From January 2017 Meeting Minutes

Request for Reinstatement of Pharmacist License – Appearance:

Justin Curnutt

Darla Zarley disclosed that Justin Curnutt was a former student, but stated that she would be able to participate in this matter fairly and without bias.

Justin Curnutt appeared and was sworn by President Basch prior to answering questions or offering testimony.

Mr. Edwards explained that the Board heard Mr. Curnutt’s case during the January 2016 board meeting. He stated that Mr. Curnutt committed prescription fraud and insurance fraud by creating, filling and dispensing multiple fraudulent prescriptions for himself and another staff member. Those fraudulent prescriptions were then billed to an insurance provider.

Mr. Curnutt agreed to Mr. Edwards’ summary of the facts. He requested reinstatement of his pharmacist license and described his activities during the last year.

Mr. Curnutt explained that he is active with the Boy Scouts of America and his church community. He also opened a health food store and taught courses on various aspects of maintaining a healthy lifestyle.

Board discussion ensued regarding Mr. Curnutt’s status on the OIG Blacklist. Mr. Pinson explained that if he is on that list he would not be allowed be employed by any entity that bills Medicare or Medicaid.

The Board questioned Mr. Curnutt regarding unaccounted for medications that were confiscated. Mr. Curnutt could not provide an explanation for the medications.

The Board discussed the possibility of having a mentor report on Mr. Curnutt’s activities as well as other corrective action.

Board Action:

Motion: Kirk Wentworth moved to reinstate Justin Curnutt’s Nevada Pharmacist License pending Mr. Curnutt meets with Board Staff to explain the circumstances surrounding all unaccounted for medications that remain at issue in his case. Board Staff is authorized to review and approve Mr. Curnutt’s explanation. If Board Staff accepts the explanation Justin Curnutt’s license will be reinstated, this will take place no sooner than February 5, 2017, and be put on a probationary status for a period of no less than two years from the reinstatement date. During the probationary period Mr. Curnutt may not work more than forty hours per week. He may
not work as a pharmacist in charge or pharmacy manager of any Nevada pharmacy. He may not work alone and must work at all times under the direct supervision of a Nevada licensed pharmacist. He must engage a peer mentor who must be a Nevada licensed physician or pharmacist, and is subject to Board Staff approval. The mentor must submit quarterly written status reports to the Board’s Executive Secretary explaining his or her perception and opinion of his work status, the activities in which he is engaged as part of his personal and professional recovery, his level of compliance with the terms of his probation and any other matters that the mentor deems pertinent. Mr. Curnutt shall inform all current and potential future employers of this disciplinary action. Any violation of the terms of the Board's Order may result in the immediate suspension of his pharmacist license.

Second: Jason Penrod

Action: Passed unanimously
BEFORE THE NEVADA STATE BOARD OF PHARMACY

NEVADA STATE BOARD OF PHARMACY,  )  CASE NOS. 15-051-RPH-S
 )  15-051-PT-A-S
 )  15-051-PT-B-S
 )
 )
 )
 v.
 )
 )
 )
 JUSTIN CURNUTT, RPH  )  FINDINGS OF FACT,
 )  CONCLUSIONS OF LAW
 )  AND ORDER
 )
 )
 )
 ISABEL ROMERO, PT  )
 )
 )
 )
 Certificate of Registration No. 18338  )
 )
 )
 )
 Certificate of Registration No. PT13592  )
 )
 )
 )
 LORI BRANDON, PT  )
 )
 )
 )
 Certificate of Registration No. PT09558  )
 )
 )
 )
 Respondents. /

This matter came before the Nevada State Board of Pharmacy (Board) at its regularly scheduled meeting held on Wednesday, January 13, 2016, in Las Vegas, Nevada. S. Paul Edwards, Esq., appeared before the Board in his capacity as its General Counsel. Respondent Justin Curnutt, RPh., Certificate of Registration No. 18338, appeared with his counsel, David E. Krawczyk, Esq., of Dempsey, Roberts & Smith, Ltd.; Respondent Lori Brandon, PT, Certificate of Registration No. PT13592, appeared with her counsel, Patricia A. Marr, Esq., of Patricia A. Marr, Ltd.; and Respondent Isabel Romero, PT, Certificate of Registration No. PT09558, appeared without counsel at the hearing.

Based on the evidence presented during the hearing, the Board issues the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. The Board has jurisdiction over these matters.

2. The Board served a Notice of Intended Action and Accusation (Accusation) on each of the Respondents, by certified mail, on or about December 9, 2015, which each Respondent received.

1 of 9
3. The respondents each filed an Answer and Notice of Defense in response to the Accusation.

4. Based on the evidence introduced during the hearing, including admissions and testimony given during the hearing, the Board fines as follows:

**Unlawful Activity by Ms. Romero, PT**

5. In June 2015, Smith’s Pharmacy (Smith’s) terminated Ms. Romero from her employment as a pharmaceutical technician at Smith’s Pharmacy #341.

6. Smith’s terminated Ms. Romero for attempting to falsify a prescription for a dangerous drug (oral contraceptives) for herself.

7. Ms. Romero attempted to falsify that prescription by completing a “Confidential Prescription Authorization Request” form authorizing an initial fill of Gildess Fe 1-20 tablets, with eleven (11) refills.

8. Ms. Romero patterned that request after a previous legitimate prescription from her physician.

9. Ms. Romero wrote the initials “H.D.” on the request form to falsely indicate that another pharmaceutical technician received a call from Ms. Romero’s physician and completed the authorization form.

10. There is no evidence that H.D. was actually involved in Ms. Romero’s actions.

11. When pharmaceutical technician Ms. Brandon stepped away from her computer terminal, Ms. Romero scanned the falsified request form at Ms. Brandon’s terminal under Ms. Brandon’s credentials.
12. Ms. Brandon observed Ms. Romero performing a function at her terminal and discovered that Ms. Romero had scanned in the falsified prescription for herself.

13. Ms. Brandon reported the incident to Mr. Curnutt, the pharmacist on duty at the time.

14. When Mr. Curnutt confronted Ms. Romero, she admitted to her wrongdoing and cancelled the prescription at Mr. Curnutt’s direction.

15. Smith’s did not dispense any medication pursuant to that authorization.

16. After telling Ms. Romero to cancel her falsified prescription, Mr. Curnutt further told her that if she had asked, he would have written a prescription for her oral Contraceptive.

17. Since it was 9:00 p.m. at the time, Mr. Curnutt said that he would write a prescription for Ms. Romero the following morning using the name of “any doctor”. That did not ultimately occur.

Unlawful Activities By Mr. Curnutt, R.Ph., and Ms. Brandon, PT

18. Upon receiving a report regarding Ms. Romero’s termination, Board Staff initiated an investigation of all Smith’s Pharmacy #341 employee prescription records.

19. Those records revealed questionable phoned-in and/or faxed prescriptions for Mr. Curnutt and Ms. Brandon that were processed during the approximate time period of February 4, 2014, to August 31, 2015.

20. As part of his analysis, the Board Investigator consulted with the prescribers named on the questionable prescriptions.

21. The investigation turned up evidence that Mr. Curnutt and Ms. Brandon assisted each other in falsifying and filling multiple prescriptions for themselves and each other.
22. Ms. Brandon falsified “Confidential Prescription Authorization Request” forms for some of Mr. Curnutt’s prescriptions, generally purporting to authorize an initial fill with multiple refills.

23. Ms. Brandon falsely documented either Dr. Freeman or Dr. Stoughton as the prescriber on those requests.

24. Similarly, Mr. Curnutt created “phoned in” prescriptions for Ms. Brandon and himself. He placed his initials on the written authorization requests under the “prescriber’s” name, indicating that he accepted the prescription order(s) by phone.

25. On the requests for Ms. Brandon, Mr. Curnutt falsely documented Dr. Reddy as the prescribing physician.

26. Table I below lists the fraudulent prescriptions filled for Mr. Curnutt. There are forty (40) prescriptions listed.

**Table I: Fraudulent Prescriptions Filled For Justin Curnutt, R.Ph.**

<table>
<thead>
<tr>
<th>Prescriber</th>
<th>Rx No.</th>
<th>Medication</th>
<th>Quantity</th>
<th>No. of Fills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brian Freeman, DDS</td>
<td>6128204</td>
<td>Amoxicillin 500mg</td>
<td>24 capsules</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>6128205</td>
<td>Acyclovir 400mg</td>
<td>30 tablets</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>6149267</td>
<td>Amoxicillin 500mg</td>
<td>80 capsules</td>
<td>6</td>
</tr>
<tr>
<td>Ned Stoughton, MD</td>
<td>6114710</td>
<td>Cephalexin 500mg</td>
<td>30 capsules</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>6114711</td>
<td>Methylprednisolone 4mg Dosepk</td>
<td>21 tablets</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>6128207</td>
<td>Fluocinonide 0.05% Ointment</td>
<td>60 gm</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>6128208</td>
<td>Methylprednisolone 4mg Dosepk</td>
<td>21 tablets</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>6160595</td>
<td>Prednisone 20mg</td>
<td>21 tablets</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>6171348</td>
<td>Prednisone 20mg</td>
<td>40 tablets</td>
<td>5</td>
</tr>
<tr>
<td>Michael Reiner, MD</td>
<td>6128225</td>
<td>Albuterol 0.083% INH SOL</td>
<td>25 vials</td>
<td>4</td>
</tr>
<tr>
<td>Tammy Reynolds, MD</td>
<td>6135314</td>
<td>Lidocaine HCL 1%</td>
<td>200 ml</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>6135314</td>
<td>Lidocaine HCL 1%</td>
<td>400 ml</td>
<td>2</td>
</tr>
</tbody>
</table>
27. Table II lists the fraudulent prescriptions processed for Ms. Brandon’s benefit. There are five (5) unlawful prescriptions listed.

<table>
<thead>
<tr>
<th>Prescriber</th>
<th>Rx No.</th>
<th>Medication</th>
<th>Quantity</th>
<th>No. of Fills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santosh Reddy, MD</td>
<td>6118208</td>
<td>Cephalexin 500mg</td>
<td>80 capsules</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>6140691</td>
<td>Cephalexin 500mg</td>
<td>80 capsules</td>
<td>2</td>
</tr>
</tbody>
</table>

28. Mr. Curnutt and Ms. Brandon submitted at least some, if not all, of the foregoing fraudulent prescriptions for payment to their respective insurance providers.

29. Mr. Curnutt and Ms. Brandon’s respective insurance providers paid for, at least in part, some of the fraudulent prescriptions submitted to them.

30. Drs. Freeman, Stoughton, Reiner, and Reynolds have each signed a declaration affirming that they did not authorize the prescriptions listed on Table I for Mr. Curnutt.

31. Dr. Reddy signed a declaration that he did not authorize the prescriptions for Ms. Brandon listed on Table II.

32. Mr. Curnutt admitted to falsifying several prescriptions for himself and for Ms. Brandon.

33. Mr. Curnutt wrote prescriptions for Ms. Brandon because she was experiencing pain from an abscessed tooth.

34. On September 28, 2015, Mr. Curnutt, at the suggestion of the Board Investigator, delivered the medications he purported to have in his possession to the Board Office in Las Vegas.
35. With Mr. Curnutt present, the Board Investigator inventoried the medications and impounded them.

36. There were discrepancies in the quantities of medications Mr. Curnutt returned. For instance, as to seven of the medications, Mr. Curnutt returned less product than Smith’s records show were dispensed to him.

37. Mr. Curnutt has not accounted for that missing medication.

38. As to one medication, Mr. Curnutt returned more product than Smith’s records show were dispensed to him.

39. Mr. Curnutt has not explained how the additional product came into his possession.

40. Additionally, Mr. Curnutt returned two medications¹ that were not documented in his prescription profile.

41. Mr. Curnutt has not explained how those medications came into his possession.

42. During Ms. Brandon’s interview with the Board Investigator, and in a subsequent written statement, Ms. Brandon confessed to falsifying several prescriptions for Mr. Curnutt.

43. Ms. Brandon admits that Mr. Curnutt wrote and filled fraudulent prescriptions for her.

44. On September 19, 2015, Ms. Brandon delivered to the Board Office the remaining medications that she had in her possession.

45. In Ms. Brandon’s presence, the Board Investigator inventoried the medications and impounded them.

¹ Rx No. 6128205: Acyclovir 400 mg. #30 filled 12/14/2014;
CONCLUSIONS OF LAW

Based upon the forgoing findings of fact, the Board concludes as a matter of law:

46. The Nevada State Board of Pharmacy (Board) has jurisdiction over this matter because, at the time of the events alleged in the Accusation, Respondent Justin Curnutt was a pharmacist licensed with the Board, Respondent Lori Brandon was a pharmaceutical technician registered with the Board, and Respondent Isabel Romero, was a registered pharmaceutical technician with the Board.

FIRST CAUSE OF ACTION
(Record Fraud - Isabel Romero, PT)

47. By creating and attempting to process a fraudulent prescription for a dangerous drug, Gildess Fe 1-20 tablets, without a lawful prescription or authorization from a practitioner, Isabel Romero, PT, violated Nevada Administrative Code (NAC) 639.945(1) (h) and (k).

SECOND CAUSE OF ACTION
(Record Fraud - Justin Curnutt, R.Ph.)

48. In creating fraudulent prescriptions for various dangerous drugs for himself and for Ms. Brandon, as detailed herein, including Tables I and II, Justin Curnutt, R.Ph., violated NAC 639.945(1)(h) and (k).

THIRD CAUSE OF ACTION
(Record Fraud - Justin Curnutt, R.Ph.)

49. In filling and dispensing multiple fraudulent prescriptions for various dangerous drugs for himself and Ms. Brandon without a lawful prescription or authorization from a practitioner, as detailed herein, including Tables I and II, Justin Curnutt, R.Ph., violated NAC 639.945(1) (h) and (k).

FOURTH CAUSE OF ACTION
(Record Fraud - Justin Curnutt, R.Ph.)
50. By processing multiple fraudulent prescriptions for various dangerous drugs without a lawful prescription or authorization from a practitioner, and by billing those prescriptions to an insurance provider, Justin Curnutt, R.Ph., violated Nevada Administrative Code (NAC) 639.945(1)(h) and (k).

FIFTH CAUSE OF ACTION
(Prescription Fraud - Lori Brandon, PT)

51. By creating multiple fraudulent prescriptions for various dangerous drugs without a lawful prescription or authorization from a practitioner as detailed herein, including Tables I and II, Lori Brandon, P.T., violated Nevada Administrative Code (NAC) 639.945(1) (h) and (k).

SIXTH CAUSE OF ACTION
(Insurance Fraud - Lori Brandon, PT)

52. By processing multiple fraudulent prescriptions for various dangerous drugs without a lawful prescription or authorization from a practitioner, and by billing those prescriptions to an insurance provider, Lori Brandon, P.T., violated Nevada Administrative Code (NAC) 639.945(1) (h) and (k).

THEREFORE, THE BOARD HEREBY ORDERS:

53. For the violations found under the First Cause of Action, the registration of Respondent Isabel Romero, PT, Certificate of Registration No. PT09558, is revoked effective as of the day of the hearing.

54. For the violations found under the Second Cause of Action, the license of Respondent Justin Curnutt, RPh., Certificate of Registration No. 18338, is revoked effective as of the day of the hearing.

55. For the violations found under the Third Cause of Action, the license of Respondent Justin Curnutt, RPh., Certificate of Registration No. 18338, is revoked effective as of the day of the hearing.
56. For the violations found under the Fourth Cause of Action, the license of Respondent Justin Curnutt, RPh., Certificate of Registration No. 18338, is revoked effective as of the day of the hearing.

57. For the violations found under the Fifth Cause of Action, the registration of Respondent Lori Brandon, PT, Certificate of Registration No. PT13592, is revoked effective as of the day of the hearing.

58. Related to the Fifth Cause of Action, the registration of Respondent Lori Brandon, PT, Certificate of Registration No. PT13592, is revoked effective as of the day of the hearing.

59. The Respondents, and each of them, are prohibited from working in any facility licensed by the Board, including a pharmacy, in any capacity, unless and until he or she has applied to the Board for reinstatement of his or her license/registration and the Board reinstates the same.

60. In the event any of the Respondents applies for reinstatement, or for any other registration or certificate with the Board, he or she shall appear before the Board to answer questions and give testimony regarding the application and the facts and circumstances underlying this matter.

Signed this 4\textsuperscript{th} day of February, 2016.

Leo Basch, President
Nevada State Board of Pharmacy
To whom this may concern on the NV Pharmacy Board Staff:

This letter is to satisfy number 1 requirement in the reinstatement of pharmacist license no. 18338 letter issued February 1st, 2017. Specifically:

1. You must meet with Board Staff and explain the circumstances surrounding all unaccounted for medications that remain at issue in your case. Your explanation is subject to Board Staff’s review and approval.

There were a number of medications that were returned with partial quantities. I ingested the medications that were unaccounted for personally. Since becoming a holistic health coach I have learned immense amounts of information regarding the gut and how important our microbiome is. Around 80% of our immune system resides in our gut flora. When I was taking the antibiotics and steroids continually without doctor supervision, I was causing more harm than good. Not only was I destroying the bad bacteria with the antibiotics but I was also destroying the good bacteria in my stomach. While taking the steroids, which suppress the immune system, I was hindering my body from ever recovering completely between infections and illnesses. This is a condition I now know to be called dysbiosis or dysbacteriosis. Dysbiosis is defined as such: “a term for a microbial imbalance or maladaptation on or inside the body, such as an impaired microbiota.” To add insult to injury I was standing in as the pharmacist in charge at Smith’s while Lester Sherman was out for medical reasons. I was working as the pharmacist in charge and also felt pressured to continue to work every moment outside of this capacity as part of an elite team of Smith’s as an MTM pharmacist at up to 8 other stores in the Las Vegas area. I felt over pressured, over worked, and stressed beyond belief which only adds to opportunistic infection reoccurrence. I regrettably was taking medication to mask any reoccurring infections to be able to work every moment and not use time off as that would let people down that I was working for and with. Although it seems like a lot of medications were consumed, I want to inform you that it was over a vast time period and I was a mess, both internally and externally. I realize that this may not sound like an incredible reason to have done what I had done but punishment has been exacted and I have felt these repercussions deeply and intensely.

As for an explanation on the Acyclovir, prescription number 6128205. I checked the records from Smith’s since the board hearing in order to get a more clear picture of what may have happened and to refresh my memory on dates and times. The prescriptions were put in to fill on the 14th of December 2014. I picked the prescriptions up on December 31st around 5pm. It was toward the end of the shift and there was shortened hours due to the New Years. I remember vividly that it was the end of the year and everyone was trying to pick up all their prescriptions before their deductibles started over at the beginning of the next year. I was picking up various other medications besides the Acyclovir at the same time. I had not had problems in the previous years with refills being miscounted or given abnormal amounts or quantities so I inadvertently assumed that everything was in order. I did not check every prescription as thoroughly as I should have. To show that this was true I returned the quantities as given without the knowledge that there was even a discrepancy or misfill. When I was made aware of this discrepancy upon impounding the prescriptions with Mr. Scheuber, I was just as baffled as the inspector and had no answer. At that moment of impounding I did not have dates and times that these were
picked up or a fresh recollection of the events that transpired with these prescriptions and therefore did not have any explanation. Again, when I was questioned at the board hearing I did not have a full answer for these same reasons.

The other prescription number 6171348 that was in question has a simple explanation. In the paper work printed for Mr. Scheuber that Smith’s had printed for him during his investigation the Rx number had not shown up. This was the last prescription that was filled and picked up a week prior to the investigation and it would seem that the paperwork did not yet accurately reflect that prescription. I printed the paperwork prior to seeing Mr. Scheuber after the board hearing (02/09/2017) and saw that it was there and accounted for. He made a photo copy and was satisfied. We can neither explain how long it takes Smith’s to update their system and give an accurate paper trail but it would appear that more than a week is necessary.

I lament saying that another discrepancy was noted that I would also like to explain in the same way. I was supposed to receive 1000ml of lidocaine. They come in 20ml vials and I picked up the order in multiple fills. It seems that in at least one of the fills I was given an extra 80ml. This would be 4 vials extra. I do not know how I became in possession of this extra quantity other than a misfill that I inadvertently picked up and did not count every individual vial assuming that everything was filled properly. Again, I apologize for finding out the extent of the misfills at the same time as the impounding process. Again, I turned them in completely because I had no idea of the misfill and no mal intention was meant.

I apologize entirely and completely for this entire circumstance. I betrayed the trust of this profession, the people with whom I serve, and my family and friends. I have taken some additional stipulations into my own hands to assure that this never happens. I have made a commitment to family and friends closest to me to always fill my prescriptions at a pharmacy that I do not work at, and if possible not within the same chain. In this manner I would not be able to use any authority I have as a pharmacist to fill any prescription that is fraudulent or in any other way not real. Another stipulation that I have imposed upon myself is to accurately count every medication which is dispensed to me. In this way I will not receive too much, too many, or too few prescriptions due to miscounts or mis-fills. This is inadvertently my duty as a pharmacist and I should not let the amount of hours worked in the day, nor the trust I have in the staff and their abilities to fill prescriptions and dispense them without discrepancies of any sort. They too are human beings, as am I, and are liable for mistakes and errors. To do this would not only cover my own tracks but that of the pharmacy where I fill the prescriptions.

I pride myself in this field. I love this profession. I love being on the forefront of healthcare. I take tremendous responsibility in getting other peoples' prescriptions to them without problems of any kind and lament the fact that I did not take the time nor pride in doing the same with my own prescriptions. Again, this is why I have from this moment forward placed my own set of stipulations on myself and am holding myself to the highest standards of honesty, accuracy, and integrity.

Thank you for your understanding and I plead with board staff to know that no mal intent was meant and repayment of the errors made will continue to be paid throughout the remainder of my
lifetime. I hope this explanation meets the satisfaction of explaining what happened to the unaccounted medications. I look forward to the opportunity to grow and show the board that I can once again be trusted within this field and continue to be an asset to the community at large.

X: ___________________________________________ Date: __________

Justin Daine Curnutt
To whom this may concern on the NV Pharmacy Board Staff:

This letter is to satisfy number 1 requirement in the reinstatement of pharmacist license no. 18338, for Justin Curnutt, letter issued February 1st, 2017. Specifically:

1. You must meet with Board Staff and explain the circumstances surrounding all unaccounted for medications that remain at issue in your case. Your explanation is subject to Board Staff's review and approval.

There were a number of medications that had nothing returned or were returned with partial quantities. These prescriptions were consumed by myself as numbered from the itemized xcel spreadsheet provided by Mr. Scheuber; 2-9, 11-15, 17-19, 22, 24, 27, 29, 32-34, 37-38, 41, 43. The prescriptions were originally prescribed for whole body eczema outbreaks via a dermatologist as well as occasional tooth infections via a dentist. I was working as the pharmacist in charge, as Lester Sherman was out for medical reasons, and also felt pressured to continue to work every moment outside of this capacity as part of a team for Smith's as an MTM pharmacist at up to 8 other stores in the Las Vegas area. I felt over pressured, over worked, and stressed. I was taking medication to mask any reoccurring infections to be able to work every moment and not use time off as that would let people down that I was working for and with. I did consume a lot of medication over an extended period of time. Looking at it now, I can see that I was not healthy physically or mentally because of how hard I was pushing myself.

Given those circumstances above, I believe I can explain the unaccounted for medications that remain an issue in my case. In our recent meeting (02/09/17), Mr. Scheuber shared his concern that I may have consciously been given the duplicate medications of acyclovir and extra vials of lidocaine (numbered 20, 21, 25, 26). He was primarily concerned that I had intentionally overlooked these duplicates (i.e. stole them) and chose not to correct the error. It is true and Mr. Scheuber is correct that I did see something that I did not care enough to correct and that was the prescriptions themselves. I knew I was using the doctors' names without their authorization and I did not care enough to fix that. In all honesty I picked up misfilled medications without my knowledge. I never noticed the error and to admit that in this statement does not make me look any less negligent. I would consider any pharmacist who had done these things as professionally negligent. I would admit to stealing them but I am endeavoring to be 100% honest in this disciplinary process. In that effort to be 100% honest, I do admit to stealing. However I did not steal the medications but rather I stole the use of the doctors' names without their authorization. As further evidence of my negligence, I found out about these misfills upon impounding them with Mr. Scheuber. My accepting these misfills was a genuine oversight.

The last prescription in question number 44 has a simple explanation. Smith's printed a profile of my medications which they provided to Mr. Scheuber during the investigation. In that profile number 44 was not listed. I printed a more recent medication profile prior to meeting with Mr. Scheuber and number 44 was on the updated list. (02/09/2017) Mr. Scheuber made a photo copy and appeared satisfied that it was accurate.

I thank you for your understanding. It is my hope that this statement provides a candid explanation for the unaccounted for medications. I look forward to the opportunity to grow and show the board that I can once again be trusted within this field.

Respectfully,

[Signature]

Justin Daine Curnutt

Date 03/02/17
<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
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<tr>
<td>1</td>
<td>FILL DATE</td>
<td>RX #</td>
<td>C</td>
<td>DRUG NAME</td>
<td>QTY</td>
<td>PRESCRIBER</td>
<td>QTY RETURNED</td>
</tr>
<tr>
<td>2</td>
<td>7/26/2014</td>
<td>6114710</td>
<td>Cephalaxin 500mg capsule</td>
<td>30</td>
<td>Stoughton</td>
<td>14</td>
<td>16</td>
</tr>
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<td>3</td>
<td>7/28/2014</td>
<td>6114711</td>
<td>Methylprednisolone 4 mg</td>
<td>21</td>
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<tr>
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<td>Acyclovir 400 mg tablet</td>
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