in another jurisdiction. This cohort of physicians represents a relatively small number of international medical graduates (IMGs), the umbrella term used to describe all physicians who have had their medical degree conferred outside the United States. Individuals who are ITPs, as described in most of legislative descriptions, must have previously completed graduate medical education (also known as postgraduate medical education or postgraduate training) that is “substantially similar” to that which is recognized in the United States.

The purpose of the commission’s recommendations is to support the alignment of policies, regulations and statutes, where possible, to add clarity and specificity to statutory and procedural language to better protect the public – the principal mission of all state and territorial medical boards – and to advance the safe delivery of quality health care to all citizens and residents of the United States. This guidance is provided to support those states and territories implementing new licensure pathways where legislation has been enacted and where legislation has been introduced or is being considered for introduction.

The first set of recommendations was focused on eligibility requirements. To ensure physicians entering these pathways are ultimately ready to safely practice medicine in the United States, the additional licensing pathways should optimally include assessment and supervisory elements during the entire period of provisional licensure. This second set of recommendations contains specific guidance for the consideration of state medical boards and other relevant stakeholders.

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<sup>1</sup> <https://www.fsmb.org/siteassets/communications/acalm-guidance.pdf>

## Background

**There are two primary pathways by which international medical graduates (IMGs) are eligible for medical licensure from a state medical board in the United States and its territories:**

1. Completion of one to three years – depending on the requirements of the particular state or territory<sup>2</sup> – of U.S.-based graduate medical education (GME) accredited by the ACGME, accompanied by certification by ECFMG<sup>®</sup> and successful passage of all three Steps of the United States Medical Licensing Examination<sup>®</sup> (USMLE<sup>®</sup>), is the most common pathway to medical licensure for international medical graduates (IMGs) in the United States. In addition to expanding a physician’s knowledge and skills in one or more medical or surgical specialties, U.S.-based GME affords time for participants (whether previously trained and licensed abroad or not) to acclimate to the U.S. health care system, culture and social norms, and the medical illnesses and conditions that are most prevalent (e.g., heart disease, cancer, accidents) among those residing in the United States.
2. “Eminence” pathways (for prominent mid-career physicians) have long existed in many states, and typically do not require ECFMG Certification or successful passage of any Step examination of the USMLE, and may continue to be an option for exceptional, highly qualified and fully-trained international physicians. These pathways are most often used by individuals deemed to have “extraordinary ability,” including those classified as “eminent specialist” or “university faculty” pursuing academic or research activities, and typically align with the O-1 (extraordinary ability) visa issued by the U.S. State Department.<sup>3</sup> Of note, most state medical boards also have statutes or regulations allowing for the licensing of IMGs at their discretion,<sup>4</sup> though in practice these are not commonly available or offered. A few medical boards explicitly allow postgraduate training (PGT) – also known as graduate medical education (GME) or postgraduate medical education (PGME) – that is completed in certain countries, such as England, Scotland, Ireland, Australia, New Zealand and the Philippines, to count toward the U.S.-based GME requirement for licensure.

**Since January 2023, a dozen states have enacted legislation creating additional licensing pathways for internationally trained physicians that does not require completion of U.S.-based ACGME-accredited GME training.**

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<sup>2</sup> <https://www.fsmb.org/siteassets/advocacy/policies/img-gme-requirements-key-issue-chart.pdf>

<sup>3</sup> <https://www.uscis.gov/working-in-the-united-states/temporary-workers/o-1-visa-individuals-with-extraordinary-ability-or-achievement>

<sup>4</sup> Several states have authority to issue licenses to internationally trained physicians through other innovative approaches. For example, New York offers licensure without requiring a provisional supervisory period to highly qualified IMGs. California offers a three-year non-renewable license for up to 30 Mexican physicians a year to work in community health centers. Washington has a “clinical experience license” to help IMGs compete for residency matching.

These additional licensing pathways are designed principally for ITPs who wish to enter the U.S. healthcare workforce.

A primary goal of these pathways, reflected in public testimony and written statements submitted by sponsors and supporters in many jurisdictions, is to address U.S. healthcare workforce shortages, especially in rural and underserved areas. It must be noted that U.S. federal immigration and visa requirements will impact the practical ability of physicians who are not U.S. citizens or permanent U.S. residents (Green Card holders) to utilize any additional licensure pathway. Furthermore, the ubiquity of specialty-board certification as a key factor in employment, hospital privileging, and insurance panel inclusion decisions is likely to impact the efficacy of non-traditional licensing pathways. States may, therefore, wish to consider other healthcare workforce levers that may be more effective in increasing access to care, such as advocating for increased state and Medicare/Medicaid funding to expand U.S. GME training positions, offering some means of transition assistance to IMGs, and expanding the availability and utilization of enduring immigration programs like the Conrad 30 waiver program, U.S. Department of Health and Human Services (HHS) waivers, regional commission waivers, and United States Citizenship and Immigration Service (USCIS) Physician National Interest Waivers.

While the wording of additional pathway legislation introduced and/or enacted varies from state to state, the commission's consensus-driven guidance highlights potential areas of alignment and suggests specific considerations and resources for implementation and evaluation of these pathways, where that may be possible. The commission drafted both sets of recommendations based on expert opinion and areas of concordance in legislation already introduced and enacted. The following second set of recommendations are offered for consideration to state medical boards, state legislators, policymakers, employers, and other relevant parties:

1. Internationally-trained physicians (ITPs) should be assessed during the supervisory period on all six general competencies endorsed by the Coalition on Physician Accountability: Patient Care and Procedural Skills, Medical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-based Practice.
2. ITPs should undergo a formative needs assessment at the beginning of the supervisory period in order to identify areas of strength, and areas where additional support may be needed. Ideally, the needs assessment should include a review of the participant's previous post graduate medical education (PGME) program (aka recognition of prior learning) to the extent possible.
3. A specialty-specific exam, such as an in-training exam, should be used to inform an ITP's learning plan during the supervisory period.
4. At a minimum, a standardized knowledge assessment, direct observation of the ITP's clinical skills, multi-source feedback, and medical record audits should be employed in assessing the ITP. Assessment of, and feedback with, the ITP should occur periodically at regular intervals throughout the supervisory period to support the ITP's professional development and provide robust data to help the responsible institution make

determinations of the ITP's progress. Additionally, during the supervisory period each ITP should demonstrate engagement in a sufficient volume and breadth of cases.

5. By the end of the supervisory period, an ITP should demonstrate the ability to engage in independent and unsupervised practice in all six of the general competency domains for the intended scope of clinical practice.

6. The level of supervision for an ITP during the supervisory period should be tailored to the competence of the individual ITP. At the beginning of the supervisory period this level should be informed by the results of an initial needs assessment and close supervision of all ITPs. Thereafter, the level of supervision should be adjusted based on demonstrated competence. The state medical board may choose to identify/approve the institution or individual supervisor that will be responsible for administering the initial assessment and for making recommendations about the initial level of assessment for the ITP.

7. Supervisors of ITPs during the supervisory period of the additional pathways to licensure should be physicians (MD, DO or equivalent). The supervising physician should have a full and unrestricted license to practice medicine in good standing with specialty board certification in the same specialty as the ITP's specialty. Additionally, state medical boards should establish criteria for qualifications of supervisors and supervisory sites.

8. The rights of ITPs as employees should be taken into consideration to ensure fair and equitable treatment during their supervision period. Institutions should provide ITPs information about their rights as an employee and offer resources to support their wellbeing.

## **Recommendations**

### **ASSESSMENT**

#### **Assessment Framework**

**1. Recommendation:** Internationally-trained physicians (ITPs) should be assessed during the supervisory period on all six general competencies endorsed by the Coalition on Physician Accountability: Patient Care and Procedural Skills, Medical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-based Practice.

**State Medical Board (SMB) Responsibility:** SMBs should ensure that the participating institution has incorporated the general competency framework.

**Institutional Responsibility:** The institution should ensure that the ITP's individual learning plan and assessment program incorporate all six general competencies.

**Rationale:** The aim of this recommendation is to facilitate the thoughtful provision of an additional licensure pathway for ITPs with comparable training and experience to practice medicine in the United States. The Coalition for Physician Accountability has noted that "a shared mental model of competency across the medical education continuum exists in the ideal state that involves a

standardized set of general competencies.”<sup>1</sup> The general competency framework, which is widely used in the United States to assess residents, fellows, and practicing physicians as part of continuing certification, should also be used to assess ITPs. While the ITP supervisory period in an additional pathway to licensure does not require the same processes (i.e. length and/or intensity of training or supervision) as graduate medical education, it should aim to demonstrate similar outcomes. This will help ensure equivalency of those achieving full and unrestricted licensure and prevent the development of a two-tier system with differing standards for physicians who have entered the US physician workforce through the US GME pathway and those ITPs entering through additional pathways.

### **Assessment at Start of Supervisory Period**

**2. Recommendation:** ITPs should undergo a formative needs assessment at the beginning of the supervisory period in order to identify areas of strength, and areas where additional support may be needed. Ideally, the needs assessment should include a review of the participant’s previous post graduate medical education (PGME) program (aka recognition of prior learning) to the extent possible.

**SMB Responsibility:** SMBs should recommend and support an individual needs assessment.

**Institutional Responsibility:** Institutions should administer or conduct a needs assessment that addresses an ITP’s current understanding and abilities in the general competencies, especially medical knowledge, patient care, and interpersonal skills and communication. It is also recommended that a review of the participant’s previous post graduate medical education (PGME) program (aka recognition of prior learning) be performed to the extent possible. Institutions may wish to consult physician reentry programs about assessment processes used to determine baseline physician capabilities.

#### **Rationale:**

The training and clinical experience of ITPs entering these programs will be more varied than those entering GME training, with many ITPs likely possessing more clinical experience than GME trainees.

A baseline assessment of an ITP’s competence will allow for early identification of areas of strength and areas where additional support is needed. This can be used to tailor an efficient learning plan that focuses on addressing areas of need specific to each ITP and supporting areas of an ITP’s strengths. This initial needs assessment should not be used to exclude ITPs from participation in the additional pathway to licensure program. Institutions may wish to engage existing programs to assist in the needs assessment.

### **Use of Specialty-specific Exam for Assessment of Medical Knowledge**

**3. Recommendation:** A specialty-specific exam, such as an in-training exam, should be used to inform an ITP’s learning plan during the supervisory period

**SMB Responsibility:** SMBs should recommend a specialty-specific exam.

**Institutional Responsibility:** Institutions should obtain access to, and scheduling for, specialty-specific exams.

**Rationale:** Specialty-specific exams may be helpful in assessing medical knowledge but are not intended to serve as summative assessments and should not be used for high stakes decisions. While medical licensure does not absolutely require passing a specialty-specific exam, demonstration of medical knowledge via a multiple-choice question exam is a requirement for specialty certification. Additionally, an MCQ exam could be an important way to assess medical knowledge competence within the ITP's intended scope of clinical practice.

#### **Assessment Strategies During the Supervisory Period**

**4. Recommendation:** At a minimum, a standardized knowledge assessment, direct observation of the ITP's clinical skills, multi-source feedback, and medical record audits should be employed in assessing the ITP. Assessment of, and feedback with, the ITP should occur periodically at regular intervals throughout the supervisory period to support the ITP's professional development and provide robust data to help the responsible institution make determinations of the ITP's progress. Additionally, during the supervisory period each ITP should demonstrate engagement in a sufficient volume and breadth of cases.

**SMB Responsibility:** SMBs should ensure the assessment program appropriately covers the six general competencies.

**Institutional Responsibility:** Institutions should implement, monitor, and review the assessment program and ensure all six general competencies are appropriately assessed periodically and the ITP has engaged in a sufficient volume and breadth of cases. If there is concern that the ITP may not be able to demonstrate the ability to engage in independent and unsupervised practice in all six of the general competency domains for the intended scope of clinical practice by the end of the supervisory period based on periodic assessment, the institution should share this information with the SMB whether or not remediation or additional supervisory time is available, contemplated or offered, to come to agreement on a path forward.

**Rationale:** Ongoing, reliable assessment of an ITP's skills is critical in promoting equivalency in additional licensure programs. Assessments should occur periodically throughout the supervisory period. The combination of standardized knowledge assessment, direct observation of the ITP's clinical skills, multi-source feedback, and medical record audits allows for assessment across the general competency framework. Additional assessment may be tailored to an ITP's specific needs.

Consideration should be given regarding the use of group process to review assessment data and judge the progress of the ITP. (The ACGME program requirement guidelines regarding clinical competency committees could serve as a template.)

A toolkit of assessment instruments and resources is available and will be provided separately.

### **Competence Demonstrated By the End of the Supervisory Period**

**5. Recommendation:** By the end of the supervisory period, an ITP should demonstrate the ability to engage in independent and unsupervised practice in all six of the general competency domains for the intended scope of clinical practice.

**SMB Responsibility:** SMBs should ensure the assessment program that is in place can effectively perform a final entrustment judgement regarding the ITP's readiness for unsupervised practice.

**Institutional Responsibility:** Institutions should support the process regarding a final entrustment judgement of the ITP's readiness for unsupervised practice.

**Rationale:** Requiring the same level of competency for ITPs seeking licensure through additional pathways as physicians seeking licensure through GME training in the United States will help ensure the safety of the public by avoiding the perception of a two-tiered system with different requirements.

## **SUPERVISION**

### **Initial Level of ITP Supervision**

**6. Recommendation:** The level of supervision for an ITP during the supervisory period should be tailored to the competence of the individual ITP. At the beginning of the supervisory period this level should be informed by the results of an initial needs assessment and close supervision of all ITPs. Thereafter, the level of supervision should be adjusted based on demonstrated competence. The state medical board may choose to identify/approve the institution or individual supervisor that will be responsible for administering the initial assessment and for making recommendations about the initial level of assessment for the ITP.

**SMB Responsibility:** SMBs should have oversight of this process and may choose to make specific recommendations regarding institutions and/or supervisors.

**Institutional Responsibility:** Institutions should support the individuals who are providing close supervision. This will help to ensure patient safety while concomitantly providing rich interaction and assessment data to guide changes in the level of supervision as warranted by the ITP's abilities.

**Rationale:** The training and clinical experience of ITPs entering these programs will be more varied than those entering GME training, with many ITPs likely having more clinical experience than GME trainees. A baseline assessment of an ITP's skills will help the supervisor/supervising institution make decisions that will allow the ITP to practice within the scope of their skills while ensuring patient safety.

### **Qualifications of ITP Supervisors and Sites**

**7. Recommendation:** Supervisors of ITPs during the supervisory period of the additional pathways to licensure should be physicians (MD, DO or equivalent). The supervising physician should have a

full and unrestricted license to practice medicine in good standing with specialty board certification in the same specialty as the ITP's specialty. Additionally, state medical boards should establish criteria for qualifications of supervisors and supervisory sites.

**SMB Responsibility:** SMBs should establish and apply criteria for identification of qualified supervisors and supervisory sites.

**Institutional Responsibility:** Institutions should support the training of individuals providing supervision, assessment, feedback, and coaching. National resources exist to support this training.

**Rationale:** Physicians with a full and unrestricted license and specialty board certification in the same specialty should possess the necessary expertise and experience to oversee ITPs safely while providing guidance to help ITPs prepare to meet the challenges of practicing medicine in a relatively new environment. State medical boards may have more region-specific information available to them about potential supervisors and supervisory setting to help guide this process. Institutions may wish to consult physician reentry programs about monitoring and supervision practices.

#### **ITP Employment Considerations:**

**8. Recommendation:** The rights of ITPs as employees should be taken into consideration to ensure fair and equitable treatment during their supervision period. Institutions should provide ITPs information about their rights as an employee and offer resources to support their wellbeing.

**Rationale:** It is essential to guarantee that internationally trained physicians (ITPs) have access to the same rights, benefits, resources and policies as other employees within the institution to support their wellness and to promote fair and equitable treatment. This includes consideration of appropriate work hours, guidelines for interactions between ITPs and other caregivers and employees, and establishing processes to address any potential concerns.

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DRAFT

## **Glossary:**

**Assessment:** An ongoing process of gathering and interpreting information about a learner's abilities, including knowledge, skills, attitudes, and/or behavior.

**Coalition for Physician Accountability:** Consists of the national organizations responsible for the oversight, education and assessment of medical students and physicians throughout their medical careers. <https://physicianaccountability.org/>

**Competencies:** Specific knowledge, skills, behaviors, and attitudes that physicians must develop for unsupervised practice of a specialty or subspecialty. The six Core Competencies are Professionalism; Patient Care and Procedural skills; Medical Knowledge; Practice-Based Learning and Improvement; Interpersonal and Communication Skills; and Systems-Based Practice. These have been endorsed by the Coalition for Physician Accountability.

**Entrustment:** The process by which trainees are granted increasing levels of responsibility and autonomy in their clinical work based on demonstrated levels of competence.

**Formative Evaluation:** Assessment with the primary purpose of providing feedback for improvement, as well as to reinforce skills and behaviors that meet established criteria and performance standards.

**Graduate medical education (GME):** The period of medical education that follows the completion of recognized undergraduate medical education and that prepares physicians for the independent practice of medicine in a specialty, subspecialty, or sub-subspecialty area, also referred to as residency or fellowship education. May also be referred to as "post-graduate medical education (PGME)."

**Internationally Trained Physician (ITP):** A medical doctor who has completed their medical education and training outside of the United States.

**In-Training Exam:** A standardized assessment administered to residents during their training program used to evaluate the medical knowledge residents in their specific specialty.

**Milestones:** Description of performance levels that describe skills, knowledge, and behaviors in the six Core Competency domains.

**Program evaluation:** Systematic collection and analysis of information related to the design, implementation, and outcomes of a graduate medical education program, for the purpose of monitoring and improving its quality and effectiveness.

**Sponsoring Institution:** The organization (or entity) that assumes the ultimate financial and academic responsibility for one or more ITP.

**State Medical Board (SMB):** the regulatory body established by each state responsible for overseeing the practice of medicine within that state, including licensure and regulation.

**Summative Evaluation:** An assessment that measures the extent to which learners have achieved specific desired outcomes or competencies. It is often used to make high-stakes decisions.

**EXHIBIT**

**H**

**In re:**

**DANIEL ERNEST MORGAN, D.O.,**

**Respondent.**

**BEFORE THE MEDICAL  
LICENSURE COMMISSION  
OF ALABAMA**

**ORDER**

This matter is before the Medical Licensure Commission of Alabama on Respondent's request, submitted via e-mail on April 29, 2025, that the Commission approve one of five specified alternative programs to satisfy the requirement imposed by both the Board and the Commission that he "complete an intensive treatment program for professionals." Upon review and consideration by the full Commission, Respondent's request is denied.

**DONE on this the 3rd day of June, 2025.**

**THE MEDICAL LICENSURE  
COMMISSION OF ALABAMA**

**By:**

**E-SIGNED by Jorge Alsip, M.D.  
on 2025-06-03 08:24:49 CDT**

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**Jorge A. Alsip, M.D.  
its Chairman**

**EXHIBIT  
I**

**ALABAMA STATE BOARD OF  
MEDICAL EXAMINERS,**

**Complainant,**

**v.**

**ERIC RAY BECK, M.D.,**

**Respondent.**

**BEFORE THE MEDICAL  
LICENSURE COMMISSION OF  
ALABAMA**

**CASE NO. 2022-099**

**ORDER**

This matter is before the Medical Licensure Commission of Alabama on Respondent's request for approval of a proposed practice plan in accordance with Section V.4.a. of our Findings of Fact and Conclusions of Law entered on June 6, 2024. Upon review and consideration by the full Commission, Respondent's practice plan attached to this Order as "Exhibit A" is approved.

DONE on this the 3rd day of June, 2025.

**THE MEDICAL LICENSURE  
COMMISSION OF ALABAMA**

**By:**

**E-SIGNED by Jorge Alsip, M.D.  
on 2025-06-03 08:25:55 CDT**

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**Jorge A. Alsip, M.D.  
its Chairman**

## Physician Practice Plan

Eric Beck, M.D.

**Practice:** Dr. Vitkin's Weight Loss Clinic, 7531 Memorial Pkwy SW # B, Huntsville, AL. 35802, (256) 880-2902. **Employer/supervising physician:** Dr. Michael Vitkin, c (256)458-0203, [MishaVitkin7@gmail.com](mailto:MishaVitkin7@gmail.com).

**Proposed scope of practice and services to be provided:** The proposed scope of medical practice and services to be provided by the respondent are as follows:

- Perform history and physical examinations on all new patients.
- Determine patient eligibility for weight loss medications.
- Prescribe schedule III and IV anorectic drugs such as phentermine and phendimetrazine as well as semiglutides to eligible patients.
- Monitor Patients/medications per Alabama State Medical Board guidelines.
- Provide education on diet and exercise as an essential component of weight loss.
- Provide call services for active patients and office personnel.
- Additional services- assist with computer and IT issues in the clinic,

**Days/hours of work:** Patients will be seen in the Huntsville office four days/month on alternating Wednesdays and Thursdays from 7:30-5. On alternating weeks from the Huntsville office, patients will be seen one half day a week at the Albertville office, US Hwy 431, Ste. F, Albertville, AL. (256)849-0372. Approximately one day a month I will fill in at the Cullman office, 1912 Cherokee Ave, SW, Ste. 107, Cullman, AL. (256)737-0102. Patient and staff calls will be taken Monday through Thursday from 8-4 when not seeing patients in the clinic. Additional services will be performed during the same hours as call.

**Typical patient populations to be seen:** Adults age 18-65 in stable health.

**Salary:** Salary will be fixed for the services and times listed above. No bonuses or incentives are to be provided

- Respondent will not engage in solo medical practice.
- Respondent will not apply for Alabama Medical Cannabis Certification Permit.
- Only schedule III, IV, and V controlled substances will be prescribed by respondent.
- Respondent will not engage in telemedicine services.

A handwritten signature in black ink, appearing to read "Eric Beck, M.D.", written in a cursive style.

Eric Beck, M.D.

**EXHIBIT**

**J**

**ALABAMA STATE BOARD OF  
MEDICAL EXAMINERS,**

**Complainant,**

**v.**

**STEVE ENNIS NORMAN, M.D.,**

**Respondent.**

**BEFORE THE MEDICAL  
LICENSURE COMMISSION OF  
ALABAMA**

**CASE NO. 2024-260**

**ORDER**

This matter is before the Medical Licensure Commission of Alabama on the Board's Motion to Dismiss, filed on May 19, 2025. As grounds for the motion, the Board says that Respondent has executed a voluntary surrender of his certificate of qualification and license to practice medicine. For good cause shown, therefore, the Board's Motion to Dismiss is granted, and the Administrative Complaint and Petition for Summary Suspension of License filed on September 24, 2024, is dismissed without prejudice.

**DONE on this the 3rd day of June, 2025.**

**THE MEDICAL LICENSURE  
COMMISSION OF ALABAMA**

**By:**

**E-SIGNED by Jorge Alsip, M.D.  
on 2025-06-03 08:25:05 CDT**

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**Jorge A. Alsip, M.D.  
its Chairman**

**EXHIBIT**

**K**

**ALABAMA STATE BOARD OF  
MEDICAL EXAMINERS,**

**Complainant,**

**v.**

**ALAN JOEL WAYNE, M.D.,**

**Respondent.**

**BEFORE THE MEDICAL  
LICENSURE COMMISSION OF  
ALABAMA**

**CASE NOS.  
2024-289  
2024-324**

**ORDER**

This matter is before the Medical Licensure Commission of Alabama on the Motion to Dismiss filed by the Board on May 19, 2025. As grounds for the motion, the Board says that Respondent has executed a voluntary surrender of his certificate of qualification and license to practice medicine in the State of Alabama. For good cause shown, the Commission accepts Respondent's voluntary surrender; the Board's Motion to Dismiss is granted; and the Administrative Complaint and Petition for Summary Suspension of License filed on April 15, 2025, is dismissed without prejudice.

**DONE on this the 3rd day of June, 2025.**

**THE MEDICAL LICENSURE  
COMMISSION OF ALABAMA**

**By:**

**E-SIGNED by Jorge Alsip, M.D.  
on 2025-06-03 08:25:39 CDT**

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**Jorge A. Alsip, M.D.  
its Chairman**

**ALABAMA STATE BOARD OF  
MEDICAL EXAMINERS,**

**Complainant,**

**v.**

**DAVID JAMES HALVORSON,  
M.D.,**

**Respondent.**

**EXHIBIT**

**L**

**BEFORE THE MEDICAL  
LICENSURE COMMISSION OF  
ALABAMA**

**CASE NO. 2024-143**

**FINDINGS OF FACT AND CONCLUSIONS OF LAW**

This matter came before the Medical Licensure Commission of Alabama for a contested case hearing on May 28, 2025. After receiving and considering all of the relevant evidence and argument, we find the Respondent, David James Halvorson, M.D., guilty of the disciplinary charge presented by the Board and impose professional discipline as set forth below.

**I. Introduction and Statement of the Case**

The Respondent in this case is David James Halvorson, M.D. ("Respondent"). Respondent is a licensee of this Commission who, at the relevant times, practiced otolaryngology in the Alabaster, Alabama area. Respondent was first licensed by the Commission on July 26, 1996, having been issued license no. MD.20146.

## **II. Procedural History**

This case began with an Administrative Complaint and Petition for Summary Suspension of License filed by the Board with the Commission on or about May 22, 2024. The Administrative Complaint contains just one count, which charges that Respondent is currently “unable to practice medicine or osteopathy with reasonable skill and safety to patients by reason of illness, inebriation, excessive use of . . . alcohol, chemicals, or any other substance, or as a result of any mental or physical condition,” contrary to Alabama Code § 34-24-360(19)a.

In accordance with Ala. Code § 34-24-361(f) and Ala. Admin. Code r. 545-X-3-.13(1)(a), on May 30, 2024, we entered an order summarily suspending Respondent’s license to practice medicine and set this matter for a full evidentiary hearing. Respondent has executed a valid waiver of the 120-day limit on summary suspension found in Ala. Code § 41-22-19(d).

On May 28, 2025, we conducted a full evidentiary hearing as prescribed in Ala. Admin. Code r. 545-X-3. The case supporting disciplinary action was presented by the Alabama Board of Medical Examiners through its attorneys E. Wilson Hunter and Alicia Harrison. Respondent appeared before the Commission and testified in person without legal counsel. Pursuant to Ala. Admin. Code r. 545-X-3-.08(1), the Honorable William R. Gordon presided as Hearing Officer. Each side was offered the opportunity to present evidence and argument in support of its respective contentions, and to cross-

examine the witnesses presented by the other side. Board Exhibits 1-28, and Respondent's Exhibit 1, were received into evidence without objection. After careful review, we have made our own independent judgments regarding the weight and credibility to be afforded to the evidence, and the fair and reasonable inferences to be drawn from it. Having done so, and as prescribed in Ala. Code § 41-22-16, we enter the following Findings of Fact and Conclusions of Law.

### III. Findings of Fact

1. Respondent was first licensed to practice medicine in Alabama on July 26, 1996, under license number MD.20146. He has maintained licensure at all material times.

2. On June 15, 2020, Respondent was admitted to [REDACTED] to be treated for [REDACTED]. Respondent's [REDACTED] [REDACTED] and he had developed signs and symptoms compatible with severe alcohol use disorder with severe end-organ damage. (Board Ex. 9.) Respondent spent eight days at [REDACTED] as doctors worked to lower his ammonia levels and to detoxify him. (*Id.*) Respondent does not dispute that his hospitalization at [REDACTED] was occasioned by a severe alcohol drinking binge. Respondent testified before the Commission that the drinking episode that led to his admission at [REDACTED] was triggered by his wife asking him for a divorce, [REDACTED].

3. Respondent was discharged from [REDACTED] directly to [REDACTED] on June 23, 2020. (Board Ex. 3 at 20.)

4. Respondent's first admission to [REDACTED] in June 2020 was for the purposes of assessment. Respondent reported to the [REDACTED] assessment team that he sometimes engaged in binge drinking of up to 14 standard drinks in a day. (*Id.* at 2.) One of the evaluating professionals at [REDACTED] psychiatrist [REDACTED] noted that he had "[REDACTED] [REDACTED]." (*Id.* at 5.) Dr. [REDACTED] also observed that Respondent [REDACTED]. (*Id.* at 8.) Psychological testing at [REDACTED] was administered by [REDACTED], Ph.D., a clinical addiction psychologist. According to Dr. [REDACTED] Respondent "[REDACTED] [REDACTED]" (*Id.* at 14, 17.)

5. At the conclusion of the evaluation, on October 12, 2020, the [REDACTED] professionals diagnosed Respondent with [REDACTED]. [REDACTED] assessed that Respondent was not safe to practice medicine with reasonable skill and safety at that time, and recommended a 12-week residential treatment program. (*Id.* at 23, 25.)

6. Respondent returned to [REDACTED] from September 14 through November 6, 2020, to complete [REDACTED]—an eight-week inpatient

treatment program designed for professionals. (Board Ex. 4.) At discharge from the [REDACTED] endorsed Respondent's gradual return to his medical practice, with certain conditions. Among the conditions were that Respondent attend various follow-up meetings, that he comply with all conditions of his APHP monitoring contract, and that he engage in follow-up testing using a SoberLink device. (*Id.* at 2.)

7. On November 10, 2020, Respondent entered into a new five-year [REDACTED] Monitoring Contract with APHP. (Board Ex. 5.) In the Monitoring Agreement, Respondent agreed to abstain from all consumption of alcohol, and agreed to SoberLink testing three times per day. (*Id.* at 4, 7.)

8. About six weeks after discharge from [REDACTED] on December 25, 2020, Respondent had a positive SoberLink test with an indicated breath alcohol concentration ("BAC") level of 0.044. Respondent initially attempted to blame this positive result on the SoberLink device being "cold," but follow-up phosphatidylethanol ("PEth") testing conclusively confirmed the positive result and alcohol relapse. (Board Ex. 6.) Respondent discussed this relapse with APHP and expressed remorse. APHP extended the SoberLink testing for two years, but did not report Respondent's first relapse to the Board.

9. For nearly the next three years, Respondent was generally compliant with his APHP monitoring contract. Indeed, between November 16, 2020 and May 31, 2022,

Respondent had 1,652 compliant tests, 85 missed tests, and five “non-compliant” tests. (Board Ex. 9 at 2.)

10. In April 2023, APHP required Respondent to begin using the Genotox test in addition to regular SoberLink testing. (Board Ex. 9 at 2.) The Genotox test uses DNA match confirmation, making it extremely difficult to falsify.

11. Respondent tested “high positive” for alcohol on the Genotox test submitted on December 8, 2023. (*Id.*) On January 3, 2024, APHP interviewed Respondent about this positive test. (*Id.*) In that interview, Respondent admitted that around Thanksgiving 2023, he “got complacent” and convinced himself that he could be a social drinker. Respondent told APHP that he struggled with believing that he had [REDACTED] because he had not had any professional consequences associated with drinking alcohol. Respondent also admitted that he had also consumed alcohol again, later in December, only about one week before the January 3 interview with APHP. APHP informed Respondent that because this was his second relapse under his APHP monitoring contract within the space of three years, the relapse could not simply be overlooked, and a new professional evaluation would be recommended. (*Id.*; Board Ex. 27.)

12. At APHP’s insistence, Respondent scheduled an evaluation to be conducted at [REDACTED], on February 24-27, 2024. (Board Ex. 9 at 3.)

13. As part of its evaluation, █████ determined that “[b]ased on the information provided by [Respondent], his previous diagnosis from the treatment center, and his historic use of alcohol, he would appear to meet the diagnostic criteria █████ █████.” (Board Ex. 8 at 14.) █████ highlighted concerns that “since he left primary treatment, he continued to consume alcohol while on an abstinence-based monitoring contract with the ALPHP. Of additional concern is that he missed SoberLink requirements. Following positive drug screens ALPHP informed him numerous times he must not consume alcohol, yet he did not maintain abstinence.” (*Id.* at 17.) █████ concluded: “Based on the data gathered from [Respondent’s] self-report, testing, and collateral information, [Respondent] is not currently, and may never have achieved abstinence and a healthy recovery █████. Additional treatment is warranted so he can enter into a healthy recovery.” (*Id.*)

14. In March 2024, █████ concluded with the following summary evaluation and recommendations:

It is █████’s clinical opinion that [Respondent] needs augmentation of his current treatment aftercare plan.

█████ does not have collateral data to suggest that [Respondent] is impaired currently such that his patients are in imminent risk. However, with the concerns mentioned above it is doubtful that [Respondent] would be able to maintain a good recovery without augmentation of his current treatment regimen.

█████ recommends [that Respondent] participate[] in an integrated treatment program at a facility familiar working with health care professionals at his earliest convenience but no longer than one month

after ALPHP receives these recommendations. In the meantime, consistent with the preliminary recommendations generated on February 27, 2024, [REDACTED] continues to recommend that he continues to complete SoberLink requirements four times per day and regular UDS tests. Any missed SoberLink requirements would result in an immediate urine drug screen, any positive SoberLink requirement, positive urine drug screen, or missed drug screen would result in immediate removal from practice. Likewise, any positive UDS screens should also result in immediate initiation in treatment.

(Board Ex. 8 at 23, 24.)

15. On his first SoberLink test after completing the [REDACTED] evaluation, on April 1, 2024, Respondent had another positive result with a BAC of 0.019. (Board Ex. 11.) The SoberLink system scheduled Respondent for six follow-up tests in 30-minute increments, and Respondent failed to submit to these follow-up tests. (Board Ex. 18 at 2.) Respondent's Genotox screen of March 26, 2024, was likewise positive for alcohol consumption. (Board Ex. 15.)

16. When informed of these positive test results, [REDACTED] noted that "these data are particularly concerning considering [Respondent's] past compliance issues related to his participation in SoberLink historically, his not participating in SoberLink after the generation of the preliminary [REDACTED] recommendations, his history of multiple missed tests, and the issues [] raised regarding his Gentox [*sic*] test." (Board Ex. 12.) Accordingly, on April 3, 2024, [REDACTED] amended its recommendations to clarify that "we cannot endorse [Respondent's] return to clinical practice. We would recommend that prior to reengaging in clinical practice he participates in a professionals' program that

is ALPHP approved and at the day treatment level of care or higher.” (*Id.*) [REDACTED] recommended an intensive treatment program of 8-12 weeks in duration. (*Id.* at 2.)

17. Respondent ceased compliance with the regular alcohol testing required by his APHP contract in April, 2024. Respondent has refused, and still refuses, to enter intensive treatment as recommended by [REDACTED]

18. In his testimony before the Commission, Respondent insisted that he could stop consuming alcohol if he wanted to, but he felt that his freedom to choose whether to drink or not was more important. Respondent appears to have expressed similar sentiments to [REDACTED]. As [REDACTED] noted, “[Respondent] reported he did not consume alcohol based on an urge or craving for alcohol, but rather he acknowledged that in his emotional distress and resentment, he did not like the feeling of an entity having control over him and made the decision to consume alcohol.” (Board Ex. 8 at 17.) Respondent unequivocally denies [REDACTED].

19. Based on the foregoing, it is clearly established that Respondent has a [REDACTED]. APHP has made positive efforts to assist Respondent in his recovery, but Respondent has failed or refused on multiple occasions to cooperate. Respondent has refused to comply with agreed-upon testing for more than the last full year. He has continued to consume alcohol, notwithstanding being diagnosed [REDACTED], notwithstanding signing an APHP contract in which he promised to abstain, and notwithstanding clearly foreseeable

professional consequences. The evaluating professionals at [REDACTED] have assessed, and we agree, that Respondent is presently unable to practice medicine with reasonable skill and safety to patients [REDACTED].

#### **IV. Conclusions of Law**

1. The Medical Licensure Commission of Alabama has jurisdiction over the subject matter of this cause pursuant to Act No. 1981-218, Ala. Code §§ 34-24-310, *et seq.* Under certain conditions, the Commission “shall have the power and duty to suspend, revoke, or restrict any license to practice medicine or osteopathy in the State of Alabama or place on probation or fine any licensee.” Ala. Code § 34-24-360. In addition to all other authorized penalties and remedies, the Commission may impose a fine of up to \$10,000 per violation and may require the payment of administrative expenses incurred in connection with the disciplinary proceeding. Ala. Code § 34-24-381(a), (b).

2. Respondent was properly notified of the time, date and place of the administrative hearing and of the charges against him in compliance with Ala. Code §§ 34-24-361(e) and 41-22-12(b)(1), and Ala. Admin. Code r. 545-X-3-.03(3), (4). At all relevant times, Respondent was a licensee of this Commission and was and is subject to the Commission’s jurisdiction.

3. Before making any decision on a contested case such as this one, the Commission is required by law to “receive and consider” a recommendation from the

Board. The Board's recommendation, however, is not binding upon the Commission. *See* Ala. Code § 34-24-311. The Commission has received and duly considered the Board's non-binding recommendation to find Respondent guilty of the disciplinary allegation outlined in the Administrative Complaint.

4. The facts as determined above substantiate that Respondent is presently "unable to practice medicine or osteopathy with reasonable skill and safety to patients by reason of illness, inebriation, excessive use of . . . alcohol . . . , or as a result of any mental or physical condition" within the meaning of Ala. Code § 34-24-360(19)a.

5. We reach all of these decisions based on all of the facts presented, viewed through the lens of our professional experience, expertise, and judgment. *See* Ala. Code § 41-22-13(5) ("The experience, technical competence, and specialized knowledge of the agency may be utilized in the evaluation of the evidence.").

## V. Decision

Based on all of the foregoing, it is **ORDERED, ADJUDGED, AND DECREED:**

1. That the Respondent, David James Halvorson, M.D., is adjudged **GUILTY** of the matter charged in Count One of the Administrative Complaint.

2. That Respondent's license to practice medicine in the State of Alabama is hereby **REVOKED;**

3. That Respondent shall, within 30 days of this Order,<sup>1</sup> pay an administrative fine in the amount of \$10,000.00 as to Count One of the Administrative Complaint; and

4. That within 30 days of this order, the Board shall file its bill of costs as prescribed in Ala. Admin. Code r. 545-X-3-.08(10)(b), and Respondent shall file any objections to the cost bill within 10 days thereafter, as prescribed in Ala. Admin. Code r. 545-X-3-.08(10)(c). The Commission reserves the issue of imposition of costs until after full consideration of the Board's cost bill and Respondent's objections, and this reservation does not affect the finality of this order. *See* Ala. Admin. Code r. 545-X-3-.08(10)(e).

5. It is the present sense of the Commission that any application for reinstatement pursuant to Ala. Code § 34-24-337(e)-(j) filed before the 365th day following the date of this Order will be summarily denied pursuant to Ala. Code § 34-24-361(h)(9), and any application for reinstatement filed thereafter is not likely to be granted except and unless Respondent clearly establishes that all of the following conditions have been met:

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<sup>1</sup> *See* Ala. Admin. Code r. 545-X-3-.08(8)(d)(i). Respondent is further advised that “[t]he refusal or failure by a physician to comply with an order entered by the Medical Licensure Commission” may be a separate instance of “unprofessional conduct.” *See* Ala. Admin. Code r. 545-X-4-.06(6).

- a. Respondent shall have entered into a lifetime monitoring contract with the Alabama Professionals' Health Program, Respondent shall have fully and continuously complied with such contract for at least one full year, and APHP shall advocate for Respondent;
- b. Respondent shall have complied with and fulfilled all recommendations made by [REDACTED] in its Assessment Discharge Summary of March 2024, as supplemented and amended in letters dated April 1 and April 3, 2024, specifically including the requirement that he successfully complete an intensive treatment program of between eight and 12 weeks in duration; and
- c. Respondent shall have demonstrated at least one full year of continuous and uninterrupted abstinence from any consumption of alcohol, as demonstrated by regular testing and monitoring as prescribed and administered by APHP.

DONE on this the 6th day of June, 2025.

THE MEDICAL LICENSURE  
COMMISSION OF ALABAMA

By:

E-SIGNED by Jorge Alsip, M.D.  
on 2025-06-06 12:43:21 CDT

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Jorge A. Alsip, M.D.  
its Chairman

**ALABAMA STATE BOARD OF  
MEDICAL EXAMINERS,**

**Complainant,**

**v.**

**MOHAMED ABDEL HAKEEM  
KHALAF, M.D.,**

**Respondent.**

**EXHIBIT**

**M**

**BEFORE THE MEDICAL  
LICENSURE COMMISSION OF  
ALABAMA**

**CASE NO. 2024-242**

**FINDINGS OF FACT AND CONCLUSIONS OF LAW**

This contested license reinstatement proceeding came before the Medical Licensure Commission of Alabama for a contested case hearing on May 28, 2025. After receiving and considering all of the relevant evidence and argument, we deny reinstatement of Respondent's medical license.

**I. Introduction and Statement of the Case**

The Respondent in this case is Mohamed Abdel Hakeem Khalaf, M.D. Respondent is a former licensee of this Commission who was first licensed by the Commission on March 31, 2015, having been issued license no. MD.34115. After allowing his license to expire at the end of 2021, Respondent now seeks reinstatement. The Board opposes Respondent's application for reinstatement.

## **II. Procedural History**

On April 2, 2024, Respondent filed an Application for Reinstatement pursuant to Ala. Code § 34-24-337. On September 6, 2024, the Board, as prescribed in Ala. Code § 34-24-337(e), filed its “Notice of Intent to Contest Reinstatement.” On October 3, 2024, as prescribed in Ala. Code § 34-24-337(g), the Board filed its Administrative Complaint setting forth the grounds for its opposition to reinstatement of Respondent’s license (the “Administrative Complaint”). The Administrative Complaint contains three counts. Count One alleges that Respondent is legally presumed to be unable to practice medicine with reasonable skill and safety to his patients due to clinical incompetency, as a result of his absence from the practice of medicine for more than two years, pursuant to Ala. Code § 34-24-360(20)a. and Ala. Admin. Code r. 540-X-23-.03(1). In Counts Two and Three, the Board alleges that Respondent’s medical licenses in New York and Florida, respectively, have been subjected to disciplinary actions for reasons that would be grounds for disciplinary action in Alabama, in violation of Ala. Code § 34-24-360(15).

On May 28, 2025, we conducted an evidentiary hearing on these charges as prescribed in Ala. Admin. Code r. 545-X-3. The case supporting the disciplinary charges was presented by the Alabama Board of Medical Examiners through its attorneys E. Wilson Hunter and Alicia Harrison. Respondent appeared before the

Commission and testified in person without legal counsel. Pursuant to Ala. Admin. Code r. 545-X-3-.08(1), the Honorable William R. Gordon presided as Hearing Officer. Each side was offered the opportunity to present evidence and argument in support of its respective contentions, and to cross-examine the witnesses presented by the other side. After careful review, we have made our own independent judgments regarding the weight and credibility to be afforded to the evidence, and the fair and reasonable inferences to be drawn from it. Having done so, and as prescribed in Ala. Code § 41-22-16, we enter the following Findings of Fact and Conclusions of Law.

### **III. Findings of Fact**

1. Respondent was first licensed to practice medicine in Alabama on March 31, 2015, under license number MD.34115. He maintained licensure in Alabama until December 31, 2021, when he allowed his license to lapse due to nonrenewal. Respondent filed his application for reinstatement with the Commission on or about April 2, 2024. (Board Ex. 2.)<sup>1</sup>

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<sup>1</sup> Although not part of the disciplinary charges at issue in this proceeding, we note that in his application for reinstatement, Respondent falsely claimed that he was board certified by the American Board of Family Medicine. He admitted in the hearing that he was not so certified. Moreover, in response to question No. 5, which asks, "Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed, voluntarily surrendered, or disciplined in any manor [sic]," Respondent falsely answered "No." (See Board Ex. 2 at 002, 003.)

2. Respondent attended medical school at the University of Mansura from 1969 to 1975. He subsequently completed OB/GYN postgraduate residency training in the United Kingdom from 1980 to 1985, and family medicine training in Michigan from 1991 to 1994. (Board Ex. 4 at 005.) At various times, Respondent held licenses to practice medicine in Alabama, Florida, Illinois, Michigan, New York, Oklahoma, and Virginia. In his application for reinstatement, however, Respondent states that he does not currently hold any medical licenses in any other state. Respondent has generally practiced family and OB/GYN medicine.

3. On January 10, 2006, the New York State Board for Professional Medical Conduct issued a "Statement of Charges" charging Respondent with 15 disciplinary infractions, including "Gross Negligence," "Gross Incompetence," "Negligence on More Than One Occasion," "Incompetence on More Than One Occasion," and "Failure to Maintain Records," relating to six patients. (Board Ex. 4 at 027-033.) In February 2006, Respondent entered into a Consent Agreement and Order, in which he consented to findings of guilt as to the allegations of "Negligence on More Than One Occasion" and "Failure to Maintain Adequate Records." The Consent Agreement and Order placed Respondent's New York medical license on probation for five years and required Respondent to complete 200 hours of continuing medical education. (Board Ex. 4 at 022, 035.)

4. On October 26, 2006, the Florida Department of Health filed an Administrative Complaint initiating reciprocal discipline on Respondent's Florida medical license on the basis of the New York Consent Order. (Board Ex. 4 at 051-056.) The Florida Board of Medicine, on December 13, 2006, entered a "Final Order" in which it imposed reciprocal discipline on Respondent, required him to pay a fine of \$2,000.00, and imposed a term of probation to run concurrently with the probation imposed by the New York Consent Order. (Board Ex. 4 at 047, 048.)

5. When Respondent applied for a medical license in Alabama in 2015, he entered into a "Voluntary Agreement" in which he agreed that he would not practice obstetric medicine in Alabama without advance approval by the Commission. (Board Ex. 6.)

6. Respondent's New York medical license was disciplined again in 2018. On June 26, 2017, the New York State Board for Professional Medical Conduct issued another "Statement of Charges" against Respondent. New York's 2017 Statement of Charges cited nine total counts of "Gross Negligence," "Gross Incompetence," "Negligence on More Than One Occasion," "Incompetence on More Than One Occasion," "Failure to Maintain Records," "Improper Delegation," and "Fraudulent Practice." (Board Ex. 7.) The charges related to Respondent's "inadequate prenatal and obstetrical care" provided to two patients, "Patient A" and "Patient B." (Board Ex. 9 at 2.)

7. A Hearing Committee held an evidentiary hearing on the 2017 Statement of Charges, and on January 4, 2018, entered a 20-page “Determination and Order.” (Board Ex. 9.) The Hearing Committee unanimously found Respondent guilty of seven of the nine disciplinary infractions set out in the Statement of Charges, and revoked his license to practice medicine in New York.<sup>2</sup> The Hearing Committee’s findings, which cannot be re-litigated here, are summarized in the following paragraphs.

8. Patient A was a 16-year old juvenile diabetic in early labor at 23 weeks’ gestation. Respondent ordered Pitocin to induce delivery of what was expected to be a nonviable fetus, but did not remain present to attend the delivery. Respondent alleged that Patient A and her family agreed that he did not need to be present at the delivery, and that he therefore instructed nursing staff to attend the delivery in his absence. The neonate was declared deceased approximately 45 minutes after delivery. Respondent made a discharge note in Patient A’s medical record which purported to document a physical examination on the day after the delivery. The Hearing Committee found that this entry was fraudulent, however, in that Respondent neither saw nor examined Patient A on the day in question. (Board Ex. 9 at 4, 5.)

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<sup>2</sup> The Hearing Committee sustained all disciplinary counts alleged, other than the two counts of “gross negligence” and “gross incompetence” with respect to Patient A. (Board Ex. 9 at 15, 16.)

9. With respect to Patient A, the Hearing Committee concluded that Respondent had a professional duty to attend her delivery, particularly in light of the fact that she was a juvenile, diabetic, and at elevated risk of bleeding and other complications. The Hearing Committee discredited Respondent's claimed excuse that Patient A and her family had "agreed" to him not being present for the delivery, and further found that it was "inappropriate to put them in a position of feeling compelled to disagree with the physician responsible for Patient A's well-being if they wanted him there." Respondent's failure to attend Patient A's delivery, the Hearing Committee found, "constituted a violation of his professional responsibilities." (Board Ex. 9 at 7.) The Hearing Committee further found that Respondent's discharge note for Patient A was "falsifi[ed]" and "clearly constituted a failure to maintain records that accurately reflected his care and treatment of the patient." (*Id.* at 9.)

10. Patient B was a 27-year-old female with a history of obstetrical complications and 2+ urine glucose. The Hearing Committee determined that Respondent "failed to adequately test, evaluate, or manage the patient for high blood sugar" during prenatal visits, "failed to adequately manage and treat Patient B for gestational diabetes," and "failed to monitor Patient B's blood sugar from November 8 to November 27" of 2013. (Board Ex. 9 at 5.) When Patient B later presented to the hospital with "fever, chills, abdominal pain, nausea, and vomiting," Respondent

“failed to adequately attend to or evaluate Patient B and failed to timely order appropriate laboratory bloodwork to check Patient B’s blood sugar.” (*Id.* at 6.) Patient B was later found to be in diabetic ketoacidosis, and her infant died four hours after delivery. (*Id.*)

11. With respect to Patient B, the Hearing Committee rejected all of Respondent’s explanations for failing to manage her glucose levels, and found that Respondent’s failure to provide “far more aggressive and immediate management and treatment for her very high blood sugar levels” constituted “a severe deviation from the appropriate standard of care.” (Board Ex. 9 at 11, 12.) Patient B, the Hearing Committee found, “needed proper instruction in all aspects of her diabetic management, including proper diet, use of a glucometer, frequent reporting of daily blood sugars, and probably insulin. The blood sugar monitoring from November 8-27 was egregiously inadequate.” (*Id.* at 12.) The Hearing Committee found Respondent’s assertion that “there were no issues to adjust any other management modalities” when Patient B presented to the hospital with pain, nausea, vomiting, and weight loss to be “alarmingly false.” (*Id.* at 13.) Finally, the Hearing Committee found Respondent’s apparent direction to a nurse to perform a three-hour glucose test on Patient B when the patient “was already in diabetic ketoacidosis, was also grossly incompetent, amounting to adding fuel to an already dangerous fire.” (*Id.* at 16.)

12. In conclusion, the Hearing Committee decided that revocation of Respondent's license was the only measure that would adequately protect public safety:

The Respondent showed no understanding of the serious deficiencies in his care of these patients, and was unwilling and/or unable to even acknowledge these deficiencies, let alone address them. He was dishonest in his documentation and made numerous claims at the hearing about his documentation and the care that he provided that are not credible. The Hearing Committee agreed that having been given an opportunity to improve his patient care practices, he demonstrated he is not able to do so. For that reason, probation or some other penalty that might enable him to continue to practice medicine would not adequately protect the public. Accordingly, the Hearing Committee unanimously concluded that revocation of his license is the appropriate penalty.

(Board Ex. 9 at 19.)

13. Respondent admits that the Florida Board of Medicine revoked his license in response to revocation of his license in New York. According to Respondent, Florida will not consider reinstatement of his medical license in that State unless he first obtains reinstatement in New York, which he has no intention of doing.

14. Respondent admits that he last practiced medicine in the United States in June 2020. (Board Ex. 3.) On November 16, 2021, Respondent e-mailed the Board: "Please change my medical license status from active to inactive as I retired. My medical license number is: MD.34115." (Board Ex. 12.) Respondent claims,

without any supporting evidence, that he has been practicing medicine in Egypt since 2021.

#### **IV. Conclusions of Law**

1. Respondent was properly notified of the time, date and place of the administrative hearing and of the charges against him in compliance with Ala. Code §§ 34-24-361(e) and 41-22-12(b), and Ala. Admin. Code r. 545-X-3-.03(3), (4). At the relevant times, Respondent was a licensee of this Commission whose licensing status was and is subject to the Commission's jurisdiction.

2. The Medical Licensure Commission of Alabama has jurisdiction over the subject matter of this cause pursuant to Act No. 1981-218, Ala. Code §§ 34-24-310, *et seq.* The Commission is vested by law with "*exclusive power and authority to issue, revoke, and reinstate all licenses . . . to practice medicine or osteopathy in the State of Alabama.*" Ala. Code § 34-24-311 (emphasis added). Under certain conditions, moreover, the Commission "shall have the power and duty to suspend, revoke, or restrict any license to practice medicine or osteopathy in the State of Alabama or place on probation or fine any licensee." Ala. Code § 34-24-360.

3. The Commission also has power to order reinstatement, or, in appropriate circumstances, to deny reinstatement, of licenses to practice medicine in Alabama. If the Board demonstrates any violation of Ala. Code § 34-24-360, the Commission has discretion to deny reinstatement. *See* Ala. Code § 34-24-337(h)

(“The commission may deny reinstatement of a license upon a finding that the applicant has committed any of the acts or offenses set forth in Sections 34-24-360, 34-24-57, 16-47-128, or any other provision of law establishing grounds for the revocation, suspension, or discipline of a license to practice medicine.”).

4. Before making any decision on a contested case such as this one, the Commission is required to “receive and consider” a recommendation from the Board. The Board’s recommendation, however, is not binding upon the Commission. *See* Ala. Code § 34-24-311. The Commission has received and duly considered the Board’s non-binding recommendation to deny Respondent’s application for reinstatement.

5. A physician’s license to practice medicine and/or osteopathy in Alabama may be disciplined if he or she is shown, after notice and hearing, to be “unable to practice medicine or osteopathy with reasonable skill and safety to patients by reason of a demonstrated lack of basic medical knowledge or clinical competency.” Ala. Code § 34-24-360(20)a.

6. A physician’s absence from the active practice of medicine for two years triggers a “rebuttable presumption”<sup>3</sup> of clinical incompetence:

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<sup>3</sup> A “presumption is a creature of law that assists in the matter of proof by providing that in certain situations proven facts may be strong enough that from them the trier of fact may conclude that the presumed fact exists. ... [R]ebutable presumptions, found throughout the legal system, are those under which a certain quantum of evidence gives rise to an inference of some other fact, but as to which fact the opposing party may offer evidence in rebuttal. Rebuttable presumptions are generally created by law—under statutes, case law, or rules of court—for such

A physician's absence from clinical practice for more than two years creates a rebuttable presumption of clinical incompetence. A physician, whether he or she is an applicant or licensee, who has not actively practiced or who has not maintained continued competency, as determined by the Board, during the two-year period immediately preceding the filing of an application for licensure or reinstatement or during any consecutive two-year period may be required to complete a reentry plan as a condition of licensure/reinstatement.

Ala. Admin. Code r. 540-X-23-.03(1).

7. Respondent has been absent from the practice of medicine in the United States for five years. Pursuant to Ala. Admin. Code r. 540-X-23-.03(1), therefore, Respondent is rebuttably presumed to be incompetent to practice medicine. Respondent has not offered anything to rebut the presumption of clinical incompetency. We therefore find that Respondent is unable to practice medicine with reasonable skill and safety to patients by reason of a demonstrated lack of clinical competency, in violation of Ala. Code § 34-24-360(20).

8. A physician's license to practice medicine and/or osteopathy in Alabama may be disciplined if he or she is shown, after notice and hearing, to be guilty of "[a]ny disciplinary action taken by another state against a licensee to practice medicine or osteopathy, based upon acts by the licensee similar to acts

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reasons as the promotion of some public policy (as in presumptions favoring the legitimacy of children), because the presumption is based upon human experience (illustrated by the presumption against suicide), or because of the peculiarities of the case affecting the ability to produce evidence (illustrated by the statutory presumption that upon proof of certain facts a railroad is presumed negligent)." Ala. R. Evid. 301 (Advisory Committee's Notes).

described in this section; a certified copy of the record of the disciplinary action of the state making such an action is conclusive evidence thereof.” Ala. Code § 34-24-360(15).

9. The disciplinary actions taken by the medical boards of New York in 2018, and subsequently in Florida, represent disciplinary actions described by Ala. Code § 34-24-360(15). Indeed, no suggestion to the contrary has been made to the Commission.

10. Respondent urges the Commission to reinstate his license to practice medicine in Alabama, notwithstanding the Board’s contentions, and notwithstanding the disciplinary actions taken against his licenses in New York and Florida. Respondent’s central argument is that the disciplinary actions taken in New York and Florida relate only to his practice of obstetrics, and do not reflect upon his ability to practice family medicine with reasonable skill and safety. Respondent points to his 2015 voluntary agreement not to practice obstetric medicine in Alabama as a model for how he could be allowed to practice only family medicine in Alabama.

11. We reject Respondent’s contentions. First, the clinical deficiencies at issue in the New York proceedings involved Respondent’s competence to manage and treat patients with diabetes, which is essential to the practice of family medicine. Second, the findings of the New York Hearing Committee as memorialized in its “Determination and Order” (Board Ex. 9) substantiated multiple examples of serious

deficits in medical judgment, ethics, and recordkeeping going well beyond mere medical knowledge. The Hearing Committee concluded, based on the facts before it, that there existed no combination of measures, such as probation, "that might enable [Respondent] to continue to practice medicine [while] adequately protect[ing] the public." Respondent has presented no concrete evidence upon which this Commission can decide otherwise.

#### **V. Decision**

Based on all of the foregoing, it is **ORDERED, ADJUDGED, AND DECREED:**

1. That the Respondent, Mohamed Abdel Hakeem Khalaf, M.D., is adjudged **GUILTY** of being unable to practice medicine with reasonable skill and safety to patients in violation of Ala. Code § 34-24-360(20)a., due to the legal presumption pursuant to Ala. Admin. Code r. 540-X-23-.03(1), as charged in Count One of the Administrative Complaint.

2. That the Respondent, Mohamed Abdel Hakeem Khalaf, M.D., is adjudged **GUILTY** of "disciplinary action taken by another state . . . based upon acts by the licensee similar to acts described in this section," in violation of Ala. Code § 34-24-360(15), as charged in Count Two of the Administrative Complaint.

3. That the Respondent, Mohamed Abdel Hakeem Khalaf, M.D., is adjudged **GUILTY** of "disciplinary action taken by another state . . . based upon

acts by the licensee similar to acts described in this section,” in violation of Ala. Code § 34-24-360(15), as charged in Count Three of the Administrative Complaint.

4. That Respondent’s application for reinstatement of his license to practice medicine in the State of Alabama is **DENIED**.

5. That no administrative fines nor costs of these proceedings are assessed against Respondent at this time.

**DONE** on this the 10th day of June, 2025.

**THE MEDICAL LICENSURE  
COMMISSION OF ALABAMA**

**By:**

**E-SIGNED by Jorge Alsip, M.D.  
on 2025-06-10 09:31:26 CDT**

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**Jorge A. Alsip, M.D.  
its Chairman**

**ALABAMA STATE BOARD OF  
MEDICAL EXAMINERS,**

**Complainant,**

**v.**

**BRIAN E. RICHARDSON, M.D.,**

**Respondent.**

**EXHIBIT**

**N**

**BEFORE THE MEDICAL  
LICENSURE COMMISSION OF  
ALABAMA**

**CASE NO. 2024-205**

**ORDER**

This matter is before the Medical Licensure Commission of Alabama on the Board's "Motion to Immediately Suspend License," filed on May 23, 2025. As grounds, the Board says that Respondent has refused to consent to the disclosure and use of certain records relevant to his ability to practice medicine with reasonable skill and safety to patients. That refusal has been unmistakably communicated to the Commission through Respondent's numerous *pro se* filings of May 19, 20, 23, 27, and 28, 2025. The Board further notes that, under Alabama law, such refusal "shall constitute grounds for the summary suspension of the physician's license to practice medicine by the Medical Licensure Commission, which suspension shall continue in effect until such time as the physician . . . complies with the order of the Board." Ala. Code § 34-24-360(19)e. The Commission has heard at length from both the Board and Respondent on the Board's motion.

Upon consideration by the full Commission, it is ORDERED that the Board's motion is GRANTED, and that the license to practice medicine or osteopathy, license certificate number MD.31014 of BRIAN E. RICHARDSON, M.D., be, and the same is hereby, immediately SUSPENDED pursuant to the provisions of Ala. Code § 34-24-360(19)b.-f. Respondent is hereby ORDERED and DIRECTED immediately to surrender the said license certificate to the Medical Licensure Commission of Alabama, at 848 Washington Avenue, Montgomery, Alabama, 36104. Respondent is further ORDERED immediately to CEASE and DESIST from the practice of medicine in the State of Alabama, pending further orders of the Commission.

It is further ORDERED that the hearing in this matter, currently scheduled for Wednesday, June 25, 2025, is CANCELLED and continued generally, pending further orders of the Commission.

DONE on this the 4<sup>th</sup> day of June, 2025.

THE MEDICAL LICENSURE  
COMMISSION OF ALABAMA

By:

E-SIGNED by Jorge Alsip, M.D.  
on 2025-06-04 09:13:46 CDT

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Jorge A. Alsip, M.D.  
its Chairman