IN THE MATTER OF	*	**BEFORE THE**
AMISHA SHROFF, D.D.S.	*	**STATE BOARD OF**
RESPONDENT	*	**DENTAL EXAMINERS**
LICENSE NUMBER 13054	*	**CASE NUMBERS:**
	*	**2011-022, 2011-233, 2013-009**

* * * * * * * * * * * * *

CONSENT ORDER

On October 16, 2013, the Maryland Board of Dental Examiners (the "Board") charged **AMISHA SHROFF, D.D.S.**, (the "Respondent"), license number 13054, under the Maryland Dentistry Act, Md. Health Occ. ("H.O.") Code Ann., §§ 4-101 *et seq.* (2011 Repl. Vol & 2012 Supp.) The pertinent provisions of the Act under H.O. § 4-315 are as follows:

> (a) *License to practice dentistry.* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may deny a general license to practice dentistry . . . reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist if the licensee:
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> > (3) obtains a fee by fraud or attempts to obtain a fee by fraud;
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> > (6) practices dentistry in a professionally incompetent manner or in a grossly incompetent manner;
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> > (16) behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession;
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> > (18) violates any rule or regulation adopted by the Board;
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> > (19) is disciplined by a licensing or disciplinary authority of any other state or county or convicted or disciplines by a court of any state or country for an act that would be grounds for disciplinary action under the Board's disciplinary statute; and

(20) willfully makes or files a false report or record in the practice of dentistry.

FINDINGS OF FACT

1. At all times relevant, the Respondent was licensed to practice dentistry in the State of Maryland. The Respondent initially received her license on October 30, 2002. Her Maryland license will expire on June 30, 2016.

2. At all times relevant, the Respondent maintained a private practice located in Bethesda, Maryland.

3. The Respondent was also issued a license to practice dentistry (License No. 0401-411963) by the Commonwealth of Virginia on or about September 7, 2007. Her Virginia license will expire on or about March 31, 2015. At all times relevant, the Respondent maintained a private practice located in Falls Church, Virginia.

A. Complaints

4. On or about August 9, 2010, the Board received a complaint from Patient A alleging that on or about May 19, 2008, the Respondent placed an improperly fitted crown on tooth #2 resulting in large gaps between the crown, gum and post. Patient A alleged that he experienced gum irritation, food entrapment and halitosis.

5. On or about April 29, 2011, the Board received a complaint from Patient B's father on behalf of his adult son alleging that the Respondent improperly billed for services not provided, placed an improperly fitted crown on tooth #15 and failed to diagnose and properly treat tooth decay on tooth #2, necessitating a root canal. The complaint further alleged that the Respondent's routine dental cleanings were inadequate due to lack of scaling, and the Respondent's office was unkempt and poorly maintained.

6. On or about July 19, 2012, the Board received a Complaint from Patient C alleging that the Respondent placed an improperly fitted crown on tooth #20, resulting in extreme sensitivity, irritation, discomfort and unevenness to her bite. Patient further alleged that the Respondent acknowledged that the crown was ill fitting, and offered to remake the crown using the original impression.

7. Patient C sought a second opinion during which she was advised that the crown on tooth #20 was "unsatisfactory," "far too bulky," fit improperly," and had "exposed metal on the crown". Patient C contacted the Respondent to cancel the order for the replacement crown and requested a full refund of the monies paid for the original crown.

8. On or about May 4, 2011, the Board initiated an investigation into the Respondent's practice of dentistry. As part of its investigation, the Board subpoenaed twenty-five (25) patient records from the years 2009 – 2011.

9. On or about October 1, 2012, the matter was referred to an independent expert in general dentistry (the "Board expert"). On or about January 7, 2013, the Board expert issued a comprehensive report in which he opined that the Respondent's recordkeeping was inadequate, her billing and coding were consistently fraudulent and unprofessional, and her treatment was substandard and professionally incompetent.

B. Board Investigation

Patient A

10. On or about April 19, 2008, Patient A, a 35 year old male, presented to the Respondent who diagnosed gross decay on tooth #2 and referred Patient A to an endodontist. Following endodontic treatment, Patient A returned to the Respondent for

a post and core and placement of a crown. Following placement, Patient A complained that the crown was ill fitted and causing gum irritation. He subsequently had the crown removed by another dentist.

11. The Board expert opined that based on his review of Patient A's treatment records and x-rays, the "post op periapical clearly shows a clinically unacceptable crown with open and overhanging margins that is below the standard of care."

12. The Board expert also found that the Respondent charged a fee for copying Patient A's treatment records, in excess of the statutory maximum pursuant to H.G. § 4-304.

13. The Respondent billed for services previously included in a bundled fee, but did not collect that fee from Patient A. It is unclear whether the Respondent submitted a bill for the unbundled fee to a third party payer.

Patient B

14. On or about December 30, 2010, Patient B, a 22 year old male, presented to the Respondent for placement of a crown on tooth #15. A temporary crown was placed and billed separately from the fee for impression, fabrication and placement of the permanent crown. Neither the temporary nor the permanent crown fit properly resulting in numerous adjustments to the point that the metal on the crown was exposed.

15. On or about March 18, 2011, Patient B sought emergency treatment from a cosmetic and reconstructive dental provider ("Dentist A") following fracture of tooth #30.

16. On or about April 12, 2011, Patient B sought a second opinion from Dentist A regarding possible replacement of the crown on tooth #15. X-rays revealed that the "crown on tooth #15 had a flat occlusion and no porcelain present on the occlusal surface."

17. After reviewing relevant records and x-rays, the Board expert confirmed the presence of unrecognized gross decay of tooth #30, likely necessitating emergency treatment from Dentist A on March 16, 2011. Further the Board expert found that the crown placed on tooth #15 was ill-fitted and did not provide sufficient occlusal reduction. This necessitated Patient B to seek a replacement crown from Dentist A on or about April 12, 2011. The Board expert noted that the Respondent's explanation as to the reasons for the occlusal discrepancy was "not plausible."

18. The Board expert further opined that the Respondent's recordkeeping was inadequate, her x-rays were undated and that she billed for services not adequately documented in her treatment records.

Patient C

19. On or about April 3, 2012, Patient C, a 26 year old female, presented to the Respondent for treatment of a small chip of tooth #20. The Respondent diagnosed a fractured tooth and recommended a build up and PFM crown. She placed a temporary crown and took an impression for the PFM crown. Patient C complained of extreme sensitivity with the temporary crown and scheduled an appointment with the Respondent prior to the placement of the permanent crown, which revealed that the sensitivity was caused by a hole in the temporary crown. The Respondent placed the permanent crown at this visit.

20. After placement of the permanent crown, Patient C complained that the crown was uncomfortable, bulky, and ill fitted. After numerous adjustments and attempts to correct the occlusal discrepancy, the Respondent advised Patient C that she would order a new crown using the original impression. Patient C sought a second opinion from another dental provider ("Dentist B.").

21. Dentist B's clinical findings included: "the PFM was bulky, thick margins, no papilla clearance, metal showing on occlusal surface and a grey shade that does not match the color of (Patient C's) natural teeth." Dentist B noted that the crown was of substandard quality and questioned whether the crown was necessary based on Patient C's initial report that tooth #20 had a small chip.

22. The Board expert reviewed the relevant records and x-rays from both the Respondent and Dentist B. The Board was unable to determine if the initial treatment was necessary due to the diagnostic quality of the x-rays taken by the Respondent. He concluded that the original crown was clinically unacceptable and that the Respondent's offer to fabricate a new crown from the original impression would have resulted in a second substandard crown caused by insufficient occlusal clearance.

23. The Board found that the Respondent billed for services previously included in a bundled fee, but did not collect the fee from the Patient C. It is unclear whether the Respondent submitted a bill for his unbundled fee to a third party payer.

24. The Board found that the Respondent charged a fee for copying Patient C's treatment records in excess of the statutory maximum pursuant to H.G. § 4-304.

25. The Respondent has since made full restitution to Patient C.

Patient D

26. The Respondent treated Patient D, a 31 year old female from March 30, 2005 until June 20, 2009. The Board found that the Respondent's recordkeeping was inadequate throughout the treatment period; specifically that the Respondent failed to adequately document that the restorations billed for were performed; failed to adequately document diagnostic reasons for recommended treatment; and failed to adequately document clinical findings.

Patient E

27. The Respondent treated patient E, a 58 year old male, from March 25, 2008 – July 7, 2010. The Board found that the Respondent billed Patient E for treatment using non-existent or incorrect billing code(s), and unbundled fees by billing for services included in the original procedure.

Patient F

28. The Respondent treated Patient F, a 51 year old female from May 7, 2007 – February 18, 2009. The Board found that the Respondent's limited progress notes were inadequate.

Patient G

29. The Respondent treated Patient G, a 63 year old female, on February 19, 2010. The Board found that the Respondent overcharged Patient G and provided one treatment while actually performing a lesser treatment, unbundled a fee by billing for one service included in the original procedure code, and billed under a non-existent billing code.

Patient H

30. The Respondent treated Patient H, a 38 year old female, from November 17, 2008-December 4, 2008. The Board found that the Respondent unbundled services performed on December 4, 2008 and billed for an office visit on December 18, 2008 that should have been included in the original bill for services performed on December 4, 2008. The Respondent also billed for a bonding procedure on December 1, 2008 under a non-existent billing code.

Patient I

31. The Respondent treated Patient I, a 21 year old male, from June 5, 2009-September 25, 2009. The Board expert found that the Respondent overcharged Patient I and billed for treatment while actually performing lesser treatment, unbundled fees by billing for services included in the original procedure codes and billed under non-existent billing codes.

Patient J

32. The Respondent treated Patient J, a 44 year old female, from December 21, 2009 – May 5, 2011. The Board expert found that Respondent charged a fee to Patient J for copying costs in excess of the statutory maximum pursuant to H.G. § 4-304.

33. The Board expert also found that the Respondent's fabrication of an 8 unit bridge for teeth #s 5-12 was substandard. He further concluded that the treatment records and x-rays were inadequate and failed to substantiate rationale or necessity for treatment.

34. The Respondent billed for services previously included in a bundled fee, but did not collect the fee from the Patient J. It is unclear whether the Respondent submitted a bill for the unbundled fee to a third party payer.

Patient K

35. The Respondent treated Patient K, a 35 year old male, from May 18, 2009 – March 21, 2011. The Board found that the Respondent billed for services not documented and failed to maintain adequate dental records.

Patient L

36. The Respondent treated Patient L, a 47 year old female, on April 22, 2009. The Board found that the Respondent billed for intraoral complete series, but her records document that she performed a panaromic film only.

37. The Respondent also unbundled fees by billing for a service included in the original procedure.

Patient M

38. The Respondent treated Patient M, a 35 year old male, from February 28, 2007-February 10, 2011. The Board found that a portion of the language in the Respondent's consent form was not reasonable. The Board expert found that the Respondent's recordkeeping was inadequate, hindering a thorough and proper expert review of the treatment provided.

39. The Respondent overcharged Patient M and billed for treatment while actually performing lesser treatment, unbundled fees by billing for services included in the original procedure codes, and billed under non-existent billing codes.

Patient N

40. The Respondent treated Patient N, a 62 year old female, from August 31, 2006 – April 26, 2011.

41. The Board expert found the Respondent charged a fee to Patient J for copying costs in excess of the statutory maximum pursuant to H.G. § 4-304.

42. The Board expert found that on several occasions, treatment was recommended despite documentation of a poor prognosis. He further found that Respondent's treatment was substandard and that her recordkeeping was inadequate. X-rays were missing form Patient N's chart, hindering a thorough and proper expert review.

43. The Respondent also unbundled fees billing for services included in the original procedure, and billed under incorrect, or non-existent billing codes.

Patient O

44. The Respondent treated Patient O, a 37 year old female from February 4, 2010, - April 2, 2010. The Board expert found that despite documentation of poor periodontal status and impending orthodontics, the Respondent performed extensive bridgework. The Board expert noted that the "timing and sequencing of the bridge is questionable."

45. In addition, the Board found that the Respondent overcharged Patient O and billed for treatment while actually performing lesser treatment, unbundled fees by billing for services included in the original procedure codes, and billed under non-existent billing codes.

46. Respondent charged a fee to Patient J for copying costs in excess of the statutory maximum pursuant to H.G. § 4-304.

Patient P

47. The Respondent treated Patient P, a 43 year old female from April 12, 2010 – November 8, 2010. The Board found that the Respondent performed and billed for the same procedures more frequently than necessary, and further overcharged Patient P for treatment while actually performing lesser treatment.

Patient Q

48. The Respondent treated Patient Q, a 31 year old female from August 7, 2007 – August 2, 2010. The Board found that the Respondent overcharged Patient Q and billed for treatment while actually performing lesser treatment.

49. The Board expert opined that, notwithstanding code descriptors that require that a procedure be billed only for an established patient who had experienced significant change in health status, the Respondent frequently billed for the same procedure.

50. The Respondent failed to maintain adequate dental records and x-rays, hindering a thorough and proper expert review, and further billed under non-existent billing codes.

Patient R

51. The Respondent treated Patient R, a 45 year old male from June 19, 2006 - April 21, 2010. The Board found that the Respondent's limited progress notes were inadequate.

52. The Board found that the Respondent overcharged Patient R and billed for treatment while actually performing lesser treatment, unbundled fees by billing for services included in the original procedure codes and billed under non-existent billing codes.

Patient S

53. The Respondent treated Patient S, a 61 year old female, from October 6, 2009 – December 14, 2010. The Board expert found that a portion of the language in the Respondent's consent form was not reasonable. The Board expert found that the Respondent also failed to maintain adequate treatment records.

Patient T

54. The Respondent treated Patient T, a 34 year old female, from June 19, 2010 – June 25, 2011. The Board expert found that a portion of the language in the Respondent's consent form was not reasonable and that her record keeping was inadequate.

55. Prior to initiating restorative procedures, Respondent took a panoramic x-ray, but failed to obtain bitewings or periapical x-rays.

56. Notwithstanding code descriptors that require that a procedure be billed only for an established patient who had experienced a significant change in health status, the Respondent billed for the same procedure twice within six (6) months with no supporting documentation, and submitted bills for both procedures.

57. The Board found that the Respondent overcharged Patient T and billed for treatment while actually performing lesser treatment, unbundled fees by billing for

services included in the original procedure codes, and billed under non-existent billing codes.

Patient U

58. The Respondent treated Patient U, a 31 year old female, from February 26, 2010 – March 30, 2011. The Board expert found that a portion of the language in the Respondent's consent form was not reasonable and that her recordkeeping was inadequate.

59. The Board found that the Respondent overcharged Patient U and billed for treatment while actually performing lesser treatment, unbundled fees by billing for services included in the original procedure codes and billed under non-existent billing codes. The Respondent submitted duplicate bills for orthodontic retainers, supported only by progress notes which indicate that on March 11, 2011, Patient U was fitted for an upper and lower retainer.

Patient V

60. The Respondent treated Patient V, a 57 year old female, from January 2010 – October 1, 2010. The Board expert found that the Respondent's recordkeeping was inadequate. Prior to initiating orthodontic treatment, Respondent failed to take appropriate bitewings or periapical x-rays.

61. The Board found that the Respondent overcharged Patient V and billed for treatment while actually performing lesser treatment, unbundled fees by billing for services included in the original procedure codes and billed under non-existent billing code

Patient W

62. The Respondent treated Patient W, a 58 year old male, from October 16, 2007 – May 13, 2010. The Board expert found that the Respondent failed to perform a comprehensive evaluation of Patient W. Full arch x-rays were not taken until 2 1/2 years after the initial visit.

63. Despite documentation of poor periodontal status, Respondent performed extensive bridgework resulting in failed bridge procedures. The Respondent subsequently performed extractions, repairs and other unnecessary dental treatment.

64. The Respondent's recordkeeping was inadequate hindering a thorough and proper expert review of the treatment provided.

65. The Board found that the Respondent overcharged Patient W and billed for treatment while actually performing lesser treatment, and billed under non-existent billing codes.

Patient X

66. The Respondent treated Patient X, a 54 year old female, from August 4, 2004 – August 14, 2007. The Board expert found that the Respondent failed to label and date x-rays taken during the course of treatment, hindering a thorough and proper expert review. The Board expert was unable to determine the propriety and rationale for treatment because it was impossible to correlate the date of service/procedure from the x-rays.

67. Notwithstanding an initial examination and diagnoses, the Respondent failed to order cavity –detecting x-rays until 1 1/2 years after the initial visit.

68. The Board expert found that the Respondent's recordkeeping was inadequate, hindering a thorough and proper expert review of the treatment provided.

69. The Respondent billed under non-existent billing codes.

The Virginia Board Action

70. The Board's Investigation revealed that on or about February 28, 2012, the Virginia Board of Dentistry ("VA Board") notified the Respondent of allegations of potential violations of the Virginia Dentistry Act, §54.1-2076(4),(5) and (11), arising from a patient complaint ("VA Patient A") alleging overbilling and substandard/defective placement of two crowns.

71. In lieu of proceeding to an informal conference (scheduled for April 13, 2012) to address the alleged violations, the Respondent elected to enter into a Consent Order with the VA Board, dated March 28, 2012, wherein she admitted to "violating §54.1-2706(4),(5), and (11) and 18 VAC 60-20-170(1) of the Regulations Governing Dental Practice."

72. The Respondent was subject to disciplinary action by the VA Board for grounds similar to the Board's disciplinary statutes. Specifically, the facts and circumstances that gave rise to the VA Consent Order were similar or identical to the allegations revealed during the Board's investigation and set forth *supra* in this Consent Order.

73. The Respondent was ordered to pay a monetary penalty of one thousand one hundred forty dollars ($1,140) to the VA Board within thirty (30) days, and was further ordered to present documentation within six (6) months of successful completion of four (4) continuing education hours in office billing/coding, and four (4) additional hours in crown and bridge aesthetics.

74. On July 3, 2012, the VA Board accepted the verification of Respondent's completion of the terms of the March 28, 2012 Consent Order and lifted all restrictions from Respondent's license.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent, practiced dentistry in a professionally incompetent manner in violation of H.O. §4-315(a)(6); behaved dishonorably or unprofessionally, or violated a professional code of ethics pertaining to the dentistry profession, in violation of H.O. § 4-315(a)(16); is disciplined by another state for an act that would be grounds for disciplinary action under the Board's statute in violation of H.O. §4-315(a)(19); and willfully makes or files a false report or record in the practice of dentistry in violation of H.O.§ 4-315 (a)(20).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 18TH day of JUNE, 2014, by a majority of the quorum of the Board, hereby

ORDERED that the Respondent's license to practice as a dentist in the State of Maryland is hereby **SUSPENDED** effective **JULY 3, 2014** until such time that the Respondent satisfactorily completes Board mandated training and establishes that she is competent to practice dentistry; and it is further

ORDERED that beginning **JUNE 18, 2014,** the Respondent shall commence a fifteen (15) day "wind down" period during which she shall notify the patients of her practice whom she has treated within the last three (3) years, in writing, that she will be serving in an administrative capacity only, beginning **JULY 3, 2014** and will further notify

her patients that any and all clinical care and treatment sought from the Respondent's practice on or after **JULY 3, 2014** and until further notice, shall be provided by a dental health care provider other than the Respondent during the period of **ACTIVE SUSPENSION** of the Respondent's license to practice dentistry; and it is further

ORDERED that during the fifteen (15) day "wind down" period, the Respondent shall not personally seek or accept "new patients", and shall not begin treatment for existing patients, that can be reasonably anticipated to extend beyond **JULY 3, 2014;** and it is further

ORDERED that beginning **JULY 3, 2014,** the Respondent may not provide professional, ethical, or clinical treatment, care, advice, consultation, expertise, or recommendations to any other dental or health care provider or patient; and it is further

ORDERED that during the Respondent's **ACTIVE SUSPENSION**, she is permitted to continue ownership of her dental practice, provided she has employed a licensed dentist to perform all treatment, evaluation and diagnosis of conditions. The Respondent may not "practice dentistry", with the limited exception of serving, under H.O. 4-101(i)(1), as a "manager, a proprietor, or conductor of, or an operator in any place in which a dental service or dental operation is performed intraorally". In all other capacities, the Respondent agrees and understands that she is similar to an unlicensed practitioner; and it is further

ORDERED, that within 120 days of July 3, 2014, the Respondent must enroll in the Dentist- Professional Review and Evaluation Program ("D-Prep"); and it if further

ORDERED that after enrolling in the D-Prep program and completing the initial evaluation, the Respondent will ensure that the results of the evaluation be sent to the

Board. The Board will then evaluate the recommendations made by the D-Prep program, and select Board-approved courses and/or curriculum that the Respondent shall complete as part of her remediation training as recommended by D-Prep and the Board or its agents; and it is further

ORDERED that the Respondent shall be permitted to petition the Board for a limited lifting of the ACTIVE SUSPENSION of her license to practice dentistry in specific practice areas if, after completing the initial D-Prep evaluation and remediation courses, she is deemed to be competent in those practice areas. The Respondent understands and agrees that her ACTIVE SUSPENSION will not automatically be lifted in those practice areas but rather, that the Board will review the totality of the D-Prep assessment, her course completion and her degree of documented competency, and will make the determination on whether to lift her ACTIVE SUSPENSION in any or all of the identified practice areas. One factor that the Board will consider is whether Respondent's deficiencies in certain practice areas would overlap or impact her competency in the practice areas for which the petition is being made. The Board will advise the Respondent of its determination in writing regarding the petition to lift her suspension in specific practice areas; and it is further

ORDERED that following the Board's lifting of her ACTIVE SUSPENSION of her license to practice dentistry in all or limited practice areas, the Respondent shall be placed on **PROBATION** for a period of **ONE (1) YEAR** from the date of the Board's Order, under the following terms and conditions:

a. The Respondent shall be subject to one scheduled comprehensive practice review by a Board-approved clinical practice reviewer who will

observe and evaluate her competency to practice in the areas identified during the D-Prep program as deficient. It is the Respondent's sole responsibility to demonstrate to the clinical practice reviewer and/ or the Board that she is competent to practice in those areas;

b. The Respondent's practice review shall include an evaluation of her compliance with the Consent Order and her general competency in ethics, billing and documentation requirements of the Dental Practice Act;

c. The practice review shall be subject to the following terms and conditions:

i. The practice reviewer shall be provided a copy of the Board's investigative file, and this Consent Order and any other documents relevant to the Respondent's competency;

ii. The practice review shall include on-site observation of patient care for at least one (1) full day and a random chart review of at least ten (10) patient charts;

iii. The Respondent shall provide to the reviewer the complete record for each patient whose care is being reviewed; and

iv. The Respondent shall make all reasonable efforts to ensure that the reviewer(s) submit written reports to the Board within thirty (30) days. Such reports shall include recommendations for improvement, if any. The Respondent shall comply with all written recommendations made by the reviewer(s) unless otherwise approved by the Board after consideration of a written

request submitted by the Respondent for a waiver. Failure to comply may be deemed a violation of probation; and

d. Upon the Board's receipt of the clinical practice reviewer's written report evaluating competency, the Board shall issue an Order allowing the Respondent to continue practicing in any areas of demonstrated competency.

AND IT IS FURTHER ORDERED that the Respondent shall complete all continuing education requirements for renewal of her license, including but not limited to infection control requirements. No part of the training or education that the Respondent receives in order to comply with this Consent Order shall be applied to her required continuing education credits, and it is further

ORDERED that the Respondent shall at all times cooperate with the Board, any of its agents or employees, in the monitoring, supervision and investigation of the Respondent's compliance with the terms and conditions of this Consent Order, and it is further

ORDERED that the Respondent shall be responsible for all costs incurred under this Consent Order; and it is further

ORDERED that after a minimum of one (1) year from the effective date of the Board's order lifting the Respondent's Active Suspension, and reinstating her license to practice dentistry, the Respondent may submit a written petition to the Board requesting termination of probation without conditions or restrictions. After consideration of the petition, the probation may be terminated through an order of the Board. The Board may, in its discretion issue an order terminating probation with certain restrictions to the

Respondent's license based on assessed competency. The Board shall grant termination if Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending investigations or outstanding complaints related to the charges; and be it further

ORDERED that if Respondent violates any of the terms or conditions of this Consent Order, the Board, in its discretion, after notice and an opportunity for a show cause hearing before the Board, or opportunity for an evidentiary hearing before an Administrative Law Judge at the Office of Administrative Hearings if there is a genuine dispute as to the underlying material facts, may impose any sanction which the Board may have imposed in this case under §§ 4-315 and 4-317 of the Dental Practice Act, including an additional probationary term and conditions of probation, reprimand, suspension, revocation and/or a monetary penalty, said violation of probation being proved by a preponderance of the evidence; and be it further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-601 *et seq.* (2009 Repl. Vol.)

6/18/2014
Date

Maurice Miles D.D.S., President
Maryland State Board of Dental Examiners

CONSENT

I, Amisha Shroff, D.D.S., License No. 13054, by affixing my signature hereto, acknowledge that I have consulted with counsel, Edwin L. Keating, III, Esquire, and Amanda M. Schwartzkopf, Esquire, and knowingly and voluntarily elected to enter 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 am aware that I am entitled to a formal evidentiary hearing, pursuant to Md. Health Occ. Code Ann. § 4-318 (2009 Repl. Vol. & 2013 Supp.) and Md. State Gov't Code Ann §§ 10-201 *et seq.* (2009 Repl. Vol. & 2013 Supp.).

I accept the validity and enforceability of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have 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 as provided by law. I am waiving those procedural and substantive protections.

I voluntarily enter into and agree to abide by the terms and conditions set forth herein as a resolution of the Order of Summary Suspension issued against me. I further agree that I waive my right to have Charges filed against me arising from the same circumstances. I waive any right to contest the Findings of Fact and Conclusions of Law and I waive my right to a full evidentiary hearing, as set forth above, and any right to appeal this Consent Order or any adverse ruling of the Board that might have followed any such hearing.

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

6/17/14
Date

Amisha Shroff, D.D.S.
Respondent

Read and approved:

Edwin L. Keating III, Esquire
Attorney for the Respondent

NOTARY

STATE OF MARYLAND

CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 17th day of June, 2014 before me, a Notary Public of the State and County aforesaid, personally appeared before me Amisha Shroff, D.D.S. License Number 13054, and gave oath in due form of law that the foregoing Consent Order was her voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Alicia Lyn Moskal
Notary Public

ALICIA LYN MOSKAL
NOTARY PUBLIC STATE OF MARYLAND
My Commission Expires October 5, 2017

My commission expires: _____