

BEFORE THE  
EMERGENCY MEDICAL SERVICES AUTHORITY  
STATE OF CALIFORNIA

In the Matter of the Emergency Medical  
Technician-Paramedic License Held by:

GRAHAM MITCHELL  
License No. P02017,

Respondent.

Case No.: 07-0049

OAH No.: 2009040813

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted  
by the Emergency Medical Services Authority as its Decision in the above-entitled matter.

This Decision shall become effective 10/30/09.

IT IS SO ORDERED 10/8/09.

EMERGENCY MEDICAL SERVICES AUTHORITY  
STATE OF CALIFORNIA

By



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**PROPOSED DECISION**

The hearing in the above-captioned matter was held by Joseph D. Montoya, Administrative Law Judge, Office of Administrative Hearings, at Bakersfield, California, on August 25 and 26, 2009. Cynthia L. Curry, Senior Staff Counsel, Emergency Medical Services Authority, represented Complainant. Respondent Graham Mitchell represented himself.

Evidence was received, the case was argued, and the matter submitted for decision on August 26, 2009. The Administrative Law Judge hereby makes his factual findings, legal conclusions, and order.

**FACTUAL FINDINGS**

1. Complainant Nancy Steiner filed the Accusation in the above-captioned matter while acting in her official capacity as Chief of the EMS Personnel Division of the Emergency Medical Services Authority (the Authority), State of California.
2. Respondent Graham Mitchell is licensed as an Emergency Medical Technician-Paramedic (EMT-P), holding license number P02017. He was first licensed by the Authority in January 1994. His license will expire in January 2010 unless renewed. His license was in full force and effect at all times relevant to the issues in this case. His license has not been previously disciplined.
3. In this proceeding, Complainant alleged that Respondent violated a number of the statutes and regulations that govern the professional activities of an EMT-P, in the course of three patient contacts that occurred in 2007. Among the charges leveled are functioning outside of the supervision of medical control, gross negligence, repeated negligent acts, and violation of regulations.

4. During the three incidents at issue in this proceeding, Respondent was employed by Hall Ambulance Service (Hall), and he was either stationed in Bakersfield, or in the vicinity of Frazier Park, which is located near the southern border of Kern County, where it meets Los Angeles County.

*The January 29, 2007 Incident:*

5. Just before midnight on January 29, 2007, while stationed at Frazier Park, Respondent was summoned to the home of T.K.<sup>1</sup> The patient was well known to Respondent, and other emergency service providers in the area, in that the patient was diabetic, and he or his wife had summoned help on many prior occasions due to the patient having low blood sugar. Respondent had treated the patient on several occasions before January 29, 2007.

6. Respondent was accompanied by Brian Dumont, his partner, who was at that time an EMT training to become a paramedic.<sup>2</sup> When the two arrived, members of the Kern County Fire Department (KCFD) were on scene. Respondent had informed Dumont, during their trip to the patient's house, that the patient was a frequent caller for assistance, could become violent when in that state, and that the patient always refused transport. That overall assessment of the situation was confirmed to Mr. Dumont by a captain in the KCFD when the Respondent and Dumont arrived on the scene.

7. The patient was semi-conscious when the Hall crew arrived, covered in corn syrup that his wife had been feeding him, only able to say "help me." When Respondent confirmed that the patient's wife had been giving him the corn syrup, he decided to continue with that remedy.

8. Dumont suggested that the team test the patient's blood sugar, and set up a line for administering dextrose. Respondent stated it would not be necessary, but Dumont did a blood sugar test on his own initiative. The blood sugar was low, at 30 mg./dl., and when Dumont suggested administration of Dextrose, Respondent declined to do so. Eventually, administration of the corn syrup brought the patient's blood sugar to an acceptable level, over 80 mg./dl. The patient became fully conscious and refused further treatment, including transport to a hospital. The patient signed an AMA—Against Medical Advice—release. At the time he signed that release, the patient had recovered consciousness and his mental status was no longer altered.

9. Respondent completed a Patient Care Record (PCR) which was incomplete. It was lacking any indication of the patient's blood glucose level, which as noted above had

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<sup>1</sup> Patients' initials will be used throughout in the interests of privacy.

<sup>2</sup> Mr. Dumont became a paramedic on April 20, 2007, approximately three months after the events in question.

been determined by Dumont. No vital signs were recorded. This violated Kern County EMS Policy, section 4200.2995, (III)(C), which requires the paramedic to complete the form.

10. It was not established, as alleged, that Respondent abandoned his patient by bringing his blood glucose level to an acceptable standard, and obtaining a transport waiver, despite any language contained in local protocols. Here the patient had a history of refusing transport and hospitalization, as well as IV lines, and there was testimony that after these events the patient did so as well on other occasions. To find that Respondent would have to follow a protocol requiring transport and hospitalization would be to find that he was required to act in contravention of the patient's known wishes.

11. Respondent was negligent in failing to take a blood sugar reading when he arrived on scene, and negligent in failing to administer Dextrose, in the place of the corn syrup. These acts violated Kern County Protocols as well. However, it was not established whether the Respondent's departures from the standard of care were simple departures or extreme departures.

12. There is no evidence of actual harm to the patient. Further, it was attested by Dumont that he and Respondent could not have moved the patient out of his house, due to the condition of the home, and the access stairs. Thus, attempting to transport the patient when it was known that he did not want transport and hospitalization might have threatened to harm the patient.

*The June 28, 2007 Incident:*

13. On June 28, 2007, Respondent was stationed in Bakersfield, California, when he was dispatched to the home of Mr. T.C. T.C.'s wife had called 911 and stated that her husband was "breathing funny." (Ex. 6a-003.)

14. When Respondent and his partner arrived at the patient's home, T.C. was in the bathroom. Respondent spoke to him, and the patient came out of the bathroom. The patient was able to answer questions which indicated that the patient was oriented as to date, time, and place. According to the patient's wife, she stated to Respondent and his partner, more than once, that her husband "was not himself." Respondent examined the patient, and checked his blood glucose. He took vital signs, including blood pressure (142/72), pulse (130, strong and regular), and respiration (20). The PCR shows that Respondent performed a number of assessments, including an assessment of the patient's mouth, which is described on the PCR as having no abnormalities. The patient declined treatment and transport, against medical advice.

15. The patient's wife had noted that the couple's bed was wet, and that there was blood on the pillowcase. At some point, Respondent advised the couple that T.C. probably suffered from sleep apnea, and that he should see his doctor the next morning. According to the PCR, Respondent believed that the patient had a history of drug use, based on a statement

by the patient's wife. The patient signed a waiver of transportation, and was sufficiently cogent at that time to do so.

16. At the hearing, the patient's wife denied saying words to the effect that she feared her husband was using again. She attested that she showed Respondent the blood on the pillowcase and on the wet bed; she could not recall pointing out any blood on the patient's mouth. However, in a conversation with a supervisor at Hall a few days after the visit, she stated that she had seen blood on her husband's mouth when he came out of the bathroom, and that Respondent stated that T.C. had probably bitten his tongue. When Respondent was interviewed by his supervisor regarding this matter, two weeks after the incident, he could not recall whether he had checked the patient's mouth or not.

17. The record does not establish that T.C.'s wife advised Respondent or his partner of the patient's symptoms earlier in the night, before he left the couple's bedroom and went to the bathroom. Some of those symptoms, described by her to a Hall supervisor on July 3, 2007, were indicative of a seizure, but neither her testimony nor the records generated by Hall after she contacted the firm show the information being relayed to Respondent. At the hearing, she testified that she called 911 because she thought that her husband had suffered a heart attack, and while she described conditions possibly indicating a seizure during the hearing, it is not clear how much, if any, of that information was relayed to Respondent.

18. It was not established by the clear and convincing evidence, as alleged, that T.C. had an altered mental status when Respondent interacted with him on the night of June 28, 2007. While his wife testified that "he wasn't himself," there is no indication that he failed to respond to Respondent in a way that would make him believe that the patient was in an altered status.

19. It was improper for Respondent to tell the patient and his wife that the problem was sleep apnea; a paramedic may not make such diagnoses and communicate them. While Complainant's witnesses did not clearly couch this impropriety in the context of a departure from the standard of care, such was at least simple negligence, and an act outside of the supervision of medical control.

20. There is no evidence of actual harm to the patient as a result of Respondent's actions.

*The July 9, 2007 Incident:*

21. On the evening of July 9, 2007, Respondent was stationed at the Hall station in Frazier Park. An EMT, Charles Nabb, was stationed there with him. At approximately 10:00 p.m., a woman knocked on the station door, seeking help for her daughter, who had been bitten by a snake. Mr. Nabb was the first to speak to the woman, and he followed her out to her car, where her child and her husband were located. Respondent, who had been

upstairs when the woman knocked, was summoned by Nabb, and followed the two out to the car.

22. Being first to the car, Nabb began basic assessment of the child, a 14-year-old girl. There were two puncture marks on the child's leg, and the child said a rattlesnake had bitten her. The child's father asked Nabb about anti-venom, and the EMT told him that Hall did not have the anti-venom, and he did not know if the fire department did either. Respondent got to the car, and Nabb stepped aside to allow Respondent to perform an assessment. While Respondent examined the girl and spoke to her, Nabb spoke to her mother, who was upset to the point of being hysterical, and focused very much on obtaining anti-venom for her child. Respondent took a tourniquet off of the child's leg, which had been put there by her father.

23. Respondent had a discussion with the father about whether the child could be transported by Hall to a hospital, or whether the parents could drive her. He told them that Henry Mayo Newhall Memorial Hospital (Henry Mayo) in Valencia, California was closest.<sup>3</sup> He told the parent that they could drive there faster, because the Hall Ambulances were limited to travel at 70 miles per hour by a governor installed on the engines. He stated that if Hall drove the child, they would be able to monitor her airway, monitor her vitals, provide an I.V. if necessary. It is reasonably inferred from the evidence that Respondent did not recommend transport by his ambulance.

24. The child's mother obtained directions from Mr. Nabb, and the family left. Subsequently, the child was seen by Henry Mayo staff, and then transferred to Valley Presbyterian Hospital for an overnight stay.

25. Respondent did not generate a PCR from this contact, and the matter was not logged into Hall's system, that is, no trip ticket was generated. Such records should have been generated. Hall learned of the matter because Nabb phoned a supervisor and related the matter to him, just after the family departed for Henry Mayo. Nabb did so because he was concerned about Respondent's advice and treatment of the child.

26. Respondent testified that he believed that the child was not in great danger, and believed she could get to Henry Mayo quickest if she went with her family. On the issue of speed, Mr. Nabb agreed at the hearing that a private vehicle would likely have been able to get to the hospital faster than the ambulance, but he made it clear that saving some time was sacrificing the ability to monitor and care for the patient. In deciding to take off the tourniquet and to consider sending the child to the hospital by private car, Respondent was guided by his own experience in suffering a snakebite, and a list of steps to take in responding to a snakebite that he obtained after that event. It appears from the record that there are no paramedic protocols focused exclusively on snakebites.

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<sup>3</sup> The other option was a hospital in Bakersfield. Henry Mayo is approximately 45 miles from Frazier Park.

27. (A) It was a violation of the standard of care to take the tourniquet off of the child's leg; such a step should not have occurred until the child reached the hospital. Doing so risked a sudden rush of blood from the injured area, which might have become toxic. Furthermore, there is some danger of clots moving into the bloodstream. And, because there is no protocol, a paramedic should contact a hospital for instruction on responding to the injury. Thus, Respondent violated the standard of care in that regard as well. Finally, it was a violation of the standard of care not to clearly recommend to the parents that the child be transported by ambulance. However, it was not established whether these departures were simple departures, or extreme departures, from the standard of care.

(B) Respondent acted outside of the supervision of medical control, in that he performed an assessment, and performed treatment by removing the tourniquet, without any supervision. Such supervision and control was necessary in that there were not established protocols.

28. It was not established that Respondent's acts caused harm to the child, in that she was already injured, and may have required hospitalization in any event. However, the risk of harm was significant, in that if the child's condition had deteriorated while traveling in her parent's car, she would have been isolated from help, as the route from Frazier Park to Henry Mayo runs through a sparsely populated area.

*Respondent's Background and Contentions:*

29. Respondent was a reserve firefighter in England prior to his emigration to the United States in approximately 1980. He was an EMT in Los Angeles, California, and studied to become a paramedic. He interned with the Los Angeles Fire Department, and graduated from his paramedic program with honors. He began working with Hall in September 1994, and he resigned in July 2007.

30. Although Respondent has never been disciplined by the Authority, he was suspended by Hall after the January 29, 2007 incident involving the administration of corn syrup. He was also required to work with a preceptor in an effort to refine his skills. It should be noted that his supervisors, in internal memos and in testimony at this hearing, noted that Respondent seemed unfamiliar with many of the county protocols that controlled the activities of paramedics such as Respondent.

31. Respondent contended that Hall, being in the business of transporting people, put pressure on the paramedics to always transport patients. In the case of the diabetic patient in January 2007, that patient had made clear on prior occasions that he did not want to be transported, and Respondent understood that it can be a violation of the law to transport someone against their wishes. Respondent provided evidence that on another occasion he was able to convince a recalcitrant patient that he should be transported to a hospital. However, he had little excuse for the matter of the injured child. He stated that he did not

write up a report, because after the family left, and before he could generate any paperwork, he assumed he was going to lose his job with Hall; he gave up on the matter.

32. Respondent was employed at an ambulance company in the northern part of Los Angeles County from August 2007 until March 2009, when the Authority entered a default decision against Respondent.<sup>4</sup> He attested that he has had no untoward incidents while employed there.

33. Respondent acknowledged at the hearing that grounds for discipline had been established, but asked that his entire history be considered when determining what level of discipline should be imposed.

### LEGAL CONCLUSIONS

1. The Authority has jurisdiction to proceed in this matter pursuant to Health and Safety Code section 1798.200,<sup>5</sup> based on Factual Findings 1 through 3.

2. The standard (as opposed to the burden) of proof in this proceeding is that of clear and convincing evidence, to a reasonable certainty. (*Eittinger v. Bd. of Med. Quality Assurance* (1982) 135 Cal.App.3d 853.) Complainant was therefore obligated to adduce evidence that was clear, explicit, and unequivocal—so clear as to leave no substantial doubt and sufficiently strong as to command the unhesitating assent of every reasonable mind. (*In Re Marriage of Weaver* (1990) 224 Cal.App. d 278.)

3. (A) A professional is negligent if he or she fails to use that reasonable degree of skill, care, and knowledge ordinarily possessed and exercised by members of the profession under similar circumstances, at or about the time of the incidents in question. Just what that standard of care is for a given professional is a question of fact, and in most circumstances must be proven through expert witnesses. (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 997-998, 1001; *Alef v. Alta Bates Hospital* (1992) 5 Cal.App. 4th 208, 215; see 6 B. Witkin, *Summary of California Law* (9th Ed.), *Torts*, sections 749, 750, and 774.) However, in some cases the standard may be defined by a statute or regulation.

(B) However, an error in judgment may not constitute a breach of duty. “[A]n extrajudicial statement amounting to no more than an admission of bona fide mistake of judgment or untoward result of treatment is not alone sufficient to permit the inference of breach of duty; the statement ‘must be an admission of negligence or lack of skill ordinarily required for the performance of the work undertaken.’” (*Lashley v. Koerber* (1945) 26 Cal.

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<sup>4</sup> Respondent made a timely motion to set the default aside, which was granted.

<sup>5</sup> All statutory references are to the Health and Safety Code.

2d 83, 89-90, *Contreras v. St. Luke's Hospital*, 78 Cal. App.3d 919, 933, quoted with approval in *Kilburn v. Pineda* (1982) 137 Cal.App 3d 1046, 1049-50.)

4. Respondent has been charged with gross negligence, a ground for discipline under section 1798.200, subdivision (c)(2). The Code does not define just what "gross negligence" means in proceedings of this type. The Court of Appeal addressed this matter in *Kearl v. Board of Medical Quality Assurance*, (1986) 189 Cal.App.3d 1040. There the Second District Court of Appeal stated:

"Gross negligence is "the want of even scant care or an extreme departure from the ordinary standard of conduct." (*Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 941 [123 Cal.Rptr.[page 1053] 563], quoting from *Van Meter v. Bent Construction Co.* (1956) 46 Cal.2d 588, 594 [297 Cal.Rptr. 644].) The use of the disjunctive in the definition indicates alternative elements of gross negligence—both need not be present before gross negligence will be found. (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 196-197 [167 Cal.Rptr. 881].)"<sup>6</sup>

(189 Cal.App.3d at 1052-53.)

5. It was not established that Respondent engaged in gross negligence, in that while providing opinions that Respondent had violated the standard of care, Complainant's witnesses did not make the distinction between simple and extreme departures from the standard of care. This Conclusion is based on Legal Conclusions 3 and 4, and Factual Findings 11, 19, and 27(A).

6. It was established that Respondent engaged in repeated negligent acts, based on Legal Conclusion 3, and Factual Findings 11, 19, and 27(A). Therefore, his license is subject to discipline pursuant to section 1798.200, subdivision (c)(3).

7. It was established that Respondent acted outside of the supervision of medical control in the field care system while operating at a local level, based on Factual Findings 19 and 27 (B). Therefore, his license is subject to discipline pursuant to section 1798:200, subdivision (c)(10).

8. It was established that Respondent violated county protocols when treating patients, which constitutes a violation of section 1798.200, subdivisions (c)(7) and (c)(10), based on Factual Findings 9 and 11. Therefore, his license is subject to discipline.

9. The Authority has promulgated Recommended Guidelines for Disciplinary Orders and Conditions of Probation. The July 2008 iteration, Exhibit 3, provides that the following should be considered in assessing discipline:

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<sup>6</sup> The disjunctive definition set forth in *Gore* was also followed in *Yellen v. Bd. of Med. Quality Assurance* (1985) 174 Cal.App. 3d 1040, 1058

1. Nature and severity of the act(s), offense(s), or crime(s) under consideration;
2. Actual or potential harm to the public;
3. Actual or potential harm to any patient;
4. Prior disciplinary record;
5. Prior warnings on record or prior remediation;
6. Number and/or variety of current violations;
7. Aggravating evidence;
8. Mitigating evidence;
9. Any discipline imposed by the paramedic's employer for the same occurrence of that conduct;
10. Rehabilitation evidence;
11. In case of a criminal conviction, compliance with terms of the sentence and/or court-ordered probation;
12. Overall criminal record;
13. Time that has elapsed since the act(s) or offense(s) occurred;
14. If applicable, evidence of expungement proceedings pursuant to Penal Code 1203.4.

9. The Authority's Guidelines recommend revocation of the license, stayed, with an actual suspension of 30 days, and 3 years probation in cases of gross negligence. The recommended discipline for acts outside supervision is stayed revocation, with a 15 day suspension and a 1 year probation term. The maximum discipline is outright revocation.

10. In this case, the violations pertaining to the July 2007 incident were established as the most serious. In the other cases, they were less so. In each case, actual patient harm was not established, but especially in the case of the child who suffered the snake bite, the potential harm was significant. Respondent has no prior disciplinary record, but he was disciplined by his employer for his handling of the diabetic patient, and it appears that the remediation program undertaken by the employer was not adequate. There is little mitigating evidence, except Respondent acknowledged at the hearing that grounds for discipline were established. The provisions pertaining to criminal convictions are not applicable.

11. In this case, it can be shown that Respondent had acted as a paramedic for several years without discipline, but it appears that as his relationship with his employer deteriorated, so did his performance. From continuing a "home remedy" for a recalcitrant diabetic whose blood sugar has fallen, Respondent devolved to sending an injured child on a high speed drive through the mountains to a hospital, with no one to look after her but her frightened parents. In either case, he tended to substitute his judgment for established protocols and methods of treatment. However, because of his recognition of his misconduct, it does not appear that Respondent should suffer the ultimate sanction. However, a suspension is necessary to drive home the seriousness of his misconduct, and probation terms must be sufficient to establish that his professional shortcomings are remediated.

## **ORDER**

License number P02017, issued to Respondent Graham Mitchell, is hereby revoked. However, such revocation is hereby stayed and the respondent is placed on probation for three years on the following terms and conditions:

### **1. License Suspension:**

Respondent's license shall be suspended for 90 days

### **2. Probation Compliance:**

The Respondent shall fully comply with all terms and conditions of the probationary order. The Respondent shall fully cooperate with the EMSA in its monitoring, investigation, and evaluation of the Respondent's compliance with the terms and conditions of his/her probationary order.

The Respondent shall immediately execute and submit to the EMSA all Release of Information forms that the EMSA may require of the respondent.

### **3. Personal Appearances:**

As directed by the EMSA, the Respondent shall appear in person for interviews, meetings, and/or evaluations of the Respondent's compliance with the terms and conditions of the probationary order. The Respondent shall be responsible for all of his/her costs associated with this requirement.

### **4. Quarterly Report Requirements:**

During the probationary period, the Respondent shall submit quarterly reports covering each calendar quarter which shall certify, under penalty of perjury, and document compliance by the Respondent with all the terms and conditions of his/her probation. If the Respondent submits his/her quarterly reports by mail, it shall be sent as Certified Mail.

### **5. Employment Notification:**

During the probationary period, the Respondent shall notify the EMSA in writing of any EMS employment. The Respondent shall inform the EMSA in writing of the name and address of any prospective EMS employer prior to accepting employment.

Additionally, the Respondent shall submit proof in writing to the EMSA of disclosure, by the Respondent, to the current and any prospective EMS employer of the reasons for and terms and conditions of the Respondent's probation.

The Respondent authorizes any EMS employer to submit performance evaluations and other reports which the EMSA may request that relate to the qualifications, functions, and duties of prehospital personnel.

Any and all notifications to the EMSA shall be by certified mail.

**6. Notification of Termination:**

The Respondent shall notify the EMSA within seventy-two (72) hours after termination, for any reason, with his prehospital medical care employer. The Respondent must provide a full, detailed written explanation of the reasons for and circumstances of his termination.

Any and all notifications to the EMSA shall be by certified mail.

**7. Functioning as a Paramedic:**

The period of probation shall not run anytime that the Respondent is not practicing as a paramedic within the jurisdiction of California.

If the Respondent, during his probationary period, leaves the jurisdiction of California to practice as a paramedic, the Respondent must immediately notify the EMSA, in writing, of the date of such departure and the date of return to California, if the Respondent returns.

Any and all notifications to the EMSA shall be by certified mail.

**8. Obey All Related Laws:**

The Respondent shall obey all federal, state and local laws, statutes, regulations, written policies, protocols and rules governing the practice of medical care as a paramedic. The Respondent shall not engage in any conduct that is grounds for disciplinary action pursuant to Section 1798.200. To permit monitoring of compliance with this term, if the Respondent has not submitted fingerprints to the EMSA in the past as a condition of licensure, then the respondent shall submit his fingerprints by Live Scan or by fingerprint cards and pay the appropriate fees within 45 days of the effective date of this decision.

Within 72 hours of being arrested, cited or criminally charged for any offense, the Respondent shall submit to the EMSA a full and detailed account of the circumstances thereof. The EMSA shall determine the applicability of the offense(s) as to whether the Respondent violated any federal, state and local laws, statutes, regulations, written policies, protocols and rules governing the practice of medical care as a paramedic.

Any and all notifications to the EMSA shall be by certified mail.

**9. Completion of Probation:**

The Respondent's license shall be fully restored upon successful completion of probation.

**10. Violation of Probation:**

If during the period of probation the Respondent fails to comply with any term of probation, the EMSA may initiate action to terminate probation and implement actual license suspension/revocation. Upon the initiation of such an action, or the giving of a notice to the

Respondent of the intent to initiate such an action, the period of probation shall remain in effect until such time as a decision on the matter has been adopted by the EMSA. An action to terminate probation and implement actual license suspension/revocation shall be initiated and conducted pursuant to the hearing provisions of the California Administrative Procedure Act.

The issues to be resolved at the hearing shall be limited to whether the Respondent has violated any term of his/her probation sufficient to warrant termination of probation and implementation of actual suspension/revocation. At the hearing, the Respondent and the EMSA shall be bound by the admissions contained in the terms of probation and neither party shall have a right to litigate the validity or invalidity of such admissions.

**11. Educational Course Work:**

Within 180 days of the effective date of this decision, the Respondent shall submit to the EMSA proof of completion of 10 hours of education in areas substantially related to the offense as stated in the accusation and to the satisfaction of the EMSA.

Any educational program may include community service to reinforce the learning objectives of the educational program.

All courses must be approved by the EMSA. Within thirty-five days after completing the course work, the Respondent shall submit evidence of competency in the required education. Submittal of a certificate or letter from the instructor attesting to the Respondent's competency shall suffice.

Any and all notifications to the EMSA shall be by certified mail.

**12. Practical Skills Examination:**

Within 180 days of the effective date of this decision, the Respondent shall submit to and pass a skills examination in subjects substantially related to the accusation based upon the U. S. Department of Transportation (DOT) and/or the National Registry of Emergency Medical Technicians (NREMT) skills examination, when applicable. If not addressed in the DOT or NREMT, an approved local standard shall be identified and utilized. The skills examination shall be administered by a board selected by the EMSA using the pre-established criteria (See Section VII: Review Board for criteria).

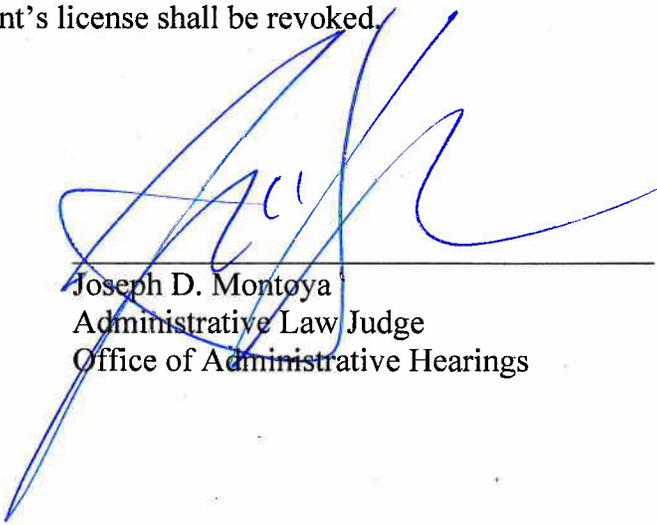
If the Respondent fails the examination, the Respondent may function as a paramedic only while under the direct supervision of a preceptor. The Respondent shall not be allowed to function as a sole paramedic until the Respondent passes the examination. The Respondent has the option and right to repeat the examination. There shall be at least a two-week period

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between examinations. No more than three attempts to pass the examination shall be allowed. If the Respondent fails to pass the exam after three attempts, or chooses not to retake the examination, the Respondent's license shall be revoked.

September 25, 2009

A large, stylized handwritten signature in blue ink, appearing to read 'J. Montoya', is written over a horizontal line.

Joseph D. Montoya  
Administrative Law Judge  
Office of Administrative Hearings