IN THE MATTER OF	*	**BEFORE THE MARYLAND**
GARY E. WARNER, D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 12139	*	**Case Number: 2014-100**

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

CONSENT ORDER

On March 6, 2019, the Maryland State Board of Dental Examiners (the "Board") charged **GARY E. WARNER, D.D.S.** (the "Respondent"), License Number 12139, with violating: the terms and conditions of his probation and the Consent Order (the "2017 Consent Order"), dated June 7, 2017; the Maryland Dentistry Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 4-101 *et seq.* (2014 Repl. Vol. and 2018 Supp.); and Md Code Regs. ("COMAR") 10.44.30 *et seq.*

Specifically, the Board charged the Respondent with violating the following provisions of the 2017 Consent Order, the Act and COMAR:

The 2017 Consent Order

1. **Within six (6) months** of the date of this Consent Order, the Respondent shall enroll in and successfully complete Board-approved in-person course(s) consisting of six (6) credit hours in dental recordkeeping. The Respondent shall be responsible for submitting written documentation to the Board of his successful completion of the course(s). The Respondent understands and agrees that he may not use this coursework to fulfill any requirements mandated for licensure renewal. The Respondent shall be solely responsible for furnishing the Board with adequate written verification that he has completed the course(s) according to the terms set forth herein.

2. **Within sixty (60) days** of the date of this Consent Order, the Respondent shall pay a fine in the amount of **One Thousand dollars ($1,000.00)** payable to the Maryland State Board of Dental Examiners.

3. The Respondent is subject to chart reviews by the Board. The Board, at its discretion, may conduct office visits for the purpose of chart review to ensure that the Respondent is in compliance with recordkeeping standards.

4. The Respondent shall comply with the Maryland Dentistry Act and all laws, statutes and regulations pertaining thereof.

Health Occ. § 4-315. Denials, reprimand, probations, suspension, and revocations— Grounds.

(a) *License to practice dentistry* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may … reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the … licensee:

(16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession;

(20) Violates any rule or regulation adopted by the Board; [and]

(33) Fails to comply with any Board order[.]

COMAR 10.44.30.02 General Provisions for Handwritten, Typed and Electronic Health Records.

I. A dental record shall contain:

. . .

(7) Medical and dental histories which shall be updated at each visit[.]

K. Dental records shall:

. . .

(2) Be detailed[.]

COMAR 10.44.30.03 Clinical Charts.

A. Each patient's clinical chart shall include at a minimum the following:

. . .

(3) Treatment plans that are signed and dated by both the treating dentist and the patient;

. . .

(7) Post operative instructions;

. . .

(10) Identification of medications prescribed, administered, dispensed, quantity, and direction for use;

. . .

(12) Radiographs of diagnostic quality;

(13) Periodontal charting;

(14) Laboratory work authorization forms and correspondence to and from laboratories;

(15) Informed consent; [and]

. . .

(18) Details regarding referrals and consultations[.]

COMAR 10.44.30.05 Violations.

Failure to comply with this chapter constitutes unprofessional conduct and may constitute other violations of law.

On May 1, 2019, a Case Resolution Conference ("CRC") was held before a committee of the Board. As a resolution of this matter, the Respondent agreed to enter this public Consent Order consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

The Board makes the following Findings of Fact:

I. LICENSING BACKGROUND

1. At all times relevant, the Respondent was licensed to practice dentistry in the State of Maryland. The Respondent was initially licensed to practice dentistry in Maryland on or about April 10, 1997, under License Number 12139. The Respondent's license is current through June 30, 2019.

2. At all times relevant, the Respondent practiced general dentistry at a dental practice in Forrestville, Maryland.

II. DISCIPLINARY HISTORY

3. On December 7, 2016, the Board charged the Respondent with behaving unprofessionally based on his violation of the Board's recordkeeping regulations. The Board's charges stemmed from a patient complaint that alleged substandard care. In its investigation, the Board retained an expert who conducted a practice review of nine patient charts. After review, the expert concluded that the Respondent violated the Board's recordkeeping regulations with respect to all nine patient charts reviewed for reasons including, but not limited to:

a) Failing to document and retain diagnostic quality x-rays;

b) Failing to document periodontal charting;

c) Failing to document review of patient medical history;

d) Failing to document written informed consent;

e) Failing to document providing post-operative instructions;

f) Failing to document treatment plans that are signed and dated by the treating dentist and patient;

g) Failing to document the prescriptions provided, the medical necessity for the prescriptions, the quantity and the instructions for use;

h) Failing to retain laboratory work authorizations;

i) Failing to document specialty referrals;

j) Failing to document all treatment rendered in sufficient clinical detail; and

k) Failing to retain patient financial and insurance records.

4. The Respondent resolved the Board's charges by agreeing to the Consent Order, dated June 7, 2017, in which the Board concluded as a matter of law that the Respondent: behaved dishonorably or unprofessionally, or violated a professional code of ethics pertaining to the dentistry profession, in violation of Health Occ. § 4-315(a)(16); and violated any rule or regulations adopted by the Board, *i.e.* the Board's recordkeeping regulations under COMAR 10.44.30.02, COMAR 10.44.30.03 and COMAR 10.44.30.04, in violation of Health Occ. § 4-315(a)(20). The Board reprimanded the Respondent and placed him on probation for a minimum period of eighteen (18) months, subject to conditions including that he: successfully complete a six (6) credit hour Board-approved course(s) in dental recordkeeping; pay a fine of $1,000.00; be subject to chart review; and

comply with the Act and all laws, statutes and regulations pertaining to the practice of dentistry.

III. VIOLATION OF PROBATION

A. Recordkeeping Course(s)

5. Condition One (1) of the Respondent's probation required that he successfully complete six (6) credit hours of Board-approved in-person course(s) in dental recordkeeping within six (6) months of the date of the Consent Order, which would be on or before December 7, 2017.

6. The Respondent failed to submit to the Board written verification of his successful completion of six (6) credit hours of Board-approved in-person dental recordkeeping course(s) by December 7, 2017.

7. In a letter dated December 23, 2017, which the Board received on December 26, 2017, the Respondent provided written verification of his completion of four video self-study courses in dental recordkeeping, totaling eight (8) credit hours.

8. By letter dated January 5, 2018, Board staff informed the Respondent that the Board determined that three of the courses he took were not in compliance with the Consent Order as they were not in-person courses. The Board, however, stated that it would accept one of the courses amounting to two (2) credit hours. In the letter, Board staff further referred the Respondent to the Director of Continuing Dental Education at the University of Maryland Dental School for availability of in-person courses on dental recordkeeping.

B. Fine of One Thousand Dollars ($1,000.00)

9. Condition Two (2) of the Respondent's probation required that he pay a fine in the amount of one thousand dollars ($1,000.00) to the Board within sixty (60) days of the date of the Consent Order, which would be on or before August 7, 2017.

10. The Respondent failed to pay the one thousand-dollar ($1,000.00) fine to the Board by August 7, 2017. The Respondent did not pay the one thousand-dollar ($1,000.00) fine to the Board until on or about August 31, 2017.

C. Compliance with the Act

11. Condition Three (3) of the Respondent's probation required that he undergo chart reviews by the Board. At the same time, Condition Four (4) of the Respondent's probation required that he comply with the Act and all laws, statute and regulations pertaining to the Act.

12. For the purpose of chart review, the Board retained a dentist (the "Reviewer") licensed in Maryland, who conducted reviews of the Respondent's dental charts on or about January 22, 2018, and January 29, 2018. For the review, the Reviewer randomly selected eight dental charts of patients ("Patients A through H")[1] whom the Respondent treated within two weeks of the date of the review. Based on his review, the Reviewer concluded that the Respondent continued to fail to comply with the Board's recordkeeping regulations with respect to all eight charts reviewed.

[1] To protect confidentiality, the name of the Complainant, patients, other dentists or dental practices will not be identified by name in this document. The Respondent may obtain the identity of all individuals/entities referenced herein by contacting the assigned administrative prosecutor.

i. Summary of Deficiencies

13. The Respondent's post-Consent Order recordkeeping practices with respect to Patients A through H were deficient for reasons including but not limited to:

a) Failing to document and retain diagnostic quality x-rays;

b) Failing to document periodontal charting;

c) Failing to document review of patient medical history;

d) Failing to document written informed consent;

e) Failing to document providing post-operative instructions;

f) Failing to document treatment plans that are signed and dated by the treating dentist and patient;

g) Failing to document the prescriptions provided, the medical necessity for the prescriptions, the quantity and the instructions for use;

h) Failing to retain laboratory work authorizations;

i) Failing to document specialty referrals; and

j) Failing to document all treatment rendered in sufficient clinical detail.

ii. Patient-Specific Allegations

Patient A

14. Patient A, a female born in the 1990s, began seeing the Respondent for dental care on or about May 18, 2015. On or about February 20, 2017, the Respondent performed root canal treatment ("RCT") and build up on Tooth #3.

15. Since June 7, 2017, the effective date of the Consent Order, the Respondent has seen Patient A twice, on or about January 16, 2018, and on or about January 26, 2018.

16. On or about January 16, 2018, the Respondent noted that Patient A was "now in to see about crown prep for tooth." The Respondent performed a limited oral evaluation and took a periapical radiograph on Tooth #3. The Respondent, however, failed to document his clinical findings from the radiograph.

17. Patient A returned on or about January 26, 2018, for crown preparation for Tooth #3. The Respondent documented performing a comprehensive examination and taking four bitewing radiographs and periapical radiographs for Tooth #12. The Respondent, however, failed to retain the four bitewing radiographs in the chart. The Respondent also failed to document an odontogram or make any mention of Patient A's periodontal condition. With respect to crown preparation for Tooth #3, the Respondent failed to document a treatment plan signed by both him and Patient A, any final impression or laboratory authorization, and clinical details about the temporary crown, such as the material used and how it was cemented. The Respondent also failed to document post-operative instructions. Finally, the Respondent noted preauthorization for RCT, post and crown on Tooth #12 but failed to document the dental necessity for such treatment.

18. The Respondent's recordkeeping practices with respect to Patient A were deficient for reasons including:

a) Failing to document all treatment rendered in sufficient clinical detail;

b) Failing to retain laboratory work authorizations;

c) Failing to document treatment plan signed and dated by the treating dentist and Patient A;

d) Failing to document providing post-operative instructions; and

e) Failing to document and retain diagnostic quality radiographs.

Patient B

19. Patient B, a female born in the 1970s, initially presented to the Respondent on or about December 1, 2017, for tooth cleaning. At this visit, a dental hygienist signed a progress note stating that she reviewed Patient B's medical history, performed a comprehensive evaluation and dental prophylaxis, took one panoramic and four bitewing radiographs and provided oral hygiene instructions. The Respondent did not sign the progress note or otherwise document he ever saw Patient B that day. Patient B's chart contained a rudimentary treatment plan that was not signed by the Respondent and Patient B, which noted restoration plans for Teeth #14, 18 and 30 without any documented dental reasoning. The Respondent failed to document any periodontal charting or informed consent for the radiographs taken (Patient B indicated in her dental history that she had dental radiographs taken six months ago). In addition, the panoramic radiograph taken was not of diagnostic quality.

20. On or about December 11, 2017, Patient B returned for restorations on Teeth #14-O and #18-O. The Respondent completed the occlusal composite on Teeth #14 and #18. The Respondent, however, failed to document clinical details regarding the restorations, including the materials used, the method of anesthesia and the final disposition of the procedure.

21. On or about January 26, 2017, the Respondent placed occlusal composite filling on Tooth #30 and adjusted the filling on Tooth #14, after Patient B complained about sensitivity. The Respondent, however, failed to document sufficient clinical details regarding the procedures performed, including the reason for "refilling" Tooth #30 and the method of anesthesia. The Respondent took periapical radiographs of Teeth #16 and #17 but failed to document the reason they were taken. The Respondent also failed to provide or document providing post-operative instructions.

22. The Respondent's recordkeeping practices with respect to Patient B were deficient for reasons including:

a) Failing to retain diagnostic quality radiographs;

b) Failing to document periodontal charting;

c) Failing to document reviewing Patient B's medical history;

d) Failing to obtain a signed HIPAA form;

e) Failing to document informed consent for radiographs taken;

f) Failing to document providing post-operative instructions;

g) Failing to document a treatment plan signed and dated by Patient B and the Respondent; and

h) Failing to document all treatment and diagnosis in sufficient clinical details.

Patient C

23. Patient C, a female born in the 1950s, had been seeing the Respondent for dental care since October 2014. Patient C's first visit to the Respondent's dental practice after the Consent Order went into effect was on or about November 9, 2017. At this visit, a dental hygienist signed a progress note stating that she reviewed Patient C's medical history, performed a period examination and dental prophylaxis, and provided oral hygiene instructions to Patient C. The Respondent did not sign the progress note or otherwise document he ever saw Patient C that day. Patient C's dental chart contained a rudimentary treatment plan that was not signed by the Respondent and Patient C, which noted restoration plans for Teeth #9 – DFL and #12 – O. The Respondent, however, failed to document the reasons for the restorations. There was no periodontal charting done at this visit.

24. On or about November 14, 2017, Patient C returned for restorations on Teeth #9 and #12. The Respondent noted that he reviewed Patient C's medical history and obtained a signed informed consent, even though Patient C's chart did not contain a copy of the signed informed consent. The Respondent performed a four-surface restoration, even though he treatment-planned a three-surface restoration. The Respondent further noted a need for a crown on Tooth #9 but failed to document the reason for such need. The Respondent performed a restoration on Tooth #12 but failed to document sufficient clinical details regarding the procedures.

25. On or about December 20, 2017, Patient C presented to the Respondent complaining that the crown on Tooth #31 came off. The Respondent noted that part of the tooth was in the crown and suggested that Patient C may require RCT on Tooth #31. The Respondent failed to document sufficient clinical details such as whether the margin was intact or whether there was any decay. Patient C was dismissed and told to return at a later date for crown buildup and RCT assessment.

26. Patient C returned on or about January 2, 2018, for an RCT on Tooth #31. The Respondent failed to document sufficient clinical details and dental justification for an RCT on Tooth #31. The Respondent also failed to document providing post-operative instructions to Patient C.

27. On or about January 16, 2018, the Respondent performed a crown buildup and preparation for Tooth #31. The Respondent noted cementing a temporary crown. The Respondent, however, failed to document taking a final impression or providing post-operative instructions. Patient C returned the next day on or about January 17, 2018, to re-cement the temporary crown, but the Respondent failed to document the type of cement used.

28. The Respondent's recordkeeping practices with respect to Patient C were deficient for reasons including:

a) Failing to document periodontal charting;

b) Failing to obtain a signed HIPAA form;

c) Failing to document providing post-operative instructions;

d) Failing to document treatment plans signed and dated by the Respondent and Patient C; and

e) Failing to document all treatment rendered in sufficient clinical details.

Patient D

29. Patient D, a male born in the 1980s, initially presented to the Respondent's dental practice on or about November 27, 2017, for teeth cleaning and a checkup. At this visit, a dental hygienist signed a progress notes stating that she performed a comprehensive examination and took a number of radiographs, including one panoramic, four bitewing and two periapical. The Respondent did not sign the progress note or otherwise document he ever saw Patient D that day. Patient D's chart contained a rudimentary treatment plan that was not signed and dated by the Respondent and Patient D. The treatment plan called for composite restorations on Teeth #29, 20, 19, 18, 30, 6, 7, 10, 11 and 15, and a crown on Tooth #31. The Respondent, however, failed to document sufficient clinical details to justify the treatment plan. There was no periodontal charting done at this visit.

30. Patient D returned on or about December 6, 2017, for restorative work on Teeth #29-DO and #30-OB, and a crown on Tooth #31. The Respondent failed to document sufficient clinical details regarding the procedures performed and the justification for the procedures. The Respondent failed to document taking a final impression as well as the type of temporary crown placed. Although the Respondent obtained signed informed consent for crown placement, he did not obtain informed

consent for the filling placed. The Respondent billed Patient D's insurance company for crown placement even though he had not completed the procedure.

31. On or about December 13, 2017, the Respondent performed restorations on Teeth #15-OB, #18-O, #19-OB, #20-O and #21-MO. The Respondent, however, failed to document sufficient clinical details regarding the procedures performed and the dental necessity for the procedures.

32. On or about December 22, 2017, the Respondent performed restorations on Teeth #6, #7, #10 and #11. The informed consent Patient D signed failed to specify the teeth involved. The Respondent also failed to document sufficient clinical details regarding the procedures performed and the dental necessity for the procedures.

33. Patient D returned on or about January 16, 2018, for placement of the permanent crown on Tooth #31. The Respondent failed to document taking a radiograph to check proper seating and margins. The Respondent also failed to document the type of cement used and the periodontal aspect of the treatment.

34. The Respondent's recordkeeping practices with respect to Patient D were deficient for reasons including:

a) Failing to document periodontal charting;

b) Failing to properly label radiographs;

c) Failing to document in sufficient clinical details all treatment rendered and the dental necessity for the treatment rendered; and

d) Failing to submit insurance claim on the proper date.

Patient E

35. Patient E, a female born in the 1970s, initially visited the Respondent's dental practice on or about December 1, 2017, for a routine examination and teeth cleaning. At this visit, a dental hygienist signed a progress note stating that she performed a comprehensive examination, a periodontal evaluation and full mouth debridement. The hygienist further noted that she took one panoramic and four bitewing radiographs. The Respondent did not sign the progress note or otherwise document that he ever saw Patient E that day. Patient E's chart contained a rudimentary treatment plan that was not signed by the Respondent and Patient E. The treatment plan called for restorations on Teeth #7 and #10, and a crown on Tooth #31. There was no informed consent in Patient E's chart for the procedures performed.

36. On or about January 4, 2018, a dental hygienist performed prophylaxis and provided oral hygiene instructions.

37. On or about January 17, 2018, the Respondent performed restorations on Teeth #7 and #10. The Respondent failed to document sufficient clinical details regarding the procedures performed and the dental necessity for the procedures. There were no periapical radiographs taken of Teeth #7 and #10, and the panoramic radiograph was not of diagnostic quality. The Respondent noted instructing Patient E to return at a later date for crown preparation on Tooth #31, even though there was no periapical radiograph on that tooth to justify a crown placement.

38. The Respondent's recordkeeping practices with respect to Patient E were deficient for reasons including:

a) Failing to document complete periodontal charting;

b) Failing to document sufficient clinical details regarding the treatment performed and the dental necessity for the treatment;

c) Failing to obtain written informed consent; and

d) Failing to document a treatment plan that was signed and dated by the Respondent and Patient E.

Patient F

39. Patient F, a male born in the 1980s, initially presented to the Respondent on or about January 18, 2018, with complaints of lower right quadrant pain. The Respondent performed a limited examination and took a number of radiographs, including panoramic and periapical radiographs on Teeth #5, #12, #17, #30 and #32. The panoramic radiograph was not of diagnostic quality. Patient F's chart included a rudimentary treatment plan that was not signed and dated by the Respondent and Patient F. The Respondent failed to perform periodontal charting. The Respondent prescribed Motrin 800 mg and PenVK 500 mg but failed to document the quantity, use instructions and dental necessity for the prescriptions.

40. Patient F returned on or about January 22, 2018, for extractions, but the Respondent changed the treatment plan to restorations of Teeth #9 and #11 without documenting his reasoning. The Respondent performed restorations on Teeth #9 and #11 but failed to obtain written informed consent prior to the procedures.

41. The Respondent's recordkeeping with respect to Patient F were deficient for reasons including:

a) Failing to document and retain diagnostic quality radiographs;

b) Failing to document written informed consent;

c) Failing to document a treatment plan signed and dated by the Respondent and Patient F; and

d) Failing to document the quantity, use instructions and dental necessity for prescriptions provided.

Patient G

42. Patient G, a female born in the 1960s, began seeing the Respondent for dental care in May 2010. Patient G's first visit to the Respondent's dental practice after the Consent Order went into effect was on or about January 26, 2018. At this visit, a dental hygienist signed the progress note stating that she performed a periodic examination, took four bitewing radiographs and performed a dental prophylaxis. The Respondent did not sign the progress note or otherwise document that he ever saw Patient G that day. As of this date, Patient G: had not had a comprehensive examination performed since May 10, 2010; had not had a medical history update and review since May 10, 2010; never had a treatment plan signed and dated by the Respondent and Patient G; and never had a periodontal charting done.

43. The Respondent's recordkeeping practices with respect to Patient G were deficient for reasons including:

a) Failing to document a comprehensive examination;

b) Failing to document an updated medical history review;

c) Failing to document a treatment plan signed and dated by the Respondent and Patient G; and

d) Failing to document periodontal charting.

Patient H

44. Patient H, a male born in the 1960s, initially presented to the Respondent on or about July 21, 2016 with complaints of bleeding gums, clicking/popping jaw and sensitivity to cold. Patient H's treatment plan included implant abutments and crowns on Teeth #14, #28, #29 and #30. On or about December 8, 2016, the Respondent placed the abutment and crown on Tooth #14.

45. The Respondent's post-Consent Order interaction with Patient H began on or about October 10, 2017, when Patient H sent him a letter complaining of the Respondent's failure to consider Patient H's medical and financial issues.

46. On or about January 16, 2018, Patient H presented for a final impression to fabricate new crowns for Teeth #28, #29 and #30. As of this date, Patient H still had not undergone: a comprehensive examination; full mouth series x-ray; initial oral examination; periodontal charting; oral cancer screening; periodontal treatment; treatment plan signed and dated by the Respondent and Patient H; review of medical history; medical consultation; and financial treatment plan, all of which the Respondent should have performed and documented on this date. The Respondent's documentation of this visit failed to contain sufficient clinical details, including but not limited to: how the procedures were performed; the materials used for the procedures; and Patient H's disposition prior to dismissal. The Respondent took two periapical radiographs, which he

failed to document in Patient H's progress notes. The Respondent initiated the procedures without first securing insurance preauthorization.

47. The Respondent's recordkeeping practices with respect to Patient H were deficient for reasons including:

a) Failing to document periodontal charting;

b) Failing to document medical history review;

c) Failing to document crucial and appropriate medical and dental consultations;

d) Failing to document a treatment plan signed and dated by the Respondent and Patient H;

e) Failing to document treatment rendered in sufficient clinical detail; and

f) Failing to document timely and proper financial/insurance records.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's actions, as described above, constitute violations of Conditions One (1), Two (2), Three (3) and Four (4) of his probation and the 2017 Consent Order, and the following violation of the Act: behaving dishonorably or unprofessionally, or violating a professional code of ethics pertaining to the dentistry profession, in violation of Health Occ. § 4-315(a)(16); and violating any rule or regulation adopted by the Board, *i.e.* COMAR 10.44.30 *et seq.*, in violation of Health Occ. § 4-315(a)(18); and failing to comply with any Board order, in violation of Health Occ. § 4-315(a)(33).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is hereby:

ORDERED that the Respondent is **REPRIMANDED;** and it is further

ORDERED that the Respondent is placed on **PROBATION** for a minimum period of **TWO (2) YEARS** to begin from the date of this Consent Order. During the probationary period, the Respondent must comply with the following terms and conditions:

1. **Within one (1) year** of the date of this Consent Order, the Respondent shall enroll in and successfully complete the following Board-approved courses: four (4) credit-hour in-person course(s) on professional ethics; four (4) credit-hour in-person course(s) on dental recordkeeping; and four (4) credit-hour online course(s) on dental recordkeeping. The Respondent shall be responsible for submitting written documentation to the Board of his successful completion of the course(s). The Respondent understands and agrees that he may not use this coursework to fulfill any requirements mandated for licensure renewal. The Respondent shall be solely responsible for furnishing the Board with adequate written verification that he has completed the course(s) according to the terms set forth herein.

2. **Within sixty (60) days** of the date of this Consent Order, the Respondent shall pay a fine in the amount of **Two Thousand dollars ($2,000.00)** payable to the Maryland State Board of Dental Examiners.

3. The Respondent is subject chart reviews by the Board. The Board, at its discretion, may conduct office visits for the purpose of chart review to ensure that the Respondent is in compliance with dental and recordkeeping standards.

4. The Respondent shall comply with the Maryland Dentistry Act and all laws, statutes and regulations pertaining thereof.

AND IT IS FURTHER ORDERED that after the conclusion of **TWO (2) YEARS** from the date of this Consent Order, 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, may grant the termination if the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending complaints similar to the violations found in this case; and it is further

ORDERED that if the Respondent violates any of the terms and conditions of 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 before the Board otherwise, may impose any sanction which the Board may have imposed in this case, including additional probationary terms and conditions, a reprimand, suspension, revocation and/or a monetary penalty; and it is further

ORDERED that the effective date of this Consent Order is the date the Consent Order is signed by the Executive Director of the Board. The Executive Director signs the Consent Order on behalf of the Board which has imposed the terms and conditions of this Consent Order; 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 it is further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Provisions, §§ 4-101 *et seq.* (2014 Repl. Vol.).

May 15, 2019
Date

Francis X. McLaughlin
Executive Director
Maryland State Board of Dental Examiners

CONSENT

I, Gary E. Warner, D.D.S., acknowledge that I am represented by counsel and have consulted with counsel 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 after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

5/9/2019
Date

Gary E. Warner, D.D.S.
Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF PRINCE GEORGE'S, MARYLAND

I HEREBY CERTIFY that on this 9TH day of MAY _____, 2019, before me, a Notary Public of the foregoing State and City/County personally appear Gary E. Warner, D.D.S., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notary seal.

Irvin Tracy Harris
Notary Public

My commission expires:

IRVIN TRACY HARRIS
NOTARY PUBLIC STATE OF MARYLAND
My Commission Expires 12/08/2022