



I do hereby certify this to be a complete, accurate and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.  
*Kristin K. Benton, DNP, RN*  
Kristin K. Benton, DNP, RN  
Executive Director  
Texas Board of Nursing

**DOCKET NUMBER 507-24-16722**

**IN THE MATTER OF  
PERMANENT CERTIFICATE  
NUMBER LVN 231944  
ISSUED TO  
DAVID ALVAREZ-BERNAL**

**§ BEFORE THE STATE OFFICE  
§  
§ OF  
§  
§ ADMINISTRATIVE HEARINGS**

**OPINION AND ORDER OF THE BOARD**

TO: DAVID ALVAREZ-BERNAL  
1761 DAVE ELLIOTT  
EL PASO, TEXAS 79936

HEATHER D. HUNZIKER  
ADMINISTRATIVE LAW JUDGE  
PO BOX 13025  
AUSTIN, TX 78711-3025

At the regularly scheduled public meeting on April 23, 2026, the Texas Board of Nursing (Board) considered the following items: the Proposal for Decision (PFD) regarding the above cited matter; Staff's recommendation to the Board regarding the PFD and order; and Respondent's recommendation to the Board regarding the PFD and order, if any.

The Board finds that after proper and timely notice was given, the above styled case was heard by an Administrative Law Judge (ALJ) who made and filed a PFD containing the ALJ's findings of facts and conclusions of law. The PFD was properly served on all parties and all parties were given an opportunity to file exceptions and replies as part of the record herein. No exception were filed by either parties in this case.

The Board, after review and due consideration of the PFD; Staff's recommendations; and the recommendations made by the Respondent, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

**Recommendation for Sanction**

Pursuant to Tex. Occ. Code. §301.459(a-1), an Administrative Law Judge may make a recommendation regarding an appropriate action or sanction. The Board, however, has the sole authority and discretion to determine the appropriate action or sanction.

On six occasions in late 2021, while employed as an LVN with Americare Nursing Services, PLLC (Americare), Respondent falsely documented and submitted nursing notes, and received payment, for visits to patient G.D. at Casa de Bellamie Assisted Living Home (Casa) in El Paso, Texas, that Respondent did not conduct because G.D. was actually hospitalized, first at University Medical Center and then at Los Arcos Del Norte Care Center (Los Arcos). “While Respondent argues that this was merely an administrative error resulting from confusing two different agencies’ clients with the same initials, the evidence belies this characterization.”<sup>1</sup> Respondent never mentioned documenting the wrong patient during his termination from his employer, his documentation for the patient included patient-specific details, and he admitted to these acts “because [of his] economic situation.” “His agreement to pay back the money and his signing of the agreement also support misconduct, not mistake.”<sup>2</sup> Further, Respondent presented no actual evidence that he was working for another home healthy agency at that time.

The inaccuracy of Respondent’s documentation elevated the risk of harm to the patient, because it left subsequent providers unaware of G.D.’s hospitalization and could have affected G.D.’s insurance coverage due to inaccurate billing. Respondent was previously disciplined in 2019 “for inappropriate conduct with a patient due to his personal financial situation, which he has also blamed for these six instances of 2021 misconduct. This patten of unprofessional conduct shows disregard for the laws and rules of nursing practice, and a lack of concern for patients’ healthy and safety, particularly when Respondent’s financial situation is insecure.”<sup>3</sup> Further, “Respondent’s repeated self-dealing against his patient’s interests, for which he was previously penalized, indicates that the previous penalty, an order to complete remedial education, had no effect on his nursing practice.”<sup>4</sup> The ALJ found that “Respondent should not practice nursing in an autonomous role. His acts of poor judgment and non-conformance to professional standards do not show good professional character.”<sup>5</sup> The Board agrees with the ALJ’s recommendation for sanction for Reprimand and imposes the sanctions set out below.

## TERMS OF ORDER

### I. SANCTION AND APPLICABILITY

IT IS THEREFORE AGREED and ORDERED that RESPONDENT SHALL receive the sanction of **REPRIMAND WITH STIPULATIONS AND FINE** in accordance with the terms of this Order.

A. This Order SHALL apply to any and all future licenses issued to

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<sup>1</sup> PFD at 16.

<sup>2</sup> *Id.*

<sup>3</sup> PFD at 17.

<sup>4</sup> PFD at 18.

<sup>5</sup> *Id.*

RESPONDENT to practice nursing in the State of Texas.

- B. This Order SHALL be applicable to RESPONDENT'S nurse licensure compact privileges, if any, to practice nursing in the State of Texas.
- C. Until successfully completed, RESPONDENT may not practice nursing in the State of Texas except in accordance with the terms of this Order.
- D. As a result of this Order, RESPONDENT'S license(s) will be designated "single state" as applicable and RESPONDENT may not work outside the State of Texas in another nurse licensure compact party state using a Texas compact license.

## **II. COMPLIANCE WITH LAW**

While under the terms of this Order, RESPONDENT agrees to comply in all respects with the Nursing Practice Act, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nursing Education, Licensure and Practice, 22 TEX. ADMIN. CODE §§211.1 *et seq.*, and this Agreed Order.

## **III. UNDERSTANDING BOARD ORDERS**

Within thirty (30) days of entry of this Order, RESPONDENT must successfully complete the Board's online course, "Understanding Board Orders", which can be accessed on the Board's website from the "Discipline & Complaints" drop-down menu or directly at: <http://www.bon.texas.gov/UnderstandingBoardOrders/index.asp>. Upon successful completion, RESPONDENT must submit the course verification at the conclusion of the course, which automatically transmits the verification to the Board.

## **IV. REMEDIAL EDUCATION COURSE(S)**

In addition to any continuing education requirements the Board may require for licensure renewal, RESPONDENT SHALL successfully complete the following

remedial education course(s) **within one (1) year of the effective date of this**

**Order, unless otherwise specifically indicated:**

- A. **A Board-approved course in Texas nursing jurisprudence and ethics** that shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft, and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. Home study and video programs will not be approved.
- B. **The course "Righting a Wrong."** a 3.0 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) International Center for Regulatory Scholarship (ICRS).
- C. **The course "Professional Accountability."** a 5.4 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension.
- D. **A Board-approved course in nursing documentation** that shall be a minimum of six (6) hours in length. The course's content shall include: nursing standards related to accurate and complete documentation; legal guidelines for recording; methods and processes of recording; methods of alternative record-keeping; and computerized documentation. Home study courses and video programs will not be approved.

In order to receive credit for completion of this/these course(s), RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form or SHALL submit the continuing education certificate, as applicable, to the attention of Monitoring at the Board's office. RESPONDENT SHALL first obtain Board approval of any course prior to enrollment if the course is not being offered by a pre-approved provider. *Information about Board-approved courses and Verification of Course Completion forms are available from the Board at [www.bon.texas.gov/compliance](http://www.bon.texas.gov/compliance).*

#### V. MONETARY FINE

RESPONDENT SHALL **pay a monetary fine in the amount of fifteen hundred dollars (\$1500.00) within ninety (90) days of the effective date of this Order.** Payment is to be made directly to the Texas Board of Nursing in the

form of cashier's check or U.S. money order. Partial payments will not be accepted.

## VI. EMPLOYMENT REQUIREMENTS

In order to complete the terms of this Order, RESPONDENT must work as a nurse in the State of Texas, providing direct patient care in a clinical healthcare setting, for a minimum of sixty-four (64) hours per month for eight (8) quarterly periods [two (2) years] of employment. This requirement will not be satisfied until eight (8) quarterly periods of employment as a nurse have elapsed. Periods of unemployment or of employment that do not require the use of a registered nurse (RN) or a vocational nurse (LVN) license, as appropriate, will not apply to this period and will not count towards completion of this requirement.

- A. **Notifying Present and Future Employers:** RESPONDENT SHALL notify each present employer in nursing and present each with a complete copy of this Order, including all attachments, if any, within five (5) days of receipt of this Order. While under the terms of this Order, RESPONDENT SHALL notify all future employers in nursing and present each with a complete copy of this Order, including all attachments, if any, prior to accepting an offer of employment.
- B. **Notification of Employment Forms:** RESPONDENT SHALL CAUSE each present employer in nursing to submit the Board's "Notification of Employment" form to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Board's "Notification of Employment form" to the Board's office within five (5) days of employment as a nurse.
- C. **Direct Supervision:** For the first year [four (4) quarters] of employment as a Nurse under this Order, RESPONDENT SHALL be directly supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse. Direct supervision requires another nurse, as applicable, to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home

health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

D. **Indirect Supervision:** For the remainder of the supervisory period, RESPONDENT SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse, who is on the premises. The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years of experience in the same or similar practice setting to which the RESPONDENT is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

E. **Nursing Performance Evaluations:** RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the RESPONDENT by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the individual who supervises the RESPONDENT and these reports shall be submitted by the supervising individual to the office of the Board at the end of each three (3) month quarterly period for eight (8) quarters [two (2) years] of employment as a nurse.

## VII. SUBSEQUENT CRIMINAL PROCEEDINGS

IT IS FURTHER AGREED, should the RESPONDENT'S conduct, as outlined in the findings of fact of this Agreed Order, result in subsequent judicial action, including a deferred disposition, RESPONDENT may be subject to further disciplinary action, up to, and including, revocation of RESPONDENT'S license(s) to practice nursing in the State of Texas.

## VIII. RESTORATION OF UNENCUMBERED LICENSE(S)

Upon full compliance with the terms of this Agreed Order, all encumbrances will be removed from RESPONDENT'S license(s) and/or privilege(s) to practice nursing in the State of Texas and, subject to meeting all existing eligibility

requirements in Texas Occupations Code Chapter 304, Article III, RESPONDENT  
may be eligible for nurse licensure compact privileges, if any.

Entered this 23rd day of April, 2026.

TEXAS BOARD OF NURSING

*Kristin K. Benton, DNP, RN*

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KRISTIN K. BENTON, DNP, RN  
EXECUTIVE DIRECTOR FOR THE BOARD

Attachments: Proposal for Decision; Docket No. 507-24-16722 (September 17, 2025),  
Exceptions Letter issued October 9, 2025.

FILED  
507-24-16722  
9/17/2025 3:23 PM  
STATE OFFICE OF  
ADMINISTRATIVE HEARINGS  
Jessica Rodriguez, CLERK

ACCEPTED  
507-24-16722  
9/17/2025 3:30:06 pm  
STATE OFFICE OF  
ADMINISTRATIVE HEARINGS  
Jessica Rodriguez, CLERK

# State Office of Administrative Hearings

Kristofer S. Monson  
Chief Administrative Law Judge

September 17, 2025

JoAnna Starr, TBN Staff Attorney

VIA EFILE TEXAS

David Alvarez-Bernal  
1761 Dave Elliott  
El Paso, TX 79936

VIA EFILE TEXAS & REGULAR MAIL

**RE: SOAH Docket Number 507-24-16722; *Texas Board of Nursing v. David Alvarez-Bernal***

Dear Parties:

Please find attached a Proposal for Decision in this case.

Exceptions and replies may be filed by any party in accordance with 1 Texas Administrative Code section 155.507(b), a SOAH rule which may be found at [www.soah.texas.gov](http://www.soah.texas.gov).

CC: Service List

**BEFORE THE  
STATE OFFICE OF ADMINISTRATIVE  
HEARINGS**

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**TEXAS BOARD OF NURSING,  
PETITIONER  
v.  
DAVID ALVAREZ-BERNAL,  
RESPONDENT**

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**PROPOSAL FOR DECISION**

The staff (Staff) of the Texas Board of Nursing (Board) seeks disciplinary action against the Vocational Nurse (LVN) license held by David Alvarez-Bernal (Respondent), alleging he violated the Nursing Practice Act (Act)<sup>1</sup> and the Board's rules by documenting and submitting false nursing visit notes.<sup>2</sup> The Administrative Law Judge (ALJ) concludes that Staff met its burden and recommends that the Board

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<sup>1</sup> Tex. Occ. Code ch. 301 (Nursing Practice Act (Act)).

<sup>2</sup> 22 Tex. Admin. Code ch. 217. All citations in this Proposal for Decision are to the substantive provisions in effect at the time of the underlying incident, in November and December 2021. For ease of reference, the Board's rules, found in title 22, part 11, chapters 211 to 228 of the Texas Administrative Code, will be referred to as "Board Rule \_\_\_\_."

issue a Reprimand with Stipulations ordering Respondent to work under direct supervision for one year, followed by a year of indirect supervision; complete remedial education; and pay a fine of \$1,500.

## **I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY**

Notice and jurisdiction were undisputed and are set out in the Findings of Fact and Conclusions of Law without further discussion here.

The hearing on the merits was held on July 21, 2025, via the Zoom videoconferencing platform, before ALJ Heather D. Hunziker of the State Office of Administrative Hearings (SOAH).<sup>3</sup> Assistant General Counsel JoAnna Starr represented Staff and Respondent appeared on his own behalf. The record closed on August 26, 2025, the deadline for filing admitted evidence.<sup>4</sup>

## **II. APPLICABLE LAW**

Under the Act, the Board is authorized to take disciplinary action against a nurse for, among other things, a violation of the Act or a Board Rule;<sup>5</sup> unprofessional conduct in the practice of nursing that is likely to deceive, defraud, or injure a patient

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<sup>3</sup> The case was initially dismissed without prejudice on April 30, 2025, upon Staff's motion requesting dismissal, which stated that the matter had been handled informally by agreed order. Staff then filed a Motion to Set Hearing on the Merits on the basis that Respondent had withdrawn his acceptance of the settlement, which resulted in a re-setting. Respondent did not appear at the re-set hearing on the merits held on July 1, 2025, and the ALJ issued an order of default dismissal that same day. That default dismissal was subsequently set aside in an order issued July 9, 2025.

<sup>4</sup> SOAH Order No. 11, issued August 19, 2025, held the record open until August 26, 2025, for Respondent to file his admitted exhibits. Respondent filed some of his admitted exhibits on August 25, 2025.

<sup>5</sup> Act § 301.452(b)(1).

or the public;<sup>6</sup> or failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that, in the [B]oard's opinion, exposes a patient or other person unnecessarily to risk of harm.<sup>7</sup> Staff asserts that Respondent's conduct is grounds for disciplinary action under these provisions, as well as pursuant to Board Rules 217.11 and 217.12.<sup>8</sup>

Board Rules 217.11 and 217.12 address minimum standards of nursing practice and unprofessional conduct, respectively; and Staff alleges Respondent is subject to sanction under multiple provisions:

- Board Rule 217.11(1)(A): Know and conform to the Act and Board Rules as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice;
- Board Rule 217.11(1)(D): Accurately and completely report and document client status including signs and symptoms, nursing care rendered, physician orders, administration of medications and treatments, client response, and contacts with other health care team members concerning significant events regarding client's status;
- Board Rule 217.12(1)(A): Carelessly failing, repeatedly failing, or exhibiting an inability to perform vocational nursing in conformity with the standards of minimum acceptable level of nursing practice set out in Board Rule 217.11;
- Board Rule 217.12(1)(B): Failing to conform to generally accepted nursing standards in applicable practice settings;
- Board Rule 217.12(1)(C): Improper management of client records;

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<sup>6</sup> Act § 301.452(b)(10).

<sup>7</sup> Act § 301.452(b)(14).

<sup>8</sup> Staff Ex. 4c at 4.

- Board Rule 217.12(4): Conduct that may endanger a client’s life, health, or safety;
- Board Rule 217.12(6)(A): Misconduct—actions or conduct including falsifying reports, client documentation, agency records or other documents; and
- Board Rule 217.12(6)(H): Misconduct—providing false, deceptive, or misleading information in connection with the practice of nursing.<sup>9</sup>

When a nurse has violated the Act or Board Rules, the Board is required to impose a disciplinary sanction.<sup>10</sup> Board Rule 213.33 includes a Disciplinary Matrix that the Board and SOAH are required to use in all disciplinary matters.<sup>11</sup> The Disciplinary Matrix categorizes violations into tiers and sanction levels, based on the seriousness of the offense and risk of harm to patients or the public; and it lists certain aggravating and mitigating factors that must be considered.<sup>12</sup> Both the Act and the Board Rules direct the Board to consider taking a more severe disciplinary action, including revocation of the nurse’s license, when the nurse is being disciplined for multiple violations or has previously been the subject of disciplinary action by the Board.<sup>13</sup>

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<sup>9</sup> Staff Ex. 4.

<sup>10</sup> Act § 301.453(a).

<sup>11</sup> Board Rule 213.33(a), (b).

<sup>12</sup> Board Rule 213.33(b)-(c).

<sup>13</sup> Act § 301.4531(c); Board Rule 213.33(b).

Board Rule 213.33(c) includes another list of factors that the Board and SOAH must analyze in determining the appropriate disciplinary sanction.<sup>14</sup> The relevant factors include:

- (1) evidence of actual or potential harm to patients, clients, or the public;
- (2) evidence of a lack of truthfulness or trustworthiness;
- (6) whether the person has been subject to previous disciplinary action by the Board and, if so, the history of compliance with those actions;
- (7) the length of time the person has practiced;
- (8) the actual damages, physical, economic, or otherwise, resulting from the violation;
- (9) the deterrent effect of the penalty imposed;
- (11) any mitigating or aggravating circumstances, including those specified in the Disciplinary Matrix;
- (13) whether the person is being disciplined for multiple violations of the Act or its derivative rules and orders;
- (14) the seriousness of the violation;
- (15) the threat to public safety;
- (16) evidence of good professional character as set forth and required by Board Rule 213.27; and
- (18) any other matter that justice may require.<sup>15</sup>

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<sup>14</sup> Board Rule 213.33(c).

<sup>15</sup> Board Rule 213.33(c).

Staff had the burden of proving its allegations and aggravating factors by a preponderance of the evidence.<sup>16</sup> Respondent had the burden of proving mitigating factors.<sup>17</sup>

### III. DISCUSSION

#### A. BACKGROUND

Respondent received his LVN license (license no. 231944) in Texas on November 30, 2010.<sup>18</sup> Respondent was disciplined by the Board in a January 2019 order (2019 Order) that required him to complete remedial education as a result of his “inappropriate” 2017 request of a \$300 loan from a patient when Respondent was experiencing personal financial hardship.<sup>19</sup>

In this proceeding, Staff alleges that, on six occasions in late 2021,<sup>20</sup> while employed as an LVN with Americare Nursing Services, PLLC (Americare), Respondent falsely documented and submitted nursing notes, and received payment, for visits to patient G.D. at Casa de Bellamie Assisted Living Home (Casa) in El Paso, Texas, that Respondent did not conduct because G.D. was actually hospitalized, first at University Medical Center and then at Los Arcos Del Norte Care Center

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<sup>16</sup> 1 Tex. Admin. Code § 155.427. See *Granek v. Tex. State Bd. of Med. Exam'rs*, 172 S.W.3d 761, 777 (Tex. App.—Austin 2005, no pet.).

<sup>17</sup> 1 Tex. Admin. Code § 155.427.

<sup>18</sup> Staff Ex. 1.

<sup>19</sup> Staff Ex. 4c at 10, 21-22.

<sup>20</sup> The alleged dates are November 24, 2021; December 2, 2021; December 10, 2021; December 17, 2021; December 21, 2021; and December 27, 2021.

(Los Arcos).<sup>21</sup> Staff argues that Respondent's conduct was deceptive, created an inaccurate medical record, and was likely to defraud Casa of money paid to Respondent for hours not worked, in violation of Board Rule 217.11(1)(A) and (D), and Board Rule 217.12(1)(A)-(C), (4), and (6)(A) and (H). Staff also argues that Respondent's 2017 transgression that resulted in his 2019 Order relates to his conduct in this matter, in that he explained his conduct in both cases as resulting from his economic situation.

Respondent admits to documenting and submitting nursing visit notes for patient G.D. with Americare, without actually visiting G.D. as recorded. Respondent argues, however, that it was merely a mistake; that he confused two different patients, both with the same initials; and that he actually visited the other G.D., whom he was caring for through a different agency.

## **B. EVIDENCE**

Staff offered 16 exhibits, all of which were admitted.<sup>22</sup> Staff also called witnesses Stephanie Martinez, Director of Nursing at Americare in 2021; Staff's

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<sup>21</sup> Patients are identified by their initials for confidentiality.

<sup>22</sup> Staff's exhibits consisted of: the Board's Computer Licensure Record (Staff Ex. 1); Investigatory Letter (Staff Ex. 2); Formal Charges (Staff Ex. 3); August 23, 2024 Notice of Hearing (Staff Ex. 4); December 3, 2024 Notice of Hearing (Staff Ex. 4a); June 18, 2025 Notice of Hearing (Staff Ex. 4b); July 10, 2025 Notice of Hearing (Staff Ex. 4c); Personnel Records from Americare (Staff Ex. 5); Departmental Records from Americare (Staff Ex. 6); Departmental Records from Los Arcos (Staff Ex. 7); Medical Records from Casa (Staff Ex. 8); Medical Records from University Medical Center (Staff Ex. 9); Medical Records from Americare (Staff Ex. 10); Payroll Records from Americare (Staff Ex. 11); Medical Records from Los Arcos (Staff Ex. 12); and the CV/Resume of Paul Bradley (Staff Ex. 13).

expert, Paul Bradley; and Respondent. Respondent testified on his own behalf and had three exhibits admitted.<sup>23</sup>

## 1. Testimony of Stephanie Martinez

Ms. Martinez, who has been a registered nurse for over 20 years, was the Director of Nursing at Americare in 2021 when Respondent was employed there as an LVN. She oversaw patient care, clinicians, and operation flow.

Ms. Martinez said she contacted Respondent when she learned he had documented visits to G.D., whom he was assigned to, at Casa while G.D. was not at Casa. Ms. Martinez testified that Respondent admitted what he had done, apologized, and explained that he “needed the money”; and he was terminated immediately. She said Respondent never told her he had documented visits with the *wrong* patient; and she observed that his documentation for G.D. included patient assessments, vital signs, narratives, and other specifics.

Ms. Martinez introduced Staff Exhibit 5, which includes Respondent’s Employee Counseling Record, signed by her and Respondent on January 3, 2022, which she said was an accurate, contemporaneous record of the events, including Respondent’s immediate termination. It states:

[Respondent] turned in notes for [G.D.] for dates 11/24/21, 12/2/21, 12/10/21, 12/17/21, 12/21/21, and 12/27/21. At time of RN visit for recertification it was found that patient had been admitted to the

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<sup>23</sup> Respondent’s admitted exhibits consisted of: Letter from Christine Pruitt (Resp. Ex. 1); Letter from Dr. Zina Shani (Resp. Ex. 2); and Letter from Marisela Dudu (Resp. Ex. 3). During the hearing, these three letters were admitted as Respondent’s exhibits; however, because only two of them were subsequently filed as the ALJ required in Order No. 11, the record in this case does not contain Respondent Exhibit 1 and it is not part of the ALJ’s analysis.

hospital and then rehab from 11/24/21 – 12/31/21, therefore making it impossible for [Respondent] to have visited [G.D.]. Upon questioning [Respondent] he admitted to not seeing the patient and stated, “I’m sorry, I needed the money.” When I explained this was fraudulent behavior, [Respondent] admitted to the behavior and apologized. A total of 6 visits have been paid to [Respondent] when no visit was performed. [Respondent] agrees to pay agency back a total of \$180.00 to reimburse money paid out for visit [sic] not performed.<sup>24</sup>

The record of termination also includes a text message that Ms. Martinez testified Respondent sent to her, stating in part:

I know that I fail you, But I just do it because my economic situation, please help me and not report me, let me keep working as an LVN Im begin you for your help, I learned my lesson believe me, my license is my family well being , so please please, help me from the bottom of my heart Im sorry.<sup>25</sup>

According to Ms. Martinez, nursing documentation is important so that patients’ needs are correctly documented, both for patients’ medical care and for nurses’ reimbursement. She stated that the nurse should let the company know—should proactively call the company—if a patient is hospitalized so the company can coordinate with the hospital, send proper documentation for the patient, and so on. She said home health companies can get into deep trouble with the state for receiving money for services that were not provided. She noted that this matters for patient care, too—the home health care company could not know that G.D. was hospitalized or what care he got at the hospital without the nurse informing them.

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<sup>24</sup> Staff Ex. 5 at 1.

<sup>25</sup> Staff Ex. 5 at 3 (errors in original).

Ms. Martinez stated that, in her communications with Respondent, he never indicated that he had documented the wrong patient.

As a result of Respondent's actions, Ms. Martinez concluded that she would not trust him to work in a home health setting again.

## **2. Testimony of Paul Bradley**

Mr. Bradley has been a registered nurse for over ten years and is an Advanced Practice Nurse licensed to practice in Texas, and he works for the Board as a consultant. His duties include consulting on investigations and training nurses; and he has written articles on nursing practice and been involved in drafting the Board's rules. He was tendered and accepted as an expert in nursing.

Mr. Bradley testified that he reviewed the formal charges and exhibits and listened to the testimony presented at the hearing. He noted that Staff Exhibit 10, Americare's medical records for G.D., shows six skilled nursing notes digitally signed by Respondent for G.D. during the timeframe when G.D. was either hospitalized or in rehab.<sup>26</sup> He opined that Respondent's mis-documentation or false documentation on multiple occasions is especially concerning for patient safety in this home health setting, because multiple caregivers are involved and subsequent caregivers need to be able to rely on documentation in order to make treatment decisions for the patient. Without knowing G.D. was hospitalized, subsequent providers might assume he was

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<sup>26</sup> Compare Staff Ex. 10 with Staff Exs. 7, 9.

fine and determine treatment accordingly. Additionally, G.D.'s insurance coverage could be impacted based on double billing.

Mr. Bradley opined that Respondent's false documentation was unprofessional conduct that subjects him to disciplinary action under Act section 301.452(b)(10) and Board Rule 217.12(1)(A)-(C), (4), and (6)(A) and (H). Additionally, this conduct subjects Respondent to discipline under Act section 301.452(b)(14) and Board Rule 217.11(1)(A), for failure to adequately care for a patient or conform to minimum standards of acceptable nursing practice in a manner that exposed a patient unnecessarily to risk of harm. While Respondent argued that G.D. was not medically affected, Mr. Bradley noted that the *risk* of harm was still elevated for G.D. because subsequent providers were blind to G.D.'s hospitalization based on Respondent's false medical documentation. Mr. Bradley observed that, whether the care was totally fabricated or done on another patient but mistakenly documented, the multiple instances of Respondent digitally signing nursing notes for services that were not provided were still incorrect for this patient. And, he stated, "hospitalization definitely constitutes a significant event" for the purposes of what must be accurately and completely reported and documented under Board Rule 217.11(1)(D)(vi).

Lastly, Mr. Bradley applied the Disciplinary Matrix to the alleged charges. Regarding Respondent's unprofessional conduct under Act section 301.452(b)(10), he opined that second-tier discipline is appropriate, because it consisted of multiple incidents over multiple dates, rather than an isolated incident. As for Respondent's failure to conform to minimum nursing practice standards under Act

section 301.452(b)(14), Mr. Bradley opined that second-tier discipline is appropriate because of the risk of harm due to bad documentation.

As aggravating factors, Mr. Bradley listed Respondent's prior history with a similar issue, with the pattern being the financial-necessity basis for the conduct; Respondent's failure to practice competently; and the number of instances. He noted that the level of material gain would be an aggravating factor if it reached a certain threshold (over \$5,000), which this did not reach. As for mitigating factors, he noted that full restitution was paid. He found this to lead to Sanction Level 1; therefore, he recommended a reprimand of two years. He stated that, in fraud cases, the Board typically imposes at least a \$250 fine; remedial education in critical thinking, righting a wrong, professional responsibility, and documentation; and one year of direct supervision followed by one year of indirect supervision, with the supervisor at the same location as the nurse.

Mr. Bradley testified that incident reporting is the only way a nurse could work under an order in home health or with multiple employers; and opined that it would not be appropriate in this case. He said there is less supervision of a nurse in a home health setting and it is not appropriate to return a nurse to a home health or other reduced-supervision setting after the nurse has shown practices preferential to the nurse's own economic situation over patient safety.

### **3. Testimony of Respondent**

Respondent testified that he has been a licensed LVN for 15 years, working in nursing homes and home health. He is currently 67 years old and is working as a nurse

for two home health companies. He is the “sole bread winner” for his family, including two grandchildren in high school whom he supports, one of whom Respondent said stays home due to psychological problems. He needs to work to care for his grandchildren but hopes to retire someday. He could not accept a Board settlement offer because of his financial situation. Home health care work allows him to move around to help those at his house.

Respondent admitted documenting and submitting nursing visit notes for Americare patient G.D. without actually visiting that patient. He admitted he was not aware that G.D. was hospitalized, because he did not visit G.D. He claimed, however, that he put the notes of another patient with the same initials, whom he was caring for through another home health agency, in the notes of Americare’s patient G.D., which he characterized as a mere paperwork mistake. Respondent said that he confused the two patients and that he actually visited the other G.D. Respondent stated, “that was during Covid,” during which time he was still working and was “very, very stressed.”

Answering Ms. Martinez’s testimony, Respondent clarified that he had said “I need the job” rather than that he “needed the money”; but he conceded that he did send her the text about his economic situation and had agreed to pay back the money. He said he made restitution and signed the termination because Americare told him that if he did so then they would not report him to the Board, about which he was very nervous. In the four years since then, he stated, he has been working in home health and there have been no complaints or reports of any other bad behavior,

and his patients specifically request him. He concluded, “I made a mistake, but it doesn’t affect any patients physically, mentally, or medically.”

Respondent acknowledged the 2019 Order, that he was sworn in as a witness in the SOAH hearing for that case, and that the resulting proposal for decision (PFD) recommended remedial education and a \$250 fine. On cross examination, he confirmed the PFD’s finding of fact that, on October 26, 2017, he telephoned one of his home health patients and requested to borrow money. However, he clarified that he had, in fact, asked the patient *if she knew someone from whom* he could borrow money. He differentiated the conduct in that case with his actions here, explaining that the first instance was “due to economics” but this was merely a mistake, concluding that this was not a recurrence of the previous issue.

Respondent asked that he be able to continue working in home health because he is too old to find another employer who will supervise him in another type of practice setting. He asserted he can follow the rest of the Board’s order regarding continuing education and such, but he needs to continue with home health. He stated that his current home health care employer has agreed to supervise him, if needed; and he has a tablet computer, so they can supervise and monitor where he goes.

#### **4. Respondent’s Documentary Evidence**

Respondent presented two character reference letters from individuals with Urgent Care Home Health, Inc. (UCHH). In March 2024, UCHH Administrator Dr. Zina Shani wrote that Respondent had been employed as a field LVN with UCHH since August 2023 and was meeting their duties, policies, and procedures;

and, while they were aware of the pending Board case against him, they had no restrictions on his employment.<sup>27</sup> Also in March 2024, UCHH’s Marisela Dudu wrote that she had supervised Respondent as a field nurse for seven months, during which he had shown good character, rapport with clients, nursing skill, excellent patient care, consideration, dedication, common sense, and compassion.<sup>28</sup>

#### IV. ANALYSIS

##### A. SANCTIONABLE CONDUCT

Staff alleges that Respondent falsely documented and submitted nursing notes to Americare, and received payment, for six visits to G.D. at Casa in 2021 (November 24 and December 2, 10, 17, 21, and 27), when G.D. was instead hospitalized—a “significant event” for patient reporting and documentation purposes. Staff asserts that this conduct represents a pattern of deceptive behavior, created an inaccurate medical record that exposed a patient unnecessarily to risk of harm, and was likely to defraud the facility, in violation of Board Rule 217.11(1)(A) and (D), and Board Rule 217.12(1)(A)-(C), (4), and (6)(A) and (H). Staff also argues that Respondent’s 2017 conduct underlying his 2019 Order relates to this matter because, in both cases, his misbehavior resulted from his economic situation.

It is undisputed that Respondent documented and submitted false nursing visit notes and was paid for those visits, without visiting that patient, six times.<sup>29</sup> While

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<sup>27</sup> Resp. Ex. 2.

<sup>28</sup> Resp. Ex. 3.

<sup>29</sup> See also Staff Exs. 6, 10, 11.

Respondent argues that this was merely an administrative error resulting from confusing two different agencies' clients with the same initials, the evidence belies this characterization. According to Ms. Martinez's testimony and Respondent's Medicare termination notice, Respondent never mentioned documenting the wrong patient; his documentation for G.D. included patient-specific details; and he admitted to wrongdoing by explaining, "I'm sorry, I needed the money" and "I just do it because my economic situation."<sup>30</sup> His agreement to pay back the money and his signing of the termination statement also support misconduct, not mistake. Finally, Respondent did not present any evidence that he was working with another home health agency at that time, such as pay stubs or witnesses, to corroborate his claim of mistake.

Additionally, regardless whether the care documented was fictitious or just mistakenly documented, Respondent's multiple instances of logging services not provided were still incorrect for this patient. Mr. Bradley, an expert in nursing practice, testified that such inaccuracy unnecessarily elevated the risk of harm to G.D., because it left subsequent providers unaware of G.D.'s hospitalization.

The ALJ finds the evidence establishes that Respondent's false documentation, on six occasions in late 2021, was unprofessional conduct in the practice of nursing that was likely to deceive, defraud, and injure a patient and/or the public. As Mr. Bradley testified, Respondent's conduct did not conform to generally accepted nursing standards. And, as Mr. Bradley made clear, hospitalization is a "significant event" for the purposes of what must be accurately and completely

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<sup>30</sup> Staff Ex. 5 at 1, 3 (errors in original).

reported and documented under Board Rule 217.11(1)(D)(vi). Accordingly, the ALJ finds Respondent subject to disciplinary action under Act section 301.452(b)(10) for unprofessional conduct violating Board Rule 217.12(1)(A)-(C), (4), and (6)(A) and (H); and under Act section 301.452(b)(14) for failure to meet minimum standards of nursing practice violating Board Rule 217.11(1)(A) and (D).

## **B. DISCIPLINE**

Staff established violations that subject Respondent to sanction by the Board; therefore, aggravating and mitigating factors must be considered. The following are considerations under the relevant penalty factors in Board Rule 213.33(c):

- While there was no evidence that Respondent's conduct caused *actual* harm to G.D., the evidence does establish that his conduct had the *potential* to harm G.D. because subsequent providers would be unaware of G.D.'s hospitalization, and because Respondent's billing could have affected G.D.'s insurance coverage.
- The preponderant evidence, as discussed above, indicates Respondent was deliberately untruthful, rather than mistaken, in documenting patient visits to G.D.
- Respondent was previously disciplined in 2019 for inappropriate conduct with a patient due to his personal financial situation, which he has also blamed for these six instances of 2021 misconduct. This pattern of unprofessional conduct shows a disregard for the laws and rules of nursing practice, and a lack of concern for patients' health and safety, particularly when Respondent's financial situation is insecure.
- Respondent has practiced since 2010 and is not new to the profession.
- The actual damages, according to the record evidence, amount to \$180 in money paid by Medicare for Respondent's visits not performed, which Respondent agreed to repay.

- Respondent’s repeated self-dealing against his patient’s interests, for which he was previously penalized, indicates that the previous penalty, an order to complete remedial education, had no effect on his nursing practice.
- Respondent committed six violations in 2021, encompassing numerous Board Rules.
- The repetition of events and Respondent’s personal material gain are aggravating circumstances under Act sections 301.452(b)(10) and (14).
- Respondent’s character reference letter from Ms. Dudu indicates he has demonstrated competency in nursing and Mr. Bradley testified Respondent has paid full restitution—which are mitigating circumstances under Act sections 301.452(b)(10) and (14).
- Respondent’s conduct is a serious patient safety concern because subsequent providers would be unaware of G.D.’s hospitalization.
- Respondent’s repeated self-dealing over patients’ interests represents a threat to public safety.
- Respondent has 15 years of nursing experience, and he professes to have good intentions; yet, he has repeatedly shown a willingness to place his own financial interests over patients’ interests. The evidence shows that Respondent should not practice nursing in an autonomous role. His acts of poor judgment and non-conformance to professional standards do not show good professional character.

Both the Act and the Board Rules direct the Board to consider taking a more severe disciplinary action, including license revocation, because Respondent is being disciplined for multiple violations and has previously been the subject of disciplinary action by the Board.<sup>31</sup>

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<sup>31</sup> See Act § 301.4531(c); Board Rule 213.33(b).

The ALJ agrees with Staff that it would not be appropriate to return Respondent to a home health or other reduced-supervision setting, since he has shown practices preferential to his own economic situation over patient safety.

Respondent's repeated acts of unethical behavior violating Act section 301.452(b)(10) and (14) placed his patient at risk of harm; therefore, they are Second Tier offenses under the Disciplinary Matrix.<sup>32</sup> Aggravating factors include the number of events and the prior discipline for related conduct (i.e., also based on Respondent's financial needs). As a mitigating factor, Respondent paid full restitution. Therefore, the ALJ finds Sanction Level I appropriate. The recommended sanction for that level is a warning or reprimand with stipulations that may include remedial education, supervised practice, and/or public service; and a possible fine of \$250 or more for each violation.

After reviewing the guidelines set out in the Board's Disciplinary Matrix and the evidence pertinent to the relevant penalty factors, the ALJ recommends the Board issue Respondent a Reprimand with Stipulations, ordering Respondent to work under direct supervision for one year followed by a year of indirect supervision. In addition, the ALJ recommends remedial education in critical thinking, righting a wrong, professional responsibility, and documentation. Finally, the ALJ recommends a fine of \$250 per violation, totaling \$1,500.

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<sup>32</sup> Board Rule 213.33(b).

In support of the recommended sanction, the ALJ makes the following findings of fact and conclusions of law.

## **V. FINDINGS OF FACT**

1. David Alvarez-Bernal (Respondent) was issued Vocational Nurse (LVN) License No. 231944 by the Texas Board of Nursing (Board) in 2010.
2. On or about January 24, 2019, the Board ordered Respondent to complete remedial education as a result of his 2017 request of a \$300 loan from a patient when Respondent was experiencing family financial hardship.
3. In November and December 2021, Respondent worked as an LVN at Americare Nursing Services, PLLC (Americare) in Texas.
4. On six occasions in 2021 (November 24 and December 2, 10, 17, 21, and 27), while working at Americare, Respondent falsely documented and submitted nursing notes, and received payment, for visits to patient G.D. at Casa de Bellamie Assisted Living Home (Casa) in El Paso, Texas, when G.D. was not at Casa, but rather was hospitalized. Respondent did not visit G.D. for Americare on those six occasions and was not aware that G.D. was hospitalized. Respondent's care documentation for G.D. on those dates included patient-specific details.
5. Hospitalization is a significant event for patient reporting and documentation purposes.
6. Respondent explained his behavior to his Americare supervisor by explaining, "I'm sorry, I needed the money" and "I just do it because my economic situation." He agreed to pay back the money to Americare; and he signed his termination statement.
7. The actual damages amounted to \$180 in money paid by Americare for Respondent's visits not performed. Respondent has paid full restitution.
8. Respondent presented no evidence to corroborate his testimony that he was working with another home health agency in November and December 2021

and confused Americare's patient G.D. with another patient with the same initials.

9. Inaccurate medical records elevate the risk of harm to patients by causing subsequent providers to be unaware of the patient's true medical status.
10. Respondent's fraudulent billing could have affected G.D.'s insurance coverage.
11. Respondent's conduct did not conform to generally accepted nursing standards, and it shows poor judgment and professional character.
12. Respondent's conduct was deceptive, created an inaccurate medical record for G.D. that exposed G.D. unnecessarily to risk of harm, and was likely to defraud Casa and/or Americare of money paid to Respondent for hours not worked.
13. On July 10, 2025, staff of the Board (Staff) sent Respondent a Notice of Hearing and Formal Charges. The notice contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and either a short, plain statement of the factual matters asserted or an attachment that incorporated by reference the factual matters asserted in the complaint or petition filed with the state agency.
14. Administrative Law Judge Heather D. Hunziker of the State Office of Administrative Hearings (SOAH) convened the hearing on the merits on July 21, 2025, via the Zoom videoconferencing platform. Assistant General Counsel JoAnna Starr represented Staff and Respondent appeared on his own behalf. The record closed on August 26, 2025, the deadline for filing admitted exhibits.
15. Aggravating factors related to Respondent's conduct include the multiple events, serious risk of harm to a patient, and prior discipline for related conduct.
16. Restitution being fully paid is a mitigating factor.

17. It is not appropriate to return a nurse to home health care or another reduced-supervision setting, if he has shown practices preferential to his own economic interests over patient safety.

## **VI. CONCLUSIONS OF LAW**

1. The Board has jurisdiction over the licensing and discipline of nurses. Tex. Occ. Code (Code) ch. 301.
2. SOAH has jurisdiction over contested cases referred by the Board, including the authority to issue a proposal for decision with findings of fact and conclusions of law. Tex. Occ. Code § 301.459; Tex. Gov't Code ch. 2003.
3. Respondent received adequate and proper notice of the hearing on the merits. Tex. Occ. Code § 301.454; Tex. Gov't Code §§ 2001.051-.052.
4. Staff had the burden of proof by a preponderance of the evidence on the allegations of misconduct and aggravating factors. Respondent had the burden of proof by a preponderance of the evidence on mitigating factors. 1 Tex. Admin. Code § 155.427; *Granek v. Tex. State Bd. of Med. Exam'rs*, 172 S.W.3d 761, 777 (Tex. App.—Austin 2005, no pet.).
5. Respondent is subject to sanction for his fraudulent medical documentation and billing; unprofessional conduct in the practice of nursing that was likely to deceive, defraud, and injure a patient; and failure to conform to minimum standards of acceptable nursing practice. Tex. Occ. Code § 301.452(b)(10), (14); 22 Tex. Admin. Code §§ 217.11(1)(A), (D), 217.12(1)(A)-(C), (4), (6)(A), (H).
6. The Board may impose a disciplinary sanction, which can range from remedial education to revocation of a nurse's license, and which may include assessment of a fine. Tex. Occ. Code § 301.453; 22 Tex. Admin. Code § 213.33(e).
7. To determine the appropriate disciplinary sanction to be imposed in this case, the Board must consider the factors set forth in 22 Texas Administrative Code section 213.33 and the Board's Disciplinary Matrix.

8. The Board may also consider any aggravating and mitigating circumstances set forth in the findings of fact above. 22 Tex. Admin. Code § 213.33.
9. The Board must consider taking a more severe disciplinary action because Respondent is being disciplined for multiple violations and has previously been the subject of Board disciplinary action. *See* Tex. Occ. Code § 301.4531(c); 22 Tex. Admin. Code § 213.33(b).

## VII. RECOMMENDATION

Based on the above findings of fact and conclusions of law, the ALJ recommends a Reprimand with Stipulations that would direct Respondent to work for one year under direct supervision followed by one year under indirect supervision, subject to the same terms required in the 2019 Order and/or additional restrictions as the Board sees fit (e.g., Respondent may not be employed by a nurse registry, temporary placement agency, hospice, or home health agency, and may not work for multiple employers); complete remedial education; and pay a fine of \$1,500.

**Signed September 17, 2025.**



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Heather D. Hunziker

Presiding Administrative Law Judge

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Status as of 9/17/2025 3:31 PM CST

#### Case Contacts

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FILED  
507-24-16722  
10/9/2025 3:01 PM  
STATE OFFICE OF  
ADMINISTRATIVE HEARINGS  
Jessica Rodriguez, CLERK

ACCEPTED  
507-24-16722  
10/9/2025 3:09:57 pm  
STATE OFFICE OF  
ADMINISTRATIVE HEARINGS  
Jessica Rodriguez, CLERK

# State Office of Administrative Hearings

Kristofer S. Monson  
Chief Administrative Law Judge

October 9, 2025

JoAnna Starr, TBN Staff Attorney

VIA EFILE TEXAS

David Alvarez-Bernal  
1761 Dave Elliotts  
El Paso, Texas 79936

VIA EFILE TEXAS AND REGULAR MAIL

**RE: SOAH Docket Number 507-24-16722; *Texas Board of Nursing v. David Alvarez-Bernal***

Dear Parties:

I issued a Proposal for Decision (PFD) in this case on September 17, 2025. Please be advised that the time period to file exceptions to the PFD or request extensions for exceptions expired October 2, 2025, without either party filing exceptions or requesting an extension.<sup>1</sup> On October 3, 2025, a letter was issued noting that, because no exceptions were filed, the case was being returned to the Texas Board of Nursing.

At 6:00 p.m. on October 3, 2025, Respond David Alvarez-Bernal filed "Exemptions to proposal." Because SOAH no longer has jurisdiction over this matter, the Administrative Law Judge is unable to respond to this filing. Therefore, the PFD is ready for your review, and I recommend it be adopted as written.

Sincerely,

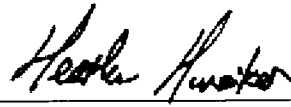
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<sup>1</sup> 1 Tex. Admin. Code § 155.507(b)(1), (3).

No Exceptions Letter

October 9, 2025

Page 2 of 2

A handwritten signature in black ink, appearing to read "Heather Hunziker", written in a cursive style.

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Heather D. Hunziker,

Presiding Administrative Law Judge

CC: Service List

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Filing Description: EXCEPTIONS LETTER BY ALJ

Status as of 10/9/2025 3:10 PM CST

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