B/C: y
Accred: y

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P.O. Box 946, Montgomery, AL 36101

1

Office-Based Surgery
Adverse Event Report Form

Name: [redacted] AL License # [redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Plastic Surgery

Date of Surgery: 12/15/03 Type of Surgery: Breast

Type of Anesthesia (Moderate, Deep, or General): General

Name & Title of Person Administering Anesthesia: [redacted] CRNA

Date of Adverse Event: 12/15/03

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.):

Negative Pressure Pulmonary Edema

Patient Hospitalized: Yes ✓ No ___
Patient Outcome: Full Recovery ✓ Disability ___ Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

Pt. developed p-op pulm. edema 2° to neg. pressure phenomenon. Rx c O2, lasix; resolved within 12°. We will cont. to monitor for this random event.

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 2/23/04

B/C: y
Accred: N

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Office-Based Surgery
Adverse Event Report Form

Name: [redacted] AL License # [redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Nephrology / Interventional Nephrology

Date of Surgery: 3/5/04 Type of Surgery: Angioplasty of shunt graft

Type of Anesthesia (Moderate, Deep, or General): NONE

Name & Title of Person Administering Anesthesia: NONE

Date of Adverse Event: 3/5/04

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.):

dye reaction

Patient Hospitalized: Yes ___ No ✓
Patient Outcome: Full Recovery ✓ Disability ___ Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

Pt. developed hives and increased bronchial secretions after receiving 10 cc of IV gadolinium. Pt. responded to IV steroids & epinephrine. Eventually observed in Princeton Baptist Emergency department and discharged home the same day. Known IV contrast allergy but no recorded problems with gadolinium previously.

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 3/5/04

B/C: y
accred: y

(2)

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Office-Based Surgery
Adverse Event Report Form

Name: [redacted] AL License #[redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Plastic Surgery

Date of Surgery: 03·16·04 Type of Surgery: Facelift & Temporal lift; ↑↓ lip liposuction

Type of Anesthesia (Moderate, Deep, or General): General

Name & Title of Person Administering Anesthesia: [redacted], CRNA

Date of Adverse Event: 03·16·04

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.):

Hematoma, neck

Patient Hospitalized: Yes ___ No X
Patient Outcome: Full Recovery X Disability ___ Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

Patient presented to office on POD 1 & hematoma in her neck despite overnight drain placement. Hematoma was successfully evacuated & affected areas were cauterized. New, larger drains were placed. less than 100cc was evacuated; there was no problem with her airway prior to evacuation. Patient tolerated the procedure well. No new protocols adopted as this is something that occurs in <2% of the surgical population

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

already reported April '04 on

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 3·16·04

B/C: y
accred: y

Duplicate #2

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Office-Based Surgery
Adverse Event Report Form

Name: [redacted] AL License # [redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Plastic Surgery

Date of Surgery: 03.15.04 Type of Surgery: Facelift & Temporal lift; ↑↓lip lipectomy

Type of Anesthesia (Moderate, Deep, or General): General

Name & Title of Person Administering Anesthesia: [redacted], CRNA

Date of Adverse Event: 03.16.04

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.):

Hematoma, neck

Patient Hospitalized: Yes ___ No X
Patient Outcome: Full Recovery X Disability ___ Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

Patient presented to office on POD 1 & hematoma in her neck despite overnight drain placement. Hematoma was successfully evacuated & affected areas were cauterized. New, larger drains were placed. Less than 100cc was evacuated; there was no problem with her airway prior to evacuation. Patient tolerated the procedure well. NO new protocols adopted as this is something that occurs in <2% of the surgical population

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 3.16.04

B/C: y. plastic surg
accred: yes

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Office-Based Surgery
Adverse Event Report Form

Name: [redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: PLASTIC SURGERY

Date of Surgery: 31904 Type of Surgery: AUGMENTATION

Type of Anesthesia (Moderate, Deep, or General): MODERATE

Name & Title of Person Administering Anesthesia: [redacted] CRNA

Date of Adverse Event: 31904

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.): PNEUMOTHORAX

Patient Hospitalized: Yes ___ No ✓
Patient Outcome: Full Recovery ✓ Disability ___ Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

DURING DISSECTION OF SUBPECTORAL POCKET ~~DIS~~
A RENT OCCURRED IN INTERCOSTAL SPACE INTO
PLEURA. SEE ATTACHED OP REPORT.

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 4 13 04

B/C: y
accred: y

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Office-Based Surgery
Adverse Event Report Form

Name: [redacted] AL License # [redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Plastic Surgery

Date of Surgery: 3/25/04 Type of Surgery: Breast Augmentation

Type of Anesthesia (Moderate, Deep, or General): General

Name & Title of Person Administering Anesthesia: [redacted], CRNA

Date of Adverse Event: 3/29/04

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.):

Deflation Left implant

Patient Hospitalized: Yes ___ No ✓
Patient Outcome: Full Recovery ✓ Disability ___ Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

Pt presented to office 4 days p/o with deflation of left implant. We are unsure if deflation was a result of employee error vs. implant defect. We are awaiting report from implant manufacturer.

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 5-18-04

B/C: y
accid: y

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Office-Based Surgery
Adverse Event Report Form

Name: [redacted] AL License #[redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Plastic Surgery

Date of Surgery: 3/25/04 Type of Surgery: Breast Augmentation

Type of Anesthesia (Moderate, Deep, or General): General

Name & Title of Person Administering Anesthesia: [redacted], CRNA

Date of Adverse Event: 3/26/04

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.):

Deflated (L) implant

Patient Hospitalized: Yes ___ No ✓
Patient Outcome: Full Recovery ✓ Disability ___ Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

Pt presented to office POD 1 with a deflation of the left implant. We are unsure if deflation was a result of employee error vs. implant defect. We are awaiting report from implant manufacturer.

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 5-18-04

B/C: y, colon & rectal surg
Accred: y.

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Office-Based Surgery
Adverse Event Report Form

Name: [redacted] AL License #: [redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Colon & rectal surgery

Date of Surgery: 3/25/04 Type of Surgery: colonoscopy & polypectomy

Type of Anesthesia (Moderate, Deep, or General): General

Name & Title of Person Administering Anesthesia: [redacted] MD.

Date of Adverse Event: 3/31/04

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.):

LOWER GASTROINTESTINAL BLEEDING

Patient Hospitalized: Yes ✓ No ___
Patient Outcome: Full Recovery ___ Disability ___ Death ___ ** Pending ✓

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

PT CONTACTED ME VIA ANSWERING SERVICE 3/30/04 ~9:50pm SHE COMPLAINED OF PASSING "ABOUT ½ PINT" OF BLOOD & CLOT FROM HER RECTUM - SHE HAD A COLONOSCOPY WITH POLYPECTOMY ON 3/25/04 - SHE HAD TAKEN SOME ALEVE EARLIER THAT DAY FOR ARTHRITIC PAIN SHE WAS ASKED TO PRESENT TO EMERGENCY ROOM FOR FURTHER EVALUATION AFTER SHE HAD A SECOND EPISODE WITH IN 40 MINUTES OF THE FIRST - PLEASE SEE ATTACHED H/P

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 3/31/04

B/C: y
accrd: y

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Office-Based Surgery
Adverse Event Report Form

Name: [redacted] AL License [redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Plastic Surgery

Date of Surgery: 3/25/04 Type of Surgery: Breast Augmentation

Type of Anesthesia (Moderate, Deep, or General): General

Name & Title of Person Administering Anesthesia: [redacted], CRNA

Date of Adverse Event: 4/1/04

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.):

Deflation right implant

Patient Hospitalized: Yes ___ No ✓
Patient Outcome: Full Recovery ✓ Disability ___ Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

Pt presented to office 4 days p/o with a deflation of the right implant. We are unsure if deflation was a result of employee error vs. implant defect. We are awaiting report from implant manufacturer.

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 5-18-04

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B/C: y
accred: y

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Office-Based Surgery
Adverse Event Report Form

Name: [redacted] AL License # [redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Plastic Surgery

Date of Surgery: 3/25/04 Type of Surgery: Breast Augmentation

Type of Anesthesia (Moderate, Deep, or General): General

Name & Title of Person Administering Anesthesia: [redacted] CRNA

Date of Adverse Event: 4/2/04

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.):

Deflated (Rt) implant

Patient Hospitalized: Yes ___ No ✓
Patient Outcome: Full Recovery ✓ Disability ___ Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

Pt presented to office 1 week p/o with a partial deflation of the (Rt) implant. We are unsure if deflation was a result of employee error vs. implant defect. We are awaiting report from implant manufacturer.

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 5-18-04

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B/C: y
accud: y

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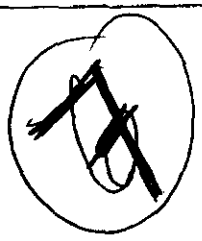

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P.O. Box 946, Montgomery, AL 36101

Office-Based Surgery
Adverse Event Report Form

Name: [redacted] AL License # [redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Plastic Surgery

Date of Surgery: 3/22/04 Type of Surgery: Breast Augmentation

Type of Anesthesia (Moderate, Deep, or General): General

Name & Title of Person Administering Anesthesia: [redacted], CRNA

Date of Adverse Event: 4-12-04

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.):

Infected (Lt) Breast / Implant

Patient Hospitalized: Yes ___ No ✓
Patient Outcome: Full Recovery ✓ Disability ___ Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

Patient presented to office 3 weeks s/p breast augmentation with fever & frank pus from wound on (L) breast which communicated with breast implant. Implant removed on day 21 with penrose drain placement. IV antibiotics given as well as oral antibiotics. Drain removed @ 5 days post-op. Patient has recovered fully & is awaiting reimplantation on 6-10-04.

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 18 MAY 04

✓

B/C: yes accred. by

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Office-Based Surgery Adverse Event Report Form

Name: [redacted] AL License # [redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Plastic Surgery

Date of Surgery: 4-22-04 Type of Surgery: Breast Augmentation

Type of Anesthesia (Moderate, Deep, or General): General

Name & Title of Person Administering Anesthesia: [redacted], CRNA

Date of Adverse Event: 4-22-04

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.):

Hematoma (Lt) Breast

Patient Hospitalized: Yes ___ No ✓
Patient Outcome: Full Recovery ✓ Disability ___ Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

Patient presented approx. 8 hrs. after breast augmentation with acute swelling of the left breast. Exploration & evacuation of left breast hematoma performed without difficulty. Patient recovered fully.

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 5-18-04

B/C: y, colon+rectal surg
accred: y

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Office-Based Surgery
Adverse Event Report Form

Name: [redacted] AL License #[redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Colon and Rectal Surgery

Date of Surgery: 4/22/04 Type of Surgery: Colonoscopy & polypectomy

Type of Anesthesia (Moderate, Deep, or General): General

Name & Title of Person Administering Anesthesia: [redacted] MD

Date of Adverse Event: 4/24/04

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.):

post-polypectomy lower gastrointestinal bleeding

Patient Hospitalized: Yes ✓ No ___
Patient Outcome: Full Recovery ___ Disability ___ Death ___ ** Pending ✓

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

Pt had colonoscopy & polypectomy 4/22/04 and called 4/24/04 c large amount of rectal bleeding, syncope + pallor, told to go to local ER stat (2 miles away) in Syracuse. Report from Dr. Pierson in ER - pt was orthostatic hypotensive, responded to IV fluid bolus & was to be admitted there to PCP. I told them I would be glad to accept him in transfer. Changes in protocol could include selective withholding of aspirin use after polypectomy.

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 4/26/04

BC: y
accd: y

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Office-Based Surgery
Adverse Event Report Form

Name: [redacted] AL License # [redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Plastic Surgery

Date of Surgery: 4/26/04 Type of Surgery: Breast Augmentation

Type of Anesthesia (Moderate, Deep, or General): General

Name & Title of Person Administering Anesthesia: [redacted], CRNA

Date of Adverse Event: 4/26/04 PM

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.):

Hematoma right breast

Patient Hospitalized: Yes ___ No ✓
Patient Outcome: Full Recovery ✓ Disability ___ Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

Pt presented to office 6 hrs after breast Augmentation with acute swelling of the right breast. Exploration & evacuation of right breast hematoma performed without difficulty. Patient recovered fully.

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 5-18-04

B/C: y, plastic surg accred: y

11

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Office-Based Surgery
Adverse Event Report Form

Name: [redacted] AL License # [redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Cosmetic + Reconstructive surgery

Date of Surgery: 05/07/04 Type of Surgery: Abdominoplasty

Type of Anesthesia (Moderate, Deep, or General): Epidural

Name & Title of Person Administering Anesthesia: [redacted], CRNA

Date of Adverse Event: 05/14/04

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.):

Pulmonary embolism, deep vein thrombosis

Patient Hospitalized: Yes X No ___
Patient Outcome: Full Recovery X Disability ___ Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

Pt. developed PE + DVT, recuperative course uneventful with full recovery.

Prevention: ace wraps +/or SCD on all pt's while on the OR table.

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 5 25 04

Board cert.: Y Plastic Surg
Accred.: Y

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Office-Based Surgery
Adverse Event Report Form

Name: [redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Plastic Surgery

Date of Surgery: 6-2-04 Type of Surgery: Evacuation (R) cheek HT

Type of Anesthesia (Moderate, Deep, or General): Local only

Name & Title of Person Administering Anesthesia: Dr [redacted]

Date of Adverse Event: 6-2-04

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.):

Hematoma Rt Cheek - Surgical Complication

Patient Hospitalized: Yes ___ No X
Patient Outcome: Full Recovery X Disability ___ Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring. 230cc Aurora

Patient developed acute hematoma Rt cheek nine days post-op. Evacuated under local anesthesia without complication. No change in procedure is indicated.

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 8 June 04

B/C: y, Nephrology
accrd: N

(13)

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Office-Based Surgery
Adverse Event Report Form

Name: [redacted] AL License # [redacted]

Address: [redacted]
Street [redacted] City State Zip

Physician Specialty: Nephrology

Date of Surgery: 6/11/04 Type of Surgery: Thrombectomy of AV Graft

Type of Anesthesia (Moderate, Deep, or General): Moderate

Name & Title of Person Administering Anesthesia: [redacted] MD

Date of Adverse Event: 6/11/04 Extravasation from vein after angioplasty

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.): interventional complication

Patient Hospitalized: Yes X No ___
Patient Outcome: Full Recovery ___ Disability X Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

In this patient with severe vascular disease & ESRD & AV Graft Fistula (clotted) we found a very diseased venous outflow segment beyond the graft. This required much high pressure angioplasty to open. When clot was removed from the AV G, blood was found to be leaking from this section of vein. It was promptly controlled by inflating the angioplasty balloon & allowing the graft to re-clot. It will require surgical revision. She was admitted x 23 hrs for observation

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 6/16/04

B/C: y. Nephrology
Accred: N

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P.O. Box 946, Montgomery, AL 36101

Office-Based Surgery
Adverse Event Report Form

Name: [redacted] AL Lice[redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Nephrology

Date of Surgery: 6/21/04 Type of Surgery: Perm Cath Insertion

Type of Anesthesia (Moderate, Deep, or General): None

Name & Title of Person Administering Anesthesia: N/A

Date of Adverse Event: 6-21-04

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.): _____

Patient Hospitalized: Yes ✓ No ___
Patient Outcome: Full Recovery ___ Disability ✓ Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

The patient presented to the Vascular Lab having not dialyzed x 4 days. Procedure was uneventful. After the procedure the pt developed dyspnea and diaphoresis.

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 6/21/04

B/C: y, Plastic surg

JUL 02 2004 9:11AM ALBME 334-240-3363

accred: y

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Office-Based Surgery
Adverse Event Report Form

Name: [redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Plastic & Reconstructive Surgery

Date of Surgery: 6/24/04 Type of Surgery: Endoscopic brow lift Upper & lower Lid blepharoplasty

Type of Anesthesia (Moderate, Deep, or General): General

Name & Title of Person Administering Anesthesia: [redacted] CRNA

Date of Adverse Event: 6/24/04

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.): admission to hospital 8 hr after disch from office facility

Patient Hospitalized: Yes ✓ No ___
Patient Outcome: Full Recovery ✓ Disability ___ Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

Pt ↑ nausea at disch. Became nauseated & vomited at home. Different pain + antinausea meds tried ↑ success. Adm to hosp for IVF and IV meds. Disch next AM on diet + po meds & resolution of Admitting Sx.

Considering requiring out of county pts to routinely spend the night when having this Sx

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 7/1/04

Bk: 4, plastic surg
Accred: 4

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Alabama Board of Medical Examiners
P.O. Box 946, Montgomery, AL 36101

Office-Based Surgery
Adverse Event Report Form

Name: [redacted] AL License # [redacted]

Address: _____
Street City State Zip

Physician Specialty: Plastics

Date of Surgery: 7/22/04 Type of Surgery: R/R (L) Implant; (L) capsulo: rhaphy (R) capsulotomy

Type of Anesthesia (Moderate, Deep, or General): General

Name & Title of Person Administering Anesthesia: [redacted] CRNA

Date of Adverse Event: 7/23

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.): _____

hematoma (R) Breast

Patient Hospitalized: Yes ___ No X
Patient Outcome: Full Recovery X Disability ___ Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

Pt CAME FOR CAPSULAR CONTRACTURE OF BREAST SURGERY PERFORMED WITHOUT INCIDENT ON 7/22/04. PHYSICIANS OFFICE WAS NOTIFIED OF HAVE SLIGHT SWELLING (R) BREAST 7/23. OBSERVED THROUGHOUT THE DAY x 3 VISITS WITH NO CHANGE IN BREAST SIZE. SITE AND PT HUSBAND INSTRUCTED TO CONTACT DR IF PROBLEMS. THIS WAS SEEN ON 7/23 - ISOLATED SURGICAL INCIDENT. NO SIGNS

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 11/3/04

B/C: y, plastic surg
Accred: y

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Office-Based Surgery
Adverse Event Report Form

Nam[redacted] AL License [redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Plastic Surgery

Date of Surgery: 7/26/04 Type of Surgery: Neck Platysma; UELS

Type of Anesthesia (Moderate, Deep, or General): General

Name & Title of Person Administering Anesthesia: [redacted] CRNA

Date of Adverse Event: 7/26/04

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.): hematoma in neck

Patient Hospitalized: Yes ___ No X
Patient Outcome: Full Recovery X Disability ___ Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

7/26/04 – NECKLIFT, LIPOSUCTION, BILATERAL BREAST REDUCTION (CM
DISCHARGED RECOVERY ROOM 11 AM
PAGED 1:45 PM – BP INCREASED OUTPUT
FROM JP DRAINS
SEEN BY DR [redacted] IN ER, ADMITTED TO CRANE
10 CRANE
HEMATOMA EVACUATED NO BLEEDER
NO BLEEDER

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 11/03/04

B/C: g. Nephrology accred: N

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Office-Based Surgery
Adverse Event Report Form

Name: [redacted] MD AL License [redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Interventional Nephrology

Date of Surgery: 8/9/04 Type of Surgery: Percutaneous Thrombectomy

Type of Anesthesia (Moderate, Deep, or General): Light - Moderate

Name & Title of Person Administering Anesthesia: [redacted] MD

Date of Adverse Event: 8-9-04

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.):

Post-op Respiratory Failure

Patient Hospitalized: Yes ___ No ✓
Patient Outcome: Full Recovery ___ Disability ___ Death ✓ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

After successful thrombectomy, patient developed resp. failure. ACLS protocol followed. Pt transferred to nearby (BMC Princeton) Hosp E.D. Pt expired in the E.D.

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 8/9/04

B/C: Y, plastic surg
Accred: Y

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Office-Based Surgery
Adverse Event Report Form

Name: [redacted] AL License #[redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Plastic Surgery

Date of Surgery: 9/2/04 Type of Surgery: Breast Augmentation

Type of Anesthesia (Moderate, Deep, or General): General

Name & Title of Person Administering Anesthesia: [redacted] CRNA

Date of Adverse Event: 9/3/04

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.): Hematoma

Patient Hospitalized: Yes ___ No X
Patient Outcome: Full Recovery X Disability ___ Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

PT. PHONED 18 HRS POST OP c SWELLING RT. BREAST. EXPLORED IN OR, 300cc c EVACUATED, BLEEDING VESSEL ELECTROCAUTERIZED. MAC ANESTHESIA.

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 3 SEP 04

B/C: y, Nephrology
Accred: N

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Office-Based Surgery
Adverse Event Report Form

Name: [redacted] AL License [redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Nephrology (Interventional)

Date of Surgery: 9/20/04 Type of Surgery: AVG thrombectomy (Left thigh)

Type of Anesthesia (Moderate, Deep, or General): moderate

Name & Title of Person Administering Anesthesia: [redacted] MD

Date of Adverse Event: 9/20!

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.):

Surgical Complication

Patient Hospitalized: Yes ✓ No ___
Patient Outcome: Full Recovery ___ Disability ___ Death ✓ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

After thrombectomy, patient developed bilateral lower extremity arterial insufficiency patient was taken to OR for lower ext. arterial bypass surgery

10/18 Addendum: patient underwent Lower extremity ~~ext~~ Arterial embolectomy, @ fem-pop Bypass, and Bilateral fasciotomy the evening of 9/20/04, pt developed cardio-pulmonary arrest twice (3Am & 5Am). Patient later found to have severe hyperkalemia (@ 5Am of 9/21/04) Patient expired evening of 9/21/04. Autopsy Results still pending

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 9/21/04
10/18/04

B/C: plastic surg

accred: y

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Office-Based Surgery
Adverse Event Report Form

Name: [redacted] AL License # [redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Plastic Surgery

Date of Surgery: 9/29/04 Type of Surgery: BAM, Abdominoplasty

Type of Anesthesia (Moderate, Deep, or General): General

Name & Title of Person Administering Anesthesia [redacted] CRNA

Date of Adverse Event: 9/30/04

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.): _____

Admission to hospital for N + V

Patient Hospitalized: Yes ✓ No ___
Patient Outcome: Full Recovery ✓ Disability ___ Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

Pt admitted 30h post op for 6h duration nausea + vomiting unrelieved by meds. Treated c IV fluids + IVP meds with resolution

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 10/7/04

B/C: Y, plastic surg
Accred: Y

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Office-Based Surgery Adverse Event Report Form

Name: [redacted] AL License # [redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Plastic Surgery

Date of Surgery: _____ Type of Surgery: Bilateral Breast Augmentation

Type of Anesthesia (Moderate, Deep, or General): General

Name & Title of Person Administering Anesthesia: [redacted], CRNA

Date of Adverse Event: 10-04-04

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.): _____

left breast implant infection

Patient Hospitalized: Yes __ No ✓
Patient Outcome: Full Recovery ✓ Disability __ Death __ ** Pending __

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

PT. DEVELOPED LOCAL WOUND INFECTION 7 WEEKS POST OP - CULTURED E. COLI. TREATED W/ IV ABX, LOCAL WOUND CARE AND PO ANTIBIOTICS - WOUND IMPROVED. WOUND INFECTION RECURRED IN 2 WEEKS LATER, EXPLORING INCISION FOUND BREAK IN CAPSULE CONTAMINATED WITH IMPLANT, IMPLANT AND FOREIGN MATERIAL REMOVED USING LOCAL ANESTHESIA. NO EVIDENCE SYSTEMIC INFECTION OR SIGNIFICANT LOCAL INFECTION AT ANY TIME

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 4 OCT 04

B/C: Y, plastic surg

Accred: 4

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Office-Based Surgery
Adverse Event Report Form

Name: [redacted] AL License # [redacted]

Address: [redacted]
Street City State Zip

Physician Specialty: Plastic Surgery

Date of Surgery: 10-04-04 Type of Surgery: Breast Augmentation

Type of Anesthesia (Moderate, Deep, or General): GENERAL

Name & Title of Person Administering Anesthesia: [redacted] CRNA

Date of Adverse Event: 10-04-04

Indicate Adverse Event (ie. Surgical complication, post-op infection, etc.):

Hematoma left breast

Patient Hospitalized: Yes ___ No Y
Patient Outcome: Full Recovery Y Disability ___ Death ___ ** Pending ___

** If patient outcome is pending, please provide a follow-up report within 14 days of the patient's discharge and/or recovery.

Please provide a brief narrative description of what occurred during this event and what changes in office protocols have been implemented in order to prevent this complication from re-occurring.

PT CALLED ~6 HRS POST OP - SWOLLEN PAINFUL L BREAST. PT C/O HEMATOMA EVACUATED 2 IV SEDATION (PREVIOUS NERVE BLOCK SELECTIVE) SMALL (~2cm) BLEEDING VESSEL ELECTROCOAGULATED. ~300 cc BLOOD + CLOT EVACUATED. ALL COMPLICATIONS

I swear (affirm) that the information set forth on this Office-Based Surgery/Adverse Event Report Form is true and correct to the best of my knowledge, information and belief. I also understand that the Board of Medical Examiners may conduct an on-site inspection at any time.

* Please return to Sherri D. Nichols, Board Secretary, at the above listed address. *

Signature of Physician: [redacted] Date: 10-04-04