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PROFESSIONAL	FINDINGS	RESOLUTION
<p>Marina Greco LPC-2159 2011-0008</p>	<p>The professional was the primary therapist for a 14-year-old client ("Client") for 4.5 years. Client was a CPS ward and had a history of living in adoptive or foster homes from a very early age. After moving from a foster family to a friend's family and then to a shelter shortly before Christmas 2009, Client went AWOL from the shelter on 2 occasions. During her second AWOL, Client was prostituted by people she met. The professional spoke to her supervisor ("Supervisor"), the CPS case manager, and other professionals regarding her desire to become Client's foster parent. Supervisor stated she told the professional that it would not be appropriate because it would create a dual relationship. The professional denied receiving this information from Supervisor. The professional acknowledged that she spoke to Client about the possibility of the professional becoming her foster parent and asked Client to think about it and to develop a list of pros and cons regarding the proposal. The professional did not document this communication with Client and did not document that she sought or received permission from Supervisor, CPS case manager, or the CFT to proceed with her proposal to become Client's foster mother. To minimize the potential harm to Client, the agency determined that it was necessary to replace the professional as Client's therapist and implemented a 90-day probationary period. The professional failed to document the communications she had with Supervisor, CPS, or anyone else that formed the basis for her determination that her proposal was potentially beneficial to Client.</p>	<p>Board Action 01/06/11 Consent Agreement and Order. Probation; 3 clock hours of continuing education addressing current behavioral health documentation requirements; 6 clock hours of the NASW Staying Out of Trouble course or an equivalent course; 6 clock hours addressing behavioral health ethics; 24 months of clinical supervision; 12 months of therapy; investigative costs of \$867.52 stayed pending compliance with this Consent Agreement and Order.</p>
<p>Burdette Leikvoll LPC-0331 LISAC-0677 2007-0037 2008-0066</p>	<p>See 2009 Adverse Action Report.</p>	<p>Board Action 01/06/11: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 04/16/09.</p>
<p>John Lare LAC-12407 (revoked) LISAC-11820 (revoked) 2009-0120</p>	<p>See 09/2010 Adverse Action Report.</p>	<p>Board Action 01/06/11 Order of Denial of Review or Rehearing Request.</p>
<p>Marianne Krivan LCSW Applicant 2010-0099</p>	<p>During employment at the City of Phoenix Head Start Program from 06/07 through 03/08, the professional failed to complete required documentation even after being instructed to do so by her supervisor. After a formal administrative hearing in 08/10, the Board offered to approve the professional's application subject to the professional's acceptance of a consent agreement requiring that she pass the ASWB exam, work only in an agency licensed by OBHL, take and pass a 3 semester credit hour graduate level course in behavioral health assessment, diagnosis and treatment, complete 6 clock hours of continuing education "Staying Out of Trouble" course, and receive 24 months of clinical supervision. When the professional failed to sign the proposed consent agreement, an order denying the licensure application was entered based on unprofessional conduct.</p>	<p>Board Action 01/25/11: The applicant's LASAC application was denied pursuant to A.R.S. §§ 32-3275(6) and 32-3251(12)(l).</p>

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<p>Kimberly Rezarch LISAC-Applicant 2011-0084</p>	<p>The professional's LISAC application was denied for failure to meet minimum licensure requirements and for unprofessional conduct related to her creation of fraudulent documentation and her forging signatures on that documentation to try to qualify for LISAC licensure.</p>	<p>Board Action 02/03/11: The applicant's LISAC application was denied pursuant to A.R.S. §§ 32-3275(6) and 32-3251(12)(b).</p>
<p>Sarah House LMSW-0589 2008-0014</p>	<p>See 2007 Adverse Action Report.</p>	<p>Board Action 02/03/11: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 12/10/07.</p>
<p>Carrie Truelove-Hernandez LPC-12095 2008-0057 2011-0074</p>	<p>On 04/02/10, the Board executed a consent agreement resolving Case No. 2008-0057 ("2008 CA"). See 2010 Adverse Action Report. The terms of the 2008 CA required that the professional work in an OBHL licensed agency and receive clinical supervision. When the professional failed to comply with the terms of the 2008 CA, the Board opened a new complaint, Case No. 2011-0074.</p>	<p>Board Action 02/03/11 Consent Agreement and Order: 12 months stayed suspension pending successful completion of terms of new consent agreement; probation; 36 months of supervised work experience in an OBHL licensed agency; 36 months clinical supervision; 3 clock hours of continuing education in the assessment and treatment of co-occurring disorders; 3 semester credit hour graduate level course in ethics; \$2,248 investigative costs stayed pending compliance with this Consent Agreement and Order.</p>
<p>Miki Kloss LMFT-0157 2010-0082</p>	<p>In 04/08, the professional and the Board entered into a Consent Agreement and Order ("04/08 CA") resolving Case No. 2008-0026. The 04/08 terms included 12 months of clinical supervision with twice monthly meetings. After terminating clinical supervision with her Board-approved supervisor in 09/09, the professional failed to complete any additional clinical supervision with a Board approved clinical supervisor.</p>	<p>Board Action 02/03/11 Consent Agreement and Order: Probation until the professional's license expires on 07/31/11, at which time she shall retire from the practice of licensed marriage and family therapy. The professional shall not accept any new marriage and family therapy clients. The professional shall submit a written plan for terminating her private practice. The professional agrees not to renew her license.</p>
<p>Daniel Herrera LASAC Applicant 2011-0035</p>	<p>In 05/10, the professional submitted an application for licensure as an associate substance abuse counselor. The professional indicated that he has been under treatment at the VA since 2003 for a number of serious behavioral health issues. Although the professional reported significant alcohol abuse issues through 10/09, he has not received any therapy or treatment to address this problem. Although the professional receives ongoing treatment with regard to his medical and behavioral health issues, his medical and employment history suggest that his condition is not stable.</p>	<p>Board Action 02/03/11: The applicant's LASAC application was denied pursuant to A.R.S. §§ 32-3275(6), 32-3251(12)(f), and 32-3251(12)(l).</p>

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<p>David Tennyson LSAT-Applicant 2010-0127</p>	<p>The professional's LSAT license was denied based on the following: (1) His 1998 federal convictions of mail fraud and attempted tax evasion. (2) His failure to take responsibility for the conduct that led to these convictions. (3) His failure to disclose his 1998 convictions on a 2006 employment application. (4) His misrepresentation on that employment application that he was employed at Nellis Air Force Base ("Nellis AFB") as an electrician when, in fact, he was incarcerated at Nellis AFB as a result of his 1998 criminal convictions. (5) His failure to advise his treating physician prescribing his pain medication of his 2006 DUI. (6) His failure to accurately disclose his employment history on his September 2008 Luke Air Force Base ("Luke AFB") employment application. (7) His misrepresentation on his Board licensure application that he voluntarily resigned from Luke AFB when, in fact, he was involuntarily terminated after he lost the necessary security clearance to work there. (8) His consistent pattern over 2.5 years of enrolling in college classes that he either withdrew from or failed. (9) His lack of stable employment history since 2000. (10) His April 2006 DUI. (11) His multiple misrepresentations during the Board's investigation of the circumstances leading to that DUI. (12) Entries in his medical records indicating that, on a number of occasions, he consistently sought early refills or increased prescriptions of narcotic medications.</p>	<p>Board Action 10/07/10: The applicant's LSAT application was denied pursuant to A.R.S. §§ 32-3275(6), 32-3251(12)(a), and 32-3251(12)(l). Board Action 02/03/11: The Board denied the professional's request for a Review or Rehearing.</p>
<p>G. Lynn Bonner LPC-1028 2009-0104</p>	<p>In 07/08, the professional started treating 14-year-old Daughter regarding possible sexual abuse issues. Daughter had 7 sessions. Prior to treating Daughter, the professional had no experience working with high-conflict post-divorce families, such as Daughter's family. Daughter reported vague, but consistent flashbacks of alleged sexual abuse when she was around 5 years old by a teacher. In a 10/08 progress note, the professional noted Daughter's "in depth" disclosure of sexual memories regarding a teacher. The professional failed to report this information as possible child abuse to the appropriate authorities. The professional indicated that she did not report Daughter's disclosure because at no time did she form a reasonable belief that sexual abuse did or did not occur. The clinical records indicate that Daughter provided consistent information during the professional's assessment and 5 sessions with Daughter regarding her memories of sexual abuse. The professional failed to include any objective or goal regarding these memories in Daughter's treatment plan. The professional failed to obtain written consent to treat Daughter from Father or Mother. There was insufficient documentation in the record that the professional attempted to involve Father in Daughter's treatment and afford Father the same opportunity as Mother to participate in Daughter's treatment. The professional's 04/09 letter to the court appointed parenting coordinator on behalf of Daughter contained factual inaccuracies and reflected a lack of objectivity. Daughter's record contained inaccurate and contradictory information. The professional did not document relevant information in Daughter's records. The progress notes failed to include the date of session, the duration of session, or whether the session was individual, family, or group.</p>	<p>Board Action 02/03/11 Consent Agreement and Order: probation; complete 3 clock hours of continuing education addressing current behavioral health documentation standards and 6 clock hours of continuing education addressing high conflict domestic cases; within 12 months, take and pass a 3 semester credit hour graduate level behavioral health ethics course; 24 months clinical supervision; \$1,360.62 investigative costs stayed pending compliance with this Consent Agreement and Order.</p>
<p>Jack Griffith LCSW-10329 2011-0024</p>	<p>In 01/11, the Board was notified that the professional was being treated for a significant health issue and/or condition affecting his ability to safely and competently practice at this time.</p>	<p>Board Action 02/03/11 Interim Consent Agreement and Order: The professional shall not practice and the professional's license shall be suspended.</p>
<p>Maureen Thatcher LISAC-10351 2011-0047</p>	<p>In 11/10, the Board became aware that the professional was being treated for significant health issues and/or condition affecting her ability to safely and competently practice at this time.</p>	<p>Board Action 02/03/11 Interim Consent Agreement and Order: The professional shall not practice and the professional's license shall be suspended.</p>

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<p>Linda Hudnall LMSW-12384 2010-0075</p>	<p>See 2010 Adverse Action Report.</p>	<p>Board Action 03/03/11: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 07/13/10.</p>
<p>Maureen Maxon LPC-10172 2010-0021</p>	<p>In 06/09, a former client sent the professional a letter containing a number of antagonistic statements. Instead of limiting her response letter to neutral comments, the professional included statements that went beyond the issues former client raised and adopted the antagonistic tone used in the former client's letter. The professional's tone was clinically inappropriate where the professional had previously diagnosed the former client with Borderline Personality Disorder in addition to other significant behavioral health issues, including a history of suicidal ideation. The professional failed to document the former client's diagnosis because she was considering differential diagnoses of PTSD and/or Depression. The professional failed to transfer voice mail messages pertaining to treatment issues to the clinical record. The professional spoke or wrote to family members, other therapists, or hospital staff about the former client without having an appropriate written release of information authorization to do so. The professional inappropriately billed AHCCCS and the former client using the wrong service code, billed for sessions that were not documented, or billed for services for which she had already been paid.</p>	<p>Board Action 03/03/11 Consent Agreement and Order: Probation; within 12 months complete 3 clock hours of continuing education addressing current behavioral health documentation requirements, 3 clock hours of continuing education addressing behavioral health billing and related documentation requirements, and a 3 semester credit hour graduate level behavioral health ethics course; 24 months of clinical supervision; \$1,498 investigative costs stayed pending compliance with this Consent Agreement and Order.</p>
<p>Roseann Schaye LPC-0454 2008-0029</p>	<p>See 2009 Adverse Action Report.</p>	<p>Board Action 03/03/11: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 03/09/09.</p>
<p>Scott L. Smith LISAC-1224 2010-0025</p>	<p>The professional operates an OBHL licensed agency ("Agency"). The professional and an unlicensed MSW ("MSW") conducted an assessment of Client at the request of the Adult Probation Department. The professional indicated that Client's assessment included a clinical interview, a review of "personal historical documents", and administration of a diagnostic survey. After this assessment, Client began alleging that the professional and the MSW were involved in a conspiracy against him. Client's attorney sought a copy of Client's record. A treating psychologist requested a copy of the diagnostic survey. These records were never provided to Client's attorney. The professional indicated that he could not provide the records because he could not locate the records. He believed that the records were accidentally shredded. Without his records, Client was deprived of an opportunity to use the contents of the records to defend his position or contest the validity of the assessment. Similarly, the source documents that the professional and MSW relied upon to support the diagnosis and recommendations made in their evaluation report, such as the diagnostic survey, "personal historical documents", and any background information provided by Client's probation officer, were not available to other behavioral health professionals, such as psychologist, who may have been tasked with evaluating Client.</p>	<p>Board Action 03/03/11 Consent Agreement and Order: Probation; within 12 months complete and pass a 3 semester credit hour graduate level behavioral health ethics course; 12 months clinical supervision; \$433 investigative costs stayed pending compliance with this Consent Agreement and Order.</p>
<p>Cory Sanchez LISAC-11625 2011-0001</p>	<p>The professional was employed at an agency ("Agency") from 03/07 to 07/10. During 03/07 to 04/07, Client received substance abuse treatment at Agency. The professional was one of several counselors providing group treatment to Client. In 03/09, Agency hired Client as a Peer Support Specialist. From 01/10 to 04/10, the professional and Client entered into an intimate sexual relationship.</p>	<p>Board Action 03/03/11: Order of Revocation.</p>

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<p>Jamie Pullin LASAC-13089 2010-0117</p>	<p>On 06/04/07, the Board entered into a consent agreement ("06/07 CA") with the professional related to Case No. 2007-0136. Pursuant to the 06/07 CA, the professional was licensed subject to successful completion of required probationary terms. After receiving her license, the professional consistently failed to comply with required probation terms. In 11/09, a new supervisor ("Supervisor 2") was approved as the professional's clinical supervisor. In 01/10, Supervisor 2 notified the Board of her "intention to resign" as the professional's clinical supervisor due to the professional's non-compliance with clinical supervision requirements. The professional also failed to comply with random monthly biological fluid testing requirements as the professional's employer allowed her to schedule the date of her monthly tests. The professional provided no credible evidence substantiating her representations that her AA sponsor's reports, which were sent to the professional's therapist, were legitimate.</p>	<p>Board Action 12/02/10 Order of Revocation, including an assessment of investigative costs of \$852.71. Board Action 03/03/11: The Board denied the professional's request for a Review or Rehearing.</p>
<p>Amy Preusch LMSW-Applicant 2011-0010</p>	<p>The professional failed to disclose 10 years of employment and all behavioral health related employment on her LMSW application, as required. The professional also failed to disclose behavioral health agency discipline on her LMSW application, as required.</p>	<p>Board Action 03/03/11: The applicant's LMSW application was denied pursuant to A.R.S. §§ 32-3275(6), 32-3251(12)(c), and 32-3251(12)(l).</p>
<p>Jeremy Ernst LAC-Applicant 2010-0085</p>	<p>The applicant was terminated from a behavioral health position and disciplined by the Ohio licensing board after an investigation resulting from a client's complaint that the professional smoked marijuana while a licensed behavioral health professional. The investigation of the complaint resulted in the professional's termination and disciplinary action by the Ohio licensing board. The applicant also misrepresented this termination on an employment application, resulting in another involuntary termination. The applicant also failed to disclose a third involuntary termination to the Board, as required. The applicant also failed to disclose his addiction to marijuana and participation in NA meetings, as required.</p>	<p>Board Action 03/03/11: The applicant's LAC application was denied pursuant to A.R.S. §§ 32-3275(6), 32-3251(12)(b), 32-3251(12)(c)(i), and 32-3251(12)(l).</p>
<p>Ann Iverson LAC-Applicant 2011-0112</p>	<p>The applicant failed to establish eligibility for licensure as a result of active habitual intemperance and any conduct, practice or condition that impairs the ability of the licensee to safely and competently practice at this time.</p>	<p>Board Action 03/03/11: The applicant's LAC application was denied pursuant to A.R.S. §§ 32-3275(5) and (6), 32-3251(12)(f), and 32-3251(12)(l).</p>
<p>Willis Beasley LPC-10904 2010-0010 2011-0021</p>	<p>2010-0010: In 12/08, the professional, at Father's request, began seeing Father's 3 oldest children. The professional was aware that Parents had a hostile relationship and Father was involved in active legal battles to restrict Mother's access to Children. The professional failed to remain neutral in this matter. He testified in court on Father's behalf and wrote a To Whom It May Concern letter recommending modification of Mother's parenting time and limiting her to supervised visitation. The professional also failed to maintain accurate documentation and billed for sessions that were not supported by accurate progress notes. Despite having minimal interactions with Mother and Children, the professional provided an opinion that Mother's parenting time should be terminated pending successfully treatment for her "mental problems". The professional provided recommendations through court testimony and letters affecting parental rights despite his limited role as Children's therapist. The professional failed to refer children to another therapist when Mother filed a Board complaint against him. The professional's clinical documentation lacked required elements.</p>	<p>Board Action 04/07/11 Consent Agreement and Order: 12 months license suspension; 3 clock hours of continuing education addressing current behavioral health recordkeeping requirements, 6 clock hours of continuing education addressing high conflict divorce/custody/visitation cases, 3 semester credit hour graduate level behavioral health ethics course; upon release from suspension, 24 months of supervised work experience in an OBHL licensed agency; 24 months clinical supervision; \$2523 stayed investigative costs pending compliance with this Consent Agreement and Order.</p>

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<p>Willis Beasley LPC-10904 2010-0010 2011-0021</p>	<p>2011-0021: Mother's attorney referred Mother and Daughter to the professional to obtain an evaluation and report regarding Daughter's allegations of maltreatment by Father. Daughter reported information indicating possible abuse by Father. The professional documented that he recommended that Mother make a CPS report. The professional failed to report Daughter's report to CPS, as required. The treatment plan for Daughter lacked required elements. Mother gave the professional original items, such as journals, and alleged that the professional failed to return these items to her. The professional acknowledged that he received items from Mother, but represented that he returned these items to her. The professional did not document that he returned these items to Mother. When Mother and Mother's attorney attempted to contact the professional to obtain his clinical records, they learned he had closed his practice without providing any notice to them. The professional indicated that he notified his clients by speaking with them or leaving them a message. There was no evidence that the professional sent timely letters notifying clients of his practice closure or providing clients with referrals or information about how to obtain copies of their records. The professional failed to notify the Board of his change of work and home addresses or contact numbers within 30 days, as required. At least 2 other clients contacted the Board after they were unable to locate the professional in order to obtain their clinical records.</p>	<p>Board Action 04/07/11 See Above.</p>
<p>Brenda S. Taylor LISAC-1503 2009-0089</p>	<p>In 1996, the professional began drinking alcohol again after 7 years of sobriety. Her drinking increased over the years, resulting in alcohol abuse by 2007. The professional did not disclose any substance abuse issues on her initial 1998 certification application or on 3 subsequent certification/licensure renewal applications in 2002, 2004, and 2006. In 02/08 to 03/08, the professional completed a 5-day detox program. On her 10/08 licensure renewal application, the professional disclosed her relapse and treatment. In 03/09, the professional and the Board entered into an Interim Consent Agreement (ICA) prohibiting the professional from practicing under her license. After entering into the ICA, the professional initiated significant personal changes in her life toward her recovery and maintaining sobriety.</p>	<p>Board Action 04/07/11 Consent Agreement and Order. Release from the ICA; while on probation, the professional shall only provide behavioral health services at an out-patient facility licensed by OBHL; complete an evaluation by an Addictionologist; participation in an approved recovery program for a minimum of 2 times per week for 24 months; participate in random biological fluid testing; \$192 stayed investigation costs pending compliance with this Consent Agreement and Order.</p>
<p>Heidi Quinlan LISAC-11071 LPC-13084 2007-0045</p>	<p>See 2008 Adverse Action Report.</p>	<p>Board Action 04/07/11: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 09/08/08.</p>

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<p>Leanne Schroeder LAC-11691 2009-0083 2011-0094</p>	<p>The professional had a consistent pattern of not completing client documentation at Agency 1, even while subject to corrective action plans requiring timely completion of all required documentation. The professional failed to either take steps to ensure compliance with Agency 1's documentation requirements or to cease practicing until she was able to meet those requirements. The professional failed to recognize the serious nature of her impairment and failed to take appropriate steps to ensure that her impairment did not negatively impact her clients or Agency 1. The professional's failure to maintain current client documentation resulted in a large amount of lost revenue for Agency 1 and poor and/or inconsistent client care. On 09/04/09, the professional and the Board entered into a Consent Agreement ("09/09 CA") requiring compliance with a number of stipulations. In 09/09, the professional began working at Agency 2 and began receiving clinical supervision in accordance with the 09/09 CA. Beginning in 02/10, the professional was again not complying with required documentation standards. In 05/10, the professional's supervisor addressed concerns about the professional's incomplete documentation. In 07/10, the professional received a formal reprimand due to her misrepresentations that she had completed required documentation. Agency 2 informed the Board that the professional began an extended work absence in accordance with FMLA. The professional did not notify the Board that she could not comply with the clinical supervision required by the 09/09 CA. After returning to work, the professional was given a position where she did not provide therapy to clients. In 10/10, the professional was terminated from Agency 2. The professional failed to complete all of her continuing education requirements in the 09/09 CA.</p>	<p>Board Action 04/07/11 Consent Agreement and Order. stayed revocation; probation; within 6 months, complete 1 clock hour of continuing education addressing current behavioral health documentation requirements, 3 clock hours of continuing education addressing time management skills, 3 clock hours of continuing education addressing current behavioral health documentation requirements; 15 months of clinical supervision; \$1784 stayed investigative costs pending compliance with this Consent Agreement and Order. Board Action 11/21/11 Order of Revocation.</p>
<p>Edward L. Coin LAC-Applicant 2011-0061</p>	<p>In 1992, the applicant was charged with a DUI with a BAC of 0.14. The applicant participated in substance abuse screening and counseling. In 1994, the applicant was charged with misdemeanor assault/domestic violence against his wife. The applicant attended counseling related to this arrest. In 06/10, the applicant submitted an LAC application. While this application was pending, the applicant was arrested for DUI with a BAC of .211/.206. During his substance abuse screening, the applicant admitted having a problem with alcohol. The applicant failed to participate in any formal relapse prevention efforts.</p>	<p>Board Action 04/07/11: The applicant's LAC application was denied pursuant to A.R.S. §§ 32-3275(6) and 32-3251(12)(l).</p>
<p>Albert Ledet LISAC-11788 2010-0105 2010-0133</p>	<p>On 10/06/09, the Board and the professional entered into a consent agreement ("10/09 CA") regarding complaint 2007-0067, requiring compliance with a number of stipulations. The professional failed to timely comply with the 10/09 CA requirements. When his employer learned of the 10/09 CA in 04/10, the professional was terminated and the employer filed a complaint with the Board about the professional's failure to disclose his 2004 DUI on his employment application and the disciplinary action taken against his license. In 04/10, the Board opened Complaint No. 2010-0105 based on the professional's failure to comply with the 10/09 CA. In 06/10, the credentialing committee reviewed the professional's continued failure to comply with the terms of the 10/09 CA and opened Complaint No. 2010-0133. In 08/10, the professional began employment at a new agency. The professional failed to notify the Board of this employment for 2 months. On 10/12/10, the professional failed to report for his random UA testing, as required by the 10/09 CA. The professional did not notify the Board regarding his missed UA test. The professional also failed to timely notify his new employer of the 10/09 CA.</p>	<p>Board Action 04/07/11: Order of Revocation.</p>

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<p>Linda Gerdes LCSW-11426 2009-0122</p>	<p>Mother brought Daughter to therapy with the professional to help Daughter cope with Parents' pending divorce. Daughter's primary residence was with Father. Mother told the professional that the Parents were engaged in a "bitter divorce", Father lived with Mother's sister in a romantic relationship, Father refused to give Daughter her ADD medication, and Father had previously intervened to prevent Daughter from receiving therapy. The professional's decision to accept Daughter as a client without Father's knowledge or consent placed Daughter in the middle of Parents' conflict. The professional did not reach out to Father to inform him of Daughter's treatment. Father learned of the treatment from Mother. The professional's discussions with Father about Daughter's ADD and Father's living arrangement with Mother's sister likely further reinforced Father's belief that the professional was not objective and sided with Mother. In 03/08, the professional agreed to testify as an expert witness for Mother during an upcoming custody hearing even though the professional had no experience or training regarding working with high-conflict divorce/custody issues and was not a custody evaluator. In 03/08, the professional began providing individual counseling to Mother. In a 03/23/08 letter to Mother's attorney, the professional made several statements that evidenced a clear loss of objectivity.</p>	<p>Board Action 04/22/11 Consent Agreement and Order. 24 months of supervised work in an agency licensed by OBHL; complete a 3 semester credit hour graduate level behavioral health ethics course; 24 months clinical supervision.</p>
<p>Linda Gerdes LCSW-11426 2009-0122</p>	<p>On 04/15/08, the professional wrote a letter for Mother's use in her effort to obtain physical custody of Daughter that contained statements not supported by the clinical record and included Mother's version of events without identifying Mother as the author of those events. The professional failed to limit her role as Daughter's therapist. The professional failed to follow her own protocol when diagnosing a child with ADD. The professional involved herself in multiple roles, such as Daughter's therapist, Mother's therapist, expert witness, and custody evaluator, which created potential conflicts of interest. The professional's clinical records did not include required elements. The professional failed to use appropriate methods to document changes she made to her clinical records. The professional failed to document communications she had regarding Mother and Daughter's therapy and failed to obtain a signed release of information authorization before releasing confidential client information. The professional also billed inappropriately for sessions.</p>	<p>Board Action See Above.</p>
<p>Karmin Fowler LAC, LPC-Applicant 2011-0040</p>	<p>In 07/09, the applicant was arrested for an extreme DUI with a BAC of 0.197. She failed to report this arrest to the Board within 10 days, as required. When the applicant applied for an LPC in 06/10, she was required to complete a substance abuse evaluation.</p>	<p>Board Action 04/07/11: The applicant's LPC application was denied pursuant to A.R.S. §§ 32-3275(6), 32-3251(12)(I) and 32-3251(12)(ii).</p>
<p>Ellen A. Talboom LAC-Applicant 2011-0088</p>	<p>In 2002, the professional received a Colorado LPC license. In 09/06, the Colorado Department of Regulatory Agencies ("CDRA") disciplined the professional by issuing a "Letter of Admonition". The CDRA indicated that the professional failed to act according to generally accepted standards, failed to provide for adequate discharges, and failed to sufficiently coordinate and provide referrals for clients. In 02/08, the professional began work at an Arizona agency ("Agency"). Agency personnel records indicated repeated client confidentiality violations, client requests for another therapist, late service plans, insufficient, clinically inappropriate case management activities, repeated failure to maintain appropriate professional boundaries, use of incendiary language with clients, failure to conduct appropriate assessments that created client and corporate risk, and failure to make timely referrals. The professional resigned in lieu of termination in 05/09.</p>	<p>Board Action 04/07/11: The applicant's LAC application was denied pursuant to A.R.S. §§ 32-3275(6) and 32-3251(12)(I).</p>

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<p>Georgia Fourlas LASAC-13167 2011-0002</p>	<p>The professional accepted 7 former clients as "friends" on her FaceBook account, including former clients where she was the primary therapist. After the professional's supervisor advised her to close these former client "friend" accounts, she continued to respond to private FaceBook messages from a former client for 1 month after the former client was deleted as a "friend".</p>	<p>Board Action 04/07/11 Consent Agreement and Order: Complete a 3 semester credit hour graduate level behavioral health ethics course; 24 months of clinical supervision; \$483.24 investigative costs stayed pending compliance with this Consent Agreement and Order.</p>
<p>Paula DeBenedetto LCSW-1922 2010-0070</p>	<p>The professional provided treatment to Client's sister ("Sister") to address Sister's restrictive eating. During one session, Mother and Client attended Sister's session and discussed concerns about Client being too thin and the belief that Client needed inpatient treatment for an eating disorder. Client did not want to discuss eating disorder treatment with her family. Client later arranged for couples counseling for Client's husband ("Husband") and herself with the professional. The professional failed to maintain clinical documentation in accordance with minimum practice standards. The professional facilitated other family sessions for Sister where Mother, and/or Stepfather and Stepsister attended. The professional told family members that she had observed Client feeding candy to Client's son and didn't know whether Client overfed son or whether son was just a big boy. When family members expressed concern about Client suffering from an eating disorder, the professional addressed various issues affecting persons with eating disorders. Thereafter, the family arranged for an intervention with Client. After learning about the professional's participation in the discussion that led to the family's decision to seek an intervention, Client terminated therapy based on Client's perception that the professional violated her trust by discussing family's concerns regarding Client's weight.</p>	<p>Board Action 04/07/11 Consent Agreement and Order: Complete 6 clock hours of continuing education of the NASW Staying Out of Trouble course, or an equivalent course; 6 months of clinical supervision; \$1,570 investigative costs stayed pending compliance with this Consent Agreement and Order.</p>
<p>Nanette Mongelluzzo LPC-11867 2009-0022 2010-0030</p>	<p>See 2010 Adverse Action Report.</p>	<p>Board Action 05/05/11: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 02/25/10.</p>
<p>Karrie Chenevert LISAC-11558 2009-0060</p>	<p>See 2009 Adverse Action Report.</p>	<p>Board Action 05/05/11: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 10/06/09.</p>
<p>Marjorie Schulte LCSW-0820 2009-0062</p>	<p>See 2010 Adverse Action Report.</p>	<p>Board Action 05/05/11: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 02/10/10.</p>
<p>Jeffery Ammon Larsen LAMFT-10278 2008-0083</p>	<p>See 2008 Adverse Action Report.</p>	<p>Board Action 05/05/11: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 05/05/08.</p>

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<p>Janice Neely LCSW-2259 2010-0081</p>	<p>The professional treated Mother from 08/08 through 10/08 for grief, depression, anger issues, stress relationship issues and parenting skills. The professional failed to maintain clinical documentation in accordance with minimum practice standards. The professional wrote To Whom It May Concern letters without obtaining appropriate release of information authorizations. Mother then requested to see the professional before a court date to observe her with Children and to write a letter to the court. The professional observed Mother and Children for approximately 2 hours. The professional wrote a To Whom It May Concern letter indicating that she had observed Children with Mother, Children appeared happy to be with Mother, she has known Mother since 08/08, and she would not hesitate to recommend that Children be placed back with Mother. The professional acknowledged that her recommendation that Children be returned to Mother was inappropriate as she did not obtain sufficient information during her brief observation of Mother and Children to support any type of placement recommendation.</p>	<p>Board Action 05/05/11 Consent Agreement and Order: Practice restricted to working at an OBHL licensed agency; complete 6 clock hours of the NASW Staying Out of Trouble course, or an equivalent course; complete a 3 semester credit hour graduate level behavioral health ethics course; \$332 investigative costs stayed pending compliance with the terms of this Consent Agreement and Order.</p>
<p>Deborah Yancer LISAC-1546 LPC-1451 2005-0090</p>	<p>In the late 1990's, the professional injured her back, underwent spinal surgery, and consistently filled legally authorized prescriptions for pain medications. In 02/02, the professional was charged with DUI alcohol and DUI drugs. Drug testing found narcotic were present. The professional continued to fill legally authorized prescriptions for pain medications. In 05/02, the professional underwent inpatient treatment for substance abuse dependency issues. Upon discharge, the professional did not fully comply with discharge recommendations. In 12/02, 11/03, and 12/04, the professional failed to fully disclose her DUI on Board renewal applications, as required. The professional failed to disclose a pending Board complaint on a ValueOptions credentialing application. During a 03/08 investigative interview by Board staff, the professional misrepresented her use of legally prescribed prescriptions and substance abuse treatment. The professional has not received any subsequent treatment or participated in any support groups related to substance abuse dependency issues since 06/02, as recommended by a 04/09 evaluator.</p>	<p>Board Action 05/05/11 Consent Agreement and Order: The professional's license shall be surrendered. The surrender shall be considered a revocation of her license.</p>
<p>Laura L. Lindsay LCSW-Applicant 2011-0090</p>	<p>Applicant is licensed as a LMSW and LISAC. The professional's LCSW application was denied based on 3 different supervisory evaluations rating the professional below average. The professional's supervisors articulated multiple concerns regarding the professional's negative attitude toward other professionals and clients, counter transference issues, interpersonal communication issues, self care issues, stress issues, boundary issues, dependency and codependency issues, inability to maintain confidentiality, below average clinical skills, employment of contraindicated therapies, failure to notify CPS when warranted, insubordination, resistance to clinical supervision, and poor clinical and professional judgment.</p>	<p>Board Action 05/05/11: The applicant's LCSW application was denied pursuant to A.R.S. §§ 32-3275(6) and 32-3251(12)(l) and AAC R4-6-212(G) and R4-6-404(B).</p>
<p>Marisa B. Spletter LMSW-Applicant 2011-0115</p>	<p>The professional disclosed a 04/10 DUI arrest with a BAC of .120%. During the 04/10 substance abuse screening, the professional represented she consumed 1 beer at 7 pm and a second beer at 1:30 am, which is not consistent with her BAC level. In a 11/10 letter to the Board, the professional represented that she had only 1 beer approximately 1 hour before attempting to drive home and being arrested. That representation was not consistent with her BAC level. The professional has not participated in any type of substance abuse treatment other than what was court ordered as a result of the DUI. During the Board's investigation, it was discovered that the professional was experiencing some behavioral health issues affecting her ability to practice safely and competently. The professional withheld information about her DUI from her treatment providers.</p>	<p>Board Action 05/05/11: The applicant's LMSW application was denied pursuant to A.R.S. §§ 32-3275(6) and 32-3251(12)(l).</p>
<p>Melissa Martinez LASAC-Applicant</p>	<p>In 06/09, the applicant submitted a LASAC application to the Board. In 08/09, she was arrested for misdemeanor DUI with a BAC of .186%. In 03/10, the applicant pled guilty to DUI. The professional failed to complete a Board ordered substance abuse evaluation.</p>	<p>Board Action 05/05/11: The applicant's LASAC application was denied pursuant to A.R.S. §§ 32-3275(6) and 32-3251(12)(n).</p>

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<p>Sharon Alarotu-Davis LMSW-12829 2011-0138</p>	<p>On 01/26/11, the professional was arrested for child/vulnerable adult abuse, a class 5 felony, and Prevent use of Telephone in an Emergency, a class 2 misdemeanor.</p>	<p>Board Action 05/31/11 Interim Consent Agreement and Order: The professional shall not practice and the professional's license shall be suspended.</p>
<p>Paul J. Harris LSAT-12030 2009-0028 2010-0012</p>	<p>See 2010 Adverse Action Report.</p>	<p>Board Action 05/31/11: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 01/11/10.</p>
<p>Connie Hillman LISAC-11446 2007-0161</p>	<p>See 2007 Adverse Action Report.</p>	<p>Board Action 05/31/11: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 11/07/07.</p>
<p>William H. Steinger LPC-1391 2010-0072</p>	<p>In 01/09, the professional was indicted by a federal grand jury for conspiracy and tax evasion. In 08/09, the professional requested that his license be placed on inactive status, which was granted in 09/09. In 12/09, the professional was convicted of conspiracy and tax evasion. On 02/17/11, the professional was sentenced to 42 months in federal prison. In 03/11, the professional's request for an extension of inactive status was denied. Due to his criminal conviction and incarceration, the professional is not currently practicing professional counseling.</p>	<p>Board Action 05/31/11 Interim Consent Agreement and Order: The professional shall not practice and the professional's license shall be suspended.</p>
<p>Debrah Delos-Santos LMFT-10229 2011-0071</p>	<p>In 2009, the professional submitted an application to the Arizona Board of Psychologist Examiners ("Psychologist Board"). In 03/09, the professional was hired at a licensed agency ("Agency"). The professional advised Agency that her psychologist license was pending. In 12/09, the professional withdrew her psychologist license application due to curriculum deficiencies. In 06/10, Agency asked for a copy of the professional's psychologist license. Instead of advising Agency that she had withdrawn her application, she told Agency that she would provide a copy of her license. After Agency reviewed the Psychologist Board's website and determined that the professional was not licensed, the professional told Agency that she had a provisional license and a letter from the Psychologist Board to prove it. On 06/17/10, the professional was suspended pending proof of licensure in all areas of practice. The professional removed her personal belongings from her office and resigned from Agency. On 06/24/10, the professional sent Agency a 04/30/10 letter purporting to be from the Psychologist Board indicating she had been issued a provisional license. The Psychologist Board advised Agency that it does not issue provisional licenses and that the letter appeared to be fraudulent. The professional also sent Agency documents allegedly from the Colorado Nursing Board's website indicating that she held a nurse practitioner's license. The license she provided belonged to another person and the Colorado Nursing Board verified that it has not issued any license to the professional. During Agency's investigation, it discovered 4 prescriptions written by the professional by using another person's prescription pad and signing her name with a RN designation. While employed at Agency, the professional had access to a locked safe used for medications.</p>	<p>Board Action 05/31/11 Consent Agreement and Order: The professional's license shall be surrendered. The surrender shall be considered a revocation of his license.</p>

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<p>Debrah Delos-Santos LMFT-10229 2011-0071</p>	<p>After the professional's resignation, Agency discovered multiple discontinued client prescriptions in the safe that had not been properly disposed of. These medications had been recorded as destroyed by the professional. In 07/10, the professional submitted another licensure application to the Psychologist Board. In 08/10, the Psychologist Board denied the professional's licensure application for unprofessional. Agency also discovered sample medications in the safe with the "discontinued medications" that lacked any type of log to indicate how many samples were received or how they were distributed. The professional entered into a Consent Agreement with the AZ Board of Nursing based on employment termination issues at 2 other agencies regarding HIPAA violation when she looked into employees' medical records, failure to accurately disclose employment termination on an employment application and breach of confidentiality issues.</p>	<p>Board Action See Above.</p>
<p>Francine Akins-Arbuckle LPC-11723 2009-0108</p>	<p>The professional had a contract with Agency 1 to provide counseling to individuals enrolled in a long term care system and in 02/08, began providing weekly counseling services to a client ("Client"). Client had expressive aphasia due to a recent cardiovascular accident ("CVA"). The professional's sole responsibility to Client was to provide counseling. The professional engaged in non-counseling activities, including providing transportation to Client, providing resource coordination services to Client, making phone calls for Client, and visiting Client in the hospital. The professional billed for counseling services for the non-counseling activities and counseling sessions occurring in her car when transporting Client. Agency 1 was responsible for coordinating Client's placement changes and so informed Client and the professional. The professional assisted Client in finding a less restrictive assisted living facility ("ALF 2"). Client engaged in a number of serious behaviors, including drinking alcohol daily and refusing medications. In 11/08, the professional noted that Client was losing weight and appeared confused.</p>	<p>Board Action 05/31/11 Consent Agreement and Order: within 12 months, take and pass a 3-semester credit hour graduate level behavioral health assessment, diagnosis, and treatment planning course; within 12 months, complete 8 clock hours of continuing education addressing behavioral health ethics that addresses both dual relationship issues and the need to refer issues outside the scope of a professional's expertise; 24 months of clinical supervision; \$1,963 investigative costs stayed pending compliance with this Consent Agreement and Order.</p>
<p>Francine Akins-Arbuckle LPC-11723 2009-0108</p>	<p>The professional did not adequately document her attempts to inform Agency 1 of Client's issues while living at ALF 2. On 11/18/08, Client suffered another CVA. In 02/09, after hospitalization and rehabilitation, Client was placed at another ALF ("ALF 3"). The professional failed to modify Client's treatment plan to address Client's ongoing desire to live independently and Client's known serious drinking problem. In early 03/09, Client informed the professional that he had resumed alcohol use and ALF 3 reported that Client would drink to the point of heavy intoxication. The professional noted that Client appeared depressed and complained of depression, sleep disturbance, and poor appetite. The professional failed to adequately document steps she took regarding Client's drinking and depression and failed to refer Client for an evaluation for possible antidepressant medication. On 03/20/09, Client requested alcohol treatment. The professional failed to contact Agency 1 for authorization for such treatment. In 04/09, the professional's counseling services to Client were terminated. The professional spoke about Client to Client's friend, Client's PCP, and Client's ex-wife utilizing an inadequate release of information authorization. After the professional had Client sign a release of information authorization, Professional added additional entities to the release based upon Client's verbal authorization.</p>	<p>Board Action See Above.</p>
<p>Kimberly Rezarch LCSW-Aplicant 2011-0083</p>	<p>The professional forged a supervisor's signature on documents provided to SWCC in support of her licensure application. The professional failed to meet minimum licensure standards.</p>	<p>Board Action 05/31/11: The applicant's LCSW application was denied based on unprofessional conduct and failure to meet minimum licensure standards.</p>

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<p>Christopher Wright LAC-Applicant 2011-0122</p>	<p>The professional misrepresented his background information and work history on this LAC application to the Board. The Board had no way to verify the accuracy of information provided regarding the professional's work experience he acquired out-of-state or determining employment issues prior to moving to Arizona. The professional acknowledged significant substance abuse and anger management issues in the past. He indicated he obtained treatment to address these issues, and that he has maintained sobriety since 2002 and participated in relapse prevention efforts through active participation in AA, but failed to submit any information supporting his representations.</p>	<p>Board Action 05/31/11: The applicant's LAC application was denied based on unprofessional conduct and failure to meet minimum licensure standards.</p>
<p>Earlene Dear LCSW-0195 2005-0127 2008-0017 2008-0033 2009-0132</p>	<p>See 2010 Adverse Action Report.</p>	<p>Board Action 07/01/11: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 03/09/10.</p>
<p>Jeffery Taylor LMSW-10568 LCSW-Applicant 2011-0075</p>	<p>The professional began working at Agency 1 in 08/05. Although the professional's 02/07 performance evaluation documented concerns about his clinical documentation, these issues continued. His 04/08 performance evaluation rated him below expectations and initiated a 30-day corrective action plan. This was disciplinary action. On 04/10/08, Agency 1 terminated the professional's employment. During the 04/11/08 termination meeting, the professional was allowed to resign in lieu of termination. While cleaning out his office, the professional attempted to shred a client's IEP that he had failed to file in client's record. Following termination, the professional made repeated and ongoing attempts to contact Agency 1 VP for at least 2 months, writing lengthy emails or leaving lengthy voice messages. The professional sought therapy to deal with his termination, which he attended only intermittently. In 08/09, the professional filed a 38 page Board Complaint against Agency 1 VP. In 08/10, the professional submitted a LCSW licensure application that included several misrepresentations regarding his employment at Agency 1. The professional left a number of long, detailed, and repetitive voicemail messages to various Board staff regarding his 08/09 complaint. In his response to inquiries about his application background responses, the professional continued to misrepresent information regarding his employment at Agency 1.</p>	<p>Board Action 07/01/11 Consent Agreement and Order: The professional shall complete 24 months of supervised work experience in an agency licensed by OBHL and shall only practice at an OBHL licensed agency; \$1,000 civil penalty stayed pending compliance with this Consent Agreement and Order.</p>

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<p>John Butler LISAC-0793 2006-0153 2007-0036</p>	<p>The professional is the owner, president and clinical director of Agency PLC and owner, president and director of Agency INC. Both agencies have the same name except for the "PLC" and "INC" designations. Agency PLC was licensed as an outpatient clinic by OBHL. Agency INC was a private professional practice that provides treatment for addiction and related services. The 2 companies were located in the same office. The differences in scope of practice and services provided by these 2 companies were not clearly delineated and/or properly documented. From 08/05 through 07/06, Agency PLC was authorized to provide the following services: counseling, DUI screening, DUI education, DUI treatment, and court-ordered misdemeanor Domestic Violence Offender treatment. Agency PLC was not authorized to provide medication services. During this timeframe, Agency INC contracted with Arizona-licensed physicians who prescribed and administered Suboxone for the treatment of opioid addiction and dependency. The professional and a contracted physician ("Dr. B") met with a 16-year-old minor male ("Minor Client") suffering from heroin addiction and his parents ("Parents") on short notice and after business hours for Suboxone treatment. Parents were informed that counseling follow-up was essential for successful Suboxone treatment. The professional later enrolled Minor Client in one of Agency INC's counseling programs even though Agency INC is not authorized to treat minor clients. On 03/08/06, Minor Client began counseling with Dr. M and Dr. C ("Psychologist") as a necessary adjunct to the Suboxone treatment. Dr. M and Psychologist were working under contract for Agency INC. Parents did not sign informed consent documentation for counseling sessions. On 03/09/06, Minor Client began participating in an 8-week IOP program. The IOP group participants consisted of young adult males receiving Suboxone treatment. Minor Client was the only minor in this program. Parents did not sign informed consent for treatment documentation for Minor Client's participation in the IOP group counseling sessions until 4 weeks later. The informed consent for treatment lacked required elements.</p>	<p>Board Action 07/01/11 Consent Agreement and Order: 24 months probation; within 12 months, complete 6 clock hours continuing education addressing clinical supervision, and 3 clock hours continuing education in each of the following: ethics and clinical recordkeeping; submit to Agency PLC and INC audits; obtain a practice monitor for 24 months.</p>
<p>John Butler LISAC-0793 2006-0153 2007-0036</p>	<p>Mother and Minor Client indicated that Dr. M misinformed them that the IOP would cost \$10 or \$20 per session. The Intake document Mother signed on 02/22/06 indicated that the IOP fee would be \$75 per group session. The professional indicated that the Intake fee for the IOP was outdated and that the IOP fee was \$2,200. Parents were not initially informed that other IOP group participants would be adults. Initially, the IOP group sessions were facilitated by an Intern ("Intern"). Later, Dr. M became the sole facilitator of the IOP group. There was no documentation in Minor Client's record that the professional conducted or caused to be conducted a formal assessment of Minor Client's behavioral health issues or developed a treatment plan for Minor Client's care. Minor Client participated in 15 IOP group sessions. Parents paid \$1,468. On 04/21/06 and 05/02/06, Mother requested a copy of Minor Client's treatment records. On 06/12/06, Mother again requested Minor Client's treatment record. On 07/12/06, Mother sent a certified letter requesting Minor Client's treatment record. Mother also requested a refund of the \$1,468 previously paid. Mother claimed that she never received a copy of Minor Client's treatment record and never received a refund. Minor Client's treatment record did not contain documentation of the professional's response(s) to Mother's requests. The professional indicated that Agency PLC and Agency INC have a "no refund" policy, but could not provide a written copy of this policy. The professional acknowledged that he had contracted with an allopathic physician whose medical license had been revoked due to addiction issues.</p>	<p>Board Action See Above.</p>

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<p>Charles Lunden LPC-0333 2011-0003</p>	<p>On 12/21/07, Client sought therapy with the professional through an employee assistance program ("EAP"). Between 12/21/07 and 01/22/08, Client had 3 therapy sessions with the professional. Client committed suicide on 02/01/08. On 12/21/07, Client completed and signed intake forms and a consent for treatment form. These forms did not include all of the consent for treatment required elements. An unsigned, undated note, hand-written on Client's consent for treatment form stated the following: "Hung Himself Early Feb. (Drunk)". The professional indicated that he wrote this note in 02/08 after learning of Client's suicide. The professional did not sign his name on the progress notes. The 12/21/07 progress note indicated some information regarding Client's presenting problem and psychosocial history. The professional diagnosed Client with Adjustment Disorder with Mixed Anxiety and Depressed Mood. The Standards and Professional Guidelines for EAP identifies assessment as an essential component for identifying client needs and the basic assessment elements include: client statement of presenting problems, level of risk to self and others, precipitating events, impact on job performance, impact on other life activities, past history of issue and attempts at resolution, alcohol and drug use/abuse history, relevant family concerns, relevant family history, observed mental/emotional state, corroborating data and initial impression. The professional's documentation contained insufficient information to demonstrate that the professional completed an adequate assessment of Client. The professional acknowledged Client's history of depression and alcohol use, his recent termination of anti-depressant over the holidays so that he could consume alcohol, his recent re-start of anti-depressant, and Client's pending divorce. Even though the professional asked Client directly about suicidal and homicidal ideation, which Client denied, there was no evidence of a complete assessment of Client's needs. The professional failed to document a telephone call to Wife and failed to document an attorney's request for records representing Client's surviving family members. The professional acknowledged that at the time of attorney's request, he did not maintain any organized records management system and was only able to locate Client's record after he hired a records management assistant to organize his records.</p>	<p>Board Action 07/12/11 Consent Agreement and Order: 12 months stayed suspension; within 6 months complete 8 clock hours of continuing education addressing comprehensive behavioral health assessments and 3 clock hours of continuing education addressing risk assessments; 24 months of clinical supervision; complete a practice audit; private practice to be subject to a practice monitor for 12 months; If the professional cannot comply with the audit and practice monitor provisions, he shall practice only in an OBHL licensed agency; \$1,000 civil penalty stayed pending compliance with this Consent Agreement and Order.</p>
<p>Karmin Fowler LAC-12527 2011-0040</p>	<p>In 07/09, the applicant was arrested for an extreme DUI with a BAC of 0.197. She failed to report this arrest to the Board within 10 days, as required. When the applicant applied for an LPC in 06/10, she was required to complete a substance abuse evaluation. The evaluation indicated that the professional is at risk for a recurrence of alcohol problems, lacked insight and knowledge about alcoholism, and was not able to connect the way in which unaddressed chemical dependency issues in her personal life could affect the clients she serves as a counselor. A supervisor at a previous employment indicated that the professional had been warned about her lack of dependability and missing client appointments. The professional indicated that the difficulties were a result of sentencing terms imposed as a result of her DUI and the grief and loss issues related to the death of a family member.</p>	<p>Board Action 07/18/11 Consent Agreement and Order: 24 months stayed suspension; 24 months of clinical supervision; 24 months of therapy; 12 months AA attendance, a minimum of 3 times per week for 12 months.</p>
<p>Gaye Adams LPC-10249 2003-0045 2007-0006</p>	<p>See 2008 Adverse Action Report.</p>	<p>Board Action 08/01/11: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 08/15/08.</p>
<p>Mary Kent LPC-1165 2010-0029</p>	<p>See 2010 Adverse Action Report.</p>	<p>Board Action 08/01/11: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 03/09/10.</p>

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<p>Tara Allen LPC-13154 2011-0069</p>	<p>The professional was acquainted with a woman ("Client") because they both attended the same church. In 08/09, Client contacted the professional for "emergency services". The professional agreed to see Client until Client was able to find another therapist. Client had an extensive behavioral health history, including recent "panic attack" symptoms and a "depressed mood". Regarding thoughts/actions of suicide, "Ideation only" was marked on Client's assessment form. There was no documentation in Client's record that professional conducted any type of formal risk assessment of Client. Client attended 6 sessions from 08/09 to 09/09. In 10/09 after treatment had ended, the professional cooked and delivered food to Client at Client's home, as part of her church duties, and also took Client to a doctor's appointment. In 12/09, Client again sought "emergency" treatment. The professional met with Client for 3 sessions in 12/09. There was no documentation in Client's record that professional conducted any type of formal risk assessment during these "emergency" treatment sessions. After the second treatment period ended in 12/09, in 02/10 the professional agreed to help Client by making an appointment to see Client at the beauty school Client attended and had Client wash and style the professional's hair. In 03/10, following Client's release from the hospital, the professional agreed to resume treatment as Client reported that she "felt like [she] was going to die". The third treatment period with Client was for 6 sessions from 03/10 to 04/10. There was no documentation in Client's record of any type of formal risk assessment during the third period of "emergency" treatment. Although the professional represented that she continually tried to seek alternative therapists for Client, there were no formal written referrals to Client and only minimal documentation in the record regarding possible referrals. The professional later agreed to join other church members in giving Client a cash gift to celebrate Client's graduation. The professional acknowledged that she should have maintained firmer professional boundaries with Client. The professional failed to have Client sign updated consent for treatment documents or updated treatment planning documents when Client returned for treatment in 12/09 and 03/10.</p>	<p>Board Action 08/01/11 Consent Agreement and Order. within 12 months, complete 6 clock hours of continuing education addressing current behavioral health documentation requirements and 3 clock hours of continuing education addressing behavioral health ethics relating to dual relationships/professional boundaries; 12 months clinical supervision; \$1,000 civil penalty stayed pending compliance with this Consent Agreement and Order.</p>
<p>Jodi Bracy LPC-10568 2011-0092</p>	<p>A client the professional formerly treated ("Client") received services at Agency from 05/06/10 to 05/25/10. Client had an extensive behavioral health history, including 10 suicide attempts, substance abuse, PTSD related to childhood sexual abuse and legal issues. The professional provided 8 group sessions to Client. The professional failed to inform Agency that she had had a personal relationship with Client prior to Client being treated by Agency. The professional developed an intimate relationship with a co-worker ("Coworker"). When the relationship with Coworker ended, the professional began experiencing problems at work, including verbalizing anger toward Coworker, displaying anger, and failing to keep accurate and timely clinical documentation. The professional received counseling/disciplinary action from Agency on 11/17/10 and 12/03/10, regarding deficient documentation issues. The professional was advised of deadlines to complete required documentation. In early 01/11, Agency discovered that the professional was living with Client. On 01/04/11, Agency terminated the professional for failing to complete required clinical documentation and for having a dual relationship with Client. The professional acknowledged that in 06/10, she allowed Client to move in with her and they began a sexually intimate relationship.</p>	<p>Board Action 08/01/11 Consent Agreement and Order. The professional's license shall be surrendered. The surrender shall be considered a revocation of her license.</p>

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<p>Alfred Dodini LCSW-11040 LAMFT-10257 2009-0043 2009-0121 2010-0019</p>	<p><u>Case 2009-0043:</u> In 06/07, Mother initiated therapy for 12-year-old son ("Son A") to address Son A's behavioral issues and help him cope with marital problems occurring between Mother and Son A's Father. Mother provided the professional with Father's history of suicidal threats and rage towards Mother, Son A and their 16-year-old son ("Son B"). At the initial session, Mother told the professional of her plans to divorce Father. Following a 06/21/07 Order of Protection ("OP") against Father, Father initiated treatment with the professional. Father disclosed problems with depression, suicidal ideation, sadness and recent thoughts of hurting or killing himself. At parents' request, the professional served as an intermediary between parents by forwarding emails from one parent to another. The professional never clarified which individuals were clients or his professional obligations to Mother, Father and Son A. During Father's second session, he continued to express suicidal ideation. There was no documented evidence in Father's record that the professional conducted any formal suicide risk assessment. In 07/07, after Mother informed Father of her intent to file for divorce, Father threatened suicide. Father was arrested and 35 guns were impounded. Father admitted to a plan and typing suicide letters. During Father's 3rd session, he reported recent suicidal ideation. The professional failed to document any suicide risk assessment or address Father's suicidal ideation on an ongoing basis. Son A began living with Father. On 08/22/07, Father requested and the professional wrote a letter to the court on Father's behalf, identifying Father as a client and provided treatment information. There was no documentation of Father signing a written release of information authorization to disclose any information about Father. The professional later spoke with Mother's Friend about Parents and Son A. The professional never obtained a written release of information authorization from Parents to speak with Friend.</p>	<p>Board Action 08/01/11 Consent Agreement and Order. The professional's license shall be surrendered. The surrender shall be considered a revocation of his license.</p>
<p>Alfred Dodini LCSW-11040 LAMFT-10257 2009-0043 2009-0121 2010-0019</p>	<p>In 09/07, Mother informed the professional that Father and Son B had a fight and Father hit Son B. The professional did not initially report this incident after speaking with Father. When Mother insisted that he report the incident, the professional reported the incident anonymously to CPS, failed to provide identifying information about Father, failed to document his report to CPS, and failed to submit a written report to CPS within 72 hours, as required. Despite the ongoing conflict within family, the professional continued to see Father and Son A for treatment until 02/08, when Mother requested that he stop counseling with Son A until after the anticipated custody evaluation. In 07/08, the professional spoke with the court-appointed custody evaluators and advised them that Mother might be experiencing aspects of schizophrenia, even though Mother had never been his client, and never participated in a behavioral health assessment with professional and professional had limited contact with Mother. In 10/08, the professional wrote Mother a letter indicating that, if she proceeded to file a Board complaint against him, he would disclose personal damaging information about Mother and Son A to the Board. Even though the professional provided therapy to Father and Son A to address their respective individual issues, he maintained a single clinical record containing treatment information regarding both Son A and Father. The progress notes were intermingled and failed to identify whether he saw Son A and Father together or individually or both. The progress notes were not signed and failed to record the duration of each session. Treatment plans failed to identify a treatment plan review date. Phone calls with family members were not recorded. Emails received or sent to Mother or Father were not maintained. The professional failed to adequately document important aspects of Father's and Son A's treatment.</p>	<p>Board Action See Above.</p>

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<p>Alfred Dodini LCSW-11040 LAMFT-10257 2009-0043 2009-0121 2010-0019</p>	<p><u>Case 2009-0121</u>: The professional's wife ("Wife") is an Arizona licensed massage therapist. The professional and Wife have both taken training courses for the provision of craniosacral therapy ("CST"). CST involves the use of physical touch to improve the functioning of the central nervous system. It is not a behavioral health treatment modality. In 05/09, the professional met with Parents of a 3-year-old Son to discuss concerns about Son's defiant, aggressive behavior and ongoing sleep problems. Parents contend that the professional recommended CST for Son, gave Parents Wife's business card and said wife could perform CST on Son, and Parents could bill their insurance for the service as a psychotherapy session. The professional indicated that he also recommended a psychiatric evaluation, medication possibilities, and to review other factors that might be contributing to Son's behaviors. Parents' insurance company told the professional that Wife's CST could not be billed because Wife was not a member of the insurance company's panel. CST was never provided to Son. The professional misrepresented to the Board that a psychiatrist endorsed the use of "bodywork modalities", which the psychiatrist denied.</p>	<p>Board Action See Above.</p>
<p>Alfred Dodini LCSW-11040 LAMFT-10257 2009-0043 2009-0121 2010-0019</p>	<p><u>Case 2010-0019</u>: Mother and Father were engaged in a high-conflict divorce/custody battle. In 04/09, Mother requested that the professional treat Son A and Son B ("Sons") to help them adjust to Parents' pending divorce. Son A began refusing visits with Father. Son A's therapy was to specifically address Son A's anger towards Father. Mother told the professional that a motion was pending before the court to have a therapist appointed and "whether or not Father was going to have access to any information". At the time the professional began seeing Sons, he did not review any court documentation pertaining to Sons' custody status or therapy-related issues. Treatment plans developed for Sons did not contain a treatment plan review date. The professional did not sign progress notes and failed to record the duration of sessions. The professional failed to document information he received from Sons' grandparents. The professional elected not to report to CPS information received from Mother about discipline involving a "2x4" because Mother indicated that she reported the incident to CPS. The professional failed to document that he gave Son B a Bow Drill Set and failed to document the therapeutic basis for this gesture. On 04/23/09, Father requested a copy of Sons' treatment records. The professional failed to provide the records to Father. On 05/03/09, the court appointed the professional as Son A's therapist and ordered that the counseling reports be submitted only to the court. The court order did not address Son B's therapy. On 05/07/09, Father called the professional indicating that he would pick up the records. The professional returned Father's call to say he would not release Sons' records. The professional never made an effort to involve Father in Son A's treatment or to obtain input into the problems between Father and Son A. The professional acknowledged that he developed negative feelings about Father. In a 08/09 letter to the court, the professional made a number of representations based on information provided by Son A that were not documented in the clinical record. The professional included a number of inflammatory statements regarding Father and recommended that Son A should not be required to participate in visits with Father.</p>	<p>Board Action See Above.</p>

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<p>George Green LISAC-0044 LPC-1784 2011-0072</p>	<p>In 09/08, Agency 1 terminated the professional for "serious misconduct". On the professional's 06/09 LPC and LISAC license renewal applications, he answered "no" to background questions regarding disciplinary action and termination. In 12/10, the professional was the program manager at Agency 2, an agency providing treatment to seriously mentally ill ("SMI") adults. The professional managed Agency 2's outpatient program, which was licensed by OBHL to provide in-home behavioral health services to SMI clients. On 12/06/10, the professional was informed by a female Client that the male BHT providing Client's in-home treatment made a number of sexually-related statements to Client. Client reported that she was uncomfortable with BHT's alleged statements, was fearful of BHT, and did not want BHT to continue providing her services. After learning of Client's allegations, the professional contacted BHT to notify him that Client was no longer on his caseload and made an appointment to meet with BHT the next morning. The professional did not immediately notify Agency Management or adult protective services ("APS"). On 12/07/10, BHT confirmed that he had crossed boundaries with Client and verified that he had "used vulgar sexualized language" during a recent in-home session with Client. The professional failed to immediately place BHT on suspension according to Agency policy or take any other action to reduce the potential risk of harm to other Agency clients. The professional told BHT that he was to have no further contact with Client and required BHT to attend training addressing ethics and boundaries. The professional failed to report Client's allegations to OBHL within 1 working day. Agency terminated the professional's employment based on his failure to take appropriate action. The professional's licenses expired on 06/30/11.</p>	<p>Board Action 08/01/11 Consent Agreement and Order. After the professional's licenses expire by rule on 06/30/11, the professional is prohibited from engaging in the practice of behavioral health as a licensee or claiming to be a licensee in Arizona. The professional agrees not to renew his licenses, LPC-1784 and LISAC-1044, or reapply for licensure for a period of 5 years.</p>
<p>Robert Collette LMSW-12469 2010-0100</p>	<p>In 04/10, the SWCC opened a complaint for further investigation regarding the professional's criminal and mental health history, as well as recent terminations. In 07/10, the SWCC ordered the professional to complete 2 different mental health examinations, which resulted in a concern that the professional is not able at this time to practice safely and competently due to ongoing serious behavioral health issues.</p>	<p>Board Action 08/01/11: Order of Revocation. Board Action 10/06/11: Denied Request for Review or Rehearing.</p>
<p>Kirstie McLean LMSW-Applicant 2011-0106</p>	<p>Since 01/08, the professional has demonstrated a consistent pattern of significant performance issues and failure to maintain adequate client documentation, leading to sequential employment terminations or abrupt resignations at her last 4 behavioral health positions. On the employment history section of her LMSW licensure application, the professional misrepresented her employment history.</p>	<p>Board Action 08/01/11: The applicant's LMSW application was denied based on unprofessional conduct and failure to meet minimum licensure standards. Board Action 11/03/11 Order of Denial of Review or Rehearing Request.</p>
<p>Joyce Nuth Non-License</p>	<p>The Board received information that Ms. Nuth represented that her LPC-11066 was "current, pending renewal process" when her license had expired in 09/09. Ms. Nuth made this representation on a motor vehicle evaluation.</p>	<p>Board Action 08/01/11: Cease & Desist Order.</p>

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<p>Jeffery Taylor LMSW-10568 LCSW-Applicant 2011-0075</p>	<p>The professional began working at Agency 1 in 08/05. Although the professional's 02/07 performance evaluation documented concerns about his clinical documentation, these issues continued. His 04/08 performance evaluation rated him below expectations and initiated a 30-day corrective action plan. This was disciplinary action. On 04/10/08, Agency 1 terminated the professional's employment. During the 04/11/08 termination meeting, the professional was allowed to resign in lieu of termination. While cleaning out his office, the professional attempted to shred a client's IEP that he had failed to file in client's record. Following termination, the professional made repeated and ongoing attempts to contact Agency 1 VP for at least 2 months, writing lengthy emails or leaving lengthy voice messages. The professional sought therapy to deal with his termination, which he attended only intermittently. In 08/09, the professional filed a 38 page Board Complaint against Agency 1 VP. In 08/10, the professional submitted a LCSW licensure application that included several misrepresentations regarding his employment at Agency 1. The professional left a number of long, detailed, and repetitive voicemail messages to various Board staff regarding his 08/09 complaint. In his response to inquiries about his application background responses, the professional continued to misrepresent information regarding his employment at Agency 1.</p>	<p>Board Action 08/01/11: The applicant's LCSW application was denied based on unprofessional conduct and failure to meet minimum licensure standards.</p>
<p>Janet Carpentier LISAC-10475 2012-0032</p>	<p>On 03/18/11, the professional caused a five car injury collision. The professional was charged with DUI-Impaired to the slightest degree; DUI-Drugs or metabolite; reckless driving; speed greater than reasonable and prudent; failure to drive in a single lane; and failure to control speed to avoid a collision.</p>	<p>Board Action 09/01/11 Interim Consent Agreement and Order: The professional shall not practice and the professional's license shall be suspended.</p>
<p>Stephen McIntyre LSAT Applicant 2011-0087</p>	<p>The professional worked at Agency 1 from 08/08 to 10/10. Beginning in 04/10, conflicts arose between the professional and Supervisor 1. In 09/10, Supervisor 1 documented that the professional was disrespectful and ranting. The professional was advised that he needed to work on the following issues: conducting himself with maturity and integrity; communicating appropriately; following policies, procedures, and assignments; presenting himself as a positive role model; discussing and implementing appropriate and acceptable solutions to problems; effectively dealing with management; and using time wisely, effectively, and efficiently. On 10/07/10, the professional resigned from Agency 1. He is not eligible for rehire. On 10/18/10, the professional began working at Agency 2. He immediately began having conflicts with Supervisor 2. Supervisor 2 documented the following regarding the professional: he displayed passive aggressive behaviors toward Supervisor 2; he appeared to have a hard time taking clinical direction from Supervisor 2; he had difficulty understanding how to document clinically in a DAP format; he was resistant to redirection; he omitting relevant information from his notes.</p>	<p>Board Action 09/01/11: The applicant's LSAT application was denied based on unprofessional conduct.</p>
<p>Stephen McIntyre LSAT Applicant 2011-0087</p>	<p>A 02/11/11 incident report from Agency 2 indicated the following: the professional appeared to be loud, agitated, and argumentative towards inmates. The professional's behavior was volatile and/or could create a volatile situation with inmates known to riot against the correctional facility and staff. On 02/14/11, the professional was issued a problem solving notice form from Supervisor 2, which indicated the following: on 02/08/11, the professional left work early without notifying Supervisor 2 or any other supervisor in violation of Agency 2's policy; the professional was previously provided with Agency 2's code of ethics and business policy and signed the related acknowledgment form on 01/27/11; this policy violation will not be tolerated. A written reprimand was recommended and issued.</p>	<p>Board Action See Above.</p>

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<p>Carlos Inostroza LMSW-11028 2012-0014</p>	<p>On 12/09/06, the professional was arrested and cited for DUI, DUI .08 or above, and extreme DUI. On 12/19/07, the professional was found guilty of driving under the influence of intoxicating liquor or drugs and was ordered to attend a screening at a court-approved agency ("Agency 1"). The professional disclosed in 12/06 DUI arrest on his 2008 renewal application. On 09/08/08, the Board opened a complaint and dismissed the complaint with a letter of concern because the professional failed to disclose his DUI to the Board within 10 days, as required. On his 2010 renewal application, the professional did not disclose his 2006 DUI, as required. On 05/21/11, the professional was again arrested for extreme DUI after he was involved in a 1-car accident. During the Board's investigative interview, the professional minimized the amount he drank on the night of his arrest. His report regarding his alcohol consumption was not consistent with the reports from the arresting officers. The professional's blood was taken in a mobile DUI van. After the professional was released and left the mobile DUI van, a police officer noticed that the professional's blood kit was missing. The police officer accused the professional of stealing the blood kit. The police never recorded the professional's BAC because the blood kit disappeared. On 05/31/11, the professional informed the Board of his 05/21/11 DUI arrest. On 06/14/11, the court dismissed without prejudice all of the charges related to the professional's 05/21/11 DUI arrest.</p>	<p>Board Action 09/01/11 Consent Agreement and Order: The professional's license shall be surrendered. The surrender shall be considered a revocation of his license.</p>
<p>Linda L. Thompson LMFT-0481 2010-0084</p>	<p>The professional worked at Agency from 11/13/06 to 02/24/10. Agency is a level II behavioral health agency that provides residential and behavioral health services to children ages 11-17. The professional clinically supervised a LAMFT at Agency. On 02/18/10, LAMFT notified the professional that a minor client had alleged abuse by a house manager. The professional did not file an immediate CPS report because she wanted to investigate the matter and interview other staff members to determine whether the client's allegations were credible. On 02/22/10, the professional instructed LAMFT to file a verbal CPS report regarding the alleged abuse. The professional failed to advise LAMFT to follow up with a written report within 72 hours, as required by A.R.S. 13-3620(D). On 02/24/10, the professional resigned from Agency effective immediately. At this time, the professional had approximately 10 clients. Many of the professional's clients were being treated for abandonment issues. The professional did not meet with any of her clients or make any arrangements for appropriate continuation of care.</p>	<p>Board Action 09/01/11 Consent Agreement and Order: The professional's license shall be placed on probation pending completion of 6 clock hours of continuing education addressing behavioral health ethics and 3 clock hours of continuing education addressing mandated reporting requirements.</p>
<p>Julie R. Browning LMSW-2669 2012-0053</p>	<p>The professional has not practiced under her license since 2001. The professional's 07/08 to 07/09 medical records indicated that her medical and addiction issues would have significantly impaired her ability to practice. On her 06/09 license renewal application, the professional failed to disclose her medical and addiction issues, as required. On her 03/11 license renewal application, the professional disclosed these issues that should have been previously disclosed to the Board.</p>	<p>Board Action 10/06/11 Consent Agreement and Order: The professional agrees not to practice under her license. The agreement not to practice shall be considered a suspension of the professional's license. The professional's license shall, by rule, expire on 06/30/13. The professional agrees not to renew her license and not to reapply for licensure in Arizona.</p>
<p>Malcom Pavey LISAC-1220 2007-0122 2010-0116</p>	<p>On 08/06/07, the Board accepted a consent agreement ("08/07 CA") resulting from Case No. 2007-0122. On 05/21/10, the Board opened a new complaint against the professional based on his failure to timely comply with the 08/07 CA and offered him an amended consent agreement including a stipulation that failure to comply will result in the immediate revocation of his license.</p>	<p>Board Action 10/06/11 Consent Agreement and Order: stayed revocation; 6 years of probation; OBHL licensed agency practice restriction; prohibited from providing any type of clinical supervision to licensed, or non-licensed, behavioral health practitioners.</p>

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<p>Steve Sadler LISAC-1540 2011-0028</p>	<p>From 08/07 to 08/10, the professional was employed at Agency as a substance abuse counselor. On 11/07/08, Agency placed the professional on a corrective action plan because of his delinquency in submitting client fees; delinquency in submitting proper written documentation; and beginning counseling sessions late or ending them early. On 06/24/09, Agency placed the professional on a second corrective action plan because of his failure to call in a lock-down and a complaint from sheriff's office staff; lack of communication by not returning phone calls or responding to emails; late renewal of his behavioral health license; and failure to follow Agency's rules, procedures, and established curriculum. In 12/09, Agency began garnishing the professional's paycheck to replace \$2,375 in client fees that the professional had failed to turn in. In 01/10, Agency sent the professional an email regarding his repeated delinquency in submitting required clinical documentation and the unacceptable quality of his clinical documentation. On 08/10, Agency placed the professional on a performance improvement plan because of his failure to check his email daily; his failure to respond to communications from managers; regularly late paperwork; and unprofessional communications with staff in front of clients. On 08/26/10, Agency sent a letter to the professional informing him that he had failed to complete his progress notes and failed to provide Agency with \$4,885 in fees he had collected from his clients. The professional failed to respond to Agency's letter. On 09/13/10, Agency filed a complaint against the professional with the Board. On 09/29/10, Agency filed a police report alleging that the professional had committed fraud. The professional admitted to Agency's allegations and to using the client fees for his living expenses.</p>	<p>Board Action 10/06/11: Order of Revocation</p>
<p>John de Pianelli LISAC-11697 2010-0061</p>	<p>In 04/09, the professional had a high conflict relationship with a 77 year-old coworker ("Coworker"). Professional and Coworker became involved in a verbal disagreement in front of clients. Professional initiated physical contact with Coworker by pushing him more than once, causing Coworker to fall. Although Professional acknowledged that his conduct towards Coworker was inappropriate, he defended his conduct by indicating that he was essentially cornered by Coworker and had no choice but to push Coworker out of the way. Professional's assertion that his actions were purely defensive in nature is contradicted by supervisor reports that Professional was at least equally responsible for sustaining the ongoing conflict with Coworker. Witnesses to the incident identified Professional as the aggressor.</p>	<p>Board Action 11/03/11 Consent Agreement and Order: stayed revocation; probation; 24 months supervised work experience; OBHL licensed agency practice restriction; 3 semester credit hour graduate level ethics course; 24 months clinical supervision; individual or group anger management therapy attendance twice monthly; shall not provide clinical supervision while subject to the consent agreement. Action 07/02/12: The stayed revocation was lifted and Licensee's license was revoked.</p>

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<p>Carol A. Pease LASAC Applicant 2011-0159</p>	<p>Applicant was licensed through the Appraisal Board. Based on problematic behavior, Applicant and the Appraisal Board entered into a consent agreement in 2000. Applicant failed to comply with that consent agreement. In 05/02, Applicant and the Appraisal Board entered into a consent agreement for the voluntary surrender of her certificate. In 07/04, Applicant signed a third consent agreement with the Department of Real Estate ("DRE") for failing to disclose the Appraisal Board sanctions on her 03/00 and 03/02 Real Estate Broker renewal applications. The DRE sanctions included a 4 month suspension of Applicant's real estate license, a \$1,000 civil penalty, and issuance of a provisional 2 year associate broker license. In 12/08, Applicant accepted a behavioral health position at Agency 1 and signed a letter accepting that her employment is contingent on obtaining a substance abuse counseling license by 06/09. In response to Agency 1's 08/09 letter regarding her failure to obtain licensure, Applicant indicated that she told Agency 1 that she would not receive her master's until the end of 2009 and that Agency 1 told her not to worry about it. Agency 1 denied telling Applicant not to worry about not complying with the terms of the contingency letter. The contingency letter provided no other promises or representations. Applicant received her master's degree in 06/10. In 09/09, Applicant submitted a LASAC application to the Board. This application was closed administratively because Applicant lacked a qualifying degree. During a Board interview, Applicant represented that Agency 1 told her that counselor employee could get a LSAT license with 18 credit hours. This representation was not credible as Applicant made no mention of such representation in a letter written to Agency 1 and Applicant never submitted a LSAT application to the Board. In a 04/10 employment application to Agency 3, Applicant represented that she was "laid off" at Agency 2, she was paid for 20 hrs per week, and her LASAC application was pending. These representation were not credible. Applicant worked at Agency 2 as an unpaid intern. Applicant left Agency 2 when her internship was completed. Applicant did not have a pending LASAC application with the Board in 04/10. Applicant was notified by the Board when her 09/09 LASAC application was closed. Applicant did not submit another LASAC application until 07/10.</p>	<p>Board Action 10/18/11: The applicant's LASAC application was denied based on unprofessional conduct. Board Action 02/03/12: The Board denied Applicant's request for a review or rehearing.</p>
<p>Kim McDonald LMSW-10080 LISAC-10088 2010-0076</p>	<p>In 04/04, Licensee opened Agency, a private practice in which she had an ownership interest and in which she was a sole practitioner. In 2008, Agency became a LLC. The scope of practice of the certificates and licenses Licensee held throughout the relevant time period authorized her to practice independently only with respect to substance abuse issues and not with respect to social work or general mental health services, either of which required her to work under direct supervision. Agency allowed other behavioral health practitioners to use space in its offices, none of whom were employed by Agency. Licensee was never directly supervised as her social work certificate and license required. In 02/06, Licensee applied to become a LCSW. Licensee attested that she was an "employee" and "independent contractor" of Agency, rather than an owner, and stated that she was supervised ("Supervisor"). Supervisor was a private practitioner who only used Agency's office space. In 07/06, Licensee provided family counseling to Mother, Son 1, and Son 2. Licensee failed to maintain an adequate consent for treatment and failed to develop adequate treatment planning documentation. Licensee's billing records were not accurate. Licensee failed to have an adequate release of information authorization from Mother to speak to Father and Father's primary care physician. When the SWCC determined Licensee exceeded the scope of her social work license, Licensee falsely stated that another person owned Agency and Licensee practiced under this person's direct supervision.</p>	<p>Board Action 10/18/11: Order of Revocation.</p>

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<p>Marie Hanna LSAT-12019 2011-0130</p>	<p>Professional participated in rehabilitation treatment and AA in 1980. Professional disclosed a 1991 DUI and addiction and criminal issues on her 01/07 LSAT application. In 06/07, the Board approved Professional's LSAT application with no action regarding her background issues. In 02/10, Professional self-reported a DUI with a .190 BAC. Professional did not identify any formal relapse prevention efforts she was engaging in prior to her 2010 DUI. Professional recalled having 5 drinks over 3 hours prior to her 2010 DUI. Professional had the equivalent of 8-9 drinks in her system when she was arrested. Following her 02/10 DUI, Professional did not participate in any type of treatment to address her substance abuse issues other than completing the court-ordered 36 hours of education and attendance at 20 AA meetings.</p>	<p>Board Action 11/03/11 Consent Agreement and Order: stayed suspension; 24 months probation; substance abuse related therapy; AA attendance a minimum of 3 times per week; shall not provide clinical supervision while subject to the consent agreement.</p>
<p>Veronica Jeffus LASAC-13181 2009-0137</p>	<p>See 2009 Adverse Action Report.</p>	<p>Board Action 11/03/11: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 08/07/09.</p>
<p>Marie Schimmel-penninck LMFT-0326 2010-0121</p>	<p>In 07/10, Professional provided copies of her progress notes regarding a minor client ("Client"). During a 07/26/11 investigative interview with Board staff, Professional referenced information in Client's progress notes that was not in the original notes provided to the Board. Professional acknowledged that, after sending the original notes to the Board, she wrote additional information on those notes to make them more accurate. Professional did not identify on the modified notes who made the changes or when they were made. Professional's consent for treatment form did not include most of the elements required by the Board's minimum practice standards. Professional's clinical record did not include any formal treatment planning documentation. An information form contained minimal treatment planning information, but lacked required elements. Professional's progress notes did not indicate whether sessions were individual counseling or family counseling, as required. Professional did not sign and date her progress notes, as required.</p>	<p>Board Action 11/03/11 Consent Agreement and Order: probation; 3 clock hours continuing education in behavioral health documentation requirements; 3 clock hours continuing education regarding ethics in family therapy; 12 months clinical supervision; shall not provide clinical supervision while subject to the Consent Agreement.</p>
<p>Susan K. Warren LPC-1182 LISAC-0717 2010-0083</p>	<p>In 05/09, Professional was in an accident that left her unable to care for the clients she was seeing in her private practice. Client alleged that Professional never provided any type of care referral following the abrupt termination of Professional's practice. Client believed the lack of continuity in her therapeutic care delayed her progress. Professional acknowledged that she did not have any type of plan in place to protect the clients in her private practice from disruption of care if she became incapacitated. She did not provide any type of written information to clients to provide referrals for continuing care or to advise clients how to obtain a copy of their records. Professional mailed Client's records to Client's home and asserted she did so based on Client's verbal request for her records. Professional did not document Client's verbal request for records. Client insisted she never requested a copy of her records and her confidentiality could have been violated by having them sent to her home. Professional's informed consent for treatment did not include required elements. Professional did not develop any formal treatment planning documentation for Client, as required. Professional did not document verbal communications with Client, as required. Professional billed Client's insurance company for a 4/27/09 session with Client that did not occur and sent a series of billing statements to Client that were incorrect. Professional threatened to send Client's account to a collection agency even though she did not appropriately advise Client in writing that failure to pay could result in Professional's use of a collection agency. Client presented with a number of serious behavioral health issues with a history of 5 traumatic episodes. Professional intended to discuss her initial diagnosis of Client and to coordinate the care she provided to Client with Client's psychiatrist, but failed to do so because she was busy.</p>	<p>Board Action 11/03/11 Consent Agreement and Order: probation; 3 clock hours of continuing education addressing medical billing practices; 6 clock hours continuing education in behavioral health ethics; 12 months clinical supervision; shall not provide clinical supervision while subject to the Consent Agreement and Order.</p>

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<p>David Olivarez LISAC-10277 2009-0007</p>	<p>Professional worked as a group counselor at Agency from 03/25/08 until 06/04/10. On 05/07/08, an Agency manager sent Professional an email noting that his group progress notes were deficient. On 06/18/08, Professional received training on Agency's documentation requirements. A 06/25/08 90-day review of Professional's job performance on 06/25/08 noted that he needed to complete documentation in a timely manner. On 09/08/08, the Board approved a signed Consent Agreement and Order resolving Case No. 2009-0007 and placing Professional's license on probation for a period of 24 months. The Agreement required clinical supervision focusing on ethics as it pertains to accurate representations. The Board required the clinical supervision because Professional had not been forthcoming with the Board during its investigation of his criminal and substance abuse history. Professional never notified the Board of his consistent and ongoing recordkeeping problems at Agency. Professional received 3 Performance Action Notices between 09/16/08 and 02/03/10 related to his documentation deficiencies. On 11/17/08, Supervisor 1 became Professional's clinical supervisor under the terms of the 09/08 Consent Agreement. Professional never informed Supervisor 1 of his documentation deficiencies at or disciplinary sanctions by Agency. In 09/09, Supervisor 2 replaced Supervisor 1 as Professional's clinical supervisor under the 09/08 Consent Agreement. 16 of Supervisor 2's 20 clinical supervision notes between 09/28/09 and 05/24/2010 indicated that Professional was behind in his recordkeeping at Agency. On 06/03/10, Agency issued Professional a Final Advisory Notice. On 06/04/10, when Professional refused to sign a commitment letter to improve his performance, Agency issued a Release of Assignment Form indicating that Professional had voluntarily quit. On 06/04/10, Professional sent an email to the Board stating that he had left Agency. Also on that date, Professional appeared telephonically before the Board to request modifications to the 09/08 Consent Agreement. The Professional did not advise the Board of his problems at or separation from Agency during the 06/10 Board meeting. Instead, Professional requested that the Board modify the 09/08 Consent Agreement to delete the requirement that Professional work only in an OBHL licensed agency.</p>	<p>Board Action 11/03/11: Order of Revocation</p>
<p>Yvonne Rios LISAC-11795 2012-0030</p>	<p>On her 05/04 application for licensure, Professional disclosed prior addiction and criminal issues. Professional represented a sobriety date in 1998. On 03/02/09, Professional notified the Board that she had suffered a confusional migraine while driving and had been arrested for DUI. The results of a urine test following the DUI indicated the presence of multiple prescription drugs in her system at the time of arrest. The medications were prescribed by her primary care physician ("PCP"). The DUI charge was dismissed on 08/25/09. In addition to being PCP's patient, Professional also provided professional services to PCP during the time that he was prescribing these medications. On her 03/17/11 renewal application, Professional listed PCP's address as her current place of employment. Professional acknowledged she was also being treated by a neurologist regarding her migraine pain. Medical records indicated that the Professional did not inform the neurologist that she was taking Hydrocodone for her migraine symptoms. Medical records indicated that Professional participated in Prometa treatment in 2007. Such treatment is used to treat alcohol, cocaine and methamphetamine addiction. During the Board investigation, Professional was asked to identify all behavioral health providers and prescribers for the last 10 years. Professional identified PCP and her neurologist as her only prescribers. Pharmacy records indicate that Professional was prescribed Adderall by 6 other prescribers from 2003 to 2008.</p>	<p>Board Action 11/03/11 Consent Agreement and Order: the professional's license shall be surrendered. The surrender shall be considered a revocation of her license.</p>

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<p>Yvonne Rios LISAC-11795 2012-0030</p>	<p>Professional is the owner and operator of Agency, through which she provides marketing services and referrals to physicians who offer suboxone treatment to patients addicted to opiates. Professional hired an independent contractor ("Supervisee") to provide services through Agency. Supervisee is not licensed to practice psychotherapy. Professional indicated that she paid Supervisee to facilitate "peer support" groups for patients receiving suboxone treatment from the physicians Professional worked with. Professional denied that Supervisee provided any type of psychotherapy services, which he was not licensed to provide. Documentation Supervisee maintained regarding the groups he facilitated for Professional consistently reflected that Supervisee was providing psychotherapy services.</p>	<p>Board Action See Above.</p>
<p>Janet Wegenast LASAC- Applicant 2012-0011</p>	<p>On the professional's 09/10 LASAC application, the professional misrepresented that she had not received any employment disciplinary actions. In fact while employed at an agency ("Agency 1"), the professional had employment issues including the following: (1) need to improve ability to act professionally; (2) areas of concern involving boundaries with clients and peers; (3) advised to seek EAP assistance; (4) In 05/05, a verbal warning; (5) In 06/05, a written warning; (6) several complaints about being too involved with clients, failing to follow vocational plans, complaints by co-workers of being intrusive and rude, and the need for repeated direction to complete tasks; (7) In 10/05, a demotion due to the inability to complete essential functions of job description; and (8) a failure to appropriately assume new duties. The professional resigned from Agency 1 in 12/05. During the investigation of this matter, the professional failed to accept any responsibility for her actions while employed at Agency 1. While employed at another agency ("Agency 2"), personnel records reflected additional issues such as boundary issues with staff and clients. In 12/08, the professional's position was eliminated through a reorganization. The professional reported that she was "bullied" by her supervisor. The professional has not practiced behavioral health for over 2 years and failed to demonstrate any period of stable employment without performance issues since her sobriety date of 10/99. A 04/11 assessment indicated continued chronic pain, lack of focus, short-term memory deficits, difficulty with authority figures, poor organization and a current diagnosis of a significant behavioral health disorder.</p>	<p>Board Action 10/06/11: The applicant's LASAC application was denied based on unprofessional conduct.</p>

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<p>Katherine Freeman LMSW-12596 (Suspended) 2009-0128</p>	<p>From 02/01 through 10/01, the professional was employed as a primary therapist at Agency 1. On 07/19/01, Agency 1 suspended the professional without pay pending an investigation into allegations of harm to another employee. Agency 1 ended the suspension on 07/24/01. On 08/23/01, Agency 1 issued the professional a Formal Reprimand for (1) triangulation of supervisory relationship; (2) neglecting to timely give a new admission direction and assignments; (3) a pattern of significant delinquency in documentation; and (4) demonstrating a pattern of defensiveness toward a supervisor and disclosing supervisor redirection to another employee. The professional resigned effective 10/12/01. From 12/01 through 01/06, the professional was employed as a therapist by Agency 2. In 12/03, Agency 2 issued the professional an Employee Warning Notice for engaging in an inappropriate discussion with a colleague in front of a patient. In 03/05, Agency 2 placed the professional on a 2-month probationary period to address the professional's becoming "overly involved with her patients" and "countertransference issues". On 11/23/05, Agency 2 issued an Employee Warning Notice to professional based upon a grievance for inappropriate anger filed by a co-worker. On 01/22/06, the professional resigned. In 03/08, the professional filed an application for a LMSW license. On the employment history section, the professional stated that she had been "laid off" from her positions at Agencies 1 and 2. In fact, the professional had resigned from both positions. On the background information section, the professional answered "no" to question #4 about whether she had every had any disciplinary actions taken against her by any employer in Arizona. On 06/08/09, the Board received an anonymous complaint regarding alleged unprofessional conduct by the professional while employed at Agency 2. Following this complaint, the professional moved to another state without informing the Board of her change of address and let her LMSW license expire.</p>	<p>Board Action 10/18/11: Order of Revocation.</p>
<p>Russell Enright LPC-12385 2012-0001</p>	<p>The professional was Client's primary therapist at Agency, a residential substance abuse treatment program. On the day after Client's discharge from Agency, the professional and Client began a sexual relationship. Client suffered significant emotional harm as an outcome of the relationship. On the professional's 10/10 LPC license renewal application, he incorrectly responded "no" to questions about being addicted to any chemical substance during the last 5 years and whether he had been treated during the last 5 years for a drug or alcohol addiction.</p>	<p>Board Action 11/03/11: Consent Agreement and Order: the professional's license shall be surrendered. The surrender shall be considered a revocation of his license.</p>
<p>Jacalyn Danchise-Edie LMSW-Applicant 2012-0051</p>	<p>The applicant worked at Hospital from 06/00 to 07/10. Personnel records from Hospital included documentation regarding numerous times the applicant was informed of concerns about her behavior towards co-workers and patients, including at least 3 corrective action plans. Senior managers felt that the applicant was not appropriately responsive to patients and staff in the ICU. Several other units declined to accept the applicant for work on their units. Several staff members voiced that they did not want to work with the applicant because she created a hostile environment. The applicant also impersonated a RN when obtaining patient authorizations from an insurance company. The applicant's termination was a direct result of her behaviors and her unwillingness or inability to correct problems repeatedly addressed by supervisors. There was no evidence in the personnel record or in information provided by the applicant that she made any concerted efforts to improve her conduct towards co-workers and patients.</p>	<p>Board Action 11/03/11: The applicant's LMSW application was denied based on unprofessional conduct.</p>

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<p>Frederic Cohen LBSW-Applicant 2012-0021</p>	<p>The applicant worked at Agency 1 from 08/90 to 06/97 until he was terminated for becoming sexually intimate with a client. While working at Agency 2, the applicant received multiple disciplinary actions regarding his lack of teamwork, failure to pick up messages for a co-worker on vacation, misrepresenting that the messages had been picked up, continuing to work overtime without prior authorization, making discourteous and derogatory comments to a co-worker, and using offensive language in the workplace. In 2008, the applicant resigned in lieu of termination from Agency 2 while sexual harassment allegations against him were being investigated. In 01/10, the applicant was involuntarily terminated from Agency 3 for contributing to a hostile work environment, following at least 3 disciplinary actions for inappropriate behavior, inappropriate communication, contributing to a hostile work environment and demeaning and berating other employees on a regular basis. On 01/21/11, the applicant was involuntarily terminated from Agency 4 based upon his offensive communication style, defensive attitude, failure to accept responsibility about behavior issues, complaints from clients, insubordination, and unprofessional behaviors toward fellow staff members during meetings. The applicant submitted his LBSW application to the Board in 03/11 and misrepresented his employment history and/or his reasons for terminations and/or reasons for his resignations. During a 05/11 investigative Board interview, the applicant initially misrepresented that he had no issues at Agency 1. The applicant also misrepresented information regarding his termination at Agency 2. The applicant also misrepresented his employment status/issues on employment applications at Agencies 3 and 4.</p>	<p>Board Action 11/03/11: The applicant's LBSW application was denied based on unprofessional conduct.</p>
<p>Sally Davis LCSW-Applicant 2012-0026</p>	<p>The applicant was employed at Agency 1 from 11/03 to 08/09. The applicant was terminated from Agency 1 following a formal hearing regarding allegations regarding borrowing money from clients; disclosing personal problems to clients during therapy sessions; socializing with clients; and failing to maintain appropriate professional boundaries with clients. The applicant has a history of behavioral health issues including plans to harm the client that accused her of borrowing money. The applicant did not advise Agency 2 of her termination from Agency 1, as required.</p>	<p>Board Action 11/03/11: The applicant's LCSW application was denied based on unprofessional conduct.</p>
<p>Monique Kimmet LAMFT-Applicant 2012-0048</p>	<p>The applicant was employed at Agency 1 from 06/07 to 10/09. A 08/08 performance evaluation noted that the professional needed improvement in treatment planning; monthly/quarterly reports; case notes; and productivity. Following the corrective action plan, there were no further concerns noted and Agency 1 indicated the applicant would be eligible for rehire. In 03/10, the applicant began to provide therapy at Agency 2. Agency 2 documented counseling sessions on 09/29/10, 11/18/10 and 11/30/10 addressing continuing documentation deficiencies. Supervisors 1 and 2 attempted to provide the applicant with assistance in time management, decreasing her caseload, and allowing time to catch up on documentation. The applicant's inability to maintain current client documentation negatively impacted clients. The Applicant was involuntarily terminated from Agency 2 when she failed to appear for work despite the denial of her request for personal time off. Following the applicant's termination, the transition of her clients was made more difficult by the fact that her documentation was not current. As a result, some clinicians did not have accurate information when they began treating the applicant's clients and had to re-gather information from the clients before they could continue treatment.</p>	<p>Board Action 11/03/11: The applicant's LAMFT application was denied based on unprofessional conduct.</p>
<p>Cherilin M. Diefenbacher-Phariss LMSW-11277 2012-0056</p>	<p>On or about 10/12/11, the Board was notified that the professional was being treated for a significant behavioral health issue and/or medical condition affecting her ability to safely and competently practice at this time.</p>	<p>Board Action 11/03/11 Interim Consent Agreement and Order: The professional shall not practice and the professional's license shall be suspended.</p>

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<p>Hal Nevitt LCSW-3406 LISAC-0837 2011-0063</p>	<p>The professional is the director of the State Bar's Member Assistance Program ("MAP"), a confidential program for impaired members. In 01/08, the professional documented communications from third parties including Complainant that a specific attorney ("Attorney") was abusing alcohol. In response, the professional encouraged Attorney to voluntarily enter MAP. After Complainant initiated her concerns about Attorney, the professional hired Complainant to provide administrative services at his private practice, independent of his MAP duties. In 01/10, Attorney entered MAP and the professional began monitoring/treating her according to Attorney's MAP program. Attorney signed a HIPAA form, which prohibited the professional from disclosing any information about Attorney without a signed release of information authorization. The professional disclosed to Complainant information about Attorney abusing alcohol and actions the State Bar took regarding its investigation of the allegations against Attorney.</p>	<p>Board Action 11/15/11 Consent Agreement and Order: probation; within 12 months, take and pass a 3 semester credit hour graduate level behavioral health ethics course; \$1,000 civil penalty stayed pending compliance with this consent agreement; shall not provide clinical supervision while subject to the consent agreement.</p>
<p>Jan Owens LISAC-1288 2011-0107</p>	<p>In 07/05, the professional began working as a therapist at an OBHL licensed agency ("Agency"). On her 07/05 employment application, she did not disclose her 09/04 Board Consent Agreement ("09/04 CA"). During Agency's verification process, Agency learned of the 09/04 CA and determined that her practice would be restricted from working with families or children. In 05/08, the professional received a verbal reprimand for acting in a "harassing" manner and using a "non-professional tone" towards Employee 1. In 10/10, an Agency client ("Client") presented with a serious mental illness, a significant psychiatric history, including 3-4 psychiatric hospitalizations, most recently in 09/10 following an overdose, and a history of depression, which was intermixed with periods of mania. Client was assigned to the professional for group therapy. The professional facilitated 97 group therapy sessions with Client from 10/10 to 02/11. On 12/30/11, the professional received a written warning and counseling regarding 2 complaints about "negative and rude" behaviors, "insubordination" and "poor professional conduct". In 02/11, Client spoke to Clinical Director about the professional "texting and calling Client outside of business hours using a personal cell phone" and having "outside personal meetings". Phone records reflected a large number of phone and text message communications between the professional and Client, many of which occurred after normal business hours. The professional failed to document any of these communications in Client's clinical record and there was nothing written in Client's treatment plan indicating the necessity of these communications. Agency has a crisis line and crisis counselors to assist clients with issues. The professional acknowledged that she might have become over involved with Client. Even though the professional asserted that the multiple phone and text message communications with Client were for the purpose of support/well-checks and were clinically related, the professional failed to document any of these alleged "support/well-checks" in the Client's clinical record. Agency terminated the professional on 02/10/11.</p>	<p>Board Action 11/28/11 Consent Agreement and Order: stayed revocation; probation; shall complete 24 months of supervised work experience at her current place of employment, Valley Hospital, or at a supervised practice setting licensed by OBHL; within 12 months, take and pass a 3 semester credit hour graduate level behavioral health ethics course and 8 clock hours of continuing education addressing current behavioral health documentation requirements; 24 months of twice weekly clinical supervision; \$1,000 civil penalty stayed pending compliance with this consent agreement; shall not provide clinical supervision while subject to the consent agreement.</p>

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<p>Kurt Woodburn LSAT-Applicant 2012-0031</p>	<p>On 10/30/01, the applicant's insurance license was revoked because he forged client signatures on checks, diverting client monies to fund substance abuse habits and a particular lifestyle. In 11/02, the applicant pled guilty to 8 felonies and was ordered to pay \$1,772,826 to 21 victims that were his clients when he was a licensed insurance agent. The applicant served 8 years in prison and was released in 09/10. He is on parole until 07/12. On 06/18/02 and 07/13/02, the applicant was arrested for domestic violence against his wife. The applicant pled guilty to the 07/13/02 incident and spent 100 days in jail. There was no evidence that he engaged in any anger management or domestic violence therapy/treatment. On 10/17/02, the applicant was arrested for extreme DUI. His BAC was .215%. He pled guilty to the extreme DUI charges, spent 30 days in jail, and paid a fine of \$556. The applicant acknowledged that over the course of the last 40 years, the only way he could maintain a substantial period of sobriety was while he was incarcerated. There was no evidence that the applicant engaged in any formal substance abuse therapy/treatment since his release from prison. The applicant provided therapy services for suboxone clients at 2 doctors' offices without being licensed by the Board. The applicant failed to obtain written informed consents for treatment, failed to develop treatment plans, and failed to note the duration of sessions on progress notes or sign progress notes. The applicant breached confidentiality when he asked his wife to assist in the development of excel spreadsheets identifying clients by name, their physician, and the dates they attended counseling without obtaining the appropriate written release of information authorizations. The applicant failed to inform clients that he would be maintaining their confidential progress notes at his home. The applicant failed to disclose on his 12/10 LSAT application that he had been treated within the last 5 years for a drug or alcohol addiction while he was incarcerated and misrepresented to Board staff that he was a facilitator of this treatment and not a patient.</p>	<p>Board Action 11/03/11: The applicant's LSAT application was denied based on unprofessional conduct. Board Action 12/01/11: Cease and Desist Order.</p>
<p>Janet McFarland LAC-12775 2011-0093</p>	<p>In 1999, Licensee began living with an elderly gentleman ("Gentleman"). In 2004, Licensee obtained ownership with Gentleman of his home as joint tenants. On 08/29/09, a Quit Claim Deed with Gentleman's signature was notarized giving Gentleman's interest in his home to Licensee. On 09/08/09, Gentleman, who was living in a nursing home, advised the Camp Verde Marshall's Office that his signature on the 2009 Quit Claim Deed was forged. When questioned by the Marshall's Office, the Notary Public on the 2009 Quit Claim Deed indicated that Licensee forged Gentleman's signatures on both the deed and the notary book. Gentleman passed away on 09/20/09. On 10/14/09, Licensee was arrested for fraud and forgery in relation to the 2009 Quit Claim Deed. Licensee was charged with 7 felonies. In 08/10, Licensee reported her criminal charges to the Board, 10 months after she was required to report these charges to the Board. On 06/30/10, Licensee accepted a plea agreement and pled guilty to a Class 6 undesignated felony, Criminal Simulation, and a Class 6 undesignated felony, Attempted Fraudulent Schemes. Licensee asserts that in 2004, she obtained joint ownership with Gentleman in a home located in Yavapai County, as a result of a consensual agreement between the two. Licensee asserts that she refinanced the home and paid the bills for maintenance and upkeep from that date forward and that she continues to pay all costs and expenses associated with the house. Licensee asserts that Gentleman assaulted her by running over her with his car in 2004. He was prosecuted and convicted for this offense and ordered to pay restitution to Licensee, which she never received. In 2009, Licensee asserts that she attempted to refinance the home, using only her credit and assets to do so. The lending company required a signature from Gentleman. Licensee asserts that she was originally charged with several felonies in connection with the signature on the deed. She did not report the fact that she had been charged with felonies within ten days of being charged because she mistakenly believed that only felony convictions were reportable. Licensee asserts that she entered pleas of guilty, which resulted in misdemeanors.</p>	<p>Board Action 11/21/11 Consent Agreement and Order: The professional's license shall be surrendered. The surrender shall be considered a revocation of his license.</p>

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<p>Amy Preusch O'Day LMSW-Applicant 2012-0042</p>	<p>In 10/10, the Board denied the applicant's initial licensure application based on misrepresentations and impairment. Seven months later, the applicant submitted a second licensure application. The applicant failed to demonstrate that there had been adequate corrective action regarding the basis of the previous denial. Agency 1's personnel records were not consistent with the employment dates the applicant submitted on the second licensure application. The applicant has been employed at Agency 2 since 07/10. Agency 2's supervisor record suggested that the applicant improve her skills in managing her professionalism and her current supervisor remained guarded regarding the applicant's abilities and that she needed "professional polishing".</p>	<p>Board Action 12/01/11: The applicant's LMSW application was denied based on unprofessional conduct.</p>
<p>Rayne Norton LMSW-Applicant 2012-0039</p>	<p>In 04/05, the applicant received a LMSW license. Almost immediately, she engaged in serious unprofessional conduct by becoming involved in a dual relationship with Client. As a result of this unprofessional conduct, she lost her job at Agency 1 and Board Complaint No. 2005-0142 was opened. In 2006, the applicant re-engaged in a relationship with Client and even though she no longer worked with Client in an official capacity, she created a treatment plan for Client that involved Client residing in the applicant's home with her family. In 08/06, after a Probation Department reported her 2006 behavior to the Board, Complaint No. 2007-0049 was opened. The applicant demonstrated a lack of insight, ownership, and/or desire to correct the issues leading to her 2005 and 2006 unprofessional conduct. This matter proceeded to a formal hearing, which resulted in an 11/08 Board Order. The applicant continued to dispute the Order and made only minimal attempts to satisfy the Board Order stipulations. Based on the applicant's failure to comply with the 11/08 Board Order, including non-compliance with the supervision terms, the Board opened Complaint No. 2010-0036. During a 05/07/10 formal hearing, the Board voted to revoke the applicant's LMSW license and issued a 06/10 Order of Revocation based upon the unprofessional conduct related to the applicant's failure to timely inform the Board of new employment at Agency 2 and non-compliance with the 11/08 Board Order. In 06/11, Applicant re-applied for an LMSW license. The applicant provided no information or evidence that she had taken any action to correct or resolve issues leading to her unprofessional conduct, which ultimately led to the revocation of her license.</p>	<p>Board Action 12/01/11: The applicant's LMSW application was denied based on unprofessional conduct.</p>
<p>Laura L. Lindsay LISAC-11541 LMSW-12305 (expired) 2011-0090</p>	<p>The professional worked at Agency 1 from 07/05 through 11/10. 3 different supervisory evaluations rated the professional below average. The professional's supervisors articulated multiple concerns regarding the professional's negative attitude toward other professionals and clients, counter transference issues, interpersonal communication issues, self care issues, stress issues, boundary issues, dependency and codependency issues, inability to maintain confidentiality, below average clinical skills, employment of contraindicated therapies, failure to notify CPS when warranted, insubordination, resistance to clinical supervision, and poor clinical and professional judgment. The professional worked at Agency 2 from 04/03 through 08/04. The professional received a verbal warning, a verbal written warning and an employee evaluation that included concerns about inappropriate involvement with clients, ethical conduct and boundaries, and violations of client confidentiality. The professional resigned from Agency 2 and filed a Board complaint against her Agency 2 supervisor, which was dismissed. The professional was an intern at Agency 3 from 01/05 through 05/05. The professional's supervisor at Agency 3 reported that the professional "struggled" with "authority" and became "defensive" during feedback or constructive criticism.</p>	<p>Board Action 12/01/11 Consent Agreement and Order: The professional's LISAC license will remain on probation until her license expires on 05/31/12. The professional shall not practice under her license or engage in the practice of behavioral health. The professional's agreement not to practice under her license will be considered a suspension of her license. After the professional's license expires on 05/31/12, the professional agrees not to renew her license or reapply for licensure in Arizona.</p>

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<p>Carol Hirschberg-James LMSW-12238 2011-0076 LCSW-Applciant</p>	<p>The professional holds an LMSW license. On 12/06/10, the professional submitted a LCSW application. The Chief Operating Officer ("COO") at the Agency where Professional worked, also a LCSW, completed the professional's LCSW application supervision forms. COO and the professional also worked together for about 10 years prior to working together at Agency. COO did not have any social work supervisory responsibility at Agency other than providing clinical supervision to the professional. The professional worked in the following 3 positions at Agency: Social Services Manager, Acting Director of Social Services, and then Director of Social Services. Supervision forms included a job title of psychiatric social worker, which the professional never held. COO verified the following hours for the professional: 104 hours of individual clinical supervision, 13.5 hours of direct observation, 1600 hours of direct client contact, and 3400 supervised work experience hours. The professional's job descriptions did not include any psychotherapy related duties. The professional represented that she had an average caseload of 5 clients and provided 1-2 hours of direct client contact per client per week and 1-2 hours of indirect client care hours per client per week. Agency electronic reports for 2008 and 2009 only reflected 34.5 hours of direct client contact. During the same time period, complainant recorded 1061.75 hours of direct client contact. The professional indicated that neither she nor COO tracked or documented the professional's actual direct or indirect client care hours. Instead, they made a "good faith estimate" of her hours in order to complete the LCSW application. Based on the professional's estimate, she would have completed the following during the 146 weeks she worked from 10/02/07 to 08/30/10: 1095 direct client contact hours; 1095 indirect client care hours; a total of 2190 hours of supervised work experience. Based on the hours recorded on her LCSW application, the professional overstated her hours by the following: 505 hours overstated of direct client care and 1210 hours overstated of total supervised work experience hours.</p>	<p>Board Action 12/01/11 Consent Agreement and Order: probation; within 24 months take and pass a 3 semester credit hour graduate level behavioral health ethics course; 24 months of once weekly clinical supervision; \$1,000 civil penalty stayed pending compliance with this consent agreement; shall not provide clinical supervision while subject to the consent agreement.</p>
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