

**SETTLEMENT AGREEMENT BETWEEN MISSOURI DENTAL BOARD
AND KENNETH D. SULLIVAN, D.M.D.**

Come now Kenneth D. Sullivan, D.M.D., ("Licensee") and the Missouri Dental Board ("Board") and enter into this settlement agreement for the purpose of resolving the question of whether Licensee's license as a dentist will be subject to discipline.

Pursuant to the terms of § 536.060, RSMo 2000, the parties hereto waive the right to a hearing by the Administrative Hearing Commission of the State of Missouri ("AHC") regarding cause to discipline the Licensee's license, and, additionally, the right to a disciplinary hearing before the Board under § 621.110, RSMo 2000.

Licensee acknowledges that he understands the various rights and privileges afforded him by law, including the right to a hearing of the charges against him; the right to appear and be represented by legal counsel; the right to have all charges against him proven upon the record by competent and substantial evidence; the right to cross-examine any witnesses appearing at the hearing against him; the right to present evidence on his own behalf at the hearing; the right to a decision upon the record by a fair and impartial administrative hearing commissioner concerning the charges pending against him and, subsequently, the right to a disciplinary hearing before the Board at which time he may present evidence in mitigation of discipline; and the right to recover attorney's fees incurred in defending this action against his license. Being aware of these rights provided him by operation of law, Licensee knowingly and voluntarily waives each and every one of these rights and freely enters into this settlement agreement and agrees to abide by the terms of this document, as they pertain to him.

Licensee acknowledges that he has received a copy of the investigative report and other documents relied upon by the Board in determining there was cause to discipline his license, along with citations to law and/or regulations the Board believes was violated.

For the purpose of settling this dispute, Licensee stipulates that the factual allegations contained in this settlement agreement are true and stipulates with the Board that Licensee's license, numbered 2006013084 is subject to disciplinary action by the Board in accordance with the provisions of Chapter 621, Cum. Supp. 2009 and Chapter 332, RSMo.



Joint Stipulation of Fact and Conclusions of Law

1. The Missouri Dental Board ("Board") is an agency of the State of Missouri created and established pursuant to § 332.021, RSMo 2000, for the purpose of executing and enforcing the provisions of Chapter 332.
2. Licensee Kenneth D. Sullivan, D.M.D. is licensed by the Board as a dentist, License No. 2006013084. Licensee's Missouri license is current and active.
3. On October 30, 2008, the Board received a complaint against Licensee from Sharon Keppner, a former patient. Ms. Keppner alleged that she was treated by Licensee and his colleague Dr. Sylvester Parker. Ms. Keppner alleged that Licensee allowed a dental assistant, Marilyn, to make an upper denture for her. She stated the denture was made improperly and caused her to have "buck teeth" because it was too big. She stated she also had a tooth she wanted extracted. She stated that Licensee was joking around with Dr. Parker and acting unprofessionally about the tooth. She stated Licensee told her that he could remove the crown but would leave the remainder of the tooth for another time. She stated that she went to another dentist to examine the tooth who told her the tooth could be saved.
4. The Board conducted an investigation based on Licensee's complaint.
 - a. As part of the investigation, Board Investigator Mark Dudenhoeffer visited Licensee's practice on May 12, 2009. Investigator Dudenhoeffer met with Dr. Sylvester Parker. Dr. Parker stated he is an associate in the practice owned by Licensee. He stated it is mostly a denture practice and they do "same day dentures." He stated they have a dental laboratory that manufactures full and partial dentures on site. He stated that all four of the dental assistants are expanded function assistants in the area of prosthodontics. He stated there are four laboratory employees who rarely interact with patients. He stated rarely, Licensee has the technician explain more difficult things to a patient. However, he stated the dentist always completes an official laboratory work order for every denture made.
 - b. Investigator Dudenhoeffer also met with Marilyn Wilderness, the assistant Ms. Keppner referenced. Ms. Wilderness is an expanded function dental assistant in prosthodontics. She



adjusts dentures and takes impressions as part of her job duties. She stated she had been with the practice since 1998 and got her expanded function certificate in 2002.

5. On October 29, 2008, the Board received a complaint regarding Licensee from Lillian Hawkins. Ms. Hawkins alleged that Licensee did not make her dentures properly and that she wanted her money which she paid up front. Ms. Hawkins stated she was not satisfied with the service or how she was treated by Licensee and his colleagues. She stated that Licensee told her he could do the work but "it would look funn[y]" because of other problems she had with other teeth. She alleged they did not let her see how the dentures were going to look before they sent them to be made but she did have to pay up front before they would make the dentures. She alleged that she cannot wear the partial because it is uncomfortable. She alleged she tried to tell the dentist she was unhappy with it but "he was not listening to me or how I felt about anything." She stated the wire from the dentures was sticking her in her gum, causing her gums to bleed and get sore. She alleged that the dentist had to try at least ten times to adjust the partial. She stated she called the office and asked for a refund and that she wanted to speak with the dentist. She stated no one called her back and she called three more times. Finally she stated she spoke with Betty Hogan and she was rude to her and would not return her phone calls.

6. The Board provided Licensee a copy of the complaint for his response. The Board received Licensee's response on December 29, 2008. Licensee stated that Ms. Hawkins came to the office for both upper and lower removable partial dentures. He stated that after "clinical examination, various treatment options were discussed. The patient indicated that she had financial considerations and opted to have economy (acrylic) removable partial dentures with wrought wire clasp made because that was what she could afford financially." Licensee stated that alginate impressions were taken in the morning and the denture was delivered in the afternoon. He stated Ms. Hawkins received both verbal and written instructions for how to care for the denture and what to do if she had any problems. He stated the information instructed her to return to the practice if she developed sore spots or had trouble wearing it. He stated that the records do not indicate that she ever returned to the office to evaluate a problem and correct it. He stated that she did not call the patient concern representative and it was explained to her that if she needed to come into the office either to have it corrected or to receive a full refund. He stated he was still willing to do that. However, he stated that it would be impossible



to do so if she did not come to the office. He stated the office had attempted to get in contact with her to explain this.

7. In April 2009, the Board received information that Licensee's license was discipline by the State of Pennsylvania. Licensee entered into a consent agreement with the Pennsylvania Board of Dentistry on March 20, 2009 and paid a civil penalty in the amount of \$3,000. The discipline was based on the quality of care delivered to patients PA Patient 1¹ and PA Patient 2. Licensee stipulated that in giving care to PA Patient 1 and PA Patient 2 in receiving implants, he departed from or failed to conform to standards of acceptable and prevailing dental practice in violation of Pennsylvania Act 63 P.S. § 123.1(a)(8).

8. As a result of the complaints and Pennsylvania discipline, the Board conducted an investigation and invited Licensee to attend its October 22, 2009 Board meeting to discuss the complaint. Licensee appeared at the Board meeting and was represented by counsel. During his appearance, Licensee stated:

- a. He believes that in both complaints described above, the complainant was "less than truthful" and "exaggerated" the claims. He stated that he believed the complainants were treated with respect and dignity and that he strived for satisfaction but knows it cannot be achieved 100% of the time. He stated he would do whatever he could to make the patients happy.
- b. He stated he has been in practice for twenty years in Louisiana, Pennsylvania, New York and Missouri.
- c. With regard to the discipline in Pennsylvania, Licensee stated that the two complaints that were the basis of the discipline were the only two ever filed against him. He stated the complaint was actually filed by another dentist and an oral surgeon who disagreed with Licensee's use of the Imtec mini dental implant. He stated the complaining dentist called the office and complained, accusing Licensee of misleading the public because Licensee told patients it was a long term implant. Licensee stated that they can be long term implants according to the FDA. He stated the complaining dentist did not agree and made a complaint to the Pennsylvania Board. Specifically, the dentist complained that Licensee failed to take a post-operative x-ray and failed to document diagnostic casts in the patients' charts. Licensee stated he made the implants

¹ For the purposes of this Settlement Agreement, all patients will be referred to by the state in which Licensee treated them and a number. The Board will maintain a record identifying the patient name with the corresponding number.



without any stents as the complaining dentist alleged. He also stated he provided the x-ray but moved to Missouri in the middle of the case in Pennsylvania. He stated he made the deal because they wanted to have a hearing after he was in Missouri.

- d. Licensee stated he is the sole owner of the practice in Cape Girardeau, Missouri. He stated that the office policies and procedures are those that he has made.
- e. Licensee stated he saw Ms. Keppner when she came into the office because she was considering a new upper denture and also to wanted to know if she was a candidate for mini dental implants to support the denture. Licensee stated they took a panorex x-ray and examined her. Licensee stated he was consulted because he was the only one doing the implants at that time. He stated he examined her and thought she would be a good candidate. He also stated Drs. Adams and Parker examined a tooth that was symptomatic. He stated they all looked at the tooth and identified several problems with it. He stated they could save it by performing several procedures but were not certain it could be retreated. He stated he informed Keppner the treatment to save the tooth would be extensive. He stated he was not certain which of the dentists told Ms. Keppner all of the information. But he stated that it is common in the practice for the dentists to consult with one another on a patient.
- f. Licensee stated he sees 15 to 20 patients a day and would remember a conversation from a visit for any patient. He stated he remembered Keppner's case but was not sure the details of his examination and discussion with the patient was in the file. He stated he did not document what he told her in the chart. He stated that though all three dentists were involved in some way, Dr. Parker signed the note in the chart. He stated that Dr. Adams wrote the prescriptions for Ms. Keppner. However, the only signature in the chart was Dr. Parker's.
- g. He stated he often dictates to the dental assistants what to write in the chart and "normally" goes back and signs the chart but did not sign Ms. Keppner's.
- h. He stated that as for a new patient exam, the procedure is to do a screening, "like a cancer screening, look around, do an overall evaluation of their oral cavity and then make sure we don't see anything suspicious that we need to be aware of or make them aware of or that we don't need to refer them to an oral surgeon." He also stated that "if we're going to be doing any kind



of surgery, we like to take a panorex x-ray and then we evaluate them." He stated they do not do a periodontal exam including probing or charting. He stated that when they make partials around existing teeth, they do so without probing but they check for mobility and do an x-ray evaluation. He stated they do not do cleanings, perio treatments, or "endo things" in the office. He stated it is primarily a denture clinic with some extractions and "very little restorative work." He stated his prices are "very competitive" for dentures.

- i. He stated one of "our shortcomings in both these cases [see paragraphs 3 and 4 above] was not really documenting."
- j. He stated that Dr. Parker took the bite registration even though there is no record in the file.
- k. As to the process for denture fabrication, he stated that he has the patient come in at 8:00 a.m. and evaluates them. He states if they want a new denture, he takes impressions, gets a bite registration and send the dentures to the laboratory. He states he gets the dentures set in wax, tried them in, gets approval from the patients and makes sure the bite is right. If not, he states, they send it back to the lab. He stated that sometimes it cannot be done in one day. Once the dentist and patient are satisfied, the denture gets processed by the lab, then the dentist fits the denture. He stated that, "without fail in our office, we tell every single patient, 'If you have problems with these dentures, please come back to our office. There is no charge.'" He stated they will remake a denture at no charge if the patient is dissatisfied even though there is a fee listed in Licensee's brochure.
- l. He stated he does not recall what sort of impression was made for Ms. Keppner.
- m. He stated that for a bite registration, they take a wax bite against the gum tissue and articulate it against the cast. He stated that technique is a lot different than it was in dental school but that it can provide the same quality as the method taught in dental school. He stated he could make an impression as well with an alginate stock tray as with a secondary impression, though "oftentimes we do take a secondary impression."
- n. As to Ms. Hawkins, Licensee stated that Dr. Parker signed the charts and "he did not remember a whole lot about [her]." He stated it may have been me or Dr. Parker who saw her for a partial denture. He stated there were a lot of problems with the existing teeth and she might not like



the partial because of the way her teeth were. He stated she called and complained to the office and Licensee's staff tried on a daily basis to contact her but she would not return calls or come back to the office. He stated the records on Ms. Hawkins were less than ideal.

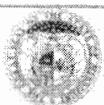
- o. He stated he has done a lot since the time of these complaints regarding record keeping. He stated they always discuss written consent of the patient although it is poorly documented. He stated they explain all the procedures to the patient.

9. Following Licensee's appearance, the Board requested twenty patient records from Licensee to review.

- a. On December 22, 2009, Board Investigator Mark Dudenhoeffer travelled to Licensee's practice in Cape Girardeau, Missouri.
- b. On December 22, 2009, Dr. Sullivan had closed the practice for the holidays but happened to be present when Investigator Dudenhoeffer arrived. Investigator Dudenhoeffer met with Dr. Sullivan, Licensee's employer and the owner of the practice and requested the twenty records from the date Licensee received notification of the complaint.
- c. Dr. Sullivan stated that he wanted to comply with the Board's request but was unable to identify the patient records. Dr. Sullivan contacted his office manager who came into the office to assist in identifying and preparing the records. The office manager explained it would take her time to identify and copy the records. Dr. Sullivan agreed to place the records in the mail by January 4, 2010.

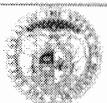
10. On January 7, 2010, the Board received records for twenty of Licensee's patients. The charts were for patients who visited the practice between August and October 2009. The Board reviewed the records and identified quality of care or incompetency concerns regarding Licensee's care in 16 of the 20 patients. In reviewing the records, the Board identified the following concerns:

- a. For patient MO patient 1, the health history was recorded in January 2007. It was never updated. The 2007 history states MO patient 1 was positive for abnormal bleeding problems, took one aspirin per day and had medically controlled diabetes. No potential concerns related to that health history and surgery were discussed or recorded in the record before a 2009 surgical visit. In September, 2009, Licensee extracted 12 teeth using five carpules of anesthetic



with epinephrine. There was no diagnosis given in the records, nor any intra or extra-oral examination noted. The records indicate that MO patient 1 was on clindamycin at the time of the September 2009 visit but no record of who prescribed it or why. There was no record of why the teeth were extracted or if alternatives were offered and discussed. The treatment form did not meet criteria for informed consent. MO patient 1 had numerous office visits with serial radiographs dating back to 2007. The radiographs show that the periodontal condition, bone loss, deteriorated dramatically during that time period. There was no record of MO patient 1's periodontal examination, periodontal treatment or consultation at any time. The record for October 5, 2009 states that "patient returning for implant placement." However, there was no record of appropriate implant treatment planning, no record of where they were going to be placed, no consent or alternatives to treatment. The Board determined that the implant protocol in the records was grossly inadequate. The Board also identified gross negligence and incompetence in MO patient 1's treatment. Additionally, the Board determined that the records were not accurate or legible and were not thorough enough for another doctor to be able to understand them.

- b. For patient MO patient 2, the records showed that MO patient 2's medical history indicated that at the time of surgery, MO patient 2 was taking levothyroxin, fluoxetine and lithium. There was no diagnosis information for any of the conditions for which MO patient 2 was taking the medications and no record of a consultation regarding the mental status or possible epinephrine interactions with thyroxin. The records for October 5, 2009 indicate that Licensee ordered four implants for MO patient 2. The records do not reflect informed consent, diagnosis or treatment plan including where Licensee intended to place the implants, and no treatment alternatives. The records for October 19, 2009 reflect that implants were placed but not where they were placed. Records also state the work was done with three carpules of septocaine with epinephrine. There was no record of an intra or extra-oral examination except one intra-oral exam form with the box for within normal limits checked and no other information. The Board determined the records were "far below any acceptable standard." There were issues involving



dental-medical consultation not dealt with and treatment planning was not handled in a competent fashion. Finally, the implant procedures were grossly inadequate.

- c. For patient MO patient 3, there was no record of examination, diagnosis, treatment plan alternatives, or informed consent. There was one note of an intra oral examination with only the box within normal limits checked. Records state that on August 21, 2009, Licensee fabricated dentures on one day without secondary impressions or bite registration. The treatment technique was not clearly stated in the records. In November 2009, the records indicate MO patient 3 had to have the teeth reset and midline "fixed" due to the "bite being off." The Board determined the records were inadequate as was the denture fabrication technique. The technique, according to the Board, was "not even reasonably adequate to expect minimally acceptable results."
- d. For patient MO patient 4, the records show that Licensee remade existing dentures. There is no record of what problems existed with the existing denture, no examination noted, no treatment alternatives noted and no diagnosis. Records for August 17, 2008 do not indicate an acceptable impression technique nor is there record of how or even if the bite registration was made. Record of August 25, 2009 indicates "delivery of dentures no good, bite off." Record also indicates the teeth had to be reset. The medical history was positive for heart attack with stent placement but there was no mention of when. The medical history was also positive for ovarian cancer but no record of when and how it was treated. Finally, there was history of high blood pressure but no record of how high and no record of a blood pressure check at any appointment. The Board determined the records were grossly inadequate as was the treatment technique and no mention of any blood pressure monitoring.
- e. For patient MO patient 5, the records show no record of an examination, diagnosis, treatment alternatives, or informed consent except for one intra oral examination form with only the box within normal limits checked. Patient's medical history indicates high blood pressure but no blood pressure was ever recorded. Licensee fabricated dentures with no secondary impression or wax try-in. The laboratory slip directed the laboratory technician to select the actual teeth to



be used. The Board determined the records were inadequate and the treatment technique improper.

- f. For patient MO patient 6, the patient file included no record of an examination, no treatment plan alternatives, and no record of informed consent except for one form which noted severe "perio" disease. There was no record of how Licensee diagnosed MO patient 6 and no record of a perio exam. However, the record stated Licensee extracted thirteen teeth and fabricated an immediate denture. The Board determined these records were inadequate.
- g. For patient MO patient 7, the records show a medical history of high blood pressure, Hepatitis C and a variety of drugs with possible complications to anesthetic and possible surgical complications. Record does not ever record MO patient 7's blood pressure and never documents a medical consultation. Licensee extracted twelve teeth using seven carpules of septocaine anesthesia. The record does not indicate why the teeth were extracted, there is no diagnosis, there were no alternative treatments records and no examination recorded except for within normal limits. The radiographs do not show significant bone loss or periodontal concerns. Licensee fabricated dentures but did not do or document a secondary impression, bite registration, or wax try. The Board determined that the records were inadequate; there was no medical consultation and unacceptable denture techniques.
- h. For patient MO patient 8, the records demonstrate that Licensee extracted a tooth using septocaine and fabricated dentures. The medical history states MO patient 8 was positive for colon cancer with chemotherapy and radiation, diabetes/kidney failure and one aspirin per day. There was no record of when he was treated for cancer, diabetes/kidney failure and no consultation with any physicians. There were no secondary impressions made, no bite record and no wax try-in. The Board determined the records were inadequate, there was no medical consultation and unacceptable denture technique.
- i. For patient MO patient 9, records indicate Licensee extracted ten teeth using ten carpules of anesthetic and fabricated dentures. There are no exam records except a note of "sever perio disease" but no actual exam to show extent of the disease. Also, no alternative treatment was noted. The treatment records were not clear regarding impression technique or bite



registration. The Board determined the records were inadequate, it was unacceptable denture technique and Licensee used too much anesthetic.

- j. For patients MO patient 10, MO patient 11, MO patient 12, and MO patient 13, medical records documented upper and lower dentures for all four patients. Patients also all reported high blood pressure which was not taken and recorded in the record. Examination only states the patients want a new lower denture without a basis as to why the new denture. Records contain no secondary impression or wax try-in. The Board determined the records were inadequate, as was the exam, and that it was unacceptable denture technique on each patient.
- k. For patient MO patient 14, the medical history reveals that the patient was previously on Fosamax. However twelve teeth were extracted using seven carpules of articaine with no physician consultation or discussion regarding possible complications with the patient when extractions and Fosamax can lead to some severely debilitating outcomes. There was no exam noted except severe perio was noted on the chart. No indication of how Licensee arrived at the diagnosis without an examination. The Board determined that the records were inadequate based on the information lacking and that there was no informed consent or consultation.
- l. For patient MO patient 15, her record reported high blood pressure for which MO patient 15 was on medication to control. However, no blood pressure was taken or noted in the record. MO patient 15 had 26 teeth extracted with six carpules of septocaine. There was no exam noted in the record except the within normal box was checked. There was no diagnosis. The radiograph did not show significant bone loss; showed some caries but salvageable teeth. The Board determined that the records were inadequate, there was a sub-standard evaluation and question why the teeth were all extracted.
- m. For patient MO patient 16, the medical chart reports a previous joint replacement, high blood pressure and bleeding problems. The exam box was checked "within normal limits" however nine teeth were extracted with no prophylactic antibiotic administered or consulted for; there was no blood pressure evaluation; or bleeding consult. The Board determined the consultation was inadequate and the records were inadequate because of the missing items.



11. Licensee's actions as described in paragraphs 3 through 6 and 8 through 10 above constitute incompetency, misconduct, and gross negligence in the functions and duties of a licensed dentist in that Licensee failed to maintain proper records, failed to properly document treatment and examination, and failed to have consultation with medical professionals as needed based on patient's stated health history.

12. Licensee's actions as described in paragraphs 7 and 8 constitute discipline by another state for which discipline is authorized in this state in that the Board can seek to discipline for incompetency, misconduct, or gross negligence in the performance of, or relating to one's ability to perform, the functions or duties of any profession licensed or regulated by this chapter and treatment below the standard of care could constitute incompetency, misconduct, or gross negligence in the performance of, or relating to one's ability to perform, the functions or duties of a dentist.

13. Cause exists for the Board to take disciplinary action against Licensee's license under § 332.321.2(5) and (8), RSMo, which states in pertinent part:

2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621, RSMo, against any holder of any permit or license required by this chapter or any person who has failed to renew or has surrendered his or her permit or license for any one or any combination of the following causes:

(5) Incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any profession licensed or regulated by this chapter;

(8) Disciplinary action against the holder of a license or other right to practice any profession regulated by this chapter imposed by another state, province, territory, federal agency or country upon grounds for which discipline is authorized in this state [.]

Joint Agreed Disciplinary Order

Based upon the foregoing, the parties mutually agree and stipulate that the following shall constitute the disciplinary order entered by the Board in this matter under the authority of § 621.045.3, RSMo 2000: The terms of discipline shall include that the dental license, license number 2006013084, be placed on **PROBATION** for a period of three (3) years ("disciplinary period"). During Licensee's probation, Licensee shall be entitled to



engage in the practice of dentistry under Chapter 332, RSMo, provided he adheres to all of the terms of the Board Settlement Agreement.

I. EDUCATIONAL REQUIREMENTS

- A. Licensee shall take and pass the Board's jurisprudence examination within the first twelve (12) months of Licensee's period of probation. Licensee shall contact the Board office to request a current law packet and permission to sit for the jurisprudence examination no less than thirty (30) days prior to the date Licensee desires to take the examination. Licensee shall submit the required re-examination fee to the Board prior to taking the examination. Failure to take and pass the examination during the first twelve (12) months of the disciplinary period shall constitute a violation of the Board Settlement Agreement.
- B. Licensee shall successfully complete forty (40) hours of education in diagnosis, treatment planning and denture fabrication at Oral Health Enrichment in Cleveland, Ohio within the first one hundred eighty (180) days of Licensee's period of probation. Following completion of the forty (40) hours of education at Oral Health Enrichment, Licensee shall take and pass a written outcome assessment test on the education with a score of at least 80%. Failure to complete the education and pass the written outcome assessment test on the education within 180 days shall constitute a violation of the Board Settlement Agreement.

II. GENERAL REQUIREMENTS

- A. Licensee shall meet with the Board or its representatives at such times and places as required by the Board after notification of a required meeting.
- B. Licensee shall submit reports to the Missouri Dental Board, P.O. Box 1367, Jefferson City, Missouri 65102, stating truthfully whether he has complied with all the terms and conditions of this Settlement Agreement by no later than January 1 and July 1 during each year of the disciplinary period.
- C. Licensee shall keep the Board apprised of his current home and work addresses and telephone numbers. Licensee shall inform the Board within ten days of any change of home or work address and home or work telephone number.
- D. Licensee shall comply with all provisions of the Dental Practice Act, Chapter 332, RSMo; all applicable federal and state drug laws, rules, and regulations; and all federal and state criminal laws. "State" here includes the state of Missouri and all other states and territories of the United States.
- E. During the disciplinary period, Licensee shall timely renew his license and timely pay all fees required for licensing and comply with all other board requirements necessary to maintain Licensee's license in a current and active state.
- F. If at any time during the disciplinary period, Licensee removes himself from the state of Missouri, ceases to be currently licensed under provisions of Chapter 332, or fails to advise the Board of his current place of business and residence, the time of his absence, unlicensed status, or unknown whereabouts shall not be deemed or taken as any part of the time of discipline so imposed in accordance with § 332.321.6, RSMo.
- G. During the disciplinary period, Licensee shall accept and comply with unannounced visits from the Board's representatives to monitor his compliance with the terms and conditions of this Settlement Agreement.



- H. If Licensee fails to comply with the terms of this Settlement Agreement, in any respect, the Board may impose such additional or other discipline that it deems appropriate, (including imposition of revocation) following a hearing before the Board.
- I. This Settlement Agreement does not bind the Board or restrict the remedies available to it concerning any other violation of Chapter 332, RSMo, by Licensee not specifically mentioned in this document.

III. ADDITIONAL REQUIREMENTS

- A. Licensee shall not allow his license to lapse.
- B. Licensee shall notify, within 15 days of the effective date of this Settlement Agreement, all hospitals, nursing homes, out-patient centers, surgical centers, clinics, and all other facilities where Licensee practices or has privileges of Licensee's disciplinary status. Notification shall be in writing and Licensee shall, contemporaneously with the giving of such notice, submit a copy of the notice to the Board for verification by the Board or its designated representative.

1. The parties to this Agreement understand that the Missouri Dental Board will maintain this Agreement as an open record of the Board as provided in Chapters 332, 610, 324, RSMo.

2. The terms of this settlement agreement are contractual, legally enforceable, and binding, not merely recital. Except as otherwise provided herein, neither this settlement agreement nor any of its provisions may be changed, waived, discharged, or terminated, except by an instrument in writing signed by the party against whom the enforcement of the change, waiver, discharge, or termination is sought.

3. Licensee, together with his heirs and assigns, and his attorneys, do hereby waive, release, acquit and forever discharge the Board, its respective members and any of its employees, agents, or attorneys, including any former Board members, employees, agents, and attorneys, of, or from, any liability, claim, actions, causes of action, fees, costs and expenses, and compensation, including but not limited to, any claims for attorney's fees and expenses, including any claims pursuant to § 536.087, RSMo, or any claim arising under 42 U.S.C. § 1983, which may be based upon, arise out of, or relate to any of the matters raised in this case, its settlement, or from the negotiation or execution of this settlement agreement. The parties acknowledge that this paragraph is severable from the remaining portions of this settlement agreement in that it survives in perpetuity even in the event that any court of law deems this settlement agreement or any portion thereof to be void or unenforceable.

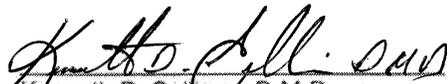
5. If no contested case has been filed against Licensee, Licensee has the right, either at the time the settlement agreement is signed by all parties or within fifteen days thereafter, to submit the agreement



to the Administrative Hearing Commission for determination that the facts agreed to by the parties to the settlement agreement constitute grounds for denying or disciplining the license of the licensee. If Licensee desires the Administrative Hearing Commission to review this Agreement, Licensee may submit this request to: **Administrative Hearing Commission, Truman State Office Building, Room 640, 301 W. High Street, P.O. Box 1557, Jefferson City, Missouri 65101.**

6. If Licensee has requested review, Licensee and Board jointly request that the Administrative Hearing Commission determine whether the facts set forth herein are grounds for disciplining Licensee's license and issue findings of act and conclusions of law stating that the facts agreed to by the parties are grounds for disciplining Licensee's license. Effective the date the Administrative Hearing Commission determines that the agreement sets forth cause for disciplining Licensee's license, the agreed upon discipline set forth herein shall go into effect.

LICENSEE


Kenneth D. Sullivan, D.M.D.

Date 04 / 26 / 2011

BOARD


Brian Barnett,
Executive Director
Missouri Dental Board

Date 5/2/11

