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PROFESSIONAL	FINDINGS	RESOLUTION
<p>Nancy C. Rybski LMFT-10146 2010-0013</p>	<p>In 08/07, the professional was arrested for DUI. The professional failed to notify the Board within 10 days after the charges were filed, as required by ARS § 32-3208(A). The professional pled guilty to 2 misdemeanor counts of DUI. In 06/08, the professional submitted her license renewal application and informed the Board of her DUI charge and participation in a treatment program. The professional is not currently practicing behavioral health.</p>	<p>Board Action 01/06/10 Consent Agreement and Order: indefinite probation; shall not engage in the practice of behavioral health; after returning to practice, 24 months clinical supervision; random biological fluid testing; investigative costs of \$500 stayed pending compliance with this Consent Agreement and Order.</p>
<p>Russ Warner LISAC-1077 2009-0079</p>	<p>In 12/08, the professional began providing telephonic counseling to a client living in California. The professional is not licensed to practice in California. The client did not seek treatment for issues related to chemical dependency/abuse problems. The professional failed to obtain a written consent for treatment. Client's record contained an undated, unsigned, written treatment plan. The progress notes were unsigned and did not indicate the duration of sessions. The progress notes did not describe the professional's assessment or the treatment that was provided. The clinical record was largely illegible. In 01/09, the client arrived in Arizona to participate in an in-person counseling session. The professional met the client at the airport, commented on her physical appearance, took her to dinner, took her to her hotel and then picked her up in the morning for a 4-hour in-person session. The professional spoke about other clients, disclosing at least one other client's identity. During the session, the professional introduced the client to a friend of the professional's wife, who had agreed to take the client for a hike.</p>	<p>Board Action 01/08/10 Consent Agreement and Order: The professional's license will be indefinitely suspended; the professional shall submit a practice termination plan; release from suspension shall not occur any sooner than 12 months; prior to requesting release from suspension, the professional shall attend therapy and take/pass a 3-semester credit hour graduate level ethics course; following reinstatement of the professional's license, the license shall be placed on 12 months probation, with the following stipulations: the professional shall only practice in an OBHL licensed agency; obtain 12 months clinical supervision; investigative costs of \$1167 shall be stayed pending compliance with this Consent Agreement and Order.</p>
<p>Sharon Cottor LCSW-0012 2009-0044</p>	<p>During the timeframe of this complaint, the professional provided psychotherapy, family business consultation, and life and business coaching to several members of the same family. The professional's practice forms did not identify or distinguish the 3 different types of services provided. In 2000, Parents saw the professional for marital therapy. Part of their marital issues were related to stress about their business. The therapy sessions included discussions about Parents' retirement plans and succession of their business to Son. In 11/01, Parents resumed treatment with the professional. Son also began treatment with the professional. In 12/01, the professional recommended that Parents hire a CEO for their family business until Son could take over the business. The professional recommended a specific person for the CEO position without advising Parents that the person recommended was one of the professional's long time clients. After Parents hired the person the professional recommended to become the CEO of the family business, Parents were dissatisfied with CEO's performance and eventually terminated her.</p>	<p>Board Action 01/08/10 Consent Agreement and Order: The professional's license shall be surrendered. The surrender shall be considered a revocation of her license.</p>
<p>Sharon Cottor Continued</p>	<p>CEO then filed a lawsuit against Parents. The professional's records indicate she had extensive discussions with CEO regarding this lawsuit. During a deposition of the professional taken during that lawsuit, the professional testified regarding information she obtained from some of her sessions with Parents and Son. The professional indicated this information was not confidential because it was obtained during business consultation sessions. None of the forms the professional used advised Parents or Son that the professional was providing business consultation services or that the information they provided would not be confidential. The professional's forms do not comply with the Board's minimum practice standards.</p>	<p>Board Action See Above.</p>

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<p>Paul Harris LSAT-12030 2009-0028 2010-0012</p>	<p>In 05/08, the professional submitted his application for licensed substance abuse technician and acknowledged a 20-year history of alcohol abuse and 2 DUI citations. The professional indicated that he had been receiving therapy from Dr. Michael Mahl. In 07/08, the Medical Board suspended Dr. Mahl's license. In 08/08 or 09/08, the professional became aware of Dr. Mahl's suspended license. On 09/19/08, the substance abuse credentialing committee (SACC) opened a complaint and approved the professional's license subject to a consent agreement for ongoing treatment with Dr. Mahl. The professional signed the consent agreement even though he knew he could not comply with the stipulation of ongoing treatment with Dr. Mahl. In 12/08, the Board issued the professional's LSAT license and approved the consent agreement and order. In 03/09, the professional advised the Board that he could not comply with the terms of the consent agreement due to the suspension of Dr. Mahl's license. In 07/09, the SACC opened a new complaint against the professional. Complaint Nos. 2009-0028 and 2010-0012 were consolidated and a new Consent Agreement was accepted.</p>	<p>Board Action 01/08/10 Consent Agreement and Order: 24 months probation; shall only practice in an agency licensed by OBHL; 24 months clinical supervision; 24 months therapy; participate in random biological fluid testing; investigative costs of \$500 stayed pending compliance with this Consent Agreement and Order.</p>
<p>Steven Brinton LCSW-1699 2008-0005</p>	<p>The professional provided a total of 159 therapy sessions to Client from 12/04 through 06/07. Client attempted suicide by overdose 1 week after her last session. The professional failed to coordinate treatment with Client's PCP, who prescribed antidepressant medication. The professional failed to obtain a signed and dated written informed consent for treatment, failed to document any type of written assessment, and failed to prepare any written treatment planning documentation. The professional's progress notes were largely illegible and were not reflective of what occurred during Client's therapy sessions. The professional failed to maintain appropriate professional boundaries with Client. The professional failed to document all of Client's diagnoses or provide appropriate treatment regarding the diagnoses.</p>	<p>Board Action 01/08/10 Consent Agreement and Order: The professional's license shall be surrendered. The surrender shall be considered a revocation of his license.</p>
<p>Steven Brinton Continued</p>	<p>Client's bishop, friends, husband, and PCP were concerned about the lack of appropriate boundaries in the relationship between Client and the professional. The professional encourages the majority of his clients to consider participating in Landmark Educational programs. Client hosted one of these sessions in her home, which the professional attended. At least 2 of the professional's other clients were also present. The professional left a message for Client to send an "Orb" to a third person. The "Orb" is healing power believed to be possessed by Client and discussed in Client's therapy sessions. The professional advised Client that the professional's son worked for a painting company Client was considering hiring. The professional's brother-in-law owned this company. The professional never discouraged Client from hiring this company. Client wrote 2 checks totaling \$870 directly to the professional's son for painting 2 rooms in her home. Client's phone records indicated that, during the last 6 months of treatment, Client and the professional engaged in frequent telephone and/or text messaging communications, which were described as intimate by 3 of Client's friends.</p>	<p>Board Action See Above.</p>

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<p>Steven Brinton Continued</p>	<p>The professional utilized "muscle testing" with Client, which is not a professionally recognized behavioral health treatment. Client developed romantic feelings for the professional, which she discussed with the professional. The professional indicated he told Client that he was not available for a personal relationship. The professional failed to therapeutically address transference issues apparent in his therapeutic relationship with Client and failed to consult with other professionals regarding how to address this issue. On 06/09, a formal interview was held and the Board issued an Order regarding this matter, placing the professional on probation subject to terms. In 09/09, the Board reviewed the professional's request for a review or rehearing and a partially modified order was issued. In 10/09, the professional notified the Board that he wished to surrender his license.</p>	<p>Board Action See Above.</p>
<p>Candace Shelton LISAC-1683 2008-0075</p>	<p>See 2009 Adverse Action Report</p>	<p>Board Action 01/08/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 06/08/09.</p>
<p>Gwendolyn Swan LISAC-0743 2010-0024 2010-0028</p>	<p>In 07/09, the professional was terminated from her job for unprofessional conduct. The professional had been told at the time of termination not to contact any of the agency's clients. After the professional's termination, a former client of the agency reported that the professional had contacted the client at home and requested that the client file a complaint against the agency with NARBHA. The professional denied making this request of the former client, but she admitted to contacting and telling the former client that she was making a complaint against the agency.</p>	<p>Board Action 01/08/10 Consent Agreement and Order: Order of Censure.</p>
<p>Kelly Tinley LMSW-12688 2010-0057</p>	<p>In 07/08, the professional submitted her licensed master social worker application to the Board. In 10/08, the professional was arrested and charged with extreme DUI. The professional admitted not disclosing this information to her employer or the Board. The Board and her employer required reporting of any DUI arrest. On 01/01/09, the Board issued an LMSW license to the professional. In 06/09, the professional pled guilty to and was convicted of extreme DUI. In 06/09, the agency where the professional worked allowed her to resign in lieu of termination, as she had to begin serving her 45-day jail sentence. On 06/25/09, the professional submitted a self-report to the Board regarding her DUI, nearly 8 months after she was required to report her arrest for extreme DUI to the Board.</p>	<p>Board Action 01/08/10 Interim Consent Agreement and Order: The professional shall not practice under her license. This restriction shall be considered a suspension of her license.</p>
<p>Christine Fielder LPC-11218 LMFT-10162 LISAC-10841 2006-0063 2007-0006 2007-0072</p>	<p>See 2008 Adverse Action Report</p>	<p>Board Action 02/05/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 10/06/08.</p>

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<p>Marjorie Schulte LCSW-0820 2009-0062</p>	<p>The professional provided marital counseling to Husband and Wife from 08/06 to 10/06 and from 07/07 to 08/07. The professional did not obtain written informed consent for treatment from Husband or Wife. The professional did not complete any type of psychosocial history or formal assessment of Husband and Wife. The professional did not complete any type of treatment planning documentation when she treated Husband and Wife. The progress notes for Husband and Wife did not include the duration of sessions, whether counseling was individual, family or group counseling, or the professional's signature and date signed. The professional did not document in the record the release of Husband's and Wife's treatment record to Husband's attorney. The professional did not provide Husband and Wife an explanation of all financial arrangements related to the professional services she provided. In 08/08, the professional provided sworn testimony during a deposition in Husband's and Wife's divorce proceedings. The professional later acknowledged that she made false representations during that deposition.</p>	<p>Board Action 02/05/10 Consent Agreement and Order: 12 months probation; 3 clock hours of continuing education addressing behavioral health ethics; obtain a private practice audit; submit to monitoring by a practice monitor; investigative costs of \$778 stayed pending compliance with this Consent Agreement and Order.</p>
<p>Marjorie Schulte Continued</p>	<p>In 02/09, the professional voluntarily acquired the services of a practice monitor to assist with record keeping remediation.</p>	<p>Board Action See Above.</p>
<p>Christa Turner LMSW-10810 2009-0135</p>	<p>On 05/29/09, the professional was arrested on child abuse charges regarding abuse of her 11-year-old son. The professional did not notify the Board of her arrest or criminal charges within 10 working days, as required. The professional stuffed a pair of shorts in her son's mouth to stop him from screaming. CPS became involved and took custody of the professional's children. CPS substantiated the professional's ongoing neglect of her children including not having adequate food and clothing, locking the children out of the house, and forcing children to steal toiletries and food. A 07/09 psychological evaluation indicated that the professional "is going to require intense psychotherapy". On 11/19/09, the professional pled guilty to 2 counts of felony child abuse related to domestic violence.</p>	<p>Board Action 02/05/10 Consent Agreement and Order: The professional's license shall be surrendered. The surrender shall be considered a revocation of her license.</p>
<p>William Jefferson LMFT-0065 LPC-0229 2009-0082</p>	<p>In 07/95, the professional was arrested for the criminal offense of resisting arrest. In 03/97, the professional was charged with resisting arrest. In 10/97, the charges were dismissed. In 2003 and 2005, the professional answered "no" on multiple renewal application background questions regarding ever being arrested or charged with a crime. From 08/90 to 08/02, the professional was employed at Agency 1. The professional's personnel record indicated that the professional demonstrated an inability to comply with the agency's policies and procedures, and an inability to perform his job at the agency's expected level of professionalism, which resulted in a termination from employment. From 1990 to 10/02, the professional was employed at Agency 2. In 10/02, 3 Agency 2 female staff members complained that the professional made inappropriate sexual comments. Agency 2 found that there was sufficient evidence to conclude that the professional's conduct was unprofessional, he engaged in sexual harassment, and created a sexually hostile environment. Agency 2 involuntarily terminated the</p>	<p>Board Action 02/05/10 Order of Revocation.</p>

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<p>William Jefferson Continued</p>	<p>professional. In 2003, 2005 and 2007, the professional answered "no" on multiple renewal application background questions regarding ever being involuntarily terminated from any behavioral health position. From 11/04 through 12/08, the professional was employed at Agency 3. In 08/05, Agency 3 issued a letter of concern to the professional based on a complaint that he was referring to female staff as "dear", and on a client complaint that he had inappropriately and in a lingering manner touch the bare shoulder of a female client in the presence of her 14-year-old daughter, an act which the client perceived as having sexual undertones. In 06/08, 2 female staff reported being uncomfortable around the professional because he loitered in the front office for extended periods staring at them and at their breasts, and because his comments were replete with sexual innuendo. The professional ignored a policy prohibiting loitering in the front office. When confronted about his ongoing loitering, the professional filed a complaint that one of the front office employees created a hostile and offensive work environment. Agency 3 began an investigation. 11 employees, 10 of whom were female, reported</p>	<p>Board Action See Above.</p>
<p>William Jefferson Continued</p>	<p>that the professional made them feel uncomfortable by talking openly about sex, making sexual innuendos, staring at their breasts or bodies, and touching them without permission. The male employee corroborated these allegations, as did documentary evidence Agency 3 obtained. The professional was suspended without pay and ultimately terminated on 12/22/08. The termination notice set forth 6 separate grounds for dismissal, including that the professional's sexual harassment had been ongoing for an extended period of time because of the female employees' feelings of intimidation and fear of retaliation if they reported the professional to his superiors. During the Board's investigation, the professional misrepresented and minimized his work history terminations.</p>	<p>Board Action See Above.</p>
<p>Nanette Mongelluzzo LPC-11867 2009-0022 2010-0030</p>	<p>In 08/06, the professional began treating Mother. Mother and Father were engaged in ongoing conflict regarding Father's visitation with Daughter. Mother provided the professional with a large amount of negative information pertaining to Father. In 01/08, the professional wrote a letter to a court-appointed parenting coordinator that supported a special circumstances parenting plan and negative information regarding Father. In 04/08, the professional wrote an addendum to her 01/08 letter that contained a number of negative comments regarding the parenting coordinator's actions and the court's decision-making regarding increased visitation for Father. In 08/08, the professional wrote a letter to the parenting coordinator expressing her objection to various recommendations that the parenting coordinator made to the court regarding Father's visitation time with Daughter. In 09/08, Mother submitted the professional's 3 letters to the court in support of her position opposing increasing Father's visitation time with Daughter. The professional failed to sign and have Mother sign treatment plan updates.</p>	<p>Board Action 02/25/10 Consent Agreement and Order: 12 months probation; 3 semester credit hour graduate level behavioral health ethics course; 6 clock hours of continuing education addressing high conflict divorce/custody cases; 3 clock hours of continuing education addressing current behavioral health documentation requirements; 12 months clinical supervision; investigative costs of \$1773 stayed pending compliance with this Consent Agreement and Order.</p>
<p>Jennifer Balistreri LMSW-12207 2007-0119</p>	<p>See July 2009 Adverse Action Report.</p>	<p>Board Action 03/05/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 07/27/09.</p>

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<p>Jolynne Buehring LCSW-2636 2009-0105</p>	<p>In 03/09, Mother took 14-year-old Daughter to treatment with the professional. After Mother filed for divorce, Stepfather petitioned the court for custody of Daughter. On 03/18/09, the professional wrote a letter to Mother's attorney that included a recommendation that Mother was the best person to parent Daughter and that with allowing Stepfather a custodial role, it would negatively impact Daughter and be extremely detrimental to her psychological well being. At the time this letter was written, the professional had limited information obtained from 2 sessions with Daughter and 1 brief contact with Mother. The professional did not have any contact with Stepfather or anyone else knowledgeable regarding Daughter's circumstances. The consent for treatment Mother signed lacked most of the required elements. The professional did not develop any type of treatment planning documentation. The progress notes did not include the duration of the sessions or the date signed by the professional. Telephone contacts with Mother were not recorded. The professional did not have appropriate written releases to release information to 2 attorneys.</p>	<p>Board Action 03/05/10 Consent Agreement and Order: 24 months probation; 3 clock hours continuing education addressing HIPAA requirements; 3 clock hours continuing education addressing current behavioral health record keeping requirements; 3 semester credit hour graduate level behavioral health ethics course; 24 months clinical supervision; investigative costs of \$397.81 stayed pending compliance with this Consent Agreement and Order.</p>
<p>Kathryn Cooper LAC-12766 2009-0094</p>	<p>Daughter had been referred for treatment for sexually assaulting a 5-year-old boy. During the intake interview on 01/21/09, Daughter disclosed that she had also sexually assaulted 5-year-old Sister on multiple occasions. The information disclosed by Daughter about her abuse of Sister was not known to the court. The professional did not immediately report this information. During a 01/29/09 session, Daughter again disclosed her abuse of sister to a surveillance officer. The professional relied on the surveillance officer's representation that he would speak with Daughter's probation officer to request that Daughter be removed from the home. This report was delayed. The professional did not report this abuse to CPS until 02/24/09.</p>	<p>Board Action 03/05/10 Consent Agreement and Order: 12 months probation; 6 clock hours continuing education addressing mandatory reporting of child abuse requirements; 3 semester credit hour graduate level behavioral health ethics course; investigative costs of \$492 stayed pending compliance with this Consent Agreement and Order.</p>
<p>Christy Graham LISAC-0874 2005-0105 2009-0131</p>	<p>Effective 02/01/08, the Board and the professional entered into a Consent Agreement resolving Complaint No. 2005-0102. Pursuant to this Consent Agreement, the professional was to complete a 3 semester credit hour graduate level ethics course by 02/01/09. The professional failed to comply with the 2008 Consent Agreement. Effective 03/05/10, the Board and the professional entered into a modified Consent Agreement resolving Case Nos. 2005-0102 and 2009-0131, which included an extension of time for the professional to complete a 3 semester credit hour graduate level ethics course.</p>	<p>Board Action 03/05/10 Modified Consent Agreement and Order: Order of Censure; 3 semester credit hour graduate level ethics course; 12 months clinical supervision (completed); investigative costs of \$500 stayed pending compliance with this Consent Agreement and Order.</p>
<p>Mary Kent LPC-1165 2010-0029</p>	<p>For approximately 9 years, the professional was the primary therapist for approximately 16 youth incarcerated in a juvenile sex offender program. The professional indicated that there were 5 youth that she suspected had been victimized by Youth K, and 2 youths who felt victimized by Youth K. The professional disclosed specific incidents where it appeared that Youth K sexually victimized 2 youth. The professional acknowledged that she did not file an incident report ("IR") regarding these incidents and others where she suspected that Youth K had engaged in inappropriate sexual conduct with other inmates. The professional indicated that she responded to incidents involving Youth K by confronting the youths involved, discussing the issue in group, giving Youth K extra help, a disciplinary action, and offense cycle paperwork, and providing individual counseling. The Arizona Department of Juvenile Corrections ("ADJC") found that the professional's failure to report sexual misconduct incidents involving Youth K violated multiple ADJC policies.</p>	<p>Board Action 03/05/10 Consent Agreement and Order: 24 months probation; 6 clock hours continuing education addressing boundaries, legal issues and behavioral health ethics; 24 months clinical supervision; investigative costs of \$1,461.54 stayed pending compliance with this Consent Agreement and Order.</p>

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<p>Mary Kent LPC-1165 2010-0029</p>	<p>The professional failed to file an IR when Youth K assaulted her in early 12/08. During a second assault by Youth K, the professional waited until the next day to report the incident and to complete an IR. The professional's impaired judgment prevented her from taking appropriate measures to protect the inmates and herself from Youth K's predatory sexual behavior. The professional acknowledged that she had serious boundary issues with Youth K.</p>	<p>Board Action See Above.</p>
<p>Brady Miller (AKA Clevenger) LMSW-12515 2010-0006</p>	<p>Client lived at and received services through Agency until 06/09. The professional was Client's therapist while Client stayed at Agency. The professional gave Client her cell number, told Client she was looking for a new apartment, rented an apartment recommended by Client, and introduced herself to one of Client's friends living in the same apartment complex. The professional's personal communications with Client created the possibility that Client would be confused with regard to the nature of her relationship with the professional. The professional met Client off-grounds at a bank to collect cash from Client so Client could repay Agency for Client's cell phone bill. Such conduct violated Agency's policies with regard to cash transactions with clients and was inappropriate. On 06/29/09, Client appeared at the professional's apartment and asked to stay with the professional. The professional allowed Client to stay until 07/05/09.</p>	<p>Board Action 03/05/10 Consent Agreement and Order: 6 months suspension; while suspended, shall not provide behavioral health services, shall take and pass a 3 semester credit hour graduate level behavioral health ethics course, and obtain a psychological evaluation. Upon reinstatement of the professional's license, the license shall be on indefinite probation; shall only provide behavioral health related services while employed in an agency licensed by OBHL; 24 months clinical supervision; investigative costs of \$565.46 stayed pending compliance with this Consent Agreement and Order.</p>
<p>Brady Miller (AKA Clevenger) Continued</p>	<p>The professional made no attempts to make other living arrangements for Client. On 07/04/09, the professional invited Client to attend a party at the professional's boyfriend's ("Boyfriend") home. During the party, Boyfriend accused Client of stealing a pack of cigarettes. On 07/05/09, Boyfriend and his father came to the professional's apartment to ask Client to immediately pack and leave the apartment. The professional was aware that, at the time, Client had no alternative living arrangement. The professional acknowledged that she told Boyfriend that Client had been a previous client of hers.</p>	<p>Board Action See Above.</p>
<p>Gary Miller LMSW-12279 2009-0059</p>	<p>It is undisputed that the professional's employment at Agency 1 ended on 11/02/06. On his 11/13/06 LMSW application, the professional misrepresented that he was still employed at Agency 1. On 12/01/06, the professional submitted a revised employment history to the Board and again misrepresented that he was still employed at Agency 1. In his 01/09 response to the complaint, the professional misrepresented that he did not leave Agency 1 until 2007. Agency 1 decided to involuntarily terminate the professional based on the unsuccessful completion of probation. On 11/02/06, the professional's direct supervisor met with the professional and advised him that he was being terminated and to immediately leave the agency. The supervisor gave the professional a written notice advising the professional that he was being involuntarily terminated, which the professional refused to sign. On the background information sections of his 11/13/06 LMSW application and his 04/09 license renewal application, the professional failed to disclose his involuntary termination from Agency 1, as required.</p>	<p>Board Action 03/05/10 Consent Agreement and Order: 24 months suspension stayed subject to successful completion of all terms in this Consent Agreement; 24 months probation; 3 clock hours continuing education addressing current behavioral health clinical documentation requirements; 3 semester credit hour graduate level behavioral health ethics course; while on probation, shall only provide behavioral health related services while employed by an agency licensed by OBHL or at Magellan; 24 months clinical supervision; investigative costs of \$600.95 stayed pending compliance with this Consent Agreement and Order.</p>

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<p>Susan Rassas LISAC-1393 LPC-2288 2006-0083</p>	<p>In 07/04, the professional was in private practice and began providing services to Client, who had been recently hospitalized for a suicide attempt. The professional diagnosed Client with Major Depression and Borderline Personality Disorder and treated Client for 1.5 years during 57 sessions. In 02/06, the professional decided to terminate services with Client by sending Client a termination letter with 3 referral sources. The professional failed to discuss the termination plan directly with Client or Client's psychiatrist in order to minimize possible negative consequences for Client. The professional did not conduct any type of behavioral health assessment of Client and stated that she does not usually conduct behavioral health assessments in her practice unless it is required by an insurance company or the court. The professional did not document any ongoing regular risk assessments for Client, which were warranted due to Client's prior suicide ideation and instability. The professional did not document any type of crisis plan for Client. The consent for treatment did not include required elements.</p>	<p>Board Action 03/05/10 Consent Agreement and Order: 36 months probation; 3 semester credit hour graduate level behavioral health ethics course; 36 months clinical supervision.</p>
<p>Susan Rassas Continued</p>	<p>The professional did not maintain adequate treatment planning documentation for Client or her other current clients. The professional failed to document her consultations with Client's psychiatrist. The professional failed to document Client's diagnoses in Client's record. The professional failed to disclose a 1983 criminal conviction in response to background questions on her 2003 license renewal application.</p>	<p>Board Action See Above.</p>
<p>Earlene Dear LCSW-0195 2009-0132</p>	<p>Effective 10/06/08, the Board and the professional entered into a Consent Agreement resolving Complaint Nos. 2005-0127, 2008-0017, and 2008-0033. Pursuant to this Consent Agreement, the professional's license was placed on 24 months probation subject to various terms and conditions. Among other things, the professional was required to take a 3 clock hour seminar in clinical record keeping and take and pass a 3 semester credit hour graduate level ethics course. The seminar was to be completed by 01/06/09, and the graduate level ethics course was to be completed by 10/06/09. In addition, the professional was to receive clinical supervision for 24 months. The professional was to submit the clinical supervisor for approval by 11/06/08. The professional failed to timely comply with the 2008 Consent Agreement.</p>	<p>Board Action 03/05/10 Consent Agreement and Order: 24 months probation; 3 semester credit hour graduate level behavioral health ethics course; continue with clinical supervision pursuant to 10/08 Consent Agreement and Order; Order of Censure for failure to comply with the terms of the 10/08 Consent Agreement and Order; investigative costs of \$500 paid within 30 days.</p>
<p>Jane Fendelman NJ07-0019</p>	<p>The professional was found to be practicing psychotherapy without being licensed to do so.</p>	<p>Board Action 03/05/10: Referral to Superior Court for an injunction prohibiting Ms. Fendelman from engaging in the unlicensed practice of psychotherapy.</p>
<p>Lucie E. LaBorde LPC-1134 2009-0055</p>	<p>In 2008, the professional was responsible for ensuring that 5-7 Level II Behavioral Health Residential Agencies owned by Agency 1 met OBHL licensure standards. The professional knowingly created falsified behavioral health professional notes ("BHP") for visits she did not make so that an OBHL audit would not detect her non-compliance with OBHL licensing standards regarding required BHP visits and client interaction. Agency 1's data indicated that the professional created at least 93 notes where there was no supporting evidence indicating that she actually visited a home as documented. During the Board's investigation, the professional made contradictory statements as represented during Agency 1's investigation and continued to minimize the seriousness of her actions and the potential harm to clients.</p>	<p>Board Action 03/05/10 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>Michael L. Decious LASAC Applicant</p>	<p>The professional failed to meet minimum curriculum requirements pertaining to LASAC Licensure requirements at this time. The professional was also denied for unprofessional conduct when misrepresenting the basis of his termination from an agency providing behavioral health services and for his failure to take appropriate action to ensure the safety of a potentially suicidal client who was unusually sleepy during a group session.</p>	<p>Board Action 03/05/10: Denial of LASAC license application due to failing to meet curriculum requirements and engaging in unprofessional conduct.</p>
<p>Gerald Garnenez LISAC-11526 2010-0001</p>	<p>In 12/08, the professional was arrested for DUI, attempted evading, and resisting/obstructing an officer. In 01/09, the professional pled guilty to the 12/08 action, self-reported this conviction to the Board, and completed an assessment where he was diagnosed with severe alcohol abuse. The professional began intensive supervision with his clinical supervisor at the agency where he worked. The professional completed 12 court-ordered drug and alcohol counseling sessions and attended traditional Native American healing ceremonies.</p>	<p>Board Action 03/09/10 Consent Agreement and Order: 24 months probation; 24 months clinical supervision; 24 months therapy; random biological fluid testing; investigative costs of \$500 stayed pending compliance with this Consent Agreement and Order.</p>
<p>Ellen Brennan LMFT-10087 2010-0037</p>	<p>The professional treated Mother and Children, 11-year-old Daughter and 10-year-old Son. During the first 2 sessions, the professional received information from Mother and Children that Father was abusing Children. The professional delayed reporting this information to CPS for about 3 weeks. The professional failed to provide a written report to CPS within 72 hours of her verbal report. Virtually all the information the professional had access to was limited to information provided by Mother and Children. The profession wrote 3 To Whom It May Concern letters that included recommendations to restrict Father's access to Children and diagnoses of Father. The professional had only seen Father on 1 occasion and had 1 telephone conversation when these letters were written. The court found no evidence that Father ever physically abused Children and that Children's negative perception of Father is the result of counseling they received. The professional failed to maintain any informed consent for treatment or treatment planning documentation.</p>	<p>Board Action 04/02/10 Consent Agreement and Order: 12 months probation; 6-clock hours continuing education addressing current behavioral health documentation requirements; 6-clock hours continuing education addressing high conflict custody/divorce cases; 3-semester credit hour graduate level behavioral health ethics course; 12 months clinical supervision; private practice audit; private practice monitor; investigative costs of \$1601.18 stayed pending compliance with this Consent Agreement and Order.</p>
<p>Ellen Brennan Continued</p>	<p>The progress notes failed to note the duration of sessions, the type of counseling provided, and the type of behavioral health services provided. The clinical record did not include some progress notes for billed sessions.</p>	<p>Board Action See Above.</p>
<p>Christy Graham LISAC-0874 2005-0102 2009-0131</p>	<p>See 2010 Adverse Action Report.</p>	<p>Board Action 04/02/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 03/09/10.</p>
<p>Lynn Tyson LMFT-0032 2007-0032 2007-0090 2007-0129 2008-0112</p>	<p>See 2008 Adverse Action Report</p>	<p>Board Action 04/02/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 12/12/08.</p>
<p>Melissa Waldrip LCSW-1712 2009-0032</p>	<p>See 2008 Adverse Action Report</p>	<p>Board Action 04/02/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 11/26/08.</p>

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<p>Martha Haskell LPC-0554 2009-0115</p>	<p>In 08/07, the professional began providing individual and family therapy to Son. Between 05/08 and 12/08, CPS received 3 physical abuse allegations regarding Son. In 02/09, CPS received 2 reports regarding Mother's neglect of Son. During a 03/30/09 session, Mother admitted that she put a lock on Son's bedroom door to prevent Son from getting up to eat in the middle of the night. Mother also admitted that she kicked Son in anger. On 04/01/09, the professional called the CPS representative on Son's CFT team and left a message regarding Mother's admissions and asked for a return call. The following day, the professional called the clinical liaison who was also on Son's CFT team and left a message regarding Mother's admissions and asked for a return call. The professional made no further attempt to communicate her concerns to CPS, the CPS representative, or the clinical liaison. The professional did not file a written report with CPS regarding Mother's admissions.</p>	<p>Board Action 04/02/10: Consent Agreement and Order: Order of Censure.</p>
<p>William Lowe LISAC-1594 2010-0047</p>	<p>The professional received a written warning at Agency 1 based on identified issues, including perceived favoritism, unprofessional comments, non-work related contact with female supervisees, inappropriate use of company email, and lack of professional conduct during team meetings. Agency 1 placed the professional on a 90-day performance improvement plan to address supervisory boundaries and skills and unprofessional activities. The professional continued to blame staff members for his written warning and plan of correction instead of taking responsibility for his actions.</p>	<p>Board Action 04/02/10 Consent Agreement and Order: 12 months probation; 3-semester credit hour graduate level behavioral health ethics course; investigative costs of \$110.51 stayed pending compliance with this Consent Agreement and Order.</p>
<p>Carrie Truelove-Hernandez LPC-12095 2008-0057</p>	<p>In 10/05, Client was referred to Agency 1. Client reported binge drinking when she was depressed and had several suicide risk factors. During the intake, Client reported she was out of medication, having racing thoughts, poor sleep, difficulty concentrating, extreme depression, and periods of binge drinking. The professional was assigned as Client's therapist. The professional was responsible for obtaining previous treatment records from Agency 1 regarding previous treatment Client might have had at Agency 1. Client had 3 prior episodes of treatment at Agency 1 regarding alcohol dependence and her history of suicidal ideation and attempts. The professional reported that she was unaware of prior treatment of Client. The professional relied on the 10/05 assessment and verbal information from the intake clinician as her primary source of background information pertaining to Client, which did not identify Client as high risk. As Client's therapist, the professional was responsible for treatment planning, providing individual therapy to Client, and coordinating other services that Client needed.</p>	<p>Board Action 04/02/10 Consent Agreement and Order: 24 months probation; shall only work at an agency licensed by OBHL; 3-clock hours of continuing education addressing assessment and treatment of co-occurring disorders; 3-semester credit hour graduate level behavioral health ethics course; 24 months of clinical supervision; investigative costs of \$1748 stayed pending compliance with this Consent Agreement and Order.</p>
<p>Carrie Truelove-Hernandez Continued</p>	<p>On 11/16/05, Client met with the professional. Client indicated she was living with Mother and that her youngest son was supportive and might participate in Client's treatment, Client denied that her recent behavior had been a suicide attempt and denied having received any previous treatment. Client completed an outcome rating scale indicating that she had not been doing well during the past week. The treatment plan included only counseling and case management services to address Client's alcohol abuse, anxiety and depression. The treatment plan did not include a referral for a psychiatric evaluation, specific goals that counseling or case management intended to address, referrals to treatment and/or support groups, coordination of care with Client's PCP, Mother, and/or any significant others, or a safety plan for Client. The professional did not make any effort to contact Client's PCP, Mother, or Son for additional information. There was no evidence that the professional scheduled any follow-up appointments.</p>	<p>Board Action See Above.</p>

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<p>Carrie Truelove-Hernandez Continued</p>	<p>On 01/05/06, Client called Agency 1's crisis line for assistance related to Mother's recent death. Although the professional received the crisis line report on 01/06/06, she did not document any effort to contact Client. On 01/12/06, another Agency 1 staff member and the professional discussed the need to refer Client for a psychiatric evaluation. Also on 01/12/06, Client called the crisis line asking for immediate support. During this call, Client again reported difficulty related to Mother's death. Client had stopped eating regularly, had lost 30 pounds, was experiencing severe highs and lows and extreme irritability, was fearful of leaving her house, had recently started to steal and wanted to try an antidepressant. On 01/13/06, Client called Agency 1's crisis line and repeated the information she provided during her 01/12/06 crisis call. Client further indicated that she felt like she was "in shock" and was "going crazy". On 01/16/06, the professional reviewed the crisis line report documenting the 01/12/06 crisis call.</p>	<p>Board Action See Above.</p>
<p>Carrie Truelove-Hernandez Continued</p>	<p>On 01/26/06, the professional completed a referral form for a psychiatric evaluation of Client. On 02/10/06, the professional spoke with Client after Client failed to attend a counseling appointment. Client reported feeling strange due to her antidepressant. The professional encouraged Client to follow-up with her PCP and planned to refer Client for an immediate psychiatric evaluation. During a 02/12/06 group supervision session, Client was identified as "high risk". On 02/18/06, Client called the crisis line asking for support for depression and repeated much of which she reported on 01/12/06 and 01/13/06. On 02/21/06, the professional reviewed the 02/18/06 crisis line report. There was no evidence that the professional followed-up with Client. On 03/13/06, the professional attempted to reach Client by phone and mail. Client did not respond and the professional did not follow-up until 08/06 when the professional closed the file. Client committed suicide on 02/18/06.</p>	<p>Board Action See Above.</p>
<p>Da'Mond O. Robinson LAC-13467 2010-0079</p>	<p>On 10/24/08, the professional submitted his LAC application. A review of the professional's personnel records from a number of employers since 2000 established that routinely misrepresented his employment history on multiple employment applications and on a credentialing application he completed at Agency 1. The professional misrepresented the bases for leaving a position and the dates of his employment. He also failed to disclose previous positions. The professional acknowledged 3 involuntary behavioral health related terminations, but failed to disclose a 4th termination. The professional was terminated after 4 months at Agency 2, after 3 months at Agency 3, and after 15 months at Agency 4. After contesting the termination at Agency 4, a DES review indicated that the professional falsified his time and mileage sheets. The professional denied falsifying any time or travel claims and indicated that Agency 4 submitted falsified documents during the DES hearing. The professional was terminated from Agency 5 after 11 months of employment. The professional has been employed at Agency 6 since 05/07 without any significant issues.</p>	<p>Board Action 04/02/10 Consent Agreement and Order: Order of Censure.</p>
<p>Dennis Andrew LMFT-0083 2009-0024</p>	<p>See 2009 Adverse Action Report.</p>	<p>Board Action 05/07/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 08/10/09.</p>

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<p>Rosemarie Ludwig LPC-0399 2007-0060</p>	<p>See 2008 Adverse Action Report.</p>	<p>Board Action 05/07/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 09/10/08.</p>
<p>Susan Forno LPC-1233 2008-0040</p>	<p>The professional provided counseling under a EAP contract to Client on 09/07/07. This initial and only session lasted 3 hours. The professional failed to obtain an informed consent for treatment. The professional failed to have Client sign any treatment planning documentation. The professional's initial contemporaneous clinical documentation failed to document whether Client's history included any past treatment, any previous behavioral health diagnoses, any current or past medications for a behavioral health conditions, or any current behavioral health symptoms. The professional documented at least 8 diagnoses for Client. Client reported Son's exposure physical violence, drugs and alcohol, and pornography when staying with Father. The professional did not seek immediate consultation and failed to make a CPS report until nearly 2 months later. The professional did not follow-up the CPS report with a written report, as required. Without having conducted any further sessions with Client, the professional updated Client's diagnoses from 8 to 4. The professional also updated the clinical record without documenting that specific alterations were made or the date the alteration was made.</p>	<p>Board Action 05/07/10 Consent Agreement and Order: The professional's license will be placed on probation until her license, by rule, expires on 11/30/10. The professional shall not accept any new clients. The professional shall close her private practice within 45 days and 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. The professional agrees not to renew her license or reapply for licensure for a period of 5 years. When the professional's license expires on 11/30/10, the professional is prohibited from engaging in the practice of behavioral health or claiming to be a licensee in Arizona.</p>
<p>Susan Forno LPC-1233 2008-0040</p>	<p>Following the complaint, the professional further expanded upon and made commentary in the clinical record that were not included in the contemporaneous clinical documentation. These additional comments were made nearly 3 months after seeing Client. The professional shared confidential client information with the EAP agency without Client's release of information authorization. The professional indicated that her husband, who is unrelated to her practice and has no confidentiality agreement with her practice, types her clinical notes. The professional allowed her husband to have access to Client's confidential record without Client's authorization.</p>	<p>Board Action See Above.</p>
<p>Jeanne Rust-Lester LPC-1997 2005-0082</p>	<p>The professional owned an agency that provided treatment for eating disorders. The professional applied for an OBHL license to open a level II residential agency in another location. Prior to the level II agency license being issued, the professional admitted and treated 6 clients at her level II agency. Prior to the arrival of the OBHL surveyor, the professional and agency staff removed clients, client belongings and client records in order to conceal their admission and treatment prior to licensure of the agency. OBHL assessed a \$15,250 penalty for admitting and treating clients prior to licensure being issued. The professional does not currently engage in any type of clinical practice or provide any type of clinical supervision. On 02/26/10, the Counseling Credentialing Committee recommended to modify the 08/08 Consent Agreement to add an additional stipulation.</p>	<p>Board Action 05/07/10 Consent Agreement and Order: minimum 24 months probation retroactive to 08/08; upon return to clinical practice, must work only under clinical supervision for a minimum of 12 months.</p>
<p>Bridgette Naughton LISAC-1538 2008-0044 2010-0065</p>	<p>On 08/07/08, the professional and the Board entered into a Consent Agreement ("08/08 CA") resolving Complaint No. 2008-0044. The 08/08 CA's probationary terms required the professional to work under clinical supervision for 12 months. The professional failed to comply with this requirement. The 08/08 CA's probationary terms required the professional to attend AA meetings at least 3 times per week. The professional failed to comply with this requirement. Attempts by Board staff to contact the professional were unsuccessful.</p>	<p>Board Action 05/07/10 Order of Revocation.</p>

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<p>Rayne Norton LMSW-11723 2010-0036</p>	<p>On 09/10/08, the Board issued an order ("2008 Order") resolving Complaint Nos. 2005-0142 and 2007-0049. The professional failed to comply with some of the 2008 Order's terms and conditions. On 09/23/09, the Board opened Complaint No. 2010-0036 regarding the professional's non-compliance with the 2008 Order. The professional failed to participate in the Board's investigation of that complaint.</p>	<p>Board Action 05/07/10 Order of Revocation.</p>
<p>William Jefferson LPC-0229 LMFT-0065 2009-0082</p>	<p>See 02/2010 Adverse Action Report.</p>	<p>Board Action 05/07/10 Order of Denial of Review or Rehearing Request.</p>
<p>Linda Bennardo LPC-12144 2010-0026</p>	<p>On 08/17/09, the Board issued an order ("08/09 Order") resolving Complaint No. 2007-0097: The professional treated Mother and Daughters from 08/06 through 12/06 and saw Son on 2 occasions in 11/06. In 12/06, the professional wrote a To Whom It May Concern letter recommending limiting Father's access to Son based solely on information provided by Mother and Daughters. The informed consent for Mother and Daughters lacked required elements; the professional failed to obtain informed consent for Son; initialed but did not sign most progress notes; failed to note the duration of sessions; and failed to maintain separate written or electronic records corresponding with client records. After Father refused to continue to pay for the professional's services, the professional agreed to provide ongoing treatment to Mother and Daughters on a pro bono basis. The professional took no action when Mother made an assignment of \$5,000 to the professional after the sale of Client's home. The professional acknowledged leaving a voice message for Mother asking Mother to tell the Victim Services Program that Mother paid \$75 per session.</p>	<p>Board Action 05/07/10 Consent Agreement and Order. The professional's license shall be surrendered. The surrender shall be considered a revocation of her license.</p>
<p>Linda Bennardo LPC-12144 2010-0026</p>	<p>Complaint No. 2010-0026: In 07/08, the professional treated Mother's 3-year-old daughter ("Daughter") to help reduce regressive behaviors Daughter experienced before and after visits with Father. Mother and Father were engaged in ongoing conflict with respect to Father's visitation. The court appointed a parenting coordinator and a best interest attorney. Mother provided the professional with a large amount of negative information regarding Father. Without ever contacting or meeting with Father, the professional concluded after 3 play sessions with Daughter that Daughter was highly traumatized by her visitation with Father and Daughter might be too young for overnight visitations or longer visits with Father. The professional sought no collateral information from the parenting coordinator or other entities. The professional never contacted Father to include him in Daughter's treatment or to discuss Father's perspective regarding Daughter's behavioral issues. The professional indicated she consulted with a colleague, but the consultation was not documented in Daughter's clinical record.</p>	<p>Board Action See Above.</p>

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<p>Linda Bennardo LPC-12144 2010-0026</p>	<p>In 09/08, Father contacted the professional and requested Daughter's clinical record. Father was told he could not pick up the records at the professional's office. Father felt that the professional was biased against him. The professional felt that her subsequent telephone interactions with Father were upsetting and she was concerned about her personal safety. The professional assigned her husband, an employee, to communicate with Father. Husband's communication with Father was not documented in the clinical record. In 10/08, the professional spoke with the parenting coordinator on 2 occasions, but only documented 1 of these conversations. After these communications, the parenting coordinator became concerned that the professional was biased against Father. The professional continued to treat Daughter despite her personal safety concerns, which prevented her from communicating directly with Father, and despite the possibility that she was biased against Father. Daughter's 11/08 and 04/09 treatment plans were not signed by Mother or the professional. In 04/09 and 05/09, the professional provided court testimony in a custody hearing regarding Daughter.</p>	<p>Board Action See Above.</p>
<p>James Gorton LPC-1295 2010-0054</p>	<p>Husband and Wife participated in marital counseling with the professional from 12/07 through 08/08. The professional acknowledged that soon after terminating treatment with Wife, he began engaging in a number of social activities with Wife. Approximately 6 months after terminating treatment with Wife, the professional began a romantic relationship with her that included holding hands, hugging and kissing, and spending the night at each other's houses. The professional indicated that the only reason he did not marry Wife was because her divorce from Husband was not final. By engaging in sexual conduct with Wife, he created a significant risk of harm to Wife. His conduct also created a significant risk of harm to Husband as a result of having Wife and his former marriage counselor begin a sexual relationship soon after Husband's separation from Wife. The professional acknowledged that he has treated individuals who are his friends and that, when treatment is complete, he resumes the personal relationship.</p>	<p>Board Action 05/07/10 Consent Agreement and Order: The professional's license shall be surrendered. The surrender shall be considered a revocation of his license.</p>
<p>James Gorton LPC-1295 2010-0054</p>	<p>The professional did not obtain written informed consent from Husband or Wife, did not maintain a written treatment plan regarding his treatment of Husband or Wife, and did not maintain progress notes for 63 sessions when he met with Husband and/or Wife. His progress notes did not always identify the client, did not always identify whether the session was individual or couples counseling, were not always dated, were not signed by the professional, and did not include the duration of the session. The professional met with Husband's and Wife's daughter ("Daughter") on 2 occasions and failed to maintain any documentation regarding his treatment of Daughter.</p>	<p>Board Action See Above.</p>
<p>Dawn Beatty LPC-10886 2006-0106</p>	<p>See 2009 Adverse Action Report.</p>	<p>Board Action 06/04/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 01/12/09.</p>
<p>Ludmela Leshney LMFT-10094 2008-0074</p>	<p>See 2009 Adverse Action Report.</p>	<p>Board Action 06/04/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 05/05/09.</p>
<p>Esther Emadi LPC-2047 2005-0030</p>	<p>See 2008 Adverse Action Report.</p>	<p>Board Action 06/04/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 03/12/08.</p>

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<p>Laura Gordon Chase LAC-11289 LISAC-11414 2005-0128</p>	<p>See 2008 Adverse Action Report.</p>	<p>Board Action 06/04/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 06/04/08.</p>
<p>Russell Bentley LAC-12855 2010-0033</p>	<p>The professional worked at Agency 1 from 08/02 through 08/09. Agency 1 allowed the professional to resign in lieu of termination after investigating a complaint from the mother ("Mother") of a 16-year-old client ("Client"). The professional treated Client from 03/08 through 07/09. Client was vulnerable with a father in prison, an alcoholic mother, and few other supports. The professional made non-therapeutic visits to Client, had dinner with Client and Mother in Mother's home on several occasions, and stayed at Client's home very late on several occasions. These activities were not documented in Client's clinical record. The professional engaged in non-therapeutic activities with Client, such as watching television and going out for food and coffee. On one occasion, Mother alleged that she woke up late at night and found the professional and Client watching TV where Client had his head in the professional's lap and the professional was stroking Client's head. Mother alleged that the professional massaged Client's back with a massage wand. The professional denied these two allegations.</p>	<p>Board Action 06/04/10 Consent Agreement and Order: The professional's license shall be surrendered. The surrender shall be considered a revocation of his license.</p>
<p>Russell Bentley LAC-12855 2010-0033</p>	<p>The professional acknowledged that he massaged Client's shoulders with his hands. The professional never documented any information regarding massaging Client or watching TV with Client. The professional bought Client pants and a shirt without documenting this purchase in Client's clinical record. The professional did not document any concerns about boundaries or his attempts to set more appropriate boundaries and he did not seek any supervision or guidance regarding his boundary issues with Client. The 03/08 treatment plan did not contain Mother's or the professional's signature and date.</p>	<p>Board Action See Above.</p>
<p>Julia Coffey LCSW-11467 2006-0093 2009-0124</p>	<p>See 2009 Adverse Action Report.</p>	<p>Board Action 07/09/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 12/08/09.</p>
<p>Linda Sherwood LPC-0357 2008-0119</p>	<p>See 2009 Adverse Action Report.</p>	<p>Board Action 07/09/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 11/10/09.</p>
<p>Donald Thomas LPC-10230 LISAC-11843 2009-0039</p>	<p>See 2009 Adverse Action Report.</p>	<p>Board Action 07/09/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 04/06/09.</p>
<p>Linda Hudnall LMSW-12384 2010-0075</p>	<p>During a 10/07 exam required for her LMSW licensure, the professional left the exam room, retrieved her cell phone from her locker, went outside the building and telephoned her supervisor. After speaking with her supervisor, she put her phone back in her locker and returned to the exam room. The proctor told the professional that she was not allowed to go outside during the exam. The professional told the proctor that she was having trouble breathing. The proctor allowed the professional to complete the exam. ASWB's exam instructions prohibit the use of any cell phones during an exam.</p>	<p>Board Action 07/09/10 Consent Agreement and Order: 12 months probation. While on probation, the professional shall not practice under her LMSW license. This practice restriction shall be considered a suspension of her license. The professional must take and pass an approved licensure exam; investigative costs of \$798.28 stayed pending compliance with this Consent Agreement and Order.</p>

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<p>Gary Miller LMSW-12279 2009-0059 2010-0112</p>	<p>On 03/09/10, the professional and the Board entered into a Consent Agreement ("03/10 CA"). The 03/10 CA suspended the professional's license and stayed the suspension subject to the professional's successful completion of all terms of the 03/10 CA. The professional failed to notify the Board of his employment status on a quarterly basis and failed to submit a qualified clinical supervisor for pre-approval in a timely manner.</p>	<p>Board Action 07/09/10 Order of Suspension. The professional's license shall be suspended for 24 months.</p>
<p>Mary Pat Sullivan LCSW-2315 2010-0077</p>	<p>In 09/07, the professional began providing individual and group psychotherapy services to a veteran client ("Client"). In 10/07, the professional began an intimate sexual relationship with Client that lasted approximately 15 months. While engaging in the intimate sexual relationship with Client, the professional continued to provide individual and group psychotherapy services to Client. In 11/08, Client relapsed. This time frame correlates to the time period when the professional began trying to end her relationship with Client. While the inappropriate relationship ended in 02/09, the professional continued to provide professional services to Client until late 2009. The professional acknowledged that she did not obtain signed informed consent from her psychotherapy clients and that her progress notes regarding services provided to Client did not include the duration of sessions or the signature date.</p>	<p>Board Action 07/09/10 Consent Agreement and Order: The professional's license shall be surrendered. The surrender shall be considered a revocation of her license.</p>
<p>Nara Dedrick LISAC-10786 2009-0057</p>	<p>In 2008, the professional was responsible for ensuring that 5-8 Level II Behavioral Health Residential Agencies owned by Agency 1 met OBHL licensure standards. The professional knowingly created falsified behavioral health professional ("BHP") notes for visits she did not make so that an OBHL audit would not detect her non-compliance with OBHL licensing standards regarding required BHP visits and client interaction. Agency 1's data indicated that the professional created at least 57 notes where there was no supporting evidence indicating that she actually visited a home as documented. Agency 1 kept the professional in the same position, but issued a final written warning. The professional later resigned and obtained employment elsewhere.</p>	<p>Board Action 07/09/10 Order of Revocation.</p>
<p>Stephanie Crawford LPC-10292 2007-0166</p>	<p>While employed at Agency 1, the professional received at least 3 written warnings, a suspension, and a job transfer prior to her termination regarding tardiness, negative attitude, poor boundaries and threatening her supervisor. On her 07/05 renewal application, the professional failed to disclose her disciplinary action by Agency 1. During the Board's investigation, the professional misrepresented Agency 1's actions and the basis of her termination. On her 07/08 renewal application, the professional failed to disclose her illegal use of a controlled substance. Although the professional denied that she ever misused or abused any chemical substances, evidence indicated that the professional had sought sobriety from controlled substances, received a prescription for a medication to wean her off a controlled substance, and had been recommended to participate in AA for her substance abuse issues. The professional denied the accuracy of certain records regarding her substance abuse issues and treatment. In 05/05, the professional received a written reprimand from Agency 2 regarding her failure to report for work and did not call in until 11:30 am, resulting in the cancellation of clients for that day.</p>	<p>Board Action 07/09/10 Consent Agreement and Order: 24 months probation; 3-semester credit hour graduate level behavioral health ethics course; 24 months of clinical supervision; 24 months of therapy; investigative costs of \$1712 stayed pending compliance with this Consent Agreement and Order.</p>

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<p>Mary Ann Turner LCSW-10951 2010-0018</p>	<p>The professional was grandfathered into licensure as a LCSW in 2004 and was not required to complete any supervised work experience specific to the practice of psychotherapy. The professional also qualified for an exam waiver during the conversion to licensure. The professional worked as a part-time psychotherapist at Agency 1 from 2004 through 2009. In 06/07, a client ("Client") filed a Board complaint against the professional based on services she provided at Agency 1. That complaint resulted in a non-disciplinary consent agreement. In 06/09, the professional opened a private psychotherapy practice out of her home and offered play therapy, animal assisted therapy, and aquatic therapy. The professional provided no evidence indicating that she completed any type of education or training specific to these types of therapies. In 06/09, the professional began treating 3 children ("Children") and provided play therapy, animal assisted therapy, and aquatic therapy. During one of Children's therapy sessions, the professional allowed Children to ride on a quad driven by the professional's grandson.</p>	<p>Board Action 07/09/10 Consent Agreement and Order: 24 months probation; While on probation, the professional shall not engage in independent practice and shall only provide therapy-related services while employed at an OBHL-licensed agency; submit a practice termination plan within 14 days; 3-semester credit hour graduate level behavioral health ethics course; 24 months of clinical supervision; take and pass the ASWB clinical exam; investigative costs of \$901.56 stayed pending compliance with this Consent Agreement and Order.</p>
<p>Mary Ann Turner LCSW-10951 2010-0018</p>	<p>The professional's progress notes reflected that she treated Children and their mother ("Mother") from 06/09 to 08/09. While the professional acknowledged that Mother and Children were her clients, the professional had Mother sign an informed consent for treatment form authorizing treatment of Mother only. The professional developed a treatment plan identifying the oldest son ("Son A") as her only client. The professional did not develop an treatment planning specific to her treatment of the middle son ("Son B"), the youngest son ("Son C") or Mother. Documentation in the clinical records indicated that Father had sole legal custody of Son A. The professional treated Son A without any information indicating that Mother was authorized to consent to treatment for Son A. The professional's notes indicated that she provided individual therapy even though Sons A, B, and C and Mother were present during each session. The professional had 1 couples counseling session with Mother and Mother's boyfriend ("Boyfriend").</p>	<p>Board Action See Above.</p>
<p>Mary Ann Turner LCSW-10951 2010-0018</p>	<p>The professional did not obtain written informed consent authorizing her treatment of Boyfriend. The professional indicated that she saw Mother 2 times after her last sessions with Children. These contacts were not documented in Mother's clinical record. The professional did not obtain any informed consent for treatment indicating that she would utilize animal assisted therapy and aquatic therapy in her treatment of Children. The clinical records did not reflect the therapeutic basis or purpose for allowing Mother to attend all of Children's sessions when Children were ages 17, 12, and 11.</p>	<p>Board Action See Above.</p>
<p>Elizabeth Rodgers LCSW-2519 2009-0056</p>	<p>In 2008, the professional was responsible for ensuring that 16 Level II Behavioral Health Residential Agencies owned by Agency 1 met OBHL licensure standards. The professional was also responsible for supervising at least 2 other licensed professionals. The professional knowingly created falsified behavioral health professional ("BHP") notes for visits she did not make so that an OBHL audit would not detect her non-compliance with OBHL licensing standards regarding required BHP visits and client interaction. Although the professional denied advising staff to falsify notes, her denial was contradicted by statements by other staff, who acknowledged that the professional instructed them how to falsify BHP notes. Agency 1's data indicated that the professional created at least 143 notes where there was no supporting evidence indicating that she actually visited a home as documented. During the Board's investigation, the professional made contradictory statements and continued to minimize the seriousness of her actions and the potential harm to clients.</p>	<p>Board Action 07/22/10 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>Joann Dudek LMSW Applicant</p>	<p>The applicant failed to meet minimum requirements for MSW licensure pursuant to A.R.S. Section 32-3275(5). In 06/08, the applicant was arrested for trying to shoplift over \$275 worth of clothing from a retail store. The applicant attributed the conduct that led to the arrest to confusion she was experiencing at the time, including memory problems and losing things. The applicant's records indicate that she is experiencing issues affecting her ability to practice safely and competently. The applicant failed to provide requested information despite repeated requests for additional information from the Board.</p>	<p>Board Action 07/09/10: The applicant's MSW application was denied pursuant to A.R.S. Section 32-3275(5).</p>
<p>Manuel Castillo LMSW-12810 2009-0037</p>	<p>See 2009 Adverse Action Report.</p>	<p>Board Action 08/06/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 08/07/09.</p>
<p>Danielle Reed LCSW-12155 2007-0132</p>	<p>See 2009 Adverse Action Report.</p>	<p>Board Action 08/06/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 03/09/09.</p>
<p>Barbara Waldman LCSW-3559 2003-0071 2003-0081 2006-0109</p>	<p>See 2009 Adverse Action Report.</p>	<p>Board Action 08/06/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 11/10/09.</p>
<p>Susan Rassas LISAC-1393 LPC-2288 2006-0083 2010-0124</p>	<p>See the 03/2010 Adverse Action Report. In 03/10, the Board accepted a Consent Agreement ("03/10 CA"). The professional failed to submit the name of a proposed clinical supervisor for the clinical supervision required pursuant to the 03/10 CA. The professional failed to respond to multiple attempts by Board staff to communicate with her.</p>	<p>Board Action 08/06/10 Consent Agreement and Order: 36 months probation; 3 semester credit hour graduate level behavioral health basic counseling skills in the helping relationship class; 36 months clinical supervision; investigative costs of \$1211 stayed pending compliance with this Consent Agreement and Order.</p>
<p>Danielle Reed LCSW-12155 2010-0039</p>	<p>In 2008, the professional began treating Daughters 1 and 2, Mother, Mother's boyfriend ("Boyfriend"), Father, and Stepmother. Daughter 1 lived with Father and did not visit Mother. Daughter 2 lived with Mother and did not visit Father. An 08/08 court order indicated the following: Father was to undergo counseling with the professional pertaining to his relationship with Daughter 2; Daughters 1 and 2 were to undergo counseling with the professional; all visits between Father and Daughter 2 were to occur under the professional's supervision; and the scheduling of these visits was to be at the professional's direction. During a 12/08 session with Daughter 2, it became clear to the professional that it would be problematic to continue working towards reunification between Father and Daughter 2 because of the extreme nature of Daughter 2's negative reaction to Father. The professional never informed the court of this development.</p>	<p>Board Action 08/06/10 Consent Agreement and Order: The professional agrees not to practice until her license expires on 10/31/10. This agreement not to practice will be reported as a suspension. The professional agrees not to renew her license or reapply for licensure in the State of Arizona. When the professional's license expires on 10/31/10, the professional is prohibited from engaging in the practice of behavioral health or claiming to be a licensee in Arizona.</p>

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<p>Danielle Reed LCSW-12155 2010-0039</p>	<p>The professional told Mother and Father that she believed Daughter 2 needed to participate in a forensic interview before reunification could occur. The professional did not report her suspicions to CPS. From 12/08 through 06/09, the professional continued to advocate that Daughter 2 needed a forensic evaluation to rule out possible abuse or trauma without reporting her suspicion of possible abuse or trauma to CPS. While she was treating this family, the professional went on FaceBook and looked up Boyfriend in order to access an article on Boyfriend's page. The professional asked to "friend" Boyfriend and maintained this social media friendship until 05/10. In 05/09, the professional sent confidential information regarding this family to a LPC when referring Daughter 2 to LPC for the court ordered psychological evaluation. The professional obtained a release of information authorization from Mother and Father to forward their information, but she failed to obtain a release of information authorization to forward Daughter 2's confidential information.</p>	<p>Board Action See Above.</p>
<p>Danielle Reed LCSW-12155 2010-0039</p>	<p>The professional's release of information authorization form lacked required elements. Pursuant to a 03/09 Consent Agreement, the professional began clinical supervision with an LPC. The LPC was required to review the professional's clinical records. The professional allowed the LPC access to this family's confidential records without obtaining any type of written release of information authorization. After learning that a psychologist voiced concerns about the professional's failure to report her concerns about Daughter 2 to CPS, the professional then called CPS in 07/09. The professional did not make a written CPS report, as required. Pursuant to the 03/09 Consent Agreement, the professional modified her practice forms. Her modified forms failed to contain required elements. On 07/11/09, Mother signed a therapist-patient services agreement for treatment for Daughters 1 and 2. This agreement did not provide adequate notice to her clients of LPC's supervision. The professional continued to treat Mother until 09/09 without obtaining Mother's written consent for treatment.</p>	<p>Board Action See Above.</p>
<p>Danielle Reed LCSW-12155 2010-0039</p>	<p>Although he professional asserted that Mother or Father were ever her clients, her billing records listed sessions with Mother and Father as "individual psychotherapy". The professional failed to maintain 3-4 progress notes for documented sessions that appeared in the billing record.</p>	<p>Board Action See Above.</p>
<p>Christiane Heyde LISAC-0880 2006-0086</p>	<p>See 2009 Adverse Action Report.</p>	<p>Board Action 09/02/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 01/26/09.</p>
<p>Alyssa Mandel LCSW-10473 2005-0022 2008-0039 2009-0106</p>	<p>See 2009 Adverse Action Report.</p>	<p>Board Action 09/02/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 06/08/09.</p>
<p>Jeanne Rust-Lester LPC-1997 2005-0082</p>	<p>See 2010 Adverse Action Report.</p>	<p>Board Action 09/02/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 05/12/09.</p>

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<p>Lynn Tyson LMFT-0032 2010-0035</p>	<p>The professional and the Board entered into a Consent Agreement on 12/12/08 ("12/08 CA") that included findings regarding the professional's inadequate recordkeeping practices. The professional was released from the 12/08 CA on 03/29/10. In 07/04, Mother brought Son for treatment. The professional failed to obtain any informed consent for treatment for Son. The professional later provided "family" and "couples" therapy to Mother, Stepfather, Father and Stepmother. The professional failed to obtain any informed consent for treatment for Mother, Stepfather, Father and Stepmother. In 12/08, after entering into the 12/08 CA, the professional had Mother and Father sign informed consent for treatment forms for Son. The professional did not obtain any informed consent for treatment for Mother, Stepfather, Father, and Stepmother.</p>	<p>Board Action 09/02/10 Consent Agreement and Order of Censure.</p>
<p>Lynn Tyson LMFT-0032 2010-0035</p>	<p>In 08/04, after Son's initial sessions, the professional failed to develop any treatment planning documentation regarding Son or Mother, Stepfather, Father, and Stepmother. On 07/29/04, the professional documented several statements made by Son about Father's abuse. The professional failed to report this information to CPS. On 08/09/04, the professional documented several statements by Son about Father's abuse. The professional reported this information to CPS on 08/09/04. The professional did not submit a written report to CPS after she made her verbal report on 08/09/04.</p>	<p>Board Action See Above.</p>
<p>Nancy Langsner LAC-Applicant 2010-0125</p>	<p>While the applicant's LAC application was pending, she was charged with aggravated assault on 06/28/08. She failed to notify the Board of this arrest within 10 working days, as required. The applicant's LAC application included multiple discrepancies and/or omissions regarding her work history. The applicant failed to accurately report her behavioral health history and treatment history to the Board as requested.</p>	<p>Board Action 09/02/10: The applicant's LAC application was denied pursuant to A.R.S. Section 32-3275(6).</p>
<p>John Lare LAC-12407 LISAC-11820 2009-0120</p>	<p>In 2006, the professional was employed as a psychology associate with ADJC. In 03/09, the professional submitted training certificates to the Board indicating that ADJC supervisors had completed the required clinical supervisor training pertaining to the professional's LPC application. The professional admitted that he obtained an ADJC training certificate to use as a template to create the false supervisor training certificates he submitted to the Board in order to receive his LPC. The professional was criminally charged with presenting forged or altered documents and fraud schemes, to which he has entered a "not guilty" plea. The professional provided copies of ADJC progress notes and case plans to the Board in support of a 03/09 complaint he filed against a licensed professional. ADJC policy prohibits the unauthorized use of clinical records and the removal of clinical records from a secure ADJC site for any purpose. ADJC policy also prohibits employees from releasing any identifying client information. Several of the ADJC records he provided to the Board included confidential information identifying juvenile offenders. In 03/09, ADJC terminated the professional from employment for cause based on various violations of ADJC's policies and procedures.</p>	<p>Board Action 09/02/10 Order of Revocation.</p>

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<p>Eve Mayer LCSW-0211 2008-0082</p>	<p>The professional has been in private practice since 1968. From 06/06 through 03/08, the professional provided weekly treatment to her client ("Husband"). The professional did not develop a written treatment plan for Husband. In 12/07, Husband signed a release authorization to release his records to his wife ("Wife"), per a court order. The professional refused to release Husband's records to Wife's attorney because Husband had some confusion about his signed authorization. The professional failed to document any information she received indicating Husband was confused regarding the release he signed. The professional eventually released Husband's records, but failed to document this release in the clinical record. The progress notes the professional maintained were extremely brief and contained no useful information regarding the substance of Husband's treatment. Following a Formal Interview on 11-06-09, the Board issued an order requiring that Respondent obtain clinical supervision related to appropriate clinical documentation and behavioral health rules and statutes. The clinical supervision also required random audits of the professional's clinical records. In 08/10, the professional's Board approved clinical supervisor discussed with the professional several concerns she had regarding the professional's ethics and questionable practice techniques, including releasing confidential information about a client to the client's adult daughter and an attorney referred to client. Soon afterwards, the client committed suicide. The professional was defensive in responding to the clinical supervisor's concerns indicating "limited insight or intent to remedy these issues in the future". The clinical supervisor also noted the professional's inappropriate records retention, inadequate storage and security for client records, and the absence of properly developed clinical forms.</p>	<p>Board Action 09/28/10 Consent Agreement and Order: The Professional's license shall be on probation until her license expires on 02/28/11; she shall not accept any new clients; shall close her private practice within 30 days; after closing her practice, she shall not practice under her license or engage in the practice of behavioral health; the agreement not to practice shall be considered a suspension of her license; after her license expires, the professional agrees not to renew her license or reapply for licensure in Arizona.</p>
<p>Sandra Black LISAC-10893 2009-0090 Delores D. Young LISAC-11359 2009-0091</p>	<p>From 07/06/08 to 10/21/08, Son, who was 25 years old, participated in a 90-day in-patient program at a licensed agency (Agency 1) to address his eating disorder and substance abuse issues. During Son's treatment at Agency 1, Sandra Black was the clinical coordinator and Delores Young was a family therapist. Neither Ms. Young nor Ms. Black (the "Professionals") had any direct care responsibilities for Son during his treatment at Agency 1. Agency 1's handbook provides that an employee who wants to operate a private practice may only do so if the private practice is approved by the executive director, the private practice does not create a conflict of interest and agency patients are not referred to the private practice. In 09/08, the Professionals opened a private practice known as Life Solutions Therapy ("Life Solutions"), which operated a residential home for individuals with eating disorders/substance abuse issues known as Life House and an out-patient therapy office. Neither of the Professionals sought or received approval by Agency 1's executive director to operate this private practice. Son's primary therapist during his treatment at Agency 1 was Lindsay Koestner. The week prior to Son's discharge from Agency 1, Ms. Koestner advised Son's parents that she was going on vacation for 1 week. She recommended that Son remain at Agency 1 for additional treatment and, following his in-patient treatment, Son should be referred to Agency 1's intensive outpatient program ("IOP"). Son decided to leave Agency 1. Although Ms. Koestner did not agree with Son's decision to leave inpatient treatment, she advised Parents of various options that would allow Son to continue with appropriate outpatient treatment programming. Upon Son's discharge from Agency 1, he moved into Life House.</p>	<p>Board Action 09/28/10 Consent Agreement and Order: The Professionals' license shall be surrendered. The surrenders shall be considered revocations of their licenses.</p>

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<p>Sandra Black LISAC-10893 2009-0090 Delores D. Young LISAC-11359 2009-0091</p>	<p>After moving into Life House, Son began treatment at the IOP. Agency 1 terminated the Professionals when it learned that they had opened a private practice without approval in violation of the non-compete provisions of Agency 1's handbook. During its investigation, Agency 1 learned the following: (a) While still employed at Agency 1, the Professionals established a website advertising that Life Soulutions offered a sober living environment at Life House and outpatient treatment at Life Soulutions specializing in eating disorders and substance abuse treatment. (b) Ms. Black emailed Agency 1's proprietary and confidential documents from her work email address to her home email address. (c) In the course of their employment at Agency 1, the Professionals solicited several current and/or former clients to enter treatment at Life Soulutions. (d) Ms. Koestner indicated that Ms. Young approached Ms. Koestner to talk about Son entering Life Soulutions. (e) Ms. Young told Ms. Koestner that she had given Son information about Life Soulutions. (f) Ms. Koestner later learned that one of the Professionals had given Son a pass to visit Life House. (g) On 10/12/08, Son was discharged from Agency 1 and moved to Life House. (h) The Professionals acknowledged that 3 individuals who were current or former Agency 1 clients received services from Life Soulutions. Agency 1 filed a lawsuit against the Professionals seeking, in part, to prevent them from continuing to use confidential and proprietary information and from soliciting or offering any services to current or former Agency 1 patients. Although the Professionals arranged for Son to live at Life House and participate in the IOP, immediately after Son began the IOP, the Professionals began indicating to Parents that Son did not like the IOP and offering to enroll Son in a Life Soulutions 90-day program.</p>	<p>Board Action See Above.</p>
<p>Sandra Black LISAC-10893 2009-0090 Delores D. Young LISAC-11359 2009-0091</p>	<p>The Professionals allowed Son to leave the IOP and begin treatment at Life Soulutions even though Life Soulutions was not prepared to offer an intensive program as recommended by his prior treatment team. Parents alleged that, based on the Professionals' representations, they understood that the \$8500 monthly fee paid to Life Soulutions would provide for a structured IOP appropriate for Son. The Professionals did not ensure that Son's treatment at Life Soulutions included individual and family therapy as recommended by his prior treatment team, which created a significant risk of harm to Son. The Professionals failed to provide an opportunity for Son to participate in a Survivors Workshop even though Parents pre-paid for this service. The Professionals represented that Son would receive programming 4 evenings per week over the course of Son's 90-day treatment. At a minimum, Life Soulutions should have provided 54 therapeutic sessions for Son. There were only 19 documented sessions, including 3 EMDR sessions, 1 session with a nurse practitioner, 6 sessions with a nutritionist, 1 session with a massage therapist, and 6 group therapy sessions. The Professionals told Parents that Son would meet weekly with a psychiatrist. Son did not meet with a psychiatrist during his 90-day treatment program at Life Soulutions. Life Soulutions indicated that Life House offered a structured program providing programming designed to enhance recovery from eating disorders and substance abuse, including process groups, swim and art therapy, house meetings, meditation, assignment of chores, 12 step programming, personal reflection and journaling, and practicing affirmations. The Professionals provided no documentation indicating that any programming was provided to Son during his residence at Life House.</p>	<p>Board Action See Above.</p>

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<p>Sandra Black LISAC-10893 2009-0090 Delores D. Young LISAC-11359 2009-0091</p>	<p>Soon after moving into Life House, Son purchased a car and began working full-time at a tattoo parlor. When Brother visited in 12/08, he rarely saw Son because Son was working extremely long hours. Parents were concerned these activities would interfere with Son's programming and asked the Professionals to address these issues with Son. The Professionals provided no information indicating that they took any action addressing Parents' concerns. The Professionals hired a LASAC as an independent contractor to provide EMDR services to Son. Nothing in the Life Soulutions or the LASAC's records suggests that Life Soulutions provided any type of supervision to the LASAC regarding Son's treatment. The LASAC's records for Son did not include a consent for treatment or a treatment plan. The Professionals' decision to hire a LASAC to provide EMDR services to Son without any type of oversight placed Son at risk. The Professionals terminated treatment without appropriate written notice to Son and without appropriate written referrals. The Life Soulutions website misrepresented the Professional's credentials. During investigative interviews by the Board, the Professionals misrepresented information. In a 08/08 email to an acquaintance, Ms. Black indicated that, if the acquaintance referred a client to Life Soulutions and the client entered treatment, Ms. Black would send the acquaintance a "finder's fee".</p>	<p>Board Action See Above.</p>
<p>Gayle Billingsley LASAC-13093 2010-0087</p>	<p>During the fall of 2008, the owners of Life Soulutions hired the professional to provide treatment to an agency client ("Client") as an independent contractor. The professional provided EMDR sessions to Client on 12/12/08, 12/19/08, and 01/02/09. There was no evidence that the agency supervised the professional with regard to the services she provided to Client. The professional's scope of practice as a LASAC is limited to the use of psychotherapy as it relates to substance abuse and chemical dependency issues. The professional acknowledged that the EMDR treatment she provided Client was related to his eating disorder. The professional failed to obtain a written informed consent for treatment before providing EMDR services to Client. The professional failed to develop any written treatment planning documentation for Client. The professional failed to document discussions she indicated she had with Client regarding his treatment goals and discussions with the owners of Life Soulutions regarding Client's treatment.</p>	<p>Board Action 10/07/10 Consent Agreement and Order: The professional is not currently practicing and will remain on indefinite probation until she returns to practice; within 12 months, take and pass a 3 semester credit hour graduate level behavioral health ethics course and a 3 semester credit hour graduate level clinical documentation course; after returning to practice, 24 months of clinical supervision; investigative costs of \$641.91 stayed pending compliance with this Consent Agreement and Order.</p>
<p>James Bissel LASAC-12585 LAC-13078 2007-0024 2010-0001</p>	<p>See 2009 Adverse Action Report.</p>	<p>Board Action 10/07/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 12/08/09.</p>
<p>Charles Combs LPC-1004 2009-0047</p>	<p>See 2009 Adverse Action Report.</p>	<p>Board Action 10/07/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 12/08/09.</p>

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<p>Jon Grossman LCSW-0754 LMFT-0182 2009-0114</p>	<p>The professional contracts with the Arizona Administrative Office of the Courts ("AOC") to provide sexual offender treatment to juveniles on probation with the Pinal County Juvenile Probation Department ("PCJPD"). In 12/05, the professional began providing sexual offender treatment to a 14-year-old male client ("Client"). Client's grandfather ("Grandfather") was Client's legal guardian. Grandfather signed Client's 12/05 consent for treatment form and the treatment plan. In 05/06, CPS took custody of Client. Client foster parents ("Foster Parents") then became his guardians. In 10/08 and 12/08, Client's CPS caseworker ("CPS CM") became Client's legal guardian. The professional failed to update Client's record to include signed coconsents for treatment and signed treatment plans by each of Client's successive legal guardians. Grandfather signed a release of information authorization allowing the professional to release information to PCJPD. The professional provided ongoing information to PCJPD after Grandfather's death without written authorization to do so from Client's from successive guardians.</p>	<p>Board Action 10/07/10 Consent Agreement and Order: 12 months probation; within 12 months, take and pass 6 clock hours of continuing education addressing clinical recordkeeping; investigative costs of \$1202 stayed pending compliance with the terms and conditions of this Consent Agreement and Order.</p>
<p>Jon Grossman LCSW-0754 LMFT-0182 2009-0114</p>	<p>Client's ongoing behavioral health problems included auditory hallucinations commanding him to commit suicide or harm himself with razors, broken glass, pens, or other available objects. In 10/08, Client was admitted to a behavioral health hospital after a self-harming episode. The professional met with admissions and clinical personnel from the Devereux Residential Treatment Center ("Devereux") regarding Client on at least 3 occasions to facilitate Client's admission to Devereux. The professional provided a written report ("12/08 Report") to Devereux that included details pertaining to Client's background and behavioral health treatment. The professional failed to obtain written authorization to release this information to Devereux from Client's legal guardian. The professional failed to obtain written authorization before providing information about Client to Client's behavioral health case manager, Client's psychiatrist, and Client's foster parents when they were no longer Client's guardians. The professional provided treatment to Client while Client was living at Devereux. The professional did not engage in any initial discussions with the Devereux clinician (Therapist) who was assigned to provide individual and group therapy to Client in order to collaborate their ongoing treatment of Client. During a session with the professional, Client complained of "frightening hallucinations" telling him to kill self. Shortly after this session, Client engaged in self harm by biting himself. During three subsequent sessions with the professional, Client made additional suicidal references and/or statements regarding self harm. The professional indicated that he reported anything of concern to Devereux school staff and Client's probation officer, but not to Therapist. The professional failed to document any conversations with Devereux school staff and/or the probation officer regarding Client's suicidal and/or self-harm statements.</p>	<p>Board Action See Above.</p>

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<p>Jon Grossman LCSW-0754 LMFT-0182 2009-0114</p>	<p>In 02/09, a Devereux therapist (Therapist) requested a copy of the professional's treatment plan for Client. The professional did not give herapist a copy of Client's treatment plan. On 03/13/09, Therapist gave the professional written authorization from Client's CPS case manager permitting the professional to provide Devereux with a copy of the professional's assessments, treatment plans and progress notes regarding Client. The professional did not provide Devereux with the requested documents without providing any written explanation regarding why he did not provide the requested documents. Client's record did not contain a copy of the 03/13/09 written authorization. On 03/26/09, Devereux agains requested Client's records. The professional again chose not to provide Devereux with the requested documents. The professional provided Devereux with a written summary regarding Client's treatment and advised Devereux that he would no longer provide on-site treatment to Client. The professional failed to document in Client's record Devereux's records requests, any steps he took to address Devereux's records requests, any basis for refusing to provide the requested records to Devereux, and any verbal communications with Devereux regarding the records requests.</p>	<p>Board Action See Above.</p>
<p>Victor Leeks LAC-13581 2011-0022</p>	<p>On 01/21/10, the professional submitted his application for licensed associate counselor and reported an employment termination 2 months after he was hired based on several peer reports of inappropriate interpersonal communication issues. He is not elegible for rehire. The professional had a history at an earlier employment of similar issues, which had improved prior to his resignation.</p>	<p>Board Action 10/07/10 Consent Agreement and Order: the professional's licensed associate counselor application is approved and immediately placed on probation; 24 months of clinical supervision; investigative costs of \$500 stayed pending compliance with this Consent Agreement and Order.</p>
<p>Karen Mavrikos LAC-13597 2010-0118</p>	<p>On 08/27/09, the professional was charged with Extreme DUI. On 09/01/09, the Board received the professional's application for licensed associate counselor. The professional did not disclose her 08/09 DUI on her license application and failed to notify the Board within 10 days of being charged with her 08/09 DUI. The Board did not learn of the professional's 08/09 DUI until it received the professional's criminal history report. The professional pled guilty to 1st offense DUI and completed her sentencing terms with the exception of an interlock device, which remains on her vehicle until 03/11. In 11/09, the professional was charged with another DUI, while her 08/09 DUI was still pending resolution. While the professional had alcohol in her system at the time of her 11/09 DUI arrest, it was below the .08 legal limit and the case was dismissed. The Board ordered a substance abuse evaluation, which indicated that the professional had no active substance abuse disorder and no treatment was recommended. The professional's conduct, which resulted in two DUI matters within 3 months, indicated impaired judgment.</p>	<p>Board Action 10/07/10 Consent Agreement and Order: the professional's licensed associate counselor application is approved and immediately placed on probation; Order of Censure; 24 months of therapy; investigative costs of \$421 stayed pending compliance with this Consent Agreement and Order.</p>

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<p>David Tennyson LSAT-Applicant 2010-0127</p>	<p>On 06/11/10, the Social Work Credentialing Committee found that the professional was not eligible for licensure based on the following findings: (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 opioid 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).</p>
<p>Christina Allen LASAC-11447 2011-0018</p>	<p>In 10/08, the professional was charged with shoplifting. The charge was dismissed after the professional participated in a deferred prosecution program. The professional paid a \$300 administrative fee. The professional did not disclose her 10/08 criminal charge to the Board within 10 days, as required, until she submitted her 05/10 renewal application.</p>	<p>Board Action 11/04/10 Consent Agreement and Order of Censure.</p>
<p>DeeDee Bassil LPC-10770 2009-0068</p>	<p>See 2009 Adverse Action Report.</p>	<p>Board Action 11/04/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 12/08/09.</p>
<p>Russell Farnsworth LAC-13332 2009-0113</p>	<p>See 2009 Adverse Action Report.</p>	<p>Board Action 11/04/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 09/08/09.</p>

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<p>Paul Cartone LPC-10042 2009-0101</p>	<p>Regarding Complaint No. 2009-0101: The professional owns A New Day Counseling Center ("ANDCC"). He employs independently licensed behavioral health professionals to provide psychotherapy to ANDCC clients. The professional resides in New York state and does not have routine access to ANDCC client records. The professional conducts and/or oversees all ANDCC billing activities regarding ANDCC clients. Two therapists ("Therapist 1 and Therapist 2") provided treatment to ANDCC clients, including individual therapy, couples therapy, play therapy, family therapy, and therapy with family members where the client was not present. The professional completed insurance billing documents regarding services that Therapist 1 and Therapist 2 provided to ANDCC clients. The professional acknowledged that he was not aware that different billing codes were to be used, depending on the type of session provided. The professional completed insurance documents without reviewing client records or speaking with Therapist 1 or 2 to ensure that the information that he provided to insurance companies was accurate. The professional did not maintain any insurance claim forms. The professional signed insurance forms as the service provider, even though Therapists 1 or 2 provided the actual therapy. In some instances, had Therapists 1 or 2 been properly listed as the service provider, some claims would not have been paid because Therapists 1 and 2 were not always approved by the client's insurance plan to provide services. The professional signed the names of Therapists 1 and 2 on insurance forms without their permission and without noting that he was signing on their behalf. The professional failed to maintain billing documentation that included the date each claim was billed, the service code billed, the client diagnosis, the date a payment was received, the payment source, and the amount received for each claim. The professional failed to maintain copies of the forms he submitted to obtain insurance reimbursement and communications he had with clients regarding financial/billing issues. In 2007, Therapist 1 provided marital counseling to a client ("Client 10") and his wife. The professional knew that Client 10's and Wife's insurance company did not provide reimbursement for marital counseling. Instead of representing that Client 10 and Wife participated in marital counseling together, the professional submitted individual therapy claims for their sessions. When Therapists 1 and 2 left ANDCC, the professional allowed them to take original clinical records for their ANDCC clients and did not retain a copy for ANDCC. As a result, for some former ANDCC clients, the only records the professional maintained were the financial/billing records.</p>	<p>Board Action 11/04/10 Consent Agreement and Order: probation; within 12 months, complete 3 clock hours of continuing education addressing behavioral health ethics and 3 clock hours addressing current behavioral health documentation requirements; 24 months clinical supervision; practice audit; investigative costs of \$2899 stayed pending compliance with this Consent Agreement and Order.</p>
<p>Paul Cartone LPC-10042 2009-0101</p>	<p>Regarding Complaint No. 2009-0134: In 2008, while employed by ANDCC, Therapist 1 provided therapy to a child ("Client 5"). Client 5's mother ("Mother") communicated with the professional on more than one occasion regarding Mother's concern that it appeared that the professional had failed to submit claims to her insurance company for Client 5's treatment. The professional failed to document his communications with Mother or any steps he took to resolve Mother's concerns. When Therapist 1 left ANDCC in 12/08, the professional allowed her to take Client 5's original clinical record and did not retain a copy for ANDCC. The only records the professional maintained pertaining to Client 5 were financial/billing records.</p>	<p>Board Action See Above.</p>

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<p>Kathleen Exelby LPC-0513 2009-0112</p>	<p>The professional has a private practice and is an approved provider with several insurance companies. A review of 10 client records found that the professional's consent for treatment and treatment planning documentation did not contain required elements. The professional failed to date her signature on a large majority of progress notes. The progress notes for family or conjoint sessions did not consistently and/or clearly identify session participants. The professional consistently used one progress note to document 90 minute sessions that included the client and one or more family members, which she billed twice: once as an individual session and once as a family session. The progress notes for these sessions did not identify the amount of time she spent individually with the client or the amount of time spent with the client and family together. The professional submitted insurance claims for a significant number of sessions where the clients advised the insurance company that these sessions never occurred. In some instances, the client records did not include a progress note for the sessions she claimed she provided. In other instances, the professional had a progress note for the session she claimed she provided, but she did not have the client sign the first page of the progress note, which was her usual practice. She submitted a claim for a session that occurred more than 1 month after her client record indicated the client terminated treatment. The clinical records contained a significant number of alterations where the professional used white-out to delete information previously recorded. In some instances, the professional deleted a previous date on a progress note and then wrote a new date. The professional made alterations to records she submitted to the Board where she failed to denote that she altered her original record or the date she made the change. The professional submitted progress notes to Ingenix that were not the same progress notes maintained in her original record for that date. The professional submitted a progress note to Ingenix that was a copy of a progress note previously provided to Ingenix for a session on a different date where she deleted the original session date and recorded a new session date. She submitted claims for individual and family therapy with a client where a majority of the sessions provided were marital therapy sessions and where marital therapy was not a covered service. The professional submitted claims using the 90809 service code. This code covers individual psychotherapy combined with a medical evaluation and management services, which are not within the professional's scope of practice.</p>	<p>Board Action 11/04/10 Consent Agreement and Order: probation; complete 6 clock hours of continuing education addressing behavioral health ethics, 3 clock hours addressing current behavioral health documentation requirements, and 1 clock hour addressing behavioral health fraud and abuse issues; 24 months clinical supervision; practice audit; investigative costs of \$1656 stayed pending compliance with the terms and conditions of this Consent Agreement and Order.</p>
<p>Stephanie Hight LPC-10323 2010-0063</p>	<p>The professional timely self-reported a 09/08 arrest for Aggravated DUI. The professional made a decision to drive with a child under 15 years of age in her vehicle after drinking alcohol. At the time of this offense, the professional's BAC was .119. In 04/09, the professional pled guilty to the reduced charge of DUI and completed all sentencing terms imposed by the Court, including 16 hours of alcohol education. A Board ordered substance abuse evaluation conducted by an addictionologist indicated that the professional does not suffer from a current substance abuse disorder.</p>	<p>Board Action 11/04/10 Consent Agreement and Order of Censure.</p>

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<p>Kyle Arena LISAC-0468 2010-0074</p>	<p>The professional has had an independent substance abuse counseling certificate/license since 1992. The professional did not renew his license when it expired on 07/31/10. His license was suspended by operation of law pending the resolution of this complaint. The professional indicated that he has not actively engaged in the practice of substance abuse counseling since 2005. On 01/27/09, the professional was arrested and charged with DUI of .08 or more BAC. On 04/30/09, the professional pled guilty to the reduced charge of first offense DUI (impaired to the slightest degree). The professional completed all sentencing terms imposed by the Court, including a substance abuse screening conducted by a licensed clinician and 16 hours of substance abuse education. On 06/10/09, the professional self-reported his DUI conviction to the Board, over 4 months after being arrested and charged. On 01/22/10, the Substance Abuse Credentialing Committee ordered the professional to obtain a substance abuse evaluation by an addictionologist. The professional failed to complete the evaluation as ordered.</p>	<p>Board Action 12/02/10 Consent Agreement and Order: Had the professional remained licensed, he would have been required to surrender his license to the Board. The surrender would have been considered a revocation of his license.</p>
<p>Amna Gilmore LAC-Applicant 2011-0030</p>	<p>On 01/20/10, the professional submitted her application for licensed associate counselor. The professional provided psychotherapy services at an agency ("Agency") for over 2 years without being licensed to do so. The professional acknowledged: (1) She ordered business cards representing that she was an LAC soon after she began working at Agency. (2) She did so because she believed that she would be obtaining her LAC shortly. (3) She took no action regarding the misrepresentation on her business cards, as time passed. (4) On occasion, she used the "LAC" designation after her name on certain records. (5) She knew from her master's ethics class that it was inappropriate for her to misrepresent her credentials. From 04/10 through 07/10, the professional maintained some client files from Agency on her personal laptop even though she was not working at Agency during that time period.</p>	<p>Board Action 12/02/10 Consent Agreement and Order of Censure.</p>
<p>Jon Grossman LCSW-0754 LMFT-0182 2009-0114</p>	<p>See 2010 Adverse Action Report.</p>	<p>Board Action 12/02/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 10/07/10.</p>
<p>Clemmer Ralph Hamby LCSW-11846 2011-0044</p>	<p>The professional acknowledged the following: (1) He is a recovering alcoholic with a long history of abusing alcohol with intermittent periods of sobriety. (2) In 2007 and 2008, he "pulled away from AA" and began to drink alcohol again. (3) In 06/09, he voluntarily admitted to a hospital for detoxification resulting from his bingeing on alcohol. His discharge plan from the hospital indicated the following: (1) An intensive outpatient program was strongly recommended. (2) His prognosis was guarded due to his recurrent return to alcohol abuse. The professional resigned from his practice within an agency effective 10/16/09. He established a small private practice following his resignation. The professional reported the following: (1) His new sobriety date is 11/24/09. (2) He has obtained a sponsor and returned to regular AA attendance. (3) He closed his private practice effective 10/17/10.</p>	<p>Board Action 12/02/10 Consent Agreement and Order: The professional's license shall be surrendered. The surrender shall be considered a revocation of his license.</p>
<p>Sandy Jardine LPC-0556 2009-0041</p>	<p>See 2009 Adverse Action Report.</p>	<p>Board Action 12/02/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 09/08/09.</p>
<p>Julie Ohlinger LCSW-10266 2009-0046</p>	<p>See 2009 Adverse Action Report.</p>	<p>Board Action 12/02/10: The Board released the professional from all terms and conditions of the Consent Agreement and Order dated 10/06/09.</p>

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<p>Margaret Cattey LCSW-1845 2008-0019</p>	<p>The professional provided 6 psychotherapy sessions to a client ("Client") beginning on 07/09/07. The professional did not obtain Client's written consent for treatment. The professional did not obtain Client's signature on Client's treatment plan. On 07/09/07, Client signed an authorization to release information form that did not contain the following required elements: (1) The individual requesting or receiving the record or information. (2) A description of the client record or information to be released or disclosed. (3) The date or circumstance when the authorization expires, not to exceed 12 months. At Client's request, the professional completed a short term disability form, which included information pertaining to Client's diagnosis, general treatment recommendations, and recommendations regarding a restriction from work. She subsequently faxed the completed short term disability form to Client's employer ("Employer") and to the company handling Client's short term disability claim ("Company"). On 07/24/07, the professional spoke with Company regarding Client's ability to return to work on 08/01/07. On 07/31/07, the professional wrote a letter to Employer regarding Client's attendance and progress during sessions and Client's ability to return to work without restrictions. The professional failed to obtain appropriate written authorization from Client to release verbal or written information to Employer or Company. Client terminated treatment shortly after an 08/27/07 psychotherapy session and requested a copy of his clinical record. The professional indicated that she initiated telephone calls to NASW, the Statewide HIPAA Office, the Board, and Client's insurance provider seeking advice about how to respond to Client's records request. The professional did not document any telephone calls pertaining to her research regarding Client's records request. A separate telephone log documented some, but not all, of these calls. The professional informed Client that she would not givr Client a copy of his records, but she would be willing to provide a copy of the clinical records to Client's new therapist ("Therapist"). On 09/15/07, the professional received a faxed authorization form from Client authorizing her to release a copy of his clinical records to Therapist. Although the professional indicated that she provided Therapist with a copy of Client's clinical record, there was no record of this release documented in Client's clinical record. Therapist indicated that she never received a copy of Client's clinical records and that the professional told Therapist that she would not release Client's records. A 09/17/07 note by the professional in Client's clinical record indicated that she spoke to Therapist about "not sending notes". On 10/27/10, the professional told the Board that she closed her private practice in 06/09.</p>	<p>Board Action 12/02/10 Consent Agreement and Order: probation; complete 6 clock hours of continuing education addressing current behavioral health documentation requirements; upon returning to practice, obtain a practice monitor to conduct regular audits of her clinical records for 12 months.</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 in Complaint No. 2007-0136. Pursuant to the 06/07 CA, the professional was licensed subject to the following terms during a probationary period of 3 years: (1) Weekly clinical supervision (2) Individual therapy (3) Attendance at 5 AA meetings weekly (4) Sponsor reports (5) Random biological fluid testing (6) Completion of a 36-hour relapse prevention program. Throughout probation, the professional has consistently been out of compliance with the terms of the 06/07 CA. In 08/09, the Board did not approve clinical supervision sessions with her supervisor ("Supervisor 1") from 04/09 through 07/09 based on the following: (1) The professional's participation in group clinical supervision sessions was not in accordance with the approved supervision plan. (2) Supervisor 1 submitted her supervision notes rather than a quarterly supervision report, as required. (3) The supervision provided did not focus on the approved supervision plan or the 06/07 CA. 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. Supervisor 2 identified the following problems: (1) The professional failed to attend her last 2 scheduled clinical supervision sessions without notice. (2) The professional continues to have boundary issues with clients and staff. (3) The professional appears defiant toward individual clinical supervision. (4) The professional's "lack of willingness to assume responsibility for her actions" is very concerning. Although the 06/07 CA requires random monthly biological fluid testing, the professional's employer allowed the professional to schedule the date of her monthly UAs. The majority of the monthly UAs have been collected on or near the last day of each month. The professional repeatedly failed to ensure that her medical provider sent quarterly reports advising the Board of the professional's UA test dates and test results. 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 investigative costs of \$852.71.</p>
<p>Cecilie Evans LMSW-Applicant 2011-0038</p>	<p>The professional was arrested in 01/06 for DUI in Nevada. She failed to disclose this arrest to the Nevada Board of Examiners for Social Workers ("Nevada Board") within 10 days, as required. She failed to disclose this arrest on the 11/06 and 11/07 license renewal applications she submitted to the Nevada Board, as required. She failed to provide police and court records regarding her DUI, as requested by the Arizona Board and failed to establish that she was unable to obtain the requested documents. She failed to provide her behavioral health records for treatment received from 2006 through 2010, as requested by the Arizona Board. She advised the Arizona Board that she would not allow the Arizona Board to access the requested behavioral health records.</p>	<p>Board Action 12/02/10: Denial of LMSW license application based on unprofessional conduct.</p>
<p>Derek Mellor LAC-Applicant</p>	<p>The professional was employed as a Behavioral Health Technician ("BHT") at an agency ("Agency 1") from 1996 through 2007. During his employment at Agency 1, he participated in a large number of trainings regarding the administration of medication to clients. Despite this training, on 3 separate occasions, he was disciplined for making medication errors. He was also disciplined for falling asleep during staffings. After a medication error that was potentially lethal to a client, he was terminated from Agency 1. The professional completed a master's internship at another agency ("Agency 2"). The professional's supervisor at Agency 2 reported that the professional failed to take immediate and appropriate action after a client disclosed a danger to self/others issue and, as a result of the professional's poor judgment, she could not recommend him for licensure.</p>	<p>Board Action 12/02/10: Denial of LAC license application based on unprofessional conduct.</p>

