IN THE MATTER OF	*	**BEFORE THE MARYLAND**
ADIL M. IRANI, P.T.	*	**STATE BOARD OF**
Respondent	*	**PHYSICAL THERAPY EXAMINERS**
License Number: 21496	*	**Case Numbers: 10-28 & 10-34**

* *

CONSENT ORDER

The Maryland State Board of Physical Therapy Examiners (the "Board") charged **ADIL M. IRANI, P.T.** (the "Respondent") License Number 20680, with violations of certain provisions of the Maryland Physical Therapy Act, (the "Act") codified at Md. Health Occ. Code Ann. ("H.O.") §§ 13-101 *et seq.* (2009 Repl. Vol. and 2011 Supp.).

Specifically, the Board charged the Respondent with violations of the following provisions of H.O. § 13-316:

> Subject to the hearing provisions of § 13-317 of this subtitle, the Board may deny a license, temporary license, or restricted license to any applicant, reprimand any licensee or holder of a temporary license or restricted license, place any licensee or holder of a temporary license or restricted license on probation, or suspend or revoke a license, temporary license, or restricted license if the applicant, licensee, or holder:
>
> (4) In the case of an individual who is authorized to practice physical therapy is grossly negligent;
>
> (i) In the practice of physical therapy;
>
> (ii) In the direction of an individual who is authorized to practice limited physical therapy; or
>
> (iii) In the supervision of a physical therapy aide;
>
> (11) Practices physical therapy or limited physical therapy with an unauthorized person or supervises or aids an unauthorized person in the practice of physical therapy or limited physical therapy;

(15) Violates any provision of this title or rule or regulation adopted by the Board; [and]

(25) Fails to meet accepted standards in delivering physical therapy or limited physical therapy.

The Board charged the Respondent with violating the following regulations: Code Md. Regs. ("COMAR") tit. 10 § 38.03.02 "Standards of Practice."

A. Physical Therapists.

(2) The physical therapist shall:

(a) Exercise sound professional judgment in the use of evaluation and treatment procedures;

* * *

(e) Evaluate the patient and develop a plan of care before the patient is treated;

* * *

(g) Reevaluate the patient as the patient's condition requires, but at least every 30 days, unless the physical therapist, consistent with accepted standards of physical therapy care, documents in the treatment record an appropriate rationale for not evaluating the patient;

(h) Provide direct supervision of students and aides; [and]

* * *

(l) Document ongoing communication with the physical therapist assistant regarding changes in a patient's status and treatment plan[.]

The Board also charged the Respondent with violating the following regulations: COMAR 10.38.03.02-1, "Requirements for Documentation."

On March 29, 2012, the Respondent appeared before the Case Resolution Conference Committee (the "CRC") of the Board. As a result of the negotiation that occurred prior to and at the CRC, the Respondent agreed to enter into this Consent Order, consisting of the Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. At all times relevant hereto, the Respondent was and is a physical therapist licensed to practice physical therapy in the State of Maryland. The Respondent was originally licensed to practice physical therapy in the State of Maryland on July 11, 2005, under license number 21496.

2. At all times relevant hereto, the Respondent was employed as a physical therapist at Physical Therapy Practice A[1] located in Arnold, Maryland.

3. On or about March 8, 2010, the Board initiated an investigation after receiving complaints from one physical therapist assistant and one occupational therapist that worked in the same facility as the Respondent at Physical Therapy Practice A. The complaints alleged that the Respondent was improperly treating patients by failing to supervise technicians, issuing unnecessary transcutaneous electrical nerve stimulation ("TNS") units to patients, and improperly billing for services.

4. In furtherance of its investigation, the Board staff interviewed the complainants, the Respondent, and other employees at Physical Therapy Practice A. The Board's investigation also included subpoenaing treatment records of the Respondent's patients at Physical Therapy Practice A and retaining an independent expert witness to evaluate the treatments rendered by the Respondent.

5. The Board's investigation determined that the Respondent violated the Act and the Board's regulations, including but not limited to: failing to properly supervise a physical therapy technician or physical therapist assistant during the performance of exercises on his patients; failing to properly evaluate or adequately document the medical history and physical therapy record for Patients 1 through 15; failing to

[1] The names of the individuals and entities referenced herein are confidential.

document devising an appropriate plan of care that adequately addresses a plan of care for Patients 1 through 15; failing to document in the physical therapy treatment records for Patients 1 through 15 support for the billing of multiple units of therapeutic procedures; failing to document in the physical therapy treatment records of Patients 1 through 15 the need for one on one patient contact during exercises; and failing to document in the physical therapy treatment records of Patients 1 through 15 ongoing communication between the physical therapist and the physical therapist assistant.

6. The Board's investigation revealed that between October 2008 and March 2010, the Respondent routinely turned his patients over to a physical therapy technician employed with Physical Therapy Practice A who would guide the patients on exercises. According to Physical Therapy Technician A, the Respondent would then leave the area and go to an area of the office where he was unable to supervise the technician or his patients completing the exercises, which the Respondent denies.

7. The Board's investigation also revealed that the Respondent failed to document evaluating the effectiveness of the TNS unit once it was issued to his patients.

8. The Respondent failed to keep up with reevaluations of his patients during this time period. The Respondent's explanation for unable to complete the reevaluations was that he attempted on numerous occasions to have a physical therapist assistant collect objective data for him but the physical therapist assistant refused to do so.

9. From May 2009 until January 2010, Physical Therapy Technician A was employed at Physical Therapy Practice A serving as the Respondent's primary assistant.

10. In an interview with Board staff on December 8, 2010, Physical Therapy Technician A reported that she assisted the Respondent's patients with exercises on numerous occasions without any supervision from the Respondent. According to Physical Therapy Technician A, the Respondent taught her how to do the exercises and then allowed her to teach new patients without any assistance or supervision from the Respondent, which the Respondent denies.

11. Physical Therapy Technician A also confirmed that the Respondent would leave her to do the exercises with patients while the Respondent went to a computer in the back of the office or spoke on his telephone. She stated that there were probably three to four occasions when the Respondent left the building while she was assisting his patients with exercises. Physical Therapy Technician A further confirmed that the Respondent would telephone when he was going to be late for work to have her begin exercises with his patients prior to his arrival. In response, the Respondent denied Physical Therapy Technician A's allegations during the investigation.

PATIENT SPECIFIC FINDINGS

Patient 1

12. Patient 1, who was forty nine (49) years old at the time of his initial visit, presented to Physical Therapy Practice A on or about November 10, 2009, with a referral due to neck and low back pain following a car accident. The Respondent performed an improper initial evaluation, which lacked a functional assessment.

13. The Respondent treated Patient 1 on six separate occasions after Patient 1's initial visit through January 19, 2010. The physical therapy treatment records for Patient 1 for these visits lack documentation of objective status; do not support the billing of multiple units of therapeutic procedures; do not support the need for one-on-one therapist presence during exercises; and failed to document evaluating Patient 1's response to TNS.

14. Furthermore, the physical therapy treatment records for Patient 1 demonstrate that there was no re-evaluation performed within thirty (30) days of the initial visit and there is no documentation demonstrating communication between the Respondent and the physical therapist assistant.

15. Finally, the Respondent documented a discharge summary dated January 19, 2010, and included objective data such as range of motion measures and manual muscle test, even though there was no patient visit on that date and the data were not recorded in Patient 1's previous visit.

Patient 2

16. Patient 2, a female who was seventy one (71) years old at the time of her initial visit, presented to Physical Therapy Practice A on or about November 9, 2009, with a referral from her physician for physical therapy after she had a total knee replacement. The Respondent, who performed the initial evaluation on Patient 2, failed to document performing it properly. The Respondent's initial evaluation for Patient 2 fails to provide any details of the treatment received by Patient 2 while she was at home recovering from surgery prior to her initial visit to Physical Therapy Practice A, even though Patient 2 reported that she had pain while completing some of these home

exercises. The Respondent's initial evaluation also failed to include standardized tests such as the balance test, time up and go, sit-to-stand, or 2-minute march.

17. Patient 2 was treated at Physical Therapy Practice A on nine separate occasions after her initial visit through January 6, 2010. The Respondent provided treatment on one of these occasions. The physical therapy treatment records for Patient 2 completed for this time period fail to demonstrate components of objective findings in Patient 2's initial evaluation; fail to demonstrate the need for the billing of multiple units of therapeutic procedures; and fail to document communication between the Respondent and the physical therapist assistant.

18. Furthermore, the Respondent documented a discharge summary dated February 1, 2010, and included objective data such as range of motion measures and strength test, even though there was no patient visit on that date and the data were not recorded in Patient 2's previous visit.

Patient 3

19. Patient 3, a female who was fifty eight (58) years old at the time of her initial visit, presented to Physical Therapy Practice A on or about January 5, 2010, due to right knee pain. The Respondent, who performed the initial evaluation on Patient 3, failed to document performing it properly. The Respondent's initial evaluation fails to document a balance test. In the assessment portion of the initial evaluation, the Respondent documents that Patient 3 presents with decreased flexibility and range of motion, but in the objective portion the Respondent notes range of motion within normal limits. The initial evaluation also lacks a patient history for Patient 3, including a medication profile and general health status.

20. The Respondent treated Patient 3 on six occasions after her initial visit through February 3, 2010. The physical therapy treatment records for Patient 3 for this time period fail to document objective status; do not support the billing of multiple units of therapeutic procedures; and fail to document ongoing communication between the Respondent and the physical therapist assistant.

Patient 4

21. Patient 4, a female who was eighty three (83) years old at the time of her initial visit, presented to Physical Therapy Practice A on or about November 3, 2009, due to a left rotator cuff tear that was found to be inoperable. The Respondent, who performed the initial evaluation on Patient 4, failed to document performing it properly. The initial evaluation fails to document a passive range of motion test or any special tests related to the rotator cuff.

22. The Respondent treated Patient 4 on six occasions after her initial visit through December 9, 2009. The physical therapy treatment records for Patient 4 for this time period fail to document objective status; fail to document the need for one on one patient contact during exercises beyond the initial teaching phase, which is generally one to three visits; and fail to support the billing of multiple units of therapeutic procedures.

23. Furthermore, the Respondent documented a discharge summary dated January 19, 2010, and included objective data such as goniometric measures, muscle and testing results, even though there was no patient visit on that date and the data were not recorded in Patient 4's previous visit.

Patient 5

24. Patient 5, a male who was twenty two (22) years old at the time of his initial visit, presented to Physical Therapy Practice A on or about October 26, 2009, because of a right ankle sprain suffered while playing basketball. The Respondent, who performed the initial evaluation on Patient 5, failed to document performing it properly. The initial evaluation lacked functional assessment and balance or proprioception evaluation.

25. The Respondent treated Patient 5 on three more occasions through November 11, 2009, prior to completing a discharge summary on November 30, 2009. The physical therapy treatment records for Patient 5 for this time period fail to document objective status; fail to support the billing of multiple units of therapeutic procedures; fail to document the need for one on one patient contact during exercises; and fail to document ongoing communication between the Respondent and the physical therapist assistant.

26. Furthermore, the Respondent documented a discharge summary dated November 30, 2009, and included objective data such as range of motion and strength test results, even though there was no patient visit on that date and the data were not recorded in Patient 5's previous visit.

Patient 6

27. Patient 6, a male who was eighty nine (89) years old at the time of his initial visit, presented to Physical Therapy Practice A on or about October 12, 2009. Patient 6 was referred to Physical Therapy Practice A due to right hip pain, which Patient 6 stated was three weeks in duration and worsening. The Respondent, who performed the initial evaluation on Patient 6, failed to document performing it properly.

The Respondent documented Patient 6's range of motion as a percentage, which is not considered objective. The initial evaluation also fails to include Patient 6's height and weight, a balance assessment, and functional tests such as a sit to stand test. There is also no information about Patient 6's living situation.

28. The Respondent treated Patient 6 on eight separate occasions after the initial evaluation through November 16, 2009. The physical therapy treatment records for Patient 6 during this time period lack objective status; fail to document the performance of appropriate tests and measures; and fail to document manual therapy listed in the initial treatment plan. The treatment records further fail to document the need for one on one patient contact during exercises beyond the initial teaching phase, which is generally one to three visits; and fail to support the billing of multiple units of therapeutic procedures.

Patient 7

29. Patient 7, a male who was forty five (45) years old at the time of his initial visit, was referred to Physical Therapy Practice A on or about November 17, 2009, due to status post cervical spine fusion. The Respondent, who performed the initial evaluation on Patient 7, failed to document performing it properly. The initial evaluation fails to document the date of Patient 7's surgery, the levels of Patient 7's spine that were fused, and the reason for the fusion. There is also no information regarding Patient 7's physical activity needs including work, home, recreational or fitness activities.

30. The Respondent treated Patient 7 on one more occasion on November 30, 2009. Patient 7 was also treated by a physical therapist assistant on four occasions after the initial evaluation through December 10, 2009. The physical therapy treatment records for Patient 7 during this time period lack objective status; fail to document the need for one on one patient contact during exercises; fail to support the billing of multiple units of therapeutic procedures; and demonstrate that functional deficits noted as being addressed by exercises are not properly assessed.

31. Furthermore, the Respondent documented a discharge summary dated December 16, 2009. The Respondent wrote down objective data from Patient 7's previous visit, but incorrectly noted the range of motion measures and failed to include the manual muscle test findings.

Patient 8

32. Patient 8, a male who was eighty one (81) years old at the time of his initial visit, was referred to Physical Therapy Practice A on or about November 9, 2009, after a right total hip replacement. The Respondent, who performed the initial evaluation on Patient 8, failed to document peforming it properly. The Respondent's initial evaluation contains no information about Patient 8's course of home therapy. The initial evaluation also fails to document Patient 8's current home situation, and there is no evaluation of Patient 8's balance, performance on sit to stand tests or stairs.

33. Patient 8 was treated at Physical Therapy Practice A on four more occasions through December 7, 2009. The physical therapy treatment records for Patient 8 during this time period lack objective status; fail to include assessment of

balance and proprioception; and fail to support the billing of multiple units of therapeutic procedures.

34. Furthermore, the Respondent documented a discharge summary dated December 15, 2009, without a patient visit and recorded manual muscle test results that were different from the results recorded in Patient 8's previous visit.

Patient 9

35. Patient 9, a female who was forty eight (48) years old at the time of her initial visit, was referred to Physical Therapy Practice A on or about January 18, 2010, due to low back and sacroiliac joint pain. The Respondent, who performed the initial evaluation on Patient 9, failed to document performing it properly. The initial evaluation fails to contain information about Patient 9's height, weight, current work status or functional activity needs. There is also no documentation of lower extremity range of motion testing.

36. Patient 9 was treated by the Respondent at Physical Therapy Practice A on two more occasions through January 25, 2010. The physical therapy treatment records for Patient 9 during this time period fail to support the billing of multiple units of therapeutic procedures; demonstrate that functional deficits noted as being addressed by exercises are not properly assessed; and contain minimal objective data on which to base care.

Patient 10

37. Patient 10, a male who was fifty five (55) years old at the time of his initial visit, was referred to Physical Therapy Practice A on or about January 26, 2010, because of cervical spine pain, low back pain, and carpal tunnel resulting from a trip

and fall. The Respondent, who performed the initial evaluation on Patient 10, failed to document performing it properly. The initial evaluation fails to document when Patient 10's injury occurred, any prior treatment for the injury, or the functional activity needs of Patient 10. The initial evaluation also fails to document radiological diagnostic studies.

38. The Respondent treated Patient 10 on six separate occasions after his initial visit through February 9, 2010. The physical therapy treatment records for Patient 10 during this time period fail to document any objective findings after the initial evaluation; fail to document Patient 10's responses to TNS units after issuance to Patient 10; contain no further testing or changes to Patient 10's treatment despite Patient 10's complaint of increased pain and neurological symptoms; fail to support the billing of multiple units of therapeutic procedures; and fail to document the need for one on one patient contact during exercises.

Patient 11

39. Patient 11, a male who was seventy (70) years old at the time of his initial visit, was referred to Physical Therapy Practice A on or about October 19, 2009, after a total knee replacement. The Respondent, who performed the initial evaluation on Patient 11, failed to document peforming it properly. The initial evaluation lacked information about Patient 11's home situation, height, weight, and passive range of motion. The initial evaluation also failed to include standardized functional tests that are typical for a patient with a knee replacement such as a balance test, sit to stand test, march test, and timed walking.

40. Patient 11 was treated at Physical Therapy Practice A on fourteen more occasions through November 23, 2009. The Respondent treated Patient 11 on ten of

these visits. The physical therapy treatment records for Patient 11 during this time period fail to support the billing of multiple units of therapeutic procedures; demonstrate that functional deficits noted as being addressed by exercises are not properly assessed; fail to document the need for one on one patient contact during exercises; contain no documentation of gait training; and fail to document Patient 11's responses to TNS units after issuance.

41. Furthermore, the Respondent documented a discharge summary dated December 15, 2009, without a patient visit and recorded range of motion measures that were different from those recorded in Patient 11's previous visit.

Patient 12

42. Patient 12, a male who was thirty two (32) years old at the time of his initial visit, was referred to Physical Therapy Practice A on or about September 5, 2009, due to thoracic and lumbar spine pain after a car accident. The Respondent, who performed the initial evaluation on Patient 12, failed to document peforming it properly. The initial evaluation failed to include Patient 12's work status and an assessment of his ability to work. The treatment goals documented in Patient 12's initial evaluation include returning Patient 12 to his prior level of functioning, but it is impossible to determine Patient 12's prior level of functioning based on the documentation completed by the Respondent.

43. Patient 12 was treated at Physical Therapy Practice A on nine more occasions through December 16, 2009. The Respondent treated Patient 12 on four of these visits. The physical therapy treatment records for Patient 12 during this time period fail to support the billing of multiple units of therapeutic procedures; demonstrate

that functional deficits noted as being addressed by exercises are not properly assessed; fail to document the need for one on one patient contact during exercises; and fail to document Patient 12's responses to TNS units after issuance.

Patient 13

44. Patient 13, a female who was sixty six (66) years old at the time of her initial visit, was referred to Physical Therapy Practice A on or about September 24, 2009, due to right Achilles tendonitis. The Respondent, who performed the initial evaluation on Patient 13, failed to document performing it properly. The initial evaluation for Patient 13 fails to document Patient 13's functional activity needs, fails to demonstrate that balance and proprioception were evaluated, and fails to document an evaluation of Patient 13's foot and ankle in weight-bearing.

45. Patient 13 was treated at Physical Therapy Practice A by the Respondent on six more occasions through November 5, 2009. The physical therapy treatment records for Patient 13 during this time period fail to document objective status; fail to justify the need for billing multiple units of therapeutic exercises; fail to demonstrate that functional activities are evaluated; and fail to document the need for one on one patient contact during exercises. In addition, there are contradictory statements in the treatment records related to Patient 13's assessment, and manual therapy is not provided to Patient 13.

Patient 14

46. Patient 14, a female who was forty four (44) years old at the time of her initial visit, was referred to Physical Therapy Practice A on or about October 9, 2009, due to neck and upper back pain after a car accident.

47. Patient 14 was treated at Physical Therapy Practice A by the Respondent on fourteen occasions after her initial evaluation. The physical therapy treatment records for Patient 14 during this time period do not contain objective measures, status, or findings on which to base ongoing skilled physical therapy care; fail to support the billing of multiple units of therapeutic procedures; demonstrate that functional deficits noted as being addressed by exercises are not properly assessed; fail to document the need for one on one patient contact during exercises; and fail to document Patient 14's responses to TNS units after issuance.

Patient 15

48. Patient 15, a female who was eighty three (83) years old at the time of her initial visit, was referred to Physical Therapy Practice A on or about January 21, 2010, due to lumbar spine degenerative disc disease with spondylosis. The Respondent, who performed the initial evaluation on Patient 15, failed to document performing it properly. The initial evaluation fails to document Patient 15's current living situation or functional activity needs. The initial evaluation also contains no posture evaluation, and balance and proprioception are not evaluated.

Patient 15 was treated at Physical Therapy Practice A on seventeen occasions after her initial evaluation through May 5, 2010. The Respondent treated Patient 15 on five of these visits. The physical therapy treatment records for Patient 15 during this time period fail to document objective status; fail to appropriately document the need for one on one patient contact during exercises; fail to support the billing of multiple units of therapeutic procedures; and demonstrate that functional deficits noted as being addressed by exercises are not properly assessed.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent violated H.O. §13-316(4), (11), (15), and (25), and COMAR 10.38.03.02A(2)(a),(e),(g),(h), and (l), and COMAR 10.38.03.02-1.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is this 18TH day of June, 2012, by a majority of the Board considering this case:

ORDERED that the Respondent's license is placed on immediate **PROBATION** for a minimum **PERIOD OF TWO (2) YEARS**, during which time the Respondent shall:

1. Enroll in and satisfactorily complete the next available Board Law and Ethics Course. The Respondent shall submit proof of his successful completion of the course.

2. Enroll in and satisfactorily complete a Board-approved documentation course within six (6) months of the date the Board executes this Consent Order. The Respondent shall submit proof of his successful completion of the course.

3. The courses outlined in paragraphs one (1) and two (2) shall be in addition to any Continuing Education requirements mandated for continuing certification as a physical therapist and shall not count toward fulfilling any licensure requirements that the Respondent must fulfill in order to renew his physical therapist license.

4. The Respondent shall be required to submit three (3) treatment records to the Board for review on a quarterly basis (every three months), subject to the following terms and conditions:

    a) The selected records shall reflect treatment by the Respondent, to include an initial evaluation, progress notes, reevaluation, and a discharge summary; and

    b) The Respondent shall comply with the Board's recommendations regarding its review of the Respondent's documentation.

5. The Respondent shall pay a fine of one thousand dollars ($1,000), by certified check or money order, made payable to the Maryland Board of Physical Therapy Examiners within 30 days of the order.

6. The Respondent shall comply with the Maryland Physical Therapy Act and all laws, statutes and regulations pertaining thereto.

7. The Respondent shall cooperate with the Board in the monitoring, supervising and investigating of his compliance with the terms and conditions of this Consent Order.

8. The Respondent's failure to fully cooperate with the Board shall be deemed a violation of the probationary terms and a violation of this Consent Order.

AND IT IS FURTHER ORDERED that after the conclusion of the entire **TWO (2) YEAR** period of **PROBATION,** the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated, through an order of the Board, or a designated Board committee. The Board, or designated Board committee, will grant the termination if the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions; and it is further

ORDERED that if the Respondent violates any of the terms and conditions of his probation and/or this Consent Order, the Board, in its discretion, after notice and an opportunity for an evidentiary hearing if there is a genuine dispute as to the underlying material facts, or an opportunity for a show cause hearing otherwise, may impose any sanctions which the Board may have imposed in this case, including an additional probationary terms and conditions, reprimand, suspension, revocation and/or monetary penalty; and it is further

ORDERED that the Respondent shall be responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and be it further

ORDERED that this Consent Order is considered a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. §§ 10-611 *et seq.* (2009 Repl. Vol. and 2011 Supp.).

John Baker, P.T., DScPT
Chairperson
State Board of Physical Therapy Examiners

CONSENT

I, **ADIL M. IRANI, P.T.**, acknowledge that I was given an opportunity to consult with counsel but elected not to do so before entering into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed after any such hearing.

I sign this Consent Order, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

05/22/2012
Date

Adil M. Irani, P.T.

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF Montgomery

I HEREBY CERTIFY that on this 22nd day of May, 2012, 2012, before me, a Notary Public of the foregoing State and City/County personally appear Adil M. Iraini, P.T., License Number 21496, and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed.

AS WITNESSETH my hand and notary seal.

Notary Public

My commission expires: 11/05/14

SERGIO E. GARCIA
NOTARY PUBLIC
MONTGOMERY COUNTY
MARYLAND
My Commission Expires 11-05-2014