IN THE MATTER OF	*	**BEFORE THE STATE**
TAMBERLEE WILLIAMS, LGSW	*	**BOARD OF SOCIAL WORK**
Respondent	*	**EXAMINERS**
License Number: G07472	*	**Case No. 06-1061**

****

CONSENT ORDER

PROCEDURAL BACKGROUND

On July 17, 2007, the State Board of Social Work Examiners (the "Board"), charged Tamberlee Williams, LGSW (the "Respondent") (D.O.B. 1/19/70), License Number G07472, under the Maryland Social Workers Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") § 19-101 *et seq.* (2000 Repl. Vol. & 2004 Supp.).

The pertinent provisions under §19-311 of the Act provide the following:

> Subject to the hearing provisions of § 19-312 of this subtitle, the Board, on the affirmative vote of a majority of its full authorized membership, may deny a license to any applicant, reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (5) Knowingly violates any provision of this title;
>
> (6) Engages in a course of conduct that is inconsistent with generally accepted professional standards in the practice of social work;
>
> (7) Violates any provision of this title or regulations governing the practice of social work adopted and published by the Board;
>
> (21) Fails to maintain adequate patient records[;].

The regulation, which the Board charged Respondent with violation of, is:

> Code Md. Regs. tit.10 § 42.03.03 A (5) (2002)
>
> A. The licensee shall:
>
> (5) Maintain documentation in the client's record which:

(b) Accurately reflects the services provided, including treatment plans, treatment goals, and progress notes;

(c) Indicates the time and date the services were provided;

(e) Is sufficient and timely to facilitate the delivery and continuity of services to be delivered in the future[.]

Respondent was notified of the Charges through service by regular and certified mail on July 17, 2007. On August 28, 2007, Respondent, her attorney, Michael Lytle, Esquire, and Janet Klein Brown, Assistant Attorney General, Administrative Prosecutor, appeared before the Case Resolution Conference committee (the "CRC") of the Board. As a result of negotiations with the Office of the Attorney General and the Board, Respondent agreed to enter into this Consent Order, consisting of Procedural Background, Findings of Fact, Conclusions of Law, and Order, with the terms and conditions set below.

FINDINGS OF FACT

The Board makes the following findings of facts:

I. Background Findings

1. Respondent was originally issued a license to practice social work in the State of Maryland on January 15, 1997, being issued license number G07472. Respondent last renewed her license on or about November 4, 2005, which will expire on October 31, 2007.

2. At all times relevant to these charges, Respondent was employed parttime by Tender Loving Care ("TLC"), a national home health care company, with an office in Burtonsville, Maryland.

3. On May 9, 2005, Respondent was hired by TLC as a home health care social worker on a *per diem* basis.[1] As a social worker, Respondent was hired to provide medical social work services to patients who were referred by their primary care physician for follow-up care in their home.

4. In or about October/November 2005, TLC stopped sending referrals to Respondent.

5. In or about October /November 2005, Respondent stopped taking referrals from TLC because she began a fulltime position as a social worker at the Children's Guild.

6. As of October 2006, Respondent has been employed fulltime during the academic year as a social worker at the Children's Guild, Chillum, Maryland, and part time on the weekends at Greater Baltimore Medical Center ("GBMC"), St. Joseph's Hospital, and Suburban Hospital. During the summer, Respondent has been employed fulltime as a social worker at GBMC and part time on weekends at St. Joseph's and Suburban hospitals.

II. Findings Pertaining to the Complaint

7. On or about June 6, 2006, the Board received a written Complaint from the National Director of Clinical Compliance and Performance Improvement at TLC regarding Respondent. The National Director stated:

> Ms. Williams did not demonstrate compliance with professional standards in that she failed to provide the services ordered by the attending physicians of several of our clients, described in detail in the attached narrative, nor did she comply with company policies and procedures related to communications, scheduling, and care coordination.

[1] During her part-time employment with TLC, Respondent was employed fulltime at Greater Baltimore Medical Center.

8. The National Director submitted an assessment of Respondent's compliance in seventeen (17) cases, prepared by a Performance Improvement and Staff Development Nurse (the "Nurse") for TLC, Burtonsville, Maryland.

9. Thereafter, the Board initiated an investigation of the Complaint. As part of the investigation, the Board interviewed the Nurse and Respondent, and subpoenaed the patients' files from TLC.

III. Findings Based on the Investigation of the Complaint

10. From May to November 2005, Respondent was a social worker at TLC, providing social work services to patients in their home.

11. Patients are referred to TLC by their physician for services by particular disciplines such as nursing, occupational therapy, and social work.

12. A "Field Service Coordinator" (the "FSC") for TLC assigns the cases to the particular health care providers.

13. If the case requires social work services, the assigned social worker performs an "MSE Evaluation" and makes a determination of what specific services are required.

14. TLC maintains internal policies on the "Initial Client Assessment," creation of a "Client Care Plan," "Documentation of Client Care," and "Coordination of Care."

15. In or about March 2006, TLC conducted an audit of patient files and determined that Respondent had violated the policies of TLC.

16. In or about March 2006, following the audit by TLC, the TLC Nurse sent correspondence by certified mail to Respondent asking her to submit the documentation

of the services she provided for seventeen (17) patients who had been assigned to her for social work services.

17. On or about March 20, 2006, Respondent left a telephone voice mail message for the Nurse, providing her explanations for the services she provided and the lack of documentation.

18. The results of the audit, and Respondent's responses, are described below:

Patient 1[2]

Patient 2[3]

19. On October 14, 2005, Respondent completed a Medical Social Services Assessment of Patient 2, which was approved by the physician. Respondent planned to meet with Patient 2 for two visits a month.

20. On January 16, 2005, TLC became aware that Respondent had not performed any follow-up visits.

21. On February 8, 2006, the Nurse from TLC called Patient 2. Patient 2 confirmed that Respondent saw her twice. Patient 2 stated that Respondent was supposed to submit a form to her physician for a Metro Access Card, but Patient 2 did not know if Respondent did this.

22. Respondent did not document the coordination of care with community resources and if follow through was completed.

23. Respondent failed to document a discharge summary to indicate that she completed the goals that she established.

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[2] Originally, the audit revealed seventeen (17) cases where Respondent's documentation was not complete. The Nurse subsequently discovered that Patient # 1 had not been assigned to Respondent.

[3] Patient names are confidential and are not using in the Consent Order. Respondent is aware of the identity of the patients.

24. On March 20, 2006, Respondent left a voice mail indicating that she had a note signed by Patient 2 for November 2, 2005, the second visit, but could not locate her notes on Patient 2.

25. As of the date of the Complaint, Respondent did not submit any further documentation on Patient 2.

26. On October 2, 2006, when interviewed by the Board investigator, Respondent submitted a statement from Patient 2 that she had been seen by Respondent on November 2, 2005.

Patient 3

27. On or about October 28, 2005, the FSC assigned Patient 3 to Respondent for a social work Evaluation for possible ACLF placement.

28. Patient 3's file does not contain any documentation of a social work Evaluation.

29. Respondent confirmed in her voice mail response on March 20, 2006 that she had not seen Patient 3.

30. On October 2, 2006, when interviewed by the Board investigator, Respondent acknowledged that she did not see Patient 3.

Patient 4

31. On or about October 28, 2005, the FSC assigned Patient 4 to Respondent for an MSW Evaluation regarding community resources and financial issues.

32. The file does not contain any documentation by Respondent.

33. The TLC Nurse called Patient 4 on 1/27/06 and 2/8/06 with no answer; therefore the Nurse was unable to verify if Respondent saw Patient 4.

34. In a voice mail response on March 20, 2006, Respondent stated that she had not seen Patient 4. Respondent stated that she called Patient 4 and sent information to him on what he wanted.

35. As of the date of the Complaint, Respondent did not submit documentation to TLC to verify that information was sent to Patient 4.

36. On October 2, 2006, when interviewed by the Board investigator, Respondent acknowledged that she did not see Patient 4. Respondent submitted a letter dated November 11, 2005 that she sent to Patient 4 providing him with applications for Medbank and Pharmacy Assistance.

Patient 5

37. On or about October 28, 2005, the FSC assigned Patient 5 to Respondent for an MSW Evaluation regarding long-range planning and community resources.

38. Respondent did not document any visit with Patient 5.

39. The TLC Nurse called Patient 5's daughter on 1/27/06. Patient 5 was unable to come to the phone; however, Patient 5's daughter was present during the visits made by TLC staff. When asked to verify if the social worker saw Patient 5, she said she "wasn't sure, that she thought the social worker had called and came over once".

40. Due to the daughter's inability to remember if Respondent actually did see Patient 5, the Nurse could not verify if Respondent had seen Patient 5.

41. In a voice mail response on March 20, 2006, Respondent said she did see Patient 5, but could not locate the paperwork.

42. As of the date of the Complaint, Respondent did not submit any documentation to TLC regarding Patient 5.

43. On October 2, 2006, when interviewed by the Board investigator, Respondent stated that she did see Patient 5 and provided a description of the interview. Respondent stated that she documented the visit; however, her documentation is not in the Patient 5's file.

Patient 6

44. On or about October 28, 2005, the FSC assigned Patient 6 to Respondent for an MSW Evaluation for possible ACLF placement.

45. On January 27, 2006, the Nurse called Patient 6. Patient 6 stated that the social worker did not visit her. Patient 6 confirmed the other disciplines that provided services to her (RN, PT, OT).

46. Respondent did not submit documentation to state why she did not make a social work visit, or if the she contacted the physician to explain why social work services were not provided.

47. In a voice mail response on March 20, 2006, Respondent confirmed that she had not seen Patient 6. Respondent did not provide an explanation.

48. On October 2, 2006, when interviewed by the Board investigator, Respondent acknowledged that she did not see Patient 6.

Patient 7

49. On or about September 21, 2005, Respondent was assigned Patient 7 for a MSW Evaluation for transportation needs.

50. On or about October 26, 2005, Respondent was assigned Patient 7 for an MSW Evaluation for day care. The referral was marked "ASAP."

51. Respondent did not document a social work Evaluation.

52. On January 27, 2006, the Nurse called Patient 7 who confirmed that RN, HHA, OT and PT came out to see her. She said a social worker named "Gloria" came to see her, but no social worker with Respondent's name saw her.

53. In a voice mail response on March 20, 2006, Respondent stated that she had not seen Patient 7. Respondent stated that she made numerous attempts to contact Patient 7 and that she had documentation to support this.

54. As of the date of the Compliant, Respondent did not submit documentation to state why she was unable to see Patient 7.

55. On October 2, 2006, when interviewed by the Board investigator, Respondent acknowledged that she did not see Patient 7, but made four phone calls to Patient 7 in an attempt to meet with her. Respondent submitted notes to support that she had made these calls.

Patient 8

56. On October 23, 2005, Respondent was assigned Patient 8 for an MSW Evaluation of psychosocial and financial situation.

57. On January 27, 2006, the Nurse called Patient 8 and spoke with Patient 8's caregiver. The caregiver confirmed PT and OT visits, indicating she was there during those visits. The caregiver advised that Patient 8's wife was present during the RN & ST visits.

58. On January 27, 2006, the Nurse spoke with Patient 8's wife who stated she could not remember if a social worker saw Patient 8 because so many disciplines were involved.

59. Respondent did not submit any documentation regarding Patient 8.

60. In a voice mail response on March 20, 2006, Respondent said Patient 8 was not seen. Respondent said there "was a reason why Patient 8 was not seen", but could not recall the reason.

61. As of the date of the Complaint, Respondent has not submitted documentation to explain why she had not seen Patient 8.

62. On October 2, 2006, when interviewed by the Board investigator, Respondent acknowledged that she did not see Patient 8.

Patient 9

63. On October 19, 2005 the FSC assigned Patient 9 to Respondent for an MSW Evaluation.

64. On January 27, 2006, the Nurse called Patient 9 who stated that she "did not get a social worker." The other disciplines were confirmed.

65. Respondent did document why she did not see Patient 9. Respondent did not document that she notified the physician that Patient 9 did not have a social work Evaluation.

66. In a voice mail response on March 20, 2006, Respondent stated she had not seen Patient 9, although she had made attempts to telephone Patient 9.

67. As of the date of the Complaint, Respondent has not submitted documentation to explain why she had not see Patient 9.

68. On October 2, 2006, when interviewed by the Board investigator, Respondent acknowledged that she did not see Patient 9, although she had scheduled an appointment and was unable to locate Patient 9's home.

Patient 10

69. On October 6, 2005, the FSC assigned Patient 10 to Respondent for an MSW psychosocial evaluation and community resource planning.

70. Respondent did not submit any documentation in the medical record on Patient 10.

71. The Nurse did not contact Patient 10 to verify social work service because Patient 10 was being serviced out of an alternate TLC office.[4]

72. In a voice mail response on March 20, 2006, Respondent stated she did not see Patient 10 but did not give an explanation.

73. As of the date of the Complaint, Respondent did not submit any documentation regarding Patient 10.

74. On October 2, 2006, when interviewed by the Board investigator, Respondent acknowledged that she did not see Patient 10.

Patient 11

75. On October 18, 2005, the FSC assigned Patient 11 to Respondent for an MSW Evaluation of financial issues, placement, and home services.

76. Respondent did not submit documentation regarding Patient 11.

77. In a voice mail response on March 20, 2006, Respondent stated she had not seen Patient 11. Respondent said she had difficulty getting in touch with Patient 11, and that she had spoken with the nurse, who told her that Patient 11 is hard to reach. Respondent stated she documented her attempts to see Patient 11.

[4] The Nurse only contacted discharged patients so as not to interfere with the current service and that relationship.

78. As of the date of the Complaint, Respondent had not submitted any documentation to support this explanation.

79. On October 2, 2006, when interviewed by the Board investigator, Respondent acknowledged that she did not see Patient 11 and stated that made attempts to reach him but could not.

Patient 12

80. On September 19, 2005, the FSC assigned Patient 12 to Respondent for an MSW Evaluation for long-range planning and community resources.

81. On September 24, 2005, Respondent saw Patient 12 and documented a visit note in the medical record. The physician plan of care indicates two social work visits were planned in one month.

82. On October 9, 2005, the FSC assigned Patient 12 for a 2nd MSW Evaluation for community resources and long term planning.

83. Respondent did not document in the medical record.

84. On January 27, 2006, the Nurse contacted Patient 12, who confirmed the social worker saw her once, but stated it was hard for her to remember if the social worker came back.

85. Respondent did not submit a discharge summary to indicate the social work goals were met.

86. In a voice mail response on March 20, 2006, Respondent said that she saw Patient 12 for a second visit. She stated she could not locate the paperwork on Patient 12 and was going to look for it.

87. As of the date of the Complaint Respondent did not submit documentation to TLC regarding Patient 12.

88. On October 2, 2006, when interviewed by the Board investigator, Respondent acknowledged that she did not see Patient 12.

Patient 13

89. On September 22, 2005, the FSC assigned Patient 13 to Respondent for an MSW Evaluation.

90. Respondent did not document a social work visit note in the medical record.

91. On January 27, 2006, the Nurse contacted Patient 13's sister who is her caregiver and was present during the home care visits. The sister confirmed PT, RN, HHA visits and stated that only "3 ladies came to the house".

92. Respondent did not document why she did not make a social work visit and whether the physician was notified the social work visit was not made.

93. In a voice mail response on March 20, 2006, Respondent said she has no documentation on Patient 13 and was not sure if she saw Patient 13 or not. Respondent could not remember why she did not see Patient 13.

94. On October 2, 2006, when interviewed by the Board investigator, Respondent acknowledged that she did not see Patient 13. Respondent submitted paperwork to demonstrate that she had scheduled an appointment but acknowledged that she did not keep it.

Patient 14

95. On August 17, 2005, the FSC assigned Patient 14 to Respondent for an MSW Evaluation for Meals on Wheels, a prescription discount plan, and a Metro Access card.

96. Respondent's Plan of Care of August 19, 2005, stated that she planned two social work visits in a 60-day period.

97. Respondent did not document a 2nd social work visit or a discharge summary to state if the social work goals were met.

98. The Nurse made two attempts to call Patient 14 to verify social work services, but no one answered the phone.

99. In a voice mail response on March 20, 2006, Respondent stated she did see Patient 14.

100. As of the date of the Complaint Respondent did not submit documentation to support the second social work visit.

101. On October 2, 2006, when interviewed by the Board investigator, Respondent acknowledged that she did not see Patient 14.

Patient 15

102. On August 3, 2005, the FSC assigned Patient 15 to Respondent for an MSW Evaluation for placement alternatives and community resources.

103. On January 27, 2006, the Nurse called Patient 15 who confirmed RN & PT services but that a social worker did not come to see her. Patient 15 said the social worker called her and told her she was in "good shape."

104. Respondent did not submit documentation to support the reason why the she did not see Patient 15. There is no documentation to support the physician was notified that Patient 15 was not seen by the social worker.

105. In a voice mail response on March 20, 2006, Respondent stated that she had not seen Patient 15 because she said she was waiting for physician orders to see the patient,

and that she could not reach Patient 15. She told the Nurse that she had the documentation on this.

106. As of the date of the Complaint, Respondent did not submit any further documentation regarding Patient 15.

107. On October 2, 2006, when interviewed by the Board investigator, Respondent acknowledged that she did not see Patient 15 although she had telephone contact with her.

Patient 16

108. On August 3, 2005, the FSC assigned Patient 16 to Respondent for an MSW Evaluation.

109. Respondent did not document a social work visit note in the patient's medical record.

110. The Nurse did not call Patient 16 because the case was still open and being seen by another MSW.

111. In a voice mail response on March 20, 2006, Respondent stated she did not see Patient 16 because she was waiting for physician orders to see Patient 16 and had a hard time reaching Patient 16. Respondent stated that she has documentation on this.

112. As of the date of the Complaint, Respondent had not submitted further documentation to TLC.

113. On October 2, 2006, when interviewed by the Board investigator, Respondent acknowledged that she did not see Patient 16, although she made several attempts to reach her. Respondent submitted notes to demonstrate the dates of the calls.

Patient 17

114. On June 27, 2005, the FSC assigned Patient 17 to Respondent for an MSW Evaluation for advanced directives.

115. Respondent saw Patient 17 on July 5, 2005. Respondent's Plan of Care states that four social work visits are planned in the next 4 weeks. Respondent documented a case management note indicating she had seen Patient 17 and his son and spoke about Medicare drug discount program and advanced directives.

116. On January 27, 2006, the Nurse contacted Patient 17 who stated the social worker did come and spoke with his son about a medication plan and that the social worker never returned.

117. Respondent did not document a discharge summary to indicate the social work goals were met. Respondent documented that she planned to revisit on July 8, 2005; however, Respondent did not document a visit on that dated or explain why Patient 17 was not seen again.

118. In a voice mail message on March 20, 2006 on the above 16 patients, Respondent did not give any report on Patient 17 to explain why she did not see Patient 17 according to the plan of care.

119. On October 2, 2006, when interviewed by the Board investigator, Respondent acknowledged that she did not see Patient 17 for the second visit although a visit was scheduled which she had to re-schedule, but never did.

IV. Summary of Findings

120. By failing to perform social work evaluations of patients as ordered by the patients' physicians, failing to communicate with the physician that the social work services

that were ordered were not performed, and failing to document her inability to see the patients or her attempts to reach the patients, Respondent knowingly violated provisions of the Social Work Practice Act and engaged in a course of conduct that is inconsistent with generally accepted professional standards in the practice of social work, in violation §§ 19-311 (5) and (6) of the Social Work Practice Act.

121. By failing to document social work visits that were held, failing to document contacts that were made with patients, or failing to document the reason that contacts and visits were not done, Respondent failed to maintain adequate patient records, in violation §§ 19-311 (7) and (21) of the Social Work Practice Act.

122. Respondent failed to maintain documentation in the client's record that accurately reflects the services provided, including treatment plans, treatment goals, and progress notes, in violation of Code Md. Regs. tit. 10 § 42.03.03A(5)(b); indicates the time and date the services were provided in violation of Code Md. Regs. tit. 10 § 42.03.03A(5)(c); and, is sufficient and timely to facilitate the delivery and continuity of services to be delivered in the future, in violation of Code Md. Regs. tit. 10 § 42.03.03A(5) (e).

CONCLUSIONS OF LAW

Based on the forgoing Findings of Fact, the Board concludes that Respondent committed prohibited acts under the Act, Md. Health Occ. Code Ann. § 19-311 (5), (6), (7) and (21), and Code Md. Regs. tit. 10 § 42.03.03A(5)(b), (c), and (e). Accordingly, the Board concludes as a matter of law that Respondent engaged in a course of conduct that is inconsistent with generally accepted standards in the practice of social work; failed to maintain adequate patient records, and violated a provision of the regulations governing the practice of social work adopted and published by the Board,

that is, failed to maintain documentation in the client's record that accurately reflects the services provided, including treatment plans, treatment goals, and progress notes, indicates the time and date the services were provided, and is sufficient and timely to facilitate the delivery and continuity of services to be delivered in the future..

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 12th day of October, 2007, by a majority of the full authorized membership of the Board considering this case:

ORDERED that Respondent shall be **REPRIMANDED,** and be it further

ORDERED that Respondent shall be on a minimum of one (1) year **PROBATION** subject to the following conditions:

1. Respondent shall successfully complete a Board approved individual tutorial in professional ethics, 10-12 weeks in duration, with specific emphasis on the professional standards of maintaining adequate patient records and following through with professional commitments to patients and colleagues;

2. Respondent shall authorize the Board to provide the tutor with the entire investigative file, including all investigative interviews and reports obtained during the investigation, the Board's Disciplinary Charges of July 17, 2007, and the Consent Order;

3. Respondent shall submit a written paper to the Board that meets the requirements of the ethics tutor and addresses the issues in this case;

4. Respondent shall authorize the ethics tutor to fully communicate with the Respondent's supervisor regarding Respondent's participation and progress in the ethics tutorial;

5. Respondent shall meet at least once a month with a Board pre-approved and registered supervisor who will review Respondent's cases on a random basis and promote Respondent's skill in maintaining documentation in the clients' records which accurately

reflects the services provided and skill in organization and time management;

6. Respondent shall authorize the Board to provide the supervisor with the entire investigative file, including all investigative interviews and reports obtained during the investigation, the Board's Disciplinary Charges of July 17, 2007, and the Consent Order;

7. Respondent shall ensure that the supervisor submits quarterly reports to the Board; the first quarterly report shall be due within three (3) months of the date of this consent Order;

8. Respondent shall authorize the supervisor to fully communicate with Respondent's ethics tutor regarding Respondent's participation and progress;

9. Respondent shall be responsible for all costs associated with fulfilling the terms and conditions of this Consent Order;

10. There shall be no early termination of probation; and be it further

ORDERED that after a minimum of one (1) year probation, Respondent may petition the Board for termination of probation; and be it further

ORDERED that if Respondent does not petition the Board for termination of probation, Respondent shall remain on probation; and be it further

ORDERED that the petition will be granted only if conditions have been met, reports are favorable and there are no new charges pending against Respondent; the decision to grant or deny said petition being at the Board's discretion and is not appealable; and be it further

ORDERED that Respondent will comply and practice within all statutes and regulations governing the practice of social work in the State of Maryland; and be it further

ORDERED that any violation of any of the terms of this Consent Order shall constitute unprofessional conduct; and be it further

ORDERED that if the Board has probable cause to believe that the public health, safety or welfare imperatively requires emergency action, the Board, without prior notice and an opportunity for a hearing, may summarily suspend the Respondent's license, provided that Respondent is given prompt written notice of the Board's suspension, the finding, and the reasons in support thereof, and an opportunity for a hearing within thirty (30) days after requesting same in accordance with Md. State Govt. Code Ann. § 10-226(c) (2004 Repl. Vol.); and be it further

ORDERED that if Respondent violates any of the terms of Respondent's probation, or fails to comply with the terms of this probation, the Board, after notice and a hearing, and a determination of violation, may impose any other disciplinary sanctions it deems appropriate, said violation of probation being proved by a preponderance of evidence; and be it further

ORDERED that this Consent Order is a public document pursuant to Md. State Govt. Code Ann. § 10-611 *et seq.*

10-12-07
Date

Yvonne M. Perret, LCSW-C
Yvonne M. Perret, LCSW-C, Chair
Board of Social Work Examiners

CONSENT

I, TAMBERLEE WILLIAMS, LGSW, acknowledge that I am represented by counsel and have reviewed this Consent Order with my attorney, Michael P. Lytle, Esquire, before signing this document.

I am aware that I am entitled to a formal evidentiary hearing before an administrative law judge of the Office of Administrative Hearings. I acknowledge 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 procedural and substantive protections to which I am entitled by law. I am waiving those procedural and substantive protections.

I voluntarily enter into and agree to abide by the foregoing Findings of Fact, Conclusions of Law, and Order and agree to abide by the terms and conditions set forth herein as a resolution of the Charges against me. 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 acknowledge that by failing to abide by the conditions set forth in this Consent Order, I may be subject to disciplinary actions, which may include revocation of my license to practice social work.

I sign this Consent Order voluntarily, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order, consisting of twenty-two (22) pages.

9/18/07
Date

Tamberlee Williams, LGSW
Respondent

Reviewed and approved by:

Michael P. Lytle, Esquire
Attorney for Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY of Laurel/Prince George's

I HEREBY CERTIFY that on this 19th day of September, 2007, before me, a Notary Public of the State and County aforesaid, personally appeared Tamberlee Williams, LGSW, and made oath in due form of law that the foregoing was her voluntary act and deed.

AS WITNESS my hand and Notarial Seal.

Notary Public

My Commission Expires: 9/27/10