STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

In re: Jeffrey E. Haddock, MD	)	Docket No. MPS 097-0918

STIPULATION AND CONSENT ORDER

NOW COME Jeffrey E. Haddock, MD, and the State of Vermont, by and through Vermont Attorney General Thomas J. Donovan, Jr. and the undersigned Assistant Attorney General Megan Campbell, and agree and stipulate as follows:

1. Jeffrey E. Haddock, MD, ("Respondent") of Burlington, Vermont holds Vermont medical license number 042.0011189 first issued by the Vermont Board of Medical Practice on July 5, 2006. Respondent is a physician.

2. Jurisdiction in these matters vests with the Vermont Board of Medical Practice ("the Board") pursuant to 26 V.S.A. §§ 1353-1354, 1370-74 and 3 V.S.A. §§ 809-814, and other authority.

FINDINGS OF FACT

3. Respondent is a practitioner at Thomas Chittenden Health Center in Williston, Vermont. His practice areas include family, internal, and sports medicine.

4. The Board opened the above-captioned matter in September of 2018, after it was discovered that Respondent was prescribing a daily morphine milligram equivalent ("MME") of 1200 to a patient without sufficient clinical monitoring measures such as urine drug screens or

pill counts. The matter was assigned to the South Investigative Committee of the Board ("the Committee").

5. While this matter was under Committee investigation, Respondent entered into a Voluntary Limitation of Practice Agreement with the Board on December 5, 2018 that limited his ability to prescribe opioids.

6. The Committee conducted an extensive investigation of Respondent's prescription practice for patients receiving controlled substances. This investigation included, but was not limited to, the review of medical records and prescribing histories for seven chronic-pain patients who receive opioid treatment from Respondent.

7. The Committee's investigation identified practice deficiencies in Respondent's treatment of chronic-pain patients who receive opioids. The Committee's findings for six of those chronic pain patients, hereafter referred to as Patients 1-6, included the practice concerns which follow.

8. Respondent treated Patient 1 for chronic pain from a number of conditions including peripheral neuropathy, complex regional pain syndrome as a result of Agent Orange exposure, and lumbar radiculopathy. Patient 1 also suffered from depression and post-traumatic stress disorder. Respondent prescribed opioids at an extremely high daily MME of 1680 to Patient 1. Given the high dosage of prescribed medication, Respondent's clinical monitoring of this patient was inadequate and included few urine drug screens.

9. Over the course of treatment, Patient 1 developed hypogonadism. Patient 1 also experienced urinary hesitancy and fatigue. Respondent's medical documentation for Patient 1 fails to consider the possible contribution of Patient 1's high dose long-acting opioids to these

medical issues. Respondent also did not institute a taper or a dose reduction in the patient's opioid medication to see if there was any corresponding alleviation or other positive benefit with respect to these conditions.

10. During 2017 and 2018, Patient 1 was informed by his insurance company that it would soon cease paying for his 300 mg/daily dose of methadone that was being prescribed by Respondent. Respondent was aware that Patient 1 was now paying out of pocket for his methadone and as a result was self-initiating a taper from this medication. Respondent's medical records do not contain evidence that he was providing clinical support to Patient 1 for what was likely to be a long and difficult taper. Respondent did not document prescriptions of standard medications for detoxification to assist Patient 1. This lack of detoxification support put Patient 1 at risk of failing to successfully taper or seeking alternative and possibly illicit sources of opioid analgesics to facilitate the taper which carry an increased risk of addiction and other misuse.

11. Over the course of the Committee's investigation, Respondent provided additional records that had not been disclosed when the Committee first asked for Patient 1's records. These records were titled 'Opioid Chronic Prescribing Notes.' Per the Respondent's report, these records were produced from handwritten notes taken contemporaneously with the patient's treatment that were not disclosed to the Board and were destroyed prior to production.[1] The delay between the date of treatment and the entry of the new electronic records ranged from 105

[1] This explanation, along with an explanation of "human error" in not copying all requested records, was used to explain Respondent's submission of numerous additional records, including the Opioid Chronic Prescribing Notes, that were not produced pursuant to the Board's initial record's request for all six patients whose medical treatment is described in this stipulation.

to 480 days with an average delay of 272 days. The new records were entered after the commencement of the Committee's investigation.

12. Respondent provided treatment to Patient 2 from 2012 to 2018 for numerous medical ailments including severe neck pain and autonomic neuropathy. At the time that Patient 2 began treatment with Respondent Patient 2 had an existing prescription for hydromorphone. The patient complained of poorly controlled pain and Respondent began to rapidly increase Patient 2's opioid medication with both short-acting and long-acting formulations of morphine. Despite this significant increase in Patient 2's medication, the patient began to complain of pain everywhere. By the eighth month of treatment with Respondent, Patient 2 increased his own dose further by taking greater quantities of opioids than prescribed.

13. Respondent subsequently increased Patient 2's dosage to the amount selected by the patient without a face-to-face visit. Respondent failed to see Patient 2 for medical treatment over the next nine months yet continued to prescribe increasing dosages of opioids. Respondent also did not perform adequate clinical monitoring including frequent urine analysis screenings given the patient's high medication dosage which eventually reached 960 MME. At that time, Respondent added a fentanyl prescription (240 MME) to Patient 2's prescribed medication elevating his MME to 1200.

14. Patient 2 subsequently complained of trouble sleeping and a potential diagnosis of obstructive sleep apnea was contemplated in his medical records, however, there is no documentation that Respondent considered whether the patient's high opioid dosage might be contributing to this condition.

15. Respondent submitted an Opioid Chronic Prescribing Note to the Board for Patient 2 which was entered into the patient's record 518 days after the date of treatment. The new record was entered after the commencement of the Committee's investigation.

16. Respondent provided treatment to Patient 3 for persistent severe back pain. Respondent prescribed Patient 3 methadone but the patient reported an inability to tolerate this medication. Respondent next prescribed Patient 3 OxyContin at 10 mg twice a day. The patient continued to receive OxyContin twice a day at incrementally increasing dosages up to 40 mg while still taking hydrocodone as well. Patient 3 then began to increase his dose on his own which Respondent ratified by increasing Patient 3's prescription to 50 mg three times a day. Respondent continued to prescribe this medication three times a day incrementally increasing the dosage multiple times up to 160 mg three times a day with an addition prescription of oxycodone at 10 mg up to 10 times a day for breakthrough pain. This brought the patient to a daily MME of 990. The patient was also prescribed a benzodiazepine. This combination of prescriptions, especially when not carefully monitored, carries life-threatening health risks as both opioid and benzodiazepine medications have sedative effects. This specific polypharmacy increases the risk of overdose.

17. After this medication dosage increase, Patient 3's insurance company wrote Respondent a letter recommending rehabilitation for Patient 3 due to the patient's medication dosage. Additionally, Patient 3's workers compensation insurance indicated a concern about whether the patient's medication dosage was medically indicated and suggested a taper. Notwithstanding the concerns, Respondent made no effort to reduce Patient 3's opioid dose to mitigate the risks to the patient's health from this dosage. He also did not engage in adequate clinical monitoring for Patient 3 given these risks.

18. The opioid prescribing notes Respondent submitted to the Board as part of Patient 3's medical records were entered into the patient's record between 76 days to 647 days after the time of the relevant treatment with an average delay of 345 days. The new records were entered after the commencement of the Committee's investigation.

19. Respondent treated Patient 4 for a complex array of conditions including severe migraine and cluster headaches as well as severe olecranon bursitis with gangrene. Over time Respondent also assessed Patient 4 to be depressed with possible suicidality. Respondent prescribed Patient 4 multiple different high dose opioids in conjunction with a benzodiazepine. By August of 2018 Patient 4 was receiving a daily MME of 1656.

20. Respondent began to express concerns to Patient 4 that he could not keep prescribing this medication at these dosages and that this prescribing was "out of his comfort zone." He cited the patient's failure to follow up with recommended specialists for care and the concerns expressed by the patient's insurance company which refused to fully cover the patient's prescribed medication given his dosage. In addition, from November 2017 to October 2018 the patient had a number of urine drug screens that returned aberrant results including the absence of prescribed morphine in one urine drug screen and the presence of oxycodone, which was not prescribed, in three urine drug screens. Respondent documented that Patient 4 was making frequent requests for early refills and increasing his own dose without authorization. Despite these warning signs of medication misuse and potential diversion, Respondent did not taper or limit Patient 4's prescribed opioid dosage during this time period or engage in adequate clinical monitoring.

21. Respondent also submitted two Opioid Chronic Prescribing Notes to the Board pertaining to Patient 4. One of these notes was completed on the day of treatment. The other

note was completed 518 days after the date of treatment; this record was entered after the commencement of the Committee's investigation.

22. Respondent treated Patient 5 for mid-thoracic back pain as well as a later diagnosis of Coccydynia. Early in Dr. Haddock's treatment of Patient 5 there were indications that the patient was reporting lost medication and seeking additional prescriptions. Additionally in 2017 the patient was non-compliant with a random pill count, and when he was contacted about his lack of attendance, stated that his medication had been stolen. Patient 5 was then non-compliant with a second random pill count and avoided urinalysis testing. Thereafter, Respondent referred Patient 5 to a pain clinic which recommended tapering the patient's opioid medications to zero.

23. Despite the pain clinic's recommendation, Dr. Haddock continued to prescribe opioids for Patient 5 at a daily MME of 855 MME. Dr. Haddock did not make adequate efforts to taper this patient or engage in sufficient monitoring for medication misuse, given the patient's high opioid dosage and aberrant behaviors.

24. Respondent provided the Board with a collection of Opioid Chronic Prescribing Notes as part of Patient 5's medical record. These notes were recorded between 133 and 829 days after Patient 5's medical visits with Respondent with an average delay in recording of 483 days. The new records were entered after the commencement of the Committee's investigation.

25. Respondent provided medical treatment to Patient 6 for a T1 vertebral compression injury. Respondent prescribed Patient 6 high doses of opioids which from 2015 onward involved prescriptions for either oxycodone, morphine, or fentanyl depending upon the patient's feedback

about what was best addressing his pain. Respondent's opioid prescribing for Patient 6 culminated in an MME of 855.

26. Throughout Respondent's treatment of Patient 6 he documented multiple concerning risk factors for the patient's medication misuse and diversion including: running out of pain medication early, reporting lost and stolen medication, and failing to come in for random pill counts. During one notable incident, Patient 6 reported losing his pain medication when he was jailed for burglary in Florida. He obtained a refill from Respondent without subsequent monitoring to evaluate the potential for aberrant medication use. Despite these documented risk factors for medication diversion and the patient's high MME, Respondent did not taper the patient's opioid dosage or otherwise adequately address the safety issues presented by Respondent's prescribing decisions.

27. Respondent supplied the Board with several Opioid Chronic Prescribing Notes as part of Patient 6's medical records. These notes were recorded between 144 to 932 days after the date of treatment with an average delay in recording of 566 days. The new records were entered after the commencement of the Committee's investigation.

CONCLUSIONS OF LAW

28. The Board may find unprofessional conduct when there is a "the failure to use and exercise on repeated occasions, that degree of care, skill, and proficiency that is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred." 26 V.S.A. § 1354(a)(22).

29. Respondent failed to meet this standard in his care of Patients 1-6. As detailed above, he maintained these six patients on high dosages of opioids while failing to safely supervise Patient 1's taper from opioid medications, engage in adequate clinical monitoring for Patients 1 and 2, consider how opioid prescriptions may be exacerbating Patient 1 and 2's other health issues, respond in a safe and acceptable manner to indicators of potential medication diversion or misuse in the treatment of Patients 4-6, and engage in safe prescribing practices for Patients 1-6.

30. The Board may also find "that failure to practice competently by reason of any cause on a single occasion or on multiple occasions constitutes unprofessional conduct." 26 V.S.A. § 1354(b). "Failure to practice competently includes, as determined by the board... (1) performance of unsafe or unacceptable patient care; or (2) failure to conform to the essential standards of acceptable and prevailing practice." 26 V.S.A. § 1354(b)(1) and (2).

31. Respondent failed to conform to the essential standards of acceptable and prevailing practice in his medical documentation for Patients 1-6. Creating an accurate and timely medical record is an essential component of competent medical care. Respondent's medical documentation fell below this standard when his recording of visits in these patients' records occurred from months to multiple years after the date of the treatment being recorded, and after the commencement of the Committee's investigation.

32. Consistent with Respondent's cooperation with the Board, he agrees that if the State were to file charges against him it could satisfy its burden at a hearing and a finding adverse to him could be entered by the Board, pursuant to 26 V.S.A. § 1354(a)(22) and § 1354(b)(1) and (2).

33. Respondent agrees that the Board will enter as its facts and conclusions in this matter Paragraphs 1 through 31 above, and further agrees that this is an adequate basis for the Board actions set forth herein. Any representation by Respondent herein is made solely for the purposes set forth in this agreement.

34. Therefore, in the interest of Respondent's desire to fully and finally resolve the matter presently before the Board, he has determined that he shall enter into this instant agreement with the Board. Respondent enters no further admission here, but to resolve this matter without further time, expense and uncertainty; he has concluded that this agreement is acceptable and in the best interest of the parties.

35. Respondent agrees and understands that by executing this document he is waiving any right to challenge the jurisdiction and continuing jurisdiction of the Board in this matter, to be presented with a specification of charges and evidence, to cross-examine witnesses, and to offer evidence of his own to contest any allegations by the State.

36. The parties agree that upon their execution of this Stipulation and Consent Order, and pursuant to the terms herein, the above-captioned matter shall be resolved by the Board. Thereafter, the Board will take no further action as to this matter absent non-compliance with the terms and conditions of this document by Respondent.

37. This Stipulation and Consent Order is conditioned upon its acceptance by the Vermont Board of Medical Practice. If the Board rejects any part of this document, the entire agreement shall be considered void. Respondent agrees that if the Board does not accept this agreement in its current form, he shall not assert in any subsequent proceeding any claim of prejudice from any such prior consideration. If the Board rejects any part of this agreement,

none of its terms shall bind Respondent or constitute an admission of any of the facts of the alleged misconduct, it shall not be used against Respondent in any way, it shall be kept in strict confidence. And it shall be without prejudice to any future disciplinary proceeding and the Board's final determination of any charge against Respondent.

38. Respondent acknowledges and understands that this Stipulation and Consent Order shall be a matter of public record, shall be entered in his permanent Board file, shall constitute an enforceable legal agreement, and may and shall be reported to other licensing authorities, including but not limited to the Federation of State Medical Boards Board Action Databank and the National Practitioner Data Bank. In exchange for the actions by the Board, as set forth herein, Respondent expressly agrees to be bound by all terms and conditions of this Stipulation and Consent Order.

39. The parties therefore jointly agree that should the terms and conditions of this Stipulation and Consent Order be deemed acceptable by the Board, it may enter an order implementing the terms and conditions herein.

ORDER

WHEREFORE, based on the foregoing and the consent of Respondent, it is hereby ORDERED that:

1. Respondent shall be REPRIMANDED for the conduct above.

2. Upon Board approval of this Stipulation, Respondent is hereby relieved from the Voluntary Limitation of Practice Agreement that went into effect on December 5, 2018, but his license will thereupon be conditioned according to the terms below.

3. Respondent's medical license shall be CONDITIONED as follows:

a. Respondent shall successfully complete AMA PRA Category 1 continuing medical education ("CME") courses on the following topics: prescribing opioids for chronic pain, medical recordkeeping, and treating patients with Opioid Use Disorder. Each CME course must be completed no later than one (1) year after this Stipulation is approved by the Board. Respondent shall seek prior approval, in writing, from the Committee for each CME course. These courses must be live in-person or live interactive courses offered remotely and should be eight or more credits apiece. Upon successful completion of each CME course, he shall provide the Committee with proof of attendance. Respondent shall also provide the Committee with a brief written narrative of each CME course which will document what he learned from each course, and how he will apply that knowledge to his practice. Respondent shall provide proof of attendance and the written narrative to the Committee. Respondent shall be solely responsible for all costs associated with meeting these CME requirements.

b. Respondent shall provide a letter to the Committee outlining the changes he will make in his treatment of chronic pain management cases and medical documentation to address the identified practice concerns. This letter shall be submitted within sixty (60) days of his completion of the

CME described in paragraph 3(a) above on the topic of prescribing opioids for chronic pain. He will provide the Committee with a second letter six (6) months later describing his implementation of these practice improvements. This condition shall not be satisfied until the Committee determines that both letters adequately address the practice concerns identified in the stipulation. This determination will be communicated to Respondent in writing.

c. Respondent shall not prescribe opioids for chronic pain to any patient until he has satisfactorily completed the approved CME on prescribing opioids for patients with chronic pain as described in subsection 3(a) above. After the successful completion of that requirement, Respondent shall be limited to treating ten (10) patients with opioids for chronic pain. At the end of one year, he may petition the Committee to expand the number of chronic pain patients he may treat with opioids to thirty (30) patients, and at the end of two years he can petition the Committee for removal of this limitation. The decision whether to grant Respondent's petitions pursuant to this provision shall be in the sole discretion of the Committee. In addition, the limitation on the number of chronic pain patients Respondent may treat with opioids will not cease until the Committee has approved, in writing, Respondent's request to end this limitation.

d. Respondent shall retain the services of a "practice monitor" for three (3) years, subject to the terms and conditions set forth in the attached Practice Monitoring Agreement ("Agreement"), which is incorporated by reference

and attached hereto as Exhibit A. The three (3) year practice monitoring requirement will not begin until the official "start date" as defined in the attached Agreement. Respondent shall comply with the terms and obligations of the Agreement. Respondent shall provide a copy of this Stipulation and Consent Order to the practice monitor. Respondent shall be responsible for ensuring that the practice monitor complies with the terms and obligations of the Agreement. The practice monitoring requirement will not cease until the Committee has approved, in writing, Respondent's request to end the monitoring.

e. Respondent shall pay a $2,000 administrative penalty consistent with 26 V.S.A. § 1374(b)(2)(A)(iii). Payment shall be made to the "State of Vermont Board of Medical Practice," and shall be sent to the Vermont Board of Medical Practice office, at the following address: David Herlihy, Executive Director, Vermont Board of Medical Practice, P.O. Box 70, Burlington VT 05402-0070. Payment shall be due no later than one (1) month after this Stipulation and Consent Order is approved by the Board.

SIGNATURES

Dated at Montpelier, Vermont, this ____ day of _____, 2021.

STATE OF VERMONT
THOMAS J. DONOVAN, JR.
ATTORNEY GENERAL

by: E-SIGNED by Megan Campbell on 2021-07-02 15:39:03 EDT

Megan Campbell, Esquire
Assistant Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, VT 05609-1001

Dated at 12:52, Vermont, this 2 day of JULY, 2021.

Jeffrey E. Haddock, MD
Respondent

Dated at Burlington, Vermont, this ____ day of _____, 2021.

E-SIGNED by Devin McKnight on 2021-07-02 15:39:45 EDT

Ian Carleton, Esquire
Sheehy Furlong & Behm P.C.
30 Main St., 6th Floor
P.O. Box 66
Burlington, VT 05402-0066
Counsel for Respondent

AS TO JEFFREY E. HADDOCK, MD

APPROVED AND ORDERED
VERMONT BOARD OF MEDICAL PRACTICE

Signed on Behalf of the Vermont Board of Medical Practice

By: _____
Richard Clattenburg, MD
Acting-Chair
Vermont Board of Medical Practice

Vote documented in the Vermont Board of Medical Practice meeting minutes, dated July 7, 2021.

Dated: July 8, 2021

PRACTICE MONITORING AGREEMENT

Vermont Board of Medical Practice

Jeffrey E. Haddock, MD

Docket No. MPS 097-0918

1. Pursuant to a Stipulation and Consent Order entered into by Jeffrey E. Haddock, MD ("Dr. Haddock") and the Vermont Board of Medical Practice ("the Board") in Docket No. MPS 097-0918, Dr. Haddock has agreed to retain a practice monitor to monitor his treatment of patients with chronic pain. The purpose of this Practice Monitoring Agreement ("Agreement") is to set forth the terms of the practice monitoring component of Dr Haddock's Stipulation and Consent Order (attached and incorporated by reference). This Agreement will be signed by Dr. Haddock and the practice monitor approved by the South Investigative Committee ("the Committee").
2. Dr. Haddock is responsible for selecting a practice monitor.
3. The practice monitor chosen by Dr. Haddock shall be a Vermont licensed physician with an unconditioned license who has experience in the treatment of chronic pain with opioids, ideally in a primary care/internal medicine practice setting.
4. Dr. Haddock shall obtain approval from the Committee for his choice of practice monitor. Dr. Haddock shall submit in writing to the Committee the practice monitor's name, contact information, and curriculum vitae. The Committee retains discretion to approve or disapprove the choice of practice monitor for any reason. The Committee shall communicate in writing its decision to Dr. Haddock. If the proposed practice monitor is not approved, Dr. Haddock remains responsible for

using the procedure outlined in this paragraph to submit his choice of another proposed practice monitor for Committee consideration.

5. The Board shall not bear any of the costs associated with the practice monitor.
6. Dr. Haddock shall provide the practice monitor with a copy of the fully executed Stipulation and Consent Order.
7. The practice monitoring shall start within sixty (60) days of the date that the Board approves the Stipulation and Consent Order (hereinafter referred to as the "start date").
8. The practice monitor will follow all state and federal health privacy regulations and statutes, including, but not limited to, HIPAA, and will review and sign any necessary HIPAA authorizations, business associate agreements, or any other required documents to enable access to, and review of, patient protected health information.
9. The practice monitor shall perform a record review monthly of ten (10) of Dr. Haddock's patients who are receiving opioid medications for chronic pain unless there are fewer than ten patients, in which case it shall be a total of ten including patients who are prescribed other controlled substances. The practice monitor shall select the patients whose records are to be reviewed. If during any thirty (30) day period Dr. Haddock has no patients receiving controlled substances, the practice monitor shall notify the Committee in writing, and the practice monitoring requirements shall be suspended until Dr. Haddock notifies the Committee that he is again prescribing controlled substances.
10. The practice monitor may review any other documents, records, files, logs, etc. for information needed to prepare written monitoring reports.

11. The practice monitor may speak with Dr. Haddock's co-workers to obtain information needed to prepare the written monitoring reports.

12. The practice monitor shall meet with Dr. Haddock every thirty (30) days to discuss the findings of his/her record review. Dr. Haddock is responsible for ensuring that there is appropriate documentation of each thirty (30) day record review and discussion. Such documentation shall include the date of each record review, and the date and length of time of each discussion between the practice monitor and Dr. Haddock regarding the findings of each chart review. This documentation shall be submitted with each thirty (30) day practice monitoring report.

13. The practice monitor shall report his/her findings in a detailed written report to the Committee for three (3) full years excluding all periods in which practice monitoring is suspended because Dr. Haddock is not prescribing controlled substances. The first report shall be submitted no later than thirty (30) days after the practice monitoring agreement is signed.

14. If at any time during the three-year practice monitoring period, Dr. Haddock is no longer prescribing controlled substances or he is no longer practicing primary care internal medicine, he may submit a written request to the Committee to end the requirement for monitoring. The practice monitoring requirement will not cease unless or until the Committee approves, in writing, Dr. Haddock's request to end the monitoring.

15. Dr. Haddock shall be responsible for ensuring that the following is reviewed by the practice monitor and discussed and documented in the practice monitoring reports:

a. The number of chronic pain patients Dr. Haddock is currently treating with opioid medications;

b. Documentation of each chart review performed by the practice monitor during that review period including the findings of the chart review;

c. Whether Dr. Haddock's prescribing of opioid medications meets the standard of care and is in accordance with the current Vermont Rule Governing the Prescribing of Opioids for Pain and the Vermont Prescription Monitoring System Rule;

d. Whether Dr. Haddock's clinical monitoring of patients to whom he is prescribing opioid medications meets the standard of care;

e. Whether Dr. Haddock's medical recordkeeping is in accordance with the standard of care;

f. Whether Dr. Haddock's general medical treatment meets the applicable standard of care; and

g. Any recommended improvements to Dr. Haddock's practice. Although the practice monitor will need to review patient charts to become familiar with patient medical history, the focus of the practice monitoring will be improving Dr. Haddock's practice prospectively.

16. Dr. Haddock shall be responsible for ensuring that the practice monitor's reports are timely submitted to the Committee, directed to the attention of the Vermont Board of Medical Practice at the following address: P.O. Box 70, Burlington VT 05402-0070.

17. After the Committee has received consecutive, favorable and timely thirty (30) day practice monitoring reports for one (1) full year, Dr. Haddock may submit a written

request to the Committee to reduce the record reviews and discussions and submission of practice monitoring reports to occur on a quarterly basis.

18. The practice monitoring shall continue for a total of three (3) years from the start date and shall include three years of active monitoring, unless a modification to the monitoring requirement is approved by the Committee. Any time periods in which Dr. Haddock is not prescribing controlled substances shall not be counted toward the three-year minimum. At the end of the monitoring period, Dr. Haddock shall submit a written request to the Committee to end the requirement for monitoring. Such a request shall not be considered by the Committee until Dr. Haddock has provided favorable and timely monitoring reports for the monitoring period. The practice monitoring requirement will not cease until the Committee has approved, in writing, Dr. Haddock's request to end the monitoring.

19. In the event that the practice monitor can no longer monitor Dr. Haddock's practice, Dr. Haddock shall notify the Committee in writing within five (5) business days. Within thirty (30) days of providing notice to the Committee, Dr. Haddock shall submit the name of an additional proposed practice monitor which will be subject to the approval process outlined in paragraph four.

20. Upon notice to the Committee that the practice monitor can no longer serve, Dr. Haddock has sixty (60) days to obtain Committee approval for a new practice monitor. If a new practice monitor is not approved in that time, Dr. Haddock shall cease prescribing any opioid and/or benzodiazepine medications. Dr. Haddock shall not resume prescribing opioid and/or benzodiazepine medications until a new practice monitor is approved by the Committee and can begin monitoring his practice. The

Committee will endeavor to communicate their decision regarding the approval of a new proposed practice monitor to Dr. Haddock in writing within thirty (30) days of when he submits the proposed monitor's name, contact information, and curriculum vitae to the Committee. In the event that the Committee's response is delayed beyond thirty (30) days, that additional response time will not count toward the 60-day limit that Dr. Haddock has to find a new practice monitor or cease prescribing opioid and/or benzodiazepine medications.

21. The Committee retains the unfettered discretion to disapprove Dr. Haddock's practice monitor at any time. If the Committee disapproves of Dr. Haddock's practice monitor, it will provide Dr. Haddock with written notice of the disapproval and a brief explanation of reasons for its decision. Upon receiving this notice Dr. Haddock shall immediately notify his practice monitor that he/she is no longer approved to monitor his practice under this Agreement. Consistent with paragraph nineteen above, Dr. Haddock will seek Committee approval for a new practice monitor. He will cease prescribing opioid and/or benzodiazepine medications if a new monitor is not approved by the Committee within sixty (60) days until such time as the Committee approves a new monitor.
22. Dr. Haddock and the practice monitor agree that they have both read this Agreement in its entirety and agree to all of its terms and obligations.
23. Dr. Haddock and the practice monitor agree that the terms of this Agreement cannot be amended or modified in any way without written approval of the Committee.

Signatures

DATED at 12:52, Vermont, this 2 day of JULY, 2021.

Jeffrey E. Haddock, MD

DATED at _____, Vermont, this _____ day of _____, 2021.

_____
Practice Monitor