

**BEFORE THE  
MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA**

In the Matter of the Accusation Against:

**CHRISTOPHER LIEN HATLESTAD, M.D.**

**MBC No. 16-2013-229512**

Physician and Surgeon's  
Certificate No. G 88309

\_\_\_\_\_  
Petitioner.

**DENIAL BY OPERATION OF LAW  
PETITION FOR RECONSIDERATION**

No action having been taken on the petition for reconsideration, filed by Petitioner Christopher Lien Hatlestad, M.D., and the time for action having expired at 5 p.m. on July 29, 2013, the petition is deemed denied by operation of law.

**BEFORE THE  
MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA**

In the Matter of the Accusation Against:

**CHRISTOPHER LIEN HATLESTAD, M.D.**

Physician's & Surgeon's  
Certificate No. G 88309

Respondent.

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**MBC No. 16-2013-229512**

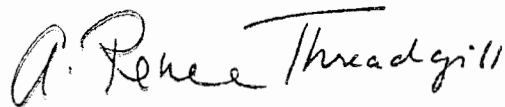
**ORDER GRANTING STAY**

The Medical Board of California (Board) has filed a Request for a Stay of execution of the Decision in this matter with an effective date of July 19, 2013.

Execution is stayed until **July 29, 2013.**

This stay is granted solely for the purpose of allowing the Board time to consider the Petition for Reconsideration.

DATED: **July 16, 2013.**



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A. Renee Threadgill  
Chief of Enforcement  
Medical Board of California

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**BEFORE THE  
MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA**

In the Matter of the Accusation Against:

**CHRISTOPHER LIEN HATLESTAD, M.D.**

PHYSICIAN'S AND SURGEON'S CERTIFICATE NO. G88309

RESPONDENT.

Case No. 16-2013-229512

**DEFAULT DECISION  
AND ORDER**

[Gov. Code, §11520]

11                   On March 19, 2013, an employee of the Medical Board of California ("Board")  
12 sent by certified mail a copy of Accusation No. 16-2013-229512, Statement to Respondent,  
13 Notice of Defense in blank, copies of the relevant sections of the California Administrative  
14 Procedure Act as required by sections 11503 and 11505 of the Government Code, and a request  
15 for discovery, to Christopher Lien Hatlestad, M.D. ("Respondent") at his address of record with  
16 the Board, 365 NE Greenwood Avenue, Suite 3, Bend, Oregon 97701. The package was returned  
17 to the Board marked by the Post Office marked "vacant." (Accusation package, proof of service  
18 and return notification, Evidence Package, Exhibit 1<sup>1</sup>.)

19                   On May 20, 2013, an employee of the Attorney General's Office sent by certified  
20 mail addressed to Respondent at the address of record set forth above and to Center for  
21 Environmental Medicine, 10748 NE Halsey Street, Portland, Oregon 97220-3961, a courtesy  
22 Notice of Default, advising Respondent of the service Accusation, and providing him with an  
23 opportunity to request relief from default. The green certified mail receipt for the package sent to  
24 the Portland address was signed and returned. (Exhibit Package, Exhibit 2, Notice of Default,  
25 proof of service, return receipt, return envelopes.) On June 3, 2013, the Deputy Attorney General  
26 assigned to this matter received a voice mail message from Dr. Hatlestad stating that he had

27                   <sup>1</sup> The evidence in support of this Default Decision and Order is submitted herewith as the  
28 "Evidence Package."

1 received the Notice of Default, his California license was not active, and he did not understand  
2 why he had to respond to the Accusation. The Deputy Attorney General returned the telephone  
3 call and left a voice message on June 3, 2013. There has been no further communication from  
4 Respondent. (Evidence Package, Exhibit 3, Declaration of Jane Zack Simon.)

5 Respondent has not filed a Notice of Defense. As a result, Respondent has waived  
6 his right to a hearing on the merits to contest the allegations contained in the Accusation.

## 7 FINDINGS OF FACT

### 8 I.

9 Linda K. Whitney was the Executive Director of the Board at the time the  
10 Accusation was filed; Kimberly Kirchmeyer is currently the Board's Interim Executive Director.  
11 The charges and allegations in the Accusation were at all times brought and made solely in the  
12 official capacity of the Board's Executive Director.

### 13 II.

14 On July 11, 2008, Physician's and Surgeon's Certificate No. G88309 was issued  
15 by the Board to Christopher Lien Hatlestad, M.D. The certificate is delinquent, having expired on  
16 February 28, 2010. (Evidence Package, Exhibit 4, license certification.)

### 17 III.

18 On March 19, 2013, Respondent was served with an Accusation, alleging causes  
19 for discipline against Respondent. The Accusation and accompanying documents were duly  
20 served on Respondent. A courtesy Notice of Default was thereafter served on Respondent.  
21 Respondent failed to file a Notice of Defense.

### 22 IV.

23 The allegations of the Accusation are true as follows:

24 On January 10, 2013, the Oregon Medical Board issued a Stipulated Order  
25 regarding Respondent's license to practice medicine in Oregon. The Stipulated Order resolved a  
26 pending Complaint and Notice of Proposed Disciplinary Action. The Stipulated Order includes a  
27 number of factual findings relating to Respondent, who is board certified in family medicine and  
28

1 practices medicine at the Center for Environmental Medicine in Portland, Oregon. The findings  
2 include: Respondent diagnosed and treated one patient for heavy metal toxicity. The diagnosis  
3 was not supported by evidence based medical science, Respondent's treatment plan was not  
4 medically indicated, and it exposed the patient to the risk of harm. The Oregon Medical Board  
5 reviewed several other patient charts, which revealed a pattern of practice in which Respondent  
6 failed to document a complete history or objective findings based on an appropriate neurological  
7 examination to establish symptoms related to heavy metal toxicity. He failed to rely upon  
8 appropriate diagnostic testing, and provided patients with unnecessary treatments which caused  
9 patients to incur unnecessary expense and exposed them to the risk of harm. Finally, Respondent  
10 failed to consider and rule out etiologies other than heavy metal toxicity to explain his patients'  
11 complaints. Based on these findings, Respondent's Oregon license was reprimanded, and he was  
12 placed on probation for five years. He may not use certain tests, and may not treat or authorize  
13 treatment of any patient for heavy metal toxicity. He may not treat or authorize treatment using  
14 any form of chelation therapy. After one year, Respondent may apply to the Oregon Board for  
15 approval to use evidence based treatment modalities that have been supported by appropriate peer  
16 reviewed studies. He is subject to random chart and practice compliance audits. A copy of the  
17 January 10, 2013 Stipulated Order issued by the Oregon Medical Board is attached to the  
18 Accusation, Evidence Package, Exhibit 1.)

#### 19 **DETERMINATION OF ISSUES**

20 Pursuant to the foregoing Findings of Fact, Respondent's conduct and the action of  
21 the Oregon Medical Board constitute cause for discipline within the meaning of Business and  
22 Professions Code sections 2305 and 141(a).

#### 23 **DISCIPLINARY ORDER**

24 Physician's and Surgeon's certificate No. G88309 issued to Christopher Lien  
25 Hatlestad, M.D. is hereby **REVOKED**.


26 Respondent shall not be deprived of making a request for relief from default as set  
27 forth in Government Code section 11520(c) for good cause shown. However, such showing must  
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1 be made in writing by way of a motion to vacate the default decision and directed to the Medical  
2 Board of California at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815 within seven  
3 (7) days of the service of this Decision.

4 This Decision will become effective July 19,, 2013

5 It is so ordered on June 21,, 2013.

6  
7 MEDICAL BOARD OF CALIFORNIA  
8 DEPARTMENT OF CONSUMER AFFAIRS  
9 STATE OF CALIFORNIA

10 By 

11 Kimberly Kirchmeyer  
12 Interim Executive Director  
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1 KAMALA D. HARRIS  
Attorney General of California  
2 JOSE R. GUERRERO  
Supervising Deputy Attorney General  
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Deputy Attorney General  
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San Francisco, CA 94102-7004  
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Fax: (415) 703-5480  
6 E-mail: Janezack.simon@doj.ca.gov

7 *Attorneys for Complainant*  
8 *Medical Board of California*

FILED  
STATE OF CALIFORNIA  
MEDICAL BOARD OF CALIFORNIA  
SACRAMENTO March 14, 2013  
BY: [Signature] ANALYST

9 BEFORE THE  
10 MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
11 STATE OF CALIFORNIA

12 In the Matter of the Accusation Against:

Case No. 16-2013-229512

13 **CHRISTOPHER LIEN HATLESTAD, M.D.**  
14 365 NE Greenwood Avenue, Suite 3  
Bend, Oregon 97701

ACCUSATION

15 Physician's and Surgeon's  
16 Certificate No. G88309

17 Respondent.

18  
19 The Complainant alleges:

20 1. Complainant Linda K. Whitney is the Executive Director of the Medical  
21 Board of California, Department of Consumer Affairs, and brings this Accusation solely in her  
22 official capacity.

23 2. On July 11, 2008, Physician's and Surgeon's Certificate No. G88309 was  
24 issued by the Medical Board of California to Christopher Lien Hatlestad, M.D. (Respondent).  
25 Said certificate is delinquent with an expiration date of February 28, 2010.

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1 **FIRST CAUSE FOR DISCIPLINE**

2 (Discipline, Restriction, or Limitation Imposed by Another State)

3 4. On January 10, 2013, the Oregon Medical Board issued a Stipulated Order  
4 regarding Respondent's license to practice medicine in Oregon. The Stipulated Order resolved a  
5 pending Complaint and Notice of Proposed Disciplinary Action. The Stipulated Order includes a  
6 number of factual findings relating to Respondent, who is board certified in family medicine and  
7 practices medicine at the Center for Environmental Medicine in Portland, Oregon. The findings  
8 include: Respondent diagnosed and treated one patient for heavy metal toxicity. The diagnosis  
9 was not supported by evidence based medical science, Respondent's treatment plan was not  
10 medically indicated, and it exposed the patient to the risk of harm. The Oregon Medical Board  
11 reviewed several other patient charts, which revealed a pattern of practice in which Respondent  
12 failed to document a complete history or objective findings based on an appropriate neurological  
13 examination to establish symptoms related to heavy metal toxicity. He failed to rely upon  
14 appropriate diagnostic testing, and provided patients with unnecessary treatments which caused  
15 patients to incur unnecessary expense and exposed them to the risk of harm. Finally, Respondent  
16 failed to consider and rule out etiologies other than heavy metal toxicity to explain his patients'  
17 complaints. Based on these findings, Respondent's Oregon license was reprimanded, and he was  
18 placed on probation for five years. He may not use certain tests, and may not treat or authorize  
19 treatment of any patient for heavy metal toxicity. He may not treat or authorize treatment using  
20 any form of chelation therapy. After one year, Respondent may apply to the Oregon Board for  
21 approval to use evidence based treatment modalities that have been supported by appropriate peer  
22 reviewed studies. He is subject to random chart and practice compliance audits. A copy of the  
23 January 10, 2013 Stipulated Order issued by the Oregon Medical Board is attached as Exhibit A.

24 5. Respondent's conduct and the action of the Oregon Medical Board as set  
25 forth in paragraph 4, above, constitute unprofessional conduct within the meaning of section 2305  
26 and conduct subject to discipline within the meaning of section 141(a).

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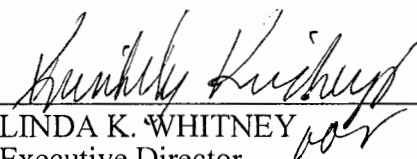
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**PRAYER**

**WHEREFORE**, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G88309 issued to respondent Christopher Lien Hatlestad, M.D.;
2. Revoking, suspending or denying approval of Respondent's authority to supervise physician assistants;
3. Ordering Respondent, if placed on probation, to pay the costs probation monitoring; and
4. Taking such other and further action as the Board deems necessary and proper.

DATED: March 19, 2013

  
LINDA K. WHITNEY  
Executive Director  
Medical Board of California  
Department of Consumer Affairs  
State of California

Complainant

# EXHIBIT A

In the Matter of )  
 )  
 CHRISTOPHER LIEN HATLESTAD, MD ) STIPULATED ORDER  
 LICENSE NO MD 24066 )  
 )

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the state of Oregon. Christopher Lien Hatlestad, MD (Licensee) is a licensed physician in the state of Oregon.

In a Complaint and Notice of Proposed Disciplinary Action issued on April 5, 2012, the Board proposed taking disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of license, a \$10,000 fine, and assessment of costs, pursuant to ORS 677.205 against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined by ORS 677.188(4)(a), (b) and (c) and ORS 677.190(13) gross or repeated negligence in the practice of medicine.

Licensee is board certified in family practice and practices medicine at the Center for Environmental Medicine in Portland, Oregon. Licensee's acts and conduct that violated the Medical Practice Act are:

Page 1 - *STIPULATED ORDER* - Christopher Lien Hatlestad, MD

1 complaining of lack of energy and severe constipation. The naturopath conducted an oral  
2 chelation dimercaptosuccinic (DMSA) challenge, assessed Patient A with "heavy metal burden"  
3 and placed him on a series of Ethylenediaminetetraacetic Acid (EDTA) IV (intravenous)  
4 chelation treatments. On November 30, 2010, Patient A presented to Licensee for evaluation of  
5 what the patient thought was possible heavy metal toxicity. Patient A complained of ringing in  
6 his ears, constipation, urinary frequency, burning in his ankles, cold feet, and fatigue. Licensee  
7 noted that Patient A's previous allopathic PCP could not find "any reasonable explanation" to  
8 explain his symptoms. Patient A also reported feeling "slightly queasy" during his last chelation  
9 treatment. Licensee relied upon the naturopath's DMSA challenge to conclude that Patient A  
10 had "fairly high levels of lead and mercury." Licensee recommended a general detoxification  
11 but also encouraged Patient A to delay doing additional medical chelation therapy. Licensee  
12 accepted Patient A's report that he had been exposed to heavy metals at the workplace (Patient A  
13 worked in drywall and plaster) without further investigation. Licensee put Patient A on Thyroid,  
14 30 mg, and placed Patient A on various supplements, ostensibly to help "cleanse" his body of  
15 toxins. Licensee's diagnosis of lead and mercury toxicity and his treatment plan was not  
16 medically indicated. The American College of Medical Toxicology disapproves of the use of  
17 post-chelator challenge urinary metal testing in clinical practice.

18         3.2     On December 20, 2010, Patient A presented to Licensee for follow-up. Licensee  
19 noted that Patient A had repeated an IV challenge and heavy metal analysis against the advice of  
20 his naturopathic physician. Patient A complained that "his bowels are shutting down." Licensee  
21 recommended titrating a dose of magnesium citrate liquid until he had regular bowel movements  
22 and to "avoid further chelation treatments." On December 24, 2010, Patient A established care  
23 with a new primary care physician (PCP), and presented with complaints of generalized malaise  
24 and diffuse myalgia and fatigue. Patient A told his PCP that he had been exposed to heavy metal  
25 poisoning when he was sanding boards to help construct a Masonic lodge. This physician noted  
26 that Patient A had recently undergone laboratory blood testing that was negative for lead or  
27 mercury, but that naturopathic lab work reported elevated levels of lead and mercury. The PCP

1 ordered another blood test, which was negative for heavy metals. The PCP offered to refer  
2 Patient A to OHSU's occupational medicine department and recommended that Patient A  
3 consider Seroquel (Quetiapine) to reduce his anxiety. The PCP charted that he did not think that  
4 Patient A's multiple somatic complaints were related to his exposure to mercury or lead. In  
5 January 2011, the PCP put Patient A on a course of Ativan (Lorazepam, Schedule IV) and Xanax  
6 (Alprazolam, Schedule IV). Patient A subsequently presented to Licensee for follow-up on  
7 January 13, 2011. Licensee noted that Patient A was under the care of a PCP, who had run  
8 several serum levels for lead and mercury that were both negative. Nevertheless, Licensee  
9 concluded that Patient A had mercury, lead and cadmium toxicity that "are likely contributing if  
10 not the primary cause of a number of his health issues." Licensee treated Patient A with 10 cc of  
11 calcium EDTA IV (intravenous) chelation therapy. Licensee also recommended that Patient A  
12 use rectal EDTA suppositories with oral DMSA and other supplements "to facilitate continued  
13 removal of the heavy metals." Patient A subsequently underwent an independent medical  
14 examination (IME) in January 2011 by a physician with board certification in medical toxicology  
15 for the purpose of evaluating his complaints in regard to his alleged exposures to lead and other  
16 substances encountered during the course of his work activities at a Masonic Lodge. Laboratory  
17 testing for blood lead and mercury were negative. This IME report concluded that there was no  
18 historical or medical data to substantiate a conclusion that Patient A had been exposed to heavy  
19 metals through the course of his work activities and that his multiple somatic complaints did not  
20 correspond with objective findings. On February 16, 2011, Patient A's PCP diagnosed him with  
21 depressive disorder and prescribed Seroquel XR 50 mg. An occupational medicine referral was  
22 made to Harborview Medical Center, which did extensive lab work and concluded that "[t]his  
23 patient does not have heavy metal toxicity. He should not pursue additional chelation therapy  
24 with his naturopath." Licensee's diagnosis of heavy metal toxicity was not supported by  
25 evidence based medical science. Licensee's treatment plan was not medically indicated, and  
26 exposed Patient A to the risk of harm, to include increased urinary excretion of essential  
27 minerals, while failing to consider other potential etiologies for Patient A's complaints.

1           3.3     The Board conducted a review of Licensee's charts for Patients B - F, which  
2 revealed the following pattern of practice: Licensee failed to document a complete occupational  
3 and environmental exposure history to assess his patients' possible sources of exposure to heavy  
4 metals; Licensee failed to document objective findings based upon an appropriate neurological  
5 examination to establish symptoms related to heavy metal toxicity; Licensee failed to rely upon  
6 appropriate diagnostic testing to establish or rule out a diagnosis of heavy metal toxicity;  
7 Licensee relied upon post-chelator challenge urinary metal testing as an indication for the  
8 administration of chelating agent to treat heavy metal toxicity (according to the American  
9 College of Medical Toxicology, this form of testing "has not been scientifically validated, has no  
10 demonstrated benefit, and may be harmful when applied in the assessment and treatment of  
11 patients in whom there is concern for metal poisoning.") Licensee also provided his patients  
12 with unnecessary treatment, to include repeated intravenous chelation therapy, and used dietary  
13 supplements to treat heavy metal toxicity and other medical conditions, in a manner that lacked  
14 adequate support in medical science to address the asserted diagnosis. These treatments caused  
15 Licensee's patients to incur unnecessary expense and exposed his patients to the risk of harm, to  
16 include increased urinary secretion of essential minerals, such as iron, copper and zinc. Finally,  
17 Licensee failed to consider and rule out other etiologies, but relied upon a diagnosis of heavy  
18 metal toxicity, to explain his patients' complaints. Examples include, but are not limited to, the  
19 following patients.

20           3.4     Patient D, a 44 year old female, presented to Licensee on March 15, 2011 with  
21 complaints of chemical sensitivities and requesting that he "assess her hormonal balance."  
22 Licensee noted a patient history of bulimia and a current report of psychotic reactions to  
23 exposures to certain vitamins and various chemicals and foods. Licensee recommended thyroid  
24 screening as well as a heavy metal challenge test. Patient D underwent a "heavy metal  
25 challenge test" with Calcium Disodium (CaEDTA) DMPS on April 11, 2011. Licensee  
26 diagnosed lead toxicity and noted that the test also revealed "relatively high levels of cadmium  
27 and aluminum." On May 27, 2011, Patient D reported a sudden onset of low backache 4 days

1 after the metal challenge test, but Licensee did not conduct further assessment for potential  
2 complication associated with the challenge test. Licensee failed to give credence to prior blood  
3 testing (all negative) for both lead and mercury and relied upon post-chelator challenge urinary  
4 metal testing, resulting in misdiagnosis of heavy metal toxicity. Licensee failed to address  
5 Patient D's history of bulimia and current reports of psychotic reactions to various substances.  
6 Licensee noted that Patient D brought in a handout that she had received about bipolar disorder,  
7 but "would not recommend a mood stabilizer at this time..." Licensee failed to assess or provide  
8 referral for Patient D's psychotic symptoms.

9       3.5     Patient F presented to Licensee on March 9, 2010, to continue chelation therapy  
10 to address various concerns, to include hypertension, fatigue, difficulty breathing, hearing loss,  
11 visual complaints and situational anxiety. Licensee relied upon past CaEDTA/DMPS challenge  
12 testing, which "found modestly elevated levels of mercury and lead and cadmium." Patient F  
13 reported shortness of breath, elevated blood pressure, and decreased exercise toleration.  
14 Licensee recommended repeating heavy metal challenge testing and the need to rule out  
15 symptomatic coronary disease. On that same day, Patient F received an IV infusion of CaEDTA.  
16 Licensee also referred Patient F for a stress echocardiogram. The results of cardiac testing were  
17 "suggestive of at least a mild amount of coronary artery disease." The consulting cardiologist  
18 recommended additional diagnostic testing. A review of Licensee's records does not reveal any  
19 additional cardiac work-up. Licensee inappropriately treated Patient F's hypertension with  
20 dietary supplements (CardioHTN) and treated Patient F's episodes of chest pain with a  
21 therapeutic trial of sublingual nitroglycerin. Licensee did not conduct a complete cardiac work-  
22 up and failed to provide appropriate treatment. Licensee also inappropriately relied upon  
23 chelation challenge testing to establish a diagnosis of heavy metal toxicity and treated Patient F  
24 with repeated intravenous chelation therapy that was not medically indicated, unnecessarily  
25 exposing this patient to the risk of an adverse reaction.

26 ///

27 ///



1 4.

2 Licensee and the Board desire to settle this matter by entry of this Stipulated Order.

3 Licensee understands that he has the right to a contested case hearing under the Administrative  
4 Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the  
5 right to a contested case hearing and any appeal therefrom by the signing of and entry of this  
6 Order in the Board's records. Licensee does not contest that he engaged in the conduct described  
7 in paragraph 3, and that this conduct violated ORS 677.190(1)(a) unprofessional or dishonorable  
8 conduct, as defined by ORS 677.188(4)(a), (b) and (c) and ORS 677.190(13) gross or repeated  
9 negligence in the practice of medicine. Licensee understands that this Order is a public record  
10 and is a disciplinary action that is reportable to the national Data Bank, and the Federation of  
11 State Medical Boards.

12 5.

13 Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order  
14 subject to the following sanctions and terms and conditions of probation:

15 5.1 Licensee is reprimanded.

16 5.2 Licensee must not use (or approve) DMPS challenge testing (to include but not  
17 limited to CaEDTA DMPS) for any patient.

18 5.3 Licensee is prohibited from treating (or authorize treating) any patient for heavy  
19 metal toxicity.

20 5.4 Licensee must not treat (or authorize treating) any patient using any form of  
21 chelation therapy, to include EDTA IV and CaEDTA chelation therapy.

22 5.5 After one year of successful compliance with the terms of this Order, Licensee  
23 may present to the Board's Medical Director for review and request approval for a proposed  
24 treatment modality to diagnose and treat heavy metal toxicity. The proposed treatment modality  
25 must be evidence based and supported by appropriate peer reviewed studies.

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27 ///

1           5.6     Licensee is placed on probation for five years. Licensee must report in person to  
2 the Board at each of its quarterly meetings at the scheduled times for a probation interview,  
3 unless otherwise directed by the Board's Compliance Officer or its Investigative Committee.

4           5.7     Licensee's medical charts and practice locations are subject to no notice  
5 compliance audits by the Board's designees.

6           5.8     Licensee stipulates and agrees that this Order becomes effective the date it is  
7 signed by the Board Chair.

8           5.9     Licensee must obey all federal and Oregon state laws and regulations pertaining  
9 to the practice of medicine.

10          5.10    Licensee stipulates and agrees that any violation of the terms of this Order shall  
11 be grounds for further disciplinary action under ORS 677.190(17).

12  
13                   IT IS SO STIPULATED THIS 19 day of December, 2012.

14  
15                                   SIGNATURES REDACTED

16                                   ~~CHRISTOPHER LIEN HATLESTAD, MD~~

17  
18                   IT IS SO ORDERED THIS 10<sup>th</sup> day of January, 2013.

19                                   OREGON MEDICAL BOARD  
20                                   State of Oregon

21                                   SIGNATURES REDACTED

22                                   W. KENT WILLIAMSON, MD  
23                                   BOARD CHAIR