DOCKET NUMBER 507-08-0836

IN THE MATTER OF	§	
PERMANENT CERTIFICATE	§	BEFORE THE TEXAS
NUMBER **116301**	§	
ISSUED TO	§	BOARD OF NURSING
DENISE M. MARTINEZ	§	

OPINION AND ORDER OF THE BOARD

TO: Denise M. Martinez
2001 Palm Village Blvd., #639
Bay City, TX 77414

During open meeting held in Austin, Texas, April 17-18, 2008, the Texas Board of Nursing finds that after proper and timely notice was given, the above-styled case was heard by an Administrative Law Judge who made and filed a proposal for decision containing the Administrative Law Judge's findings of fact and conclusions of law. The proposal for decision was properly served on all parties and all parties were given an opportunity to file exceptions and replies as part of the record herein.

The Texas Board of Nursing, after review and due consideration of the proposal for decision, and exceptions and replies filed, if any, adopts the findings of fact and conclusions of law of the Administrative Law Judge as if fully set out and separately stated herein with the exception of Conclusion of Law Number 10. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

Conclusion of Law Number 10 is hereby re-designated as a Recommendation because it is a recommendation for a sanction and therefore not a proper conclusion of law. *Chalifoux Jr. V. State Bd. Of Medical Examiners*, 2006 S.W.3d (03-05-00320-CV) (Tex.App. – Austin 2006); *Grotti v. State Bd. Of Medical Examiners*, 2005 LEXIS 8279 (Tex.App. –Austin 2005, no pet.). The Board adopts the Recommended Sanction of REVOCATION.

NOW, THEREFORE, IT IS ORDERED that Permanent Certificate Number 116301, previously issued to DENISE M. MARTINEZ, to practice professional nursing in the State of Texas be, and the same is hereby, REVOKED.

IT IS FURTHER ORDERED that Permanent Certificate Number 116301, previously issued to DENISE M. MARTINEZ, upon receipt of this Order, be immediately delivered to the office of the Texas Board of Nursing for the State of Texas.

IT IS FURTHER ORDERED that this Order SHALL be applicable to Respondent's multi-state privilege, if any, to practice professional nursing in the State of Texas.

Entered this 17th day of April, 2008.

TEXAS BOARD OF NURSING

BY: _____

KATHERINE A. THOMAS, MN, RN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

SOAH DOCKET NO. 507-08-0836

TEXAS BOARD OF NURSING, **Petitioner,**	§	**BEFORE THE STATE OFFICE**
	§	
	§	**OF**
V.	§	
	§	
DENISE M. MARTINEZ, **Respondent**	§	
	§	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

Staff of the Board of Nursing (Staff/Board) brought disciplinary action against Denise M. Martinez (Respondent) for failing to comply with an Agreed Order issued by the Board on June 14, 2005. Staff alleged that Respondent's violations of the Agreed Order were a basis for disciplinary action under the provisions of TEX. OCC. CODE ANN. § 301.452(b)(1) and (10) and 22 TEX. ADMIN. CODE (TAC) § 217.12(11)(B). Staff also sought to impose against Respondent the administrative costs of the proceeding pursuant to TEX. OCC. CODE ANN. § 301.461. The Administrative Law Judge (ALJ) recommends that Respondent's license be revoked and that administrative costs not be imposed against Respondent.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

The hearing convened January 16, 2008, before the undersigned ALJ. The hearing was held at the State Office of Administrative Hearings, William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. Staff was represented by Victoria Cox, Assistant General Counsel. Respondent represented herself. The record closed on January 16, 2008, at the conclusion of the hearing.

Notice and jurisdiction were undisputed. Those matters are set out in the Findings of Fact and Conclusions of Law.

II. BACKGROUND

A. Terms of the Agreed Order

On November 22, 1986, the Board issued to Respondent Vocational Nurse License No. 116301. On May 3, 2005, Respondent signed an Agreed Order with the Board.[1] As part of the Agreed Order, Respondent was to:

- successfully complete courses in Texas nursing jurisprudence and nursing ethics within one year of the entry of the Agreed Order; and
- submit to random periodic screens for controlled substances, tramadol hydrochloride, and alcohol.

The drug screens were to be conducted at least once a week for the first three months, at least once a month for the second three months, and at least once every three months for the remainder of the two year probation.[2] The Agreed Order became effective on June 14, 2005.

B. Compliance issues

On August 8, 2005, Respondent registered with the Board's drug testing services contractor, National Confederation of Professional Services (NCPS).[3] On the form, Respondent acknowledged her agreement to comply with NCPS' drug screening requirements. The program required Respondent to purchase from NCPS two chain of custody specimen forms. Respondent was to call NCPS every day. If she was instructed by NCPS, Respondent was to provide a specimen using one

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[1] Staff's Ex. 6.

[2] Staff's Ex. 4.

[3] Staff's Ex. 9.

of the chain of custody specimen forms.[4] As Respondent used the forms, she was required to buy new ones with a credit card or money order.

Approximately one year later, Staff sent Respondent a letter dated August 25, 2006, informing Respondent that she had failed to comply with the Agreed Order.[5] Specifically, Respondent had failed to complete her course work by the one-year deadline, and Respondent had failed to contact NCPS daily.[6] Staff directed Respondent to respond to the allegations in writing within 30 days.

On Respondent's postmarked answer of October 3, 2006, Respondent stated that she had scheduled herself to take the two required courses.[7] She also informed Staff that she had begun "taking my drug tests."[8] However, by the time of the postmark of the letter, Respondent's satisfaction of her drug testing compliance duties was seriously in arrears. In the 421 days between the date on which Respondent registered with NCPS and the date on which Respondent's response to Staff was postmarked, Respondent had failed to contact NCPS on 71 days, or about 17% of the time.[9]

On November 17, 2006, Staff sent a second letter to Respondent, this time informing her that Staff was initiating an investigation based on Respondent's continuing non-compliance with the drug

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[4] Staff's Ex. 9.

[5] Staff's Ex. 2.

[6] Staff obtained from NCPS a report on the number of days on which Respondent had failed to call, had failed to submit a specimen when instructed, and had failed to pass the drug screening. Although Respondent repeatedly failed to contact NCPS, she never failed a drug screening during her participation in the program.

[7] Staff's Ex. 5. None of Respondent's letters to Staff were dated. This letter was received by Staff on October 6, 2006.

[8] *Id.*

[9] Staff's Ex. 13.

screen program.[10] Staff gave Respondent 30 days in which to respond, and Respondent answered in a letter postmarked December 22, 2006. Respondent explained that she had failed to contact NCPS daily because

> I honestly forgot that I was suppose[d] to until I was Reminded by my employer that my evaluation was due. . . . I know that forgetfulness is not an excuse[,] and I am so sorry[.] I have been keeping up With calling everyday and when I am called I go and test."[11]

In the 80 days between the dates of the postmarks of Respondent's first and second letters, Respondent failed to contact NCPS on 13 of those days, again about 17% of the time.[12]

On April 10, 2007, Staff sent Respondent a third letter, this one formally charging Respondent with violating the Agreed Order.[13] Staff alleged that Respondent had failed to timely complete her courses and had failed to comply with the drug testing program. Staff gave Respondent three weeks in which to respond, and Respondent answered in a letter received by Staff on May 1, 2007.[14] Respondent explained that she had completed her course work in January 2007 and that she had been compliant with her drug testing obligations since her receipt of Staff's letter of November 17, 2006.

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[10] Staff's Ex. 2a.

[11] Staff's Ex. 5a.

[12] Staff's Ex. No. 13.

[13] Staff's Ex. No. 3.

[14] Staff's Ex. No. 5b.

In the 165 days between the date of Staff's letter of November 17, 2006, and May 1, 2007, the date of Staff's receipt of Respondent's letter, Respondent failed to contact NCPS on 29 of those days, or about 18% of the time.[15]

Staff's three letters gave Respondent the opportunity to address her non-compliance with the Agreed Order. The letter of August 25, 2006, informed Respondent that Staff was aware of Respondent's failure to comply with the deadline for completion or her course work and her failure to comply with her daily drug testing requirements. Her response did not address any reasons for her delays or failures.

Staff's letter of November 17, 2006, informed Respondent that Staff was aware of her failure to comply with the daily drug testing requirements between June 30 and September 27, 2006. Respondent's explanation that she simply forgot about her obligations for several months appeared to reflect her lack of priority in complying with the Agreed Order. Further, Respondent's continued failure to comply with her agreement to contact NCPS daily between September and the end of November 2006 appeared to have confirmed that lack of priority.

When Staff sent its third letter on April 10, 2007, Respondent had the opportunity to understand clearly that Staff was not treating Respondent's failure to abide by the terms of the Agreed Order as a dismissible error. Staff clearly related its concern about Respondent's failures and clearly communicated Staff's intention to take responsive action. Despite Staff's communications, Respondent continued to fail to meet her daily drug testing obligations at about the same rate had she had since August 2005.

On November 27, 2007, Staff gave Respondent notice that a hearing on the merits would be held at SOAH in this docket. In the 230 days between the dates on which Respondent received

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[15] Staff's Ex. No. 13.

Staff's third and fourth letters, Respondent failed to call NCPS on 33 of those days–or about 14% of the total.[16]

For the complete data set from NCPS, Respondent failed to contact on 138 of the 818 days between August 29, 2005, and November 25, 2007–or about 17% of the time.[17] Between August 15, 2005, and May 22, 2007, Respondent failed to respond to 20 of NCPS' random drug tests because she failed to call NCPS' office.[18] On the six dates on which Respondent submitted to drug testing after being instructed by NCPS, Respondent tested negative on every occasion.[19]

For Respondent's failures to comply, Staff sought the revocation of Respondent's license.

III. DISCUSSION

A. Violation

Staff relied on the provisions of TEX. OCC. CODE ANN. § 301.452(b)(1) and (10) and 22 TAC § 217.12(11)(B) in alleging that Respondent's violations of the Agreed Order was also a violation of law. In brief, TEX. OCC. CODE ANN. § 301.452(b)(1) provides that the Board may discipline a license holder for a violation of the statute, the Board's rules, or the Board's orders. The provisions of TEX. OCC. CODE ANN. § 301.452(b)(10) authorize the Board to discipline a license holder for unprofessional conduct.

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[16] The two dates were April 14 and November 30, 2007.

[17] Staff's Ex. No. 13.

[18] State's Ex. No. 7.

[19] State's Ex. No. 12.

The Board has adopted 22 TAC § 217.12(11)(B) to implement the Board's authority to govern licensees who engage in unprofessional conduct. The purpose of the rules is to: (1) protect clients and the public from incompetent, unethical, or illegal conduct of licensees, and (2) identify unprofessional or dishonorable behaviors of a nurse "which the board believes are likely to deceive, defraud, or injure clients or the public." The rule makes clear that actual injury to a client need not be established for a violation to be found. The rule lists one of the prohibited behaviors as "[v]iolating an order of the board."

The combination of the rules and the statute may reasonably be read to authorize the Board to discipline a licensee for the unprofessional conduct of violation of a Board order.

Respondent's failure to complete her course work within the one-year period was a violation of the Agreed Order, as was Respondent's failure to comply with the requirement of contacting NCPS on a daily basis.

In her defense, Respondent could offer little explanation of her reasons for failing to comply with the Agreed Order. She asserted that she had no drug problems, that she was out of work for an extended period, that she was experiencing financially difficult circumstances, and that she simply forgot about her obligations under the Agreed Order. She did not explain why the letters from the Board did not cause her to be more diligent in contacting NCPS daily, why she did not contact the Staff to seek advice on dealing with these issues, or why she simply allowed this matter to escalate to the point of the scheduling of a contested case.

Respondent cried during the hearing and explained that she had been a nurse for most of her adult life and that she held the position of assistant director of nurses at her place of employment, Matagorda Nursing & Rehabilitation Center in Bay City. She asserted that she did not know what she would do if she were no longer licensed as a nurse. Respondent offered letters of support from

Donna Winebrenner, R.N., her director of nurses,[20] and from Sue Goslin, a physical therapist.[21] The letters describe Respondent as a well-rounded employee, professional, compassionate, caring with the residents and their families, level-headed, friendly, cheerful, and forthright in her dealings with her co-workers and physicians.

B. Punishment

In the notice of hearing, Staff gave notice of its intention to seek revocation of Respondent's license. The basis of Staff's action was listed as 22 TAC §§ 213.27-213.33.[22]

In considering revocation, the Board is required to consider whether the person has been the subject of past disciplinary action by the Board and whether the person complied with the Board's rules and enabling statutes.[23] In this case, Respondent has been the subject of past disciplinary action and has not complied with the Board's rules through her failure to comply with the Agreed Order.

In addition, the Board is also required to consider the seriousness of the violation, the person's threat to public safety, and any mitigating factors.[24] More on point, SOAH is to consider the following when recommending a sanction in disciplinary cases:

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[20] Respondent's Ex. No. 2.

[21] Respondent's Ex. No. 1.

[22] These rules govern a broad range of the Board's authority to implement its statutory powers. The rules include the Board's definition of good professional character, the licensing of persons with criminal offenses, criteria and procedures to be used in cases involving "intemperate use and lack of fitness," a schedule of administrative fines, and factors to be considered in imposing penalties, sanctions, or fines. The language of 22 TAC § 213.33(g)(2)(H), as authorized by TEX. OCC. CODE ANN. § 301.453(a)(6), provides the Board the specific authority to seek revocation.

[23] TEX. OCC. CODE ANN. § 301.4531(b)(1)(B); 22 TAC § 213.33(g)(1)(B).

[24] TEX. OCC. CODE ANN. § 301.4531(b)(2)-(4); 22 TAC § 213.33(g)(1)(C)-(E).

1. Evidence of actual or potential harm to patients, clients, or the public.[25]

There was no evidence of Respondent's having caused any actual harm to any patient, client, or the public. The harm arose through Respondent's failure to comply with the Agreed Order. The Agreed Order was the product of Staff's agreeing to forego more stringent action against Respondent in exchange for Respondent's agreeing to abide by the terms of the Agreed Order. By failing to uphold her duties under the Agreed Order, Respondent showed herself unable to comply with the terms of an agreement with the Board. As the representative of the public, the Board is justified in regarding Respondent's action as potentially harmful.

2. Evidence of a lack of truthfulness or trustworthiness.[26]

Respondent's failure to comply with Agreed Order reflected a lack of trustworthiness. Respondent testified at the hearing that she intended to comply with the Agreed Order and that she tried to comply. However, poor judgment and bad memory prevented her from performing as she agreed.

3. Evidence of misrepresentation(s) of knowledge, education, experience, credentials, or skills which would lead a member of the public, an employer, a member of the health-care team, or a patient to rely on the fact(s) misrepresented where such reliance could be unsafe.[27]

None of these were factors in this case.

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[25] 22 TAC § 213.33(a)(1).

[26] 22 TAC § 213.33(a)(2).

[27] 22 TAC § 213.33(a)(3).

4. Evidence of practice history.[28]

This was not a factor in this case.

5. Evidence of present fitness to practice.[29]

Fitness to practice is a function of good professional character.[30] Elements include the ability to: distinguish right from wrong; think and act rationally; keep promises and honor obligations; and be accountable for her own behavior.[31]

In this proceeding, the evidence showed that Respondent had difficulty in keeping her promises and honoring her obligations. In her defense, Respondent showed that she was out of work from August 2005 to April 2006.[32] During that time, she had no money to pay for testing. However, Respondent did not try to account to Staff for her behavior. She failed to contact Staff to tell them about her financial problems or other impediments to her ability to comply with the Agreed Order. Further, by her own admission, when she went back to work, she did not resume her daily contacts with NCPS.[33]

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[28] 22 TAC § 213.33(a)(4).

[29] 22 TAC § 213.33(a)(5).

[30] The Board's rules frequently treat them as part of the same set of criteria. *See*, 22 TAC § 213.27(e)(2).

[31] 22 TAC § 213.27(b)(2).

[32] Staff's Ex. 5b.

[33] *Id.*

6. Evidence of prior disciplinary history by the Board.[34]

Staff presented uncontradicted evidence of Respondent's prior disciplinary history by the Board.

7. The length of time the licensee has practiced.[35]

The evidence was that Respondent has held a nursing license since 1986. Although she was out of work for part of that period, Respondent's practice as a nurse has spanned most of her adult life.

8. The actual damages, physical, economic, or otherwise, resulting from the violation.[36]

No actual damages were shown to have resulted from Respondent's violations.

9. The deterrent effect of the penalty imposed.[37]

The deterrent effect of the past penalty was ineffective with regard to gaining priority in Respondent's behavior. The deterrent effect of the proposed penalty will prevent Respondent from practicing her profession for at least a year.

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[34] 22 TAC § 213.33(a)(6).

[35] 22 TAC § 213.33(a)(7).

[36] 22 TAC § 213.33(a)(8).

[37] 22 TAC § 213.33(a)(9).

10. Attempts by the licensee to correct or stop the violation.[38]

Staff's letters to Respondent were multiple opportunities for Respondent to address her failure to comply with her drug testing obligations. Respondent's violations continued for periods of months and weeks, even after Staff sought explanation from Respondent for her behavior.

11. Any mitigating or aggravating circumstances.[39]

Respondent presented mitigating evidence in the form of the support of her director of nurses and of a co-worker.[40] Respondent explained that her lack of a job and money created great difficulties in her life. Nothing in the evidence suggested that Respondent failed to discharge her duties as a nurse to her patients, employer, or colleagues. Respondent's only failure was to protect her right to practice nursing.

12. The extent to which system dynamics in the practice setting contributed to the problem; and any other matter that justice may require.[41]

Neither of these were factors in this case.

C. Board policy

Staff called as a witness Carol Marshall, a consultant to the Board. Ms. Marshall is a registered nurse with almost 30 years of experience in a variety of practical and administrative fields

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[38] 22 TAC § 213.33(a)(10).

[39] 22 TAC § 213.33(a)(11).

[40] Respondent's Ex. Nos. 1 and 2.

[41] 22 TAC § 213.33(a)(12) and (13).

within the profession. Ms. Marshall assists the Enforcement and Legal Divisions with case reviews and testifies as an expert witness in SOAH hearings. Ms. Marshall testified that the Board's policy in reviewing violations of the type described in this case is to revoke the license and to consider a re-application after one year.

D. Administrative costs

The provisions of TEX. OCC. CODE ANN. § 301.461 authorize the Board to assess against a person who is found to have violated the statute the administrative costs of conducting a hearing to determine the violation. Staff alleged that the administrative costs included the cost paid by the Board to SOAH and the Office of the Attorney General, as well as amounts paid for Board legal and investigative services, court reporting, witnesses, reproduction of records, Staff time, travel, and expenses of at least $1,200.00. Proof of these administrative costs was not made in the hearing.

IV. ANALYSIS AND RECOMMENDATION

Respondent's actions violated two of the elements of the Agreed Order over a period of time sufficient to demonstrate her unwillingness or inability to come into compliance. Respondent's explanation was that financial circumstances and other issues in her life presented a hardship. This hardship prevented her from recognizing the possibility that she might lose her license as a nurse and her privilege to earn a livelihood through nursing. Respondent asserted that the loss of her license would render her even less able to maintain the priorities in her life.

Staff urged that Respondent presented a threat to the public on the basis of her failure to comply with the Agreed Order and the facts that caused the entry of the Agreed Order. These circumstances included some history of drug abuse. Staff introduced evidence about the importance of a nurse's ability to make fine distinctions in performing her duties.

The ALJ's conclusion in this case is that Respondent's only threat to the public is that she has demonstrated an inability to establish healthy priorities in her own life. The cause of that inability was never explained by Respondent or by the evidence presented by Staff. However, what was clear was that Staff was unable to get Respondent's attention through Staff's issuance of a series of increasingly sharp letters of warning. When none of these worked over a period of more than a year, Staff resorted to the last choice available under the law – a contested hearing.

The function of a contested hearing is to give the parties the opportunity to explain themselves through the introduction of evidence. Staff, through the guidance of counsel, presented the evidence necessary to prove a case that Respondent's license should be revoked. Respondent, without counsel, presented a case that: (1) she had made inescapably bad decisions with respect to her actions in response to Staff's warnings, and (2) she had the support of her colleagues.

The task of the ALJ is to weigh the evidence. In doing that, the ALJ must first determine whether the Staff sustained its burden of proving that Respondent violated the law.[42] In this case, Staff sustained that burden. Next, the ALJ had to determine whether Respondent presented sufficient mitigating evidence to overcome Staff's evidence. The ALJ had determined that Respondent's evidence did not meet that standard.

Although the ALJ recommends revocation of Respondent's license, the ALJ also urges the Board and Respondent to confer further. The purpose of that conference would be to provide Respondent with a clear understanding of the elements with which she would need to comply before she would be eligible to regain her license.

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[42] 1 TAC § 155.41(b).

VI. FINDINGS OF FACT

1. Denise M. Martinez, Respondent, holds License Number 116301 issued by the Texas Board of Nursing (Board).

2. On May 3, 2005, Respondent signed an Agreed Order with the Board.

3. The Agreed Order required Respondent to: (1) successfully complete courses in Texas nursing jurisprudence and nursing ethics within one year of the entry of the Agreed Order; and (2) submit to random periodic screens for controlled substances, tramadol hydrochloride, and alcohol.

4. On August 8, 2005, Respondent registered with the Board's drug testing services contractor, National Confederation of Professional Services (NCPS).

5. Respondent was to call NCPS every day to determine whether she was required to provide a urine specimen on that day.

6. On August 25, 2006, staff of the Board (Staff) informed Respondent by letter that she had failed to complete her course work by the one-year deadline and had failed to contact NCPS daily.

7. On November 17, 2006, Staff sent a second letter to Respondent, informing her that Staff was initiating an investigation based on Respondent's continuing non-compliance with the drug screen program.

8. Respondent failed to contact NCPS daily because she had forgotten her obligation to comply with the Agreed Order until she was reminded by her employer.

9. On April 10, 2007, Staff sent Respondent a third letter, formally charging Respondent with violating the Agreed Order by failing to timely complete her courses and failing to comply with the drug testing program.

10. Respondent completed her course work in January 2007, approximately six months past the date required under the terms of the Agreed Order.

11. Respondent failed to contact NCPS on 138 of the 818 days between August 29, 2005, and November 25, 2007–or about 17% of the time.

12. Between August 15, 2005, and May 22, 2007, Respondent failed to respond to 20 of NCPS' random drug tests because she failed to call NCPS' office.

13. On November 27, 2007, Staff gave Respondent notice that a hearing on the merits would be held at SOAH in this docket.

14. The notice of hearing 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 a short, plain statement of the matters asserted.

15. The hearing on the merits was held on January 16, 2008, in the William P. Clements Building, 300 West 15th Street, Austin, Texas. All parties appeared and participated in the hearing. The record closed on that date.

16. Factors that mitigate Respondent's failure to comply with the Agreed Order include letters of support from her director of nurses and professional colleagues, describing her as a well-rounded employee, professional, compassionate, caring with clients and families, level-headed, friendly, cheerful, and forthright in her dealings with her coworkers and physicians.

VII. CONCLUSIONS OF LAW

1. The State Board of Nursing (Board) has jurisdiction over this matter pursuant to TEX. OCC. CODE ANN. ch. 301.

2. The State Office of Administrative Hearings has jurisdiction over the hearing in this proceeding, including the authority to issue a proposal for decision with proposed findings of fact and conclusions of law, pursuant to TEX. GOV'T CODE ANN. ch. 2003.

3. Notice of the formal charges and of the hearing on the merits was provided by staff of the Board (Staff). TEX. OCC. CODE ANN. § 301.454 and by the Administrative Procedure Act. TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

4. Staff had the burden of proving the case by a preponderance of the evidence. 1 TEX. ADMIN. CODE (TAC) § 155.41(b).

5. The Board may discipline a license holder for a violation of the statute, the Board's rules, or the Board's orders. TEX. OCC. CODE ANN. § 301.452(b)(1).

6. The Board has the authority to discipline a license holder for unprofessional conduct. TEX. OCC. CODE ANN. § 301.452(b)(10).

7. The Board has the authority to govern licensees who engage in unprofessional conduct. 22 TAC § 217.12(11)(B).

8. The Board has the authority to revoke a license for violations of the Board's enabling statutes and rules. 22 TAC § 213.33(g)(2)(H); TEX. OCC. CODE ANN. § 301.453(a)(6).

9. Respondent's failure to complete her course work within the one-year period and to comply with the requirement of contacting NCPS on a daily basis was a violation of the Agreed Order and with the Board's enabling statutes and rules.

10. Respondent's license should be revoked.

SIGNED February 25, 2008.

PAUL D. KEEPER
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS