BEFORE THE KANSAS DENTAL BOARD

In the Matter of Licensure of	)	
	)	KDB Case Nos: 11-104, 11-118 and 13-5
Michael C. Reno, D.D.S.	)	OAH No.: 13DB0005
Kansas License No. 6973	)	

FINAL AGENCY ORDER

On October 27, 2014, pursuant to the hearing of this matter held on March, 24 and 25, 2014 and July 11, 2014, Administrative Law Judge/Presiding Officer Michele L. Tunnell entered an Initial Order in accordance with the provisions of K.S.A. § 77-526, and duly served the same on the Petitioner, The Kansas Dental Board, and the Respondent, Michael C. Reno, D.D.S. Neither Petitioner nor Respondent filed a petition for review of the Initial Order with The Kansas Dental Board within 15 days of service of the same. The Kansas Dental Board has not provided written notice of its intention to exercise review of the Initial Order, and review is not required by law in this case. As of the date of this Final Agency Order, 30 days have passed since service of the Initial Order.

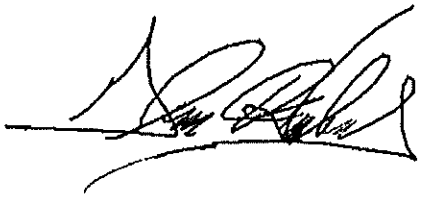
THEREFORE, pursuant to K.S.A. § 77-530, the Initial Order is and shall be a Final Order of The Kansas Dental Board, effective upon service of this Final Agency Order.

Within fifteen (15) days after service of this Final Agency Order, either party may file a petition for reconsideration of this Final Agency Order pursuant to K.S.A. § 77-529.

Within the time limits established in K.S.A. § 77-613, either party may seek judicial review of this Final Agency Order, pursuant to said statute. The agency office designated to receive service of a petition for judicial review is:

B. Lane Hemsley
Executive Director
KANSAS DENTAL BOARD
900 S.W. Jackson, Room 564-S
Topeka, Kansas 66612

IT IS SO ORDERED.



1/16/15

Glenn Hemberger, President
The Kansas Dental Board

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the above and foregoing Final Agency Order was served upon the following by depositing the same in the United States Mail, postage prepaid, on the ~~10th~~ 23rd day of ~~December, 2014~~ January 2015, addressed to:

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The Kansas Dental Board

BEFORE THE KANSAS DENTAL BOARD

In the Matter of Licensure of Michael C. Reno, D.D.S. Kansas License No. 6973	Case Nos.: 11-104, 11-118 and 13-5 OAH No.: 13DB0005

INITIAL ORDER

The above-captioned matter comes on for decision by Michele L. Tunnell, Administrative Law Judge, Office of Administrative Hearings, designated by the Kansas Dental Board (Board) as the presiding officer in the formal hearing on the Second Amended Petition for Disciplinary Action issued by the Board against Michael C. Reno, D.D.S.

The hearing in this matter was held on March 24 and 25, 2014 and July 11, 2014. Timothy D. Resner appeared as counsel for the Board. Dr. Reno appeared in person and with counsel, James P. Nordstrom.

Dr. Reno testified on his own behalf. Also testifying on behalf of Dr. Reno were Dr. Benjamin Lee and Dr. David Thein.

Testifying on behalf of the Board were Dr. Raymond Lansdowne, Dr. Joshua W. Davis, Dr. Steven L. Johnson, Dr. Scott Hamilton, Dr. Justin Trimmel, and Lane Hemsley. Lan Tran was called by the Board as a rebuttal witness.

At the conclusion of the hearing, the parties were given an opportunity to submit their proposed findings of fact and conclusions of law, which were timely submitted.

This matter is now ready for decision.

FINDINGS OF FACT

1. Dr. Reno is licensed to practice dentistry in the State of Kansas under the authority of Kansas, license no. 6973 issued by the Board.

Patient R.P. - Case Number 11-104

2. R.P. was first seen by Dr. Reno on May 27, 2009.

3. [redacted]

4. [redacted]

5. On June 30, 2009, [redacted]

6. During the June 30, 2009 appointment, [redacted]

7. On July 1, 2009, [redacted]

8. On July 2, 2009, [redacted]

9. [redacted] on July 2, 2009.

10. [redacted]

11. On or about January 12, 2010, [redacted]

12. On February 26, 2010, [redacted]

13. On May 24, 2010, [redacted]

14. On May 26, 2010, [redacted]

15. [redacted]

[redacted]

16. On June 14, 2010, [redacted]

17. Dr. Reno's clinical notes for June 14, 2010 state, in pertinent part:

[redacted]

18. [redacted]

19. On August 5, 2010, R.P. returned to Dr. Davis.

20. [redacted] August 5, 2010 and July 29, 2011 [redacted]

21. Dr. Davis' clinical notes from the R.P.'s visit on July 26, 2011 state, in pertinent part:

[redacted]

22. [redacted]

23. On July 29, 2011, R.P. filed a complaint against Dr. Reno with the Board. In the complaint, [redacted]

[redacted] However, a majority of the complaint related to interactions between R.P., his wife, and Dee, Dr. Reno's office manager.

24. On August 30, 2011, upon its request, Dr. Davis mailed a copy of R.J.'s chart, x-rays, and photos to the Board.

25. On September 2, 2011, [redacted]

Patient L.T. - Case Number 11-118

26. L.T. was first seen by Dr. Reno on October 15, 2008 [redacted]

27. [redacted]

28. [redacted]

29. On October 29, 2008, [redacted]

30. On October 29, 2008, [redacted]

31. [redacted]

32. [redacted]

[redacted]

33. [redacted]

34. [redacted]

35. [redacted]

36. [redacted] on November 10, 2008.

37. [redacted]

38. [redacted] As a result, on December 1, 2008, [redacted] on December 2, 2008.

39. [redacted] on August 18, 2010. Dr. Reno's clinical note from August 18, 2010 is as follows:

[redacted]

[redacted]

40. [redacted] on August 18, 2010, [redacted]

41. On September 20, 2010, [redacted]

42. On October 4, 2010, [redacted]

43. On November 16, 2010, [redacted]

44. On January 17, 2011, [redacted]

45. On June 6, 2011, [redacted]

46. L.T. discontinued her treatment with Dr. Reno in early August 2011 [redacted]

47. [redacted]

48. On August 3, 2011, [redacted]

49. [redacted] on September 12, 2011 [redacted]

[redacted]

50. On August 19, 2011, L.T. filed a complaint against Dr. Reno with the Board.

Patient B.H. - Case Number 13-5

51. Dr. Reno first saw B.H. on January 6, 1998.

52. [redacted] on August 19, 2002.

53. [redacted]

54. On June 15, 2005, [redacted]

55. On August 15, 2005, [redacted]

56. On May 20, 2008, [redacted]

57. [redacted] on May 20, 2008 [redacted]

58. [redacted] on May 29, 2008 appeared on B.H.'s ledger sheet.

59. On October 8, 2008, [redacted]

60. [redacted] to Dr. [redacted]

61. [redacted] on October 15, 2008. [redacted]

62. [redacted] on October 8, 2008, [redacted]

63. On March 19, 2009, [redacted]

64. On April 20, 2009, [redacted]

65. On May 4, 2009, [redacted]

66. On December 3, 2009, [redacted]

67. On January 26, 2010, [redacted]

68. On February 4, 2010, [redacted]

69. On November 18, 2011, [redacted]

70. On January 16, 2012, [redacted]

71. [redacted] on January 16, 2012, [redacted]

[redacted]

72. [redacted] on February 8, 2012 [redacted]

73. At the end of September or early October 2012, [redacted]

74. On October 16, 2012, B.H. made an appointment with Dr. Reno [redacted]

75. On October 29, 2012, B.H. presented to Dr. Raymond Lansdowne [redacted]

76. [redacted]

77. [redacted]

78. On December 8, 2012, B.H. filed a complaint against Dr. Reno with the Board.

79. On July 30, 2013, [redacted]

80. During the July 30, 2013 appointment, Dr. Lansdowne [redacted]

81. In his clinical notes from July 30, 2013, Dr. Lansdowne stated, [redacted]

82. Dr. Lansdowne [redacted] July 29, 2013 [redacted] on October 29, 2012. [redacted]

83. Dr. Lansdowne [redacted]

APPLICABLE LAW

1. K.S.A. 65-1436 provides, in pertinent part:

(a) The Kansas dental board . . . may take any of the actions with respect to any dental . . . as set forth in subsection (b), whenever it is established, after notice and opportunity for hearing in accordance with the provisions of the Kansas administrative procedure act, that any applicant for a dental or dental hygiene license or any licensed dentist or dental hygienist practicing in the state of Kansas has:

. . . .

(3) been determined by the board to be professionally incompetent;

. . . .

(17) failed to keep adequate records;

(b) Whenever it is established, after notice and opportunity for hearing in accordance with the provisions of the Kansas administrative procedure act, that a licensee is in any of the circumstances or has committed any of the acts described in subsection (a), the Kansas dental board may take one or any combination of the following actions with respect to the

license of the licensee:

(1) revoke the license;

(2) suspend the license for such period of time as may be determined by the board;

(3) restrict the right of the licensee to practice by imposing limitations upon dental . . . procedures which may be performed, categories of dental disease which may be treated or types of patients which may be treated by the dentist or dental hygienist. Such restrictions shall continue for such period of time as may be determined by the board, and the board may require the licensee to provide additional evidence at hearing before lifting such restrictions; or

(4) grant a period of probation during which the imposition of one or more of the actions described in subsections (b)(1) through (b)(3) will be stayed subject to such conditions as may be imposed by the board including a requirement that the dentist . . . refrain from any course of conduct which may result in further violation of the dental practice act or the dentist . . . complete additional or remedial instruction. The violation of any provision of the dental practice act or failure to meet any condition imposed by the board as set forth in the order of the board will result in immediate termination of the period of probation and imposition of such other action as has been taken by the board.

(c) As used in this section, "professionally incompetent" means:

. . . .

(2) repeated instances involving failure to adhere to the applicable standard of dental . . . care to a degree which constitutes ordinary negligence, as determined by the board; or

(d) In addition to or in lieu of one or more of the actions described in subsections (b)(1) through (b)(4) or in subsection (c) of K.S.A. 65-1444, and amendments thereto, the board may assess a fine not in

excess of $10,000 against a licensee. . . .

2. K.A.R. 71-1-15, which governs dental recordkeeping requirements, provides as follows:

> For the purposes of K.S.A. 65-1436 and amendments thereto, each licensee shall maintain for each patient an adequate dental record for 10 years after the date any professional service was provided. Each record **shall** disclose the justification for the course of treatment and **shall** meet all of the following minimum requirements:
>
> (a) It is legible.
>
> (b) It contains only those terms and abbreviations that are comprehensible to similar licensees.
>
> (c) It contains adequate identification of the patient.
>
> (d) It indicates the date any professional service was provided.
>
> (e) It contains pertinent and significant information concerning the patient's condition.
>
> (f) It reflects what examinations, vital signs, and tests were obtained, performed, or ordered and the findings and results of each.
>
> (g) It indicates the initial diagnosis and the patient's initial reason for seeking the licensee's services.
>
> (h) It indicates the medications prescribed, dispensed, or administered and the quantity and strength of each.
>
> (i) It reflects the treatment performed or recommended.
>
> (j) It documents the patient's progress during the course of treatment provided by the licensee.
>
> (Emphasis added.)

3. Standard of Care.

In the medical context, the duty of a doctor to a patient is known as "the applicable standard of care," and the concept of breach is expressed as "deviation from the applicable standard of care" or "failure to adhere to the applicable standard of care." *Fieser v. Kansas State Bd. of Healing Arts*, 281 Kan. 268, 273-75, (2006) (citing *Dawson v. Prager*, 276 Kan. 373, 375 (2003).

The standard of care does not require a dentist to precisely diagnose and treat a patient's ailments. Rather, all that is required is the dentist adhere to the ordinary skill and diligence of a reasonable dentist within the comparable medical community. *See Chandler v. Neosho Mem. Hosp.*, 223 Kan. 1, 574 P.2d 136, 138 (Kan.1977); *Collins v. Meeker*, 198 Kan. 390, 424 P.2d 488, 493 (Kan.1967).

In this case, with regard to "professional incompetence" under K.S.A. § 65-1436(a)(3) as further defined as "repeated instances involving failure to adhere to the applicable standard of dental or dental hygienist care to a degree which constitutes ordinary negligence, as determined by the board;" under K.S.A. § 65-1436(c)(2), the Board need only prove: (1) the existence of a duty, and (2) respondent's failure to adhere to said duty. *Fieser v. Kansas State Bd. of Healing Arts*, 281 Kan. at 273-75.

4. The Board's Burden of Proof.

The presiding ALJ has considered the parties' arguments as to the applicable burden of proof and finds the Board's burden of proof to be a preponderance of the evidence. There is no statutory authority or case law on point to show otherwise.

CONCLUSIONS OF LAW AND DISCUSSION

Count I

Patient R.P. - Case Number 11-104

1. Count I of the Board's Second Amended Petition for Disciplinary Action alleges that Dr. Reno failed to [redacted]

[redacted]

2. The Board states, in a footnote in its proposed findings of fact and conclusions of law, that "[t]he Board's position is not that [redacted] falls below the applicable standard of care. Rather, the Board's position is based on the information Respondent [Dr. Reno] had at his disposal at the point patient R.P. [redacted]

3. The evidence presented by the parties during the hearing specifically addressed the above referenced allegation in Count I, that being whether Dr. Reno failed [redacted]

4. Both parties proposed findings of fact and conclusions of law address whether Dr. Reno failed to [redacted]

5. By taking the position that [redacted] does not fall below the applicable standard of care, the Board has, in essence, conceded that even if the evidence establishes that Dr. Reno had failed to [redacted], his treatment would not be considered to fall below the applicable standard.

6. It appears that the Board is attempting to reframe the issue in Count I to be that Dr. Reno's treatment of R.P. fell below the standard of care simply by his [redacted] While there may have been some testimony that arguably may have addressed this issue, this issue certainly was not what was originally alleged in the Second Amended Petition for Disciplinary Action. As such, Dr. Reno did not have the opportunity to present evidence specifically addressing this issue.

7. Therefore, the undersigned ALJ declines to rule on this reframed issue as it is outside the scope of the issues raised in the Second Amended Petition for Disciplinary Action.

8. If the undersigned ALJ were to rule on the issue, as set forth in Count I, the ruling would be that the Board has failed to establish that Dr. Reno's treatment of R.P. [redacted] fell below the standard of care.

9. The June 14, 2010 [redacted]

10. Dr. Reno claims after he observed the [redacted]

11. Dr. Johnson testified that adjusting [redacted]

12. Without a [redacted] there is no conclusive evidence that the [redacted] after Dr. Reno made the adjustments.

13. While Dr. Davis testified he recalled observing an issue with the [redacted] during a clinical evaluation and review of radiographs taken prior to [redacted] he never noted such in his clinical notes. Certainly, it would be expected that if the [redacted] were significant enough to warrant discipline, Dr. Davis would make a note of such in his clinical notes.

14. Dr. Johnson testified that the radiographic appearance of an [redacted] in and of itself is not always a complete confirmation of a problem and one must rely upon a clinical examination.

15. Dr. Thein offered similar testimony which, with regard to R.P., was very persuasive. He testified that a physical examination of the tooth with an explorer or some type of examination tool must be done to verify that the [redacted] with the tooth structure. He

testified that it is hard, if not impossible, to really determine [redacted] just by looking at an x-ray.

Patient L.T - Case Number 11-118

16. Count I of the Board's Second Amended Petition for Disciplinary Action alleges that Dr. Reno failed to obtain [redacted] present. In the Board's proposed conclusions of law, it did not address this allegation. Therefore, it will be considered abandoned.

17. Count I of the Board's Second Amended Petition for Disciplinary Action also alleges that Dr. Reno failed to identify and/or utilize [redacted]

18. The Board alleges that Dr. Reno endeavored to treat and correct L.T.'s [redacted] however, failed to meet the standard of care by failing to identify and implement [redacted]

19. L.T. testified that she did not remember the term [redacted] being discussed but that she understood her teeth would look like what was represented in the [redacted] that Dr. Reno showed her, that being [redacted]

20. Dr. Reno testified that his aim was to [redacted] but that he did not represent to L.T. that he could [redacted]

21. The documentary evidence, consisting of Dr. Reno's clinical notes, prescription form [redacted] all demonstrate that [redacted] was always a treatment goal. In his testimony, Dr. Reno admitted that the [redacted] This is what L.T. testified she understood would happen.

22. Dr. Reno's clinical note dated August 18, 2010 states he [redacted]

23. There were no notations in Dr. Reno's clinical notes that he had advised L.T. that the [redacted] might not be realistic or that he [redacted] There was also no evidence reflecting that Dr. Reno had submitted a subsequent [redacted] showing a departure from the course of treatment and goals to be accomplished as stated in his clinical notes [redacted]

24. Dr. Reno's testimony regarding his intentions in treating L.T. were contradictory in that at one point he testified with respect to the [redacted] Then Dr. Reno later testified that he had no intention of fixing her [redacted]

25. The evidence clearly establishes that Dr. Reno identified the treatment of patient L.T.'s [redacted] as a treatment goal and endeavored to treat L.T.'s [redacted] however, did not inform L.T. of any limiting factors or mitigated treatment outcomes.

26. Dr. Reno did not testify or implement [redacted] or the treatment notes. In addition, the [redacted] nor did Dr. Reno actually provide L.T. with [redacted] up to the point her treatment by Dr. Reno was discontinued.

27. Dr. Hamilton and Dr. Trimmel, both orthodontic experts, testified that the standard of care warranted that such [redacted] should have been introduced early in treatment, [redacted] Dr. Reno failed to offer any testimony to controvert the opinions of Dr. Hamilton and Dr. Trimmell.

28. A general practitioner holding oneself out and practicing in a specialty area has the duty to use the skill and care of a reasonable specialist. *Simpson v. Davis*, 219 Kan. 584, 587 (1976)(citations omitted).

29. In offering orthodontist treatment, such as Invisalign, Dr. Reno had a duty to use the skill and care of a reasonable orthodontist. Dr. Reno deviated from the

applicable standard of care of a reasonable orthodontist with respect L.T. by failing to [redacted]

Patient B.H. - Case Number 13-5

30. Count I of the Board's Second Amended Petition for Disciplinary Action alleges that Dr. Reno failed to provide B.H. with [redacted]

31. In defense of the above allegation by the Board, Dr. Reno offered a myriad of evidence including the [redacted] and the actions by subsequent treaters, including Dr. Lansdowne.

32. This evidence, however, is irrelevant to the issue before the undersigned ALJ, that being whether Dr. Reno failed to meet the standard of care in his [redacted]

33. Dr. Lansdowne testified that when he saw B.H. clinically on October 29, 2012, he immediately noted the issues with the [redacted] Dr. Lansdowne's testified that given his extensive clinical experience, it was obvious that the [redacted] as required by the applicable standard of care.

34. Dr. Lansdowne testified that he utilized the perio-probes to demonstrate the lack of [redacted] to the patient. Dr. Lansdowne did not utilize the perio-probes for the purposes of [redacted] however, Dr. Lansdowne testified that the [redacted] was apparent from looking at the [redacted] clinically.

35. Dr. Lansdowne used paper points to demonstrate the lack of [redacted] to B.H. Dr. Lansdowne stated that in comparing the paper points on [redacted] on July 29, 2013 and the perio-probes on [redacted] on October 29, 2012, the pictures of the [redacted]

36. Dr. Reno has speculated about what occurred when B.H. had his [redacted] by an unknown dentist approximately four weeks prior to seeing Dr. Lansdowne for [redacted] on October 29, 2012.

37. Dr. Lansdowne, however, testified that he did not observe any discernible alterations in the [redacted] when he viewed the [redacted] clinically during the October 29, 2012 appointment, such as any discernible [redacted] had been altered in any form. He testified that that [redacted]

38. Dr. Johnson noted the important correlation between [redacted] Dr. Johnson testified that the [redacted] fell below the standard of care. Dr. Johnson based this opinion on his extensive clinical experience and his review of Dr. Lansdowne's x-rays, demonstrative pictures, as well as Dr. Lansdowne's testimony in this case.

39. The testimony of Dr. Reno's expert, Dr. Lee, was not persuasive. Dr. Lee assumed that [redacted] Given these assumptions, Dr. Lee opined that Dr. Reno's treatment did not fall below the standard of care, because Dr. Reno simply did the best he could do with what he had. His opinion, however, was not based on the x-rays taken by Dr. Lansdowne. Dr. Lee did not have at his disposal the resources of Dr. Lansdowne's clinical evaluation, or the resources of Dr. Johnson who viewed all of the relevant records before providing his opinion.

40. In addition, the documentary evidence offered by Dr. Reno, i.e., articles and [redacted] product information was not persuasive in establishing that Dr. Reno's [redacted] did not fall below the applicable standard of care.

41. Dr. Reno failed to provide patient B.H. with [redacted] falls below the applicable standard of care.

Count II

42. Count II of the Board's Second Amended Petition for Disciplinary Action alleges that Dr. Reno failed to keep and/or obtain adequate diagnostic records including the [redacted] for L.T. and failed to keep and/or obtain adequate records showing the date and type of treatment in connection with services rendered to B.H., in violation of K.S.A. 65-1436 (a)(17) and K.A.R. 71-1-15.

Patient L.T - Case Number 11-118

43. In the Board's proposed conclusions of law, it does not address Dr. Reno's failure to keep and/or obtain adequate diagnostic records including the [redacted] for L.T. This portion of Count II will be considered abandoned.

Patient B.H. - Case Number 13-5

44. As set forth above, K.A.R. 71-1-15 provides that the licensee shall maintain an adequate dental record for each patient and set forth a listing of the minimum requirements, including the date of any professional service was provided, the treatment performed or recommended, and the patient's progress during the course of treatment.

45. There was no entry by Dr. Reno in B.H's clinical notes regarding Dr. Reno [redacted] on May 20, 2008, [redacted] or the procedure he followed in [redacted]

46. There was no entry by Dr. Reno in B.H's clinical notes regarding Dr. Reno [redacted] on October 8, 2008, [redacted] including the date the [redacted] or the procedure he followed in [redacted]

47. There was no entry by Dr. Reno in B.H's clinical notes regarding Dr. Reno [redacted] on January 16, 2012, [redacted] or the procedure he followed n [redacted]

48. Dr. Reno claims that there are two instances of treatment of B.H. that he acknowledges he failed to include in his treatment notes (clinical notes) but no other instances over the course of fourteen years of treatment. The first being between January 2005 and July 26, 2005, when he noted [redacted] but failed to note in B.H's clinical notes when he [redacted] Dr. Reno argues the work was noted in his transactional history. The second being between October 15, 2008 and March 16, 2009, when a [redacted] was not noted in the clinical notes. As to this instance, Dr. Reno argues that during this time, other treatment pertaining to attempts to [redacted] were noted and a March 16, 2009, x-ray shows the

49. Dr. Reno argues that dentists at times accidentally forget to record something in a patient's chart inadvertently and that the instances he acknowledges were isolated instances not worthy of disciplinary actions.

50. The evidence clearly establishes that Dr. Reno repeatedly failed to record dates and treatments performed on B.H., therefore, failing to meet the requirement of K.A.R. 71-1-15; therefore, disciplinary action is warranted under K.S.A. 65-1436(a)(17).

CONCLUSION

1. The Board has not established by a preponderance of the evidence that Dr. Reno's treatment of R.P. fell below the standard of care.

2. The Board has established by a preponderance of the evidence that Dr. Reno was professionally incompetent as to his treatment of L.T. and B.H. His treatment fell below the applicable standard of care thus constituting ordinary negligence.

3. The Board has also established by a preponderance of the evidence that Dr. Reno failed to keep adequate records regarding B.H.

4. The imposition of disciplinary actions against Dr. Reno in accordance with K.S.A. 65-1436(b) is warranted. Based on the above findings, the undersigned ALJ finds the following discipline appropriate to be imposed against Dr. Reno:

Dr. Reno shall enroll in 12 hours of CE in courses to be approved by the Board to be completed within 6 months of the entry of this order as a final order, said hours to be in addition to his annual CE requirement.

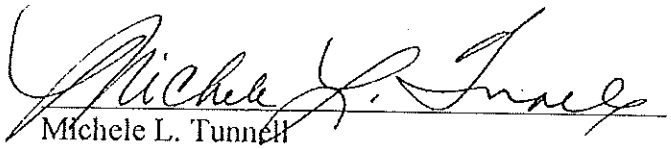
5. Based on the above findings, an assessment of a civil fine against Dr. Reno under the provisions of K.S.A. 65-1436(d) in the amount of $3,333.00 is also warranted.

IT IS SO ORDERED.

NOTICE REGARDING REVIEW

Pursuant to K.S.A. 77-527, either party may appeal this Initial Order. A petition for review must be filed within 15 days from the date of this Initial Order. Failure to timely request review may preclude further judicial review. If neither party requests a review, this Initial Order becomes final and binding on the 30th day following its mailing. Petitions for review shall be mailed or personally delivered to: B. Lane Hemsley, Executive Director, Kansas Dental Board, 900 SW Jackson, Room 564-S, Topeka, Kansas 66612-1230.

OFFICE OF ADMINISTRATIVE HEARINGS



Michele L. Tunnell
Administrative Law Judge
Office of Administrative Hearings

CERTIFICATE OF SERVICE

On October 27, 2014, I mailed a copy of this document to:

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