

Received

OCT 03 2014

Texas State Board
of Veterinary Medical Examiners

SOAH 578-14-3849
DOCKET NO. 2014-204; 2014-217

IN THE MATTER OF § TEXAS BOARD OF
THE LICENSE OF § VETERINARY
MILLARD LUCIEN TIERCE, III, D.V.M. § MEDICAL EXAMINERS

AGREED ORDER

On this the 21 day of October, 2014, came to be considered by the Texas Board of Veterinary Medical Examiners ("Board") the matter of the license of Millard Lucien Tierce, III, D.V.M. ("Respondent"). Pursuant to Section 801.408, Texas Occupations Code, and Board Rule 575.29, an informal conference was held on July 14, 2014. Pursuant to Section 801.409, Texas Occupations Code, and Board Rule 575.35, a Temporary Suspension conference was held on May 9, 2014. Respondent attended both conferences and was represented by counsel, Patty Blackburn Tillman, D.V.M. and Donald Ferrill, D.V.M.

Respondent, without admitting the truth of the findings and conclusions set out in this Agreed Order, wishes to waive a formal adjudicative hearing and thereby informally dispose of the issues without a formal adjudication. Respondent agrees to comply with the terms and conditions set forth in this Order. In waiving an adjudicative hearing, Respondent acknowledges his understanding of the alleged violations and the adequacy and sufficiency of the notice provided to him.

Upon the recommendation of the Enforcement Committee and with Respondent's consent, the Board makes the following Findings of Fact and Conclusions of Law and enters this Agreed Order as set forth below.

Findings of Fact

1. Respondent is a Texas veterinarian and holds Texas Veterinary License No. 2455, issued by the Board on September 1, 1966, which was in full force and effect at all times material and relevant to this Order.
2. The Board has jurisdiction over the subject matter and Respondent. Respondent received notice, which may be required by law and by the rules of the Board. All jurisdictional requirements have been satisfied under Tex. Occ. Code Ann. Title 4 (Act). By entering into this Agreed Order, Respondent waives any defect in the notice and any further right to notice and hearing under the Act; Tex. Gov't Code Ann. §§ 2001.051-.054; and the Rules of the Texas Board of Veterinary Medical Examiners (Board Rules) (22 Tex. Admin. Code, Chapter 575).

Sid and Clinic Investigation

1. Marian and James Harris ("Complainants") filed a complaint with the Board on April 22, 2014. The Complainants stated that they took their 170 lb. Leonberger canine, Sid, to the Camp Bowie Animal Clinic ("Clinic"), which Respondent owns, in May 2013 for an anal gland issue. Respondent diagnosed the problem as perianal fistula on May 28, 2013. According to the Complainants, Respondent wanted to perform cold laser therapy on the anal glands and to keep Sid at the clinic to do that.

2. Four months later, the Complainants visited the clinic and asked to see Sid. Up until that time, the Complainants were consistently told that Sid was improving but it would take more time. However, when Sid was presented he could not lift his hind quarters and slid across the floor to get to Mr. Harris. According to Mr. Harris, Respondent stated that Sid could not walk because of a reaction to medication, which caused a drop in blood pressure. Respondent did not believe this to be a great concern. Complainants' trusted that their veterinarian knew best and that he was acting in the best interests of Sid.

3. In October 2013, Respondent suggested using Sid, who was still at Respondent's clinic, to calibrate his portable x-ray machine as another dog belonging to the Complainants needed to have an x-ray. After reviewing the x-ray of Sid, Respondent discovered a congenital birth defect in Sid's spine. Respondent stated that there was nothing that could be done for the condition and that it was causing Sid great pain. At that time, the Complainants elected to euthanize Sid rather than have him remain in constant pain with no chance of recovery. The Complainants and their son all told Sid good-bye after again being told by Respondent that nothing could be done for Sid's condition.

4. In April 2014, Complainants were alerted by Mary Brewer, a veterinary technician from the Clinic, that Sid was still alive and that Sid was being kept in a cage at the Clinic for 23.5 hours a day. The veterinary technician from the Clinic also stated that several other animals were being kept in cages for 23.5 hours a day. Shortly after being alerted to this situation, Complainants then went to the Clinic and removed Sid from Respondent's care. Respondent then admitted to the Complainants that he had kept Sid alive and at his Clinic even though they had elected for euthanasia and thought that Sid had been euthanized.

5. On April 29, 2014, Board investigators initiated an investigation of the Clinic. During the course of their investigation, the Board investigators witnessed and took video recordings of unsanitary conditions of the Clinic. A large amount of old animal organs were kept in jars throughout the clinic. Bugs were visible in an exam room. Stacks of drugs, trash, laundry, paperwork, and other miscellaneous material were strewn about the examination rooms, hallways, stairwells, operating room, laboratories, and offices of the Clinic. Open and unsecured medications, including some controlled substances, were also strewn about the clinic and in such

a fashion that controlled substances could easily be stolen and abused by employees, clients, or visitors of the Clinic.

6. Board investigators also received a signed and handwritten statement from Respondent, stating that he had accepted five animals for euthanasia at his Clinic and proceeded to not euthanize the animals. (Respondent now asserts that he failed to euthanize four animals rather than the five he states in his written statement.) Additionally, Respondent acknowledged that at least one of the animals may have been at his clinic for years after its owner had elected to euthanize the animal. Respondent acknowledged that it was a violation to accept Sid for euthanasia and not perform the euthanasia. Respondent also acknowledged that parts of his clinic were unsanitary.

7. One of those five animals Respondent admitted to keeping alive after he was supposed to euthanize it was a neutered twelve-year-old black and white male Chihuahua named "Hercules" owned by Kim Davis of Dallas, Texas. Ms. Davis came to the Clinic and signed the euthanasia form for Hercules to be put down on December 14, 2013. On April 29, 2014, Hercules was still alive and housed at Respondent's Clinic. The medical records for Hercules Respondent provided the Board on May 28, 2014, show that Respondent provided veterinary medical treatment to Hercules from December 14, 2013 until April 29, 2014.

8. The Ft. Worth police department also came to Respondent's clinic on April 29, 2014, and eventually brought in Michael Morris, D.V.M., who identified two dogs, Hercules and another dog one of which Respondent identified as his own dog named "Trixie," as being in such decrepit shape that they had to be euthanized.

9. On April 30, 2014, an arrest warrant was issued against Respondent for animal cruelty for his treatment of Trixie.

10. Shelley Finger, D.V.M. examined Sid after he was removed from Respondent's care. Dr. Finger determined that Sid had multiple skin lesions, including patchy alopecia over much of his body with regions of erythema, as well as some collarettes with crusts. She further diagnosed Sid with hypothyroidism, dermatitis, ulcerations from ataxic/paretic gait, demodectic mange, otitis externa, and spinal neuropathy L4-S1, with the possibility of a T3-L3 lesion. She determined that he had thickened, lichenified skin above his nasal planum extending half-way up his muzzle. He further had areas of calloused hair loss on his elbows, evidencing he was laying on hard surfaces. He had mild yeast infections in each ear with no evidence of the presence of topical medication. He had 1cm diameter ulcerated lesion on the dorsal aspect of his hind left paw. The bottoms of his paws were mildly inflamed. Sid had significant hind limb muscle atrophy. His spine was not painful to palpation. Sid's veins collapsed easily and it was not easy to obtain blood from them as compared to other dogs his size.

3. Respondent further admitted that after he was to euthanize Sid, he used Sid as a blood

donor to treat another animal without obtaining permission from Sid's owners.

Temperance Bones Braden

4. On October 13, 2012, Jennifer Braden presented her four (4) year old female Dachshund breed canine named "Temperance" to Millard Tierce, III, D.V.M. ("Respondent") at the Camp Bowie Animal Clinic (the "Clinic"), which is owned by Respondent. Ms. Braden presented Temperance to Respondent for difficulty walking, dragging her hind legs, difficulty eating and drinking, and difficulty urinating and defecating.

5. Respondent performed radiographs and diagnosed Temperance with a ruptured spinal disc. Respondent informed Ms. Braden that surgery could be performed at an estimated cost of \$1,000. Respondent also told Ms. Braden that he could euthanize Temperance for free. Ms. Braden left Temperance with Respondent for further care and evaluation. On October 15, 2012, respondent euthanized Temperance.

6. On April 30, 2014, Ms. Braden filed a complaint with the Board.

7. On May 14, 2014, the Board sent a letter to Respondent through Respondent's counsel requesting a response and a complete copy of patient medical records. Respondent was to provide a response to the letter no later than June 9, 2014.

8. On June 23, 2014, the Board received a response from Respondent.

Morgan Covington

9. On August 9, 2013, Karen Covington presented her 14 year old male rat terrier breed canine named "Morgan" to the Clinic for a broken femur. Terrell Rourk, D.V.M., a veterinarian employed by Respondent, examined Morgan and confirmed the broken femur. Dr. Rourk informed Ms. Covington that Respondent would perform a surgical procedure to fix the femur.

10. On August 10th, Ms. Covington left Morgan at the Clinic for surgery. The surgery was not performed until approximately 3:00 a.m. on August 14th. No blood work was taken prior to the surgery.

11. Between August 11th and 14th, Ms. Covington called and spoke to Respondent several times to inquire as to the delay in surgery. Ms. Covington stated that Respondent told her that she was not allowed to see Morgan during this time. Respondent asserts that Ms. Covington requested to see Morgan after Clinic business hours.

12. After the surgery, Respondent told Ms. Covington that he wanted to perform an additional surgery. Respondent showed Ms. Covington a radiograph and informed her that the head of the femur was in bad shape. Ms. Covington refused the second procedure. Respondent

refused to release Morgan to Ms. Covington. Respondent asserts that if Morgan moved too much due to potential excitement of seeing Ms. Covington, that Morgan might damage the femur further.

13. Respondent failed to obtain a biopsy of the femur prior to or during the surgery.

14. A few days later, Ms. Covington physically removed her dog from the Clinic to obtain a second opinion from Gary Grote, D.V.M. Ms. Covington witnessed Clinic employees taking garbage bags full of deceased animals to a building behind the Clinic. She also witnessed post-surgery dogs lying on a filthy tile floor in their own urine and feces. She found Morgan wandering the Clinic and face down in filth in the Clinic office, despite still recovering from surgery.

15. Respondent refused to provide Ms. Covington with Morgan's patient records, including the radiographs, so that she could provide it to Dr. Grote. Respondent has not provided Morgan's records to Ms. Covington.

16. On August 22nd, Dr. Grote examined Morgan and recommended against a second procedure.

17. On October 28, 2013, Morgan was presented to Dr. Grote. Radiographs were performed that indicated some bone growth, but Morgan was still in pain.

18. On November 14, 2013, Dr. Grote euthanized Morgan.

19. On May 14, 2014, the Board sent a letter to Respondent through Respondent's counsel requesting a response and a complete copy of patient medical records. Respondent was to provide a response to the letter no later than June 9, 2014. The Board received records and a response from Respondent on June 24, 2014.

Leia McDaniel

20. On January 28, 2012, Lora McDaniel presented her three (3) year old female Brittany spaniel mix breed canine named Leia to the Clinic for chronic vomiting. Respondent diagnosed Leia with an upper respiratory infection and prescribed seven (7) different medications.

21. Respondent continued to treat Leia until February 10, 2012, when Respondent informed Ms. McDaniel that Leia passed away.

22. On April 30, 2014, Ms. McDaniel went to the Clinic to obtain a copy of Leia's medical records, including radiographs. The Clinic's staff was unable to locate Leia's complete medical records.

23. On May 14, 2014, the Board sent a letter to Respondent through Respondent's counsel requesting a response and a complete copy of patient medical records. Respondent was to provide a response to the letter no later than June 9, 2014. The Board received records and a response from Respondent on June 24, 2014.

24. The patient records appear to not include Leia's weight while hospitalized. Further, Respondent admits that much of the record was made recently based upon notes taken by an assistant. The records do not reflect when the supplementations to the record were made or that there even was a supplementation made.

Boy Snoke

25. In October of 2013, Cristina Snoke presented her male canine named "Boy" to the Clinic for a cough that had developed over several months. Respondent examined and diagnosed Boy with heartworms. Respondent recommended that Boy be hospitalized for radiographs and a possible ultrasound. Ms. Snoke agreed.

26. After two (2) weeks, Ms. Snoke retrieved Boy from the Clinic. Respondent dispensed several medications for Boy's continued cough. Respondent told Ms. Snoke that he wanted to see if the medication would resolve the cough before treating him for the heartworms.

27. Boy's cough resolved after Ms. Snoke gave him the medications for two (2) weeks. At that time she presented Boy to the Clinic to be hospitalized for heartworm treatment. She also asked Respondent to biopsy a small mass on Boy's abdomen to determine if it was malignant prior to starting heartworm treatment. Ms. Snoke stated that Boy was healthy at the time he was hospitalized.

28. About two (2) weeks later, Respondent contacted Ms. Snoke to inform her that the biopsy revealed that the mass was not cancerous. Boy was hospitalized for another three (3) to four (4) weeks.

29. During those three (3) to four (4) weeks, Ms. Snoke called Respondent and asked to bring Boy home. She was placed on hold and told that Respondent would call her back. Respondent did not return her call.

30. In December of 2013, Ms. Snoke asked to bring Boy home. Respondent told her to wait for the ice to clear on the roads. Once the roads cleared, Ms. Snoke again called Respondent and asked to bring Boy home. Respondent stated that he wanted to hospitalize Boy a few more days because he was experiencing difficulty walking and not eating.

31. A few days later, Ms. Snoke went to the Clinic to get Boy. Boy was carried out to her. Boy was severely emaciated and could not stand or walk. Boy had lost a large amount of weight and muscle mass. Respondent told Ms. Snoke that this was due to Boy's cough and the energy

Boy exerted while coughing. Ms. Snoke claims Boy's cough was under control prior to when he was hospitalized.

32. Ms. Snoke took Boy home, but he never fully recovered. He passed away about two (2) weeks after coming home.

33. On May 14, 2014, the Board sent a letter to Respondent through Respondent's counsel requesting a response and a complete copy of patient medical records. Respondent was to provide a response to the letter no later than June 9, 2014. The Board received records and a response from Respondent on June 24, 2014.

34. Respondent failed to follow the standard protocol for treating heartworm disease, which causes coughing, by prescribing and administering immiticide. Further, he failed to discuss or offer euthanasia to Ms. Snoke when it was clear that Boy would not improve but rather continue to suffer.

35. In case # 578CP14000732 the Board finds there is insufficient evidence for a violation.

Conclusions of Law

1. Respondent is required to comply with the provisions of the Veterinary Licensing Act, Chapter 801, Texas Occupations Code, and with the Board's Rules.

2. Based on the above Findings of Fact, Respondent has violated Rule 573.22, PROFESSIONAL STANDARD OF CARE, which requires veterinarians licensed in Texas to exercise the same degree of humane care, skill, and diligence in treating patients as are ordinarily used in the same or similar circumstances by average members of the veterinary medical profession in good standing in the locality or community in which they practice, or in similar communities. Throughout Texas, the standard of care for euthanasia is to euthanize that animal on the same day that it is left for euthanasia, without subjecting the animal to further suffering and to euthanize an animal when the animal is in pain and nothing can be done to alleviate that pain. Because Respondent failed to euthanize Sid and at least three other animals when they were left at his Clinic to be euthanized, Respondent did not provide the same degree of treatment as is ordinarily used by veterinarians in Ft. Worth or similar communities. Further, Respondent violated the required standard of care in his treatment of Morgan by delaying surgery, failing to obtain and review blood work prior to surgery, providing below standard aftercare in allowing Morgan to wander free around the dirty Clinic post-surgery, and by failing to properly identify the pathological break as presented in Morgan's radiograph and then either performing a biopsy of the femur, sending the radiograph to a radiologist for consultation, or referring the entire matter to a Board Certified specialist. Respondent violated the required standard of care in his

treatment of Boy by failing to follow the standard protocol for treating heartworm disease, which causes coughing, by prescribing and administering immiticide. Further, he failed to discuss and offer euthanasia to Ms. Snoke when it was clear that Boy would not improve but rather continue to suffer.

3. Based on the above Findings of Fact, Respondent has violated Rule 573.27, HONESTY, INTEGRITY, AND FAIR DEALING, which requires veterinarians licensed in Texas to conduct their practice with honesty, integrity, and fair dealing to clients in time and services rendered, and in the amount charged for services, facilities, appliances, and drugs. By Respondent's own admission, he accepted at least four animals for euthanasia, told the owners that he would euthanize their animal, and did not perform the euthanasia. That conduct is not honest, fair, or done with integrity.

4. Based on the above Findings of Fact, Respondent has violated Rule 573.52 VETERINARIAN PATIENT RECORD KEEPING, of the Board's Rules of Professional Conduct, which requires that the records include the patient's weight if required for diagnosis or treatment, and that any amendment, supplementation, change, or correction in a patient record not made contemporaneously with the act or observation be noted by indicating the time and date of the amendment, supplementation, change, or correction, and clearly indicate that there has been an amendment, supplementation, change, or correction. Respondent's records for Leia McDaniel do not reflect that, as Respondent admits, much of the information was documented in the record over two years after Leia was treated. Respondent's records for Leia further fail to include Leia's weight.

5. Based on the above Findings of Fact, Respondent has violated Rule 573.54 PATIENT RECORDS RELEASE AND CHARGES, of the Board's Rules of Professional Conduct, which requires Respondent to release records to his client within 15 days of a request. Respondent failed to timely provide Ms. Covington and Ms. McDaniel with patient records.

6. Based on the above Findings of Fact, Respondent has violated Rule 573.61, MINIMUM SECURITY FOR CONTROLLED SUBSTANCES, which requires a licensed veterinarian in Texas to establish adequate security to prevent unauthorized access to controlled substances, establish adequate security to prevent the diversion of controlled substances, during the course of business activities, not allow any individual access to controlled substances storage areas except those authorized agents required for efficient operations, and controlled substances listed in Schedules I, II, III, IV, and V shall be stored in a securely locked, substantially constructed cabinet or security cabinet. Board investigators found Respondent's controlled substances

unlocked, unsecured, and laying about the Clinic during the Board's inspection of Respondent's Clinic.

7. Based on the above Findings of Fact, Respondent has violated Rule 573.75 DUTY TO COOPERATE WITH BOARD, of the Board's Rules of Professional Conduct, by failing to respond to the Board's request for information regarding complaints within the 21 day deadline.

8. Based on the above Findings of Fact, Respondent has violated Rule 573.79, MAINTENANCE OF SANITARY PREMISES, which requires a licensed veterinarian in Texas to maintain their offices/clinics/hospitals in a clean and sanitary condition without any accumulation of trash, debris, or filth. Respondent kept his Clinic covered in trash, drugs, laundry, papers, and various articles. Further, post-surgical patients were found roaming the Clinic office in filth.

9. Based on the above Conclusions of Law, Respondent has violated Section 801.402 (4), (6), and (16) of the Veterinary Licensing Act, Texas Occupations Code, and is subject to disciplinary action by the Board:

801.402. GENERAL GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY ACTION. A person is subject to denial of a license or to disciplinary action under Section 801.401 if the person:

(4) engages in dishonest or illegal practices in, or connected with, the practice of veterinary medicine or the practice of equine dentistry; ...

(6) engages in practices or conduct that violates the board's rules of professional conduct; ...

(16) commits gross malpractice or a pattern of acts that indicate consistent malpractice, negligence, or incompetence in the practice of veterinary medicine.

10. Based on the above Conclusions of Law, Respondent is subject to disciplinary action under Section 801.401 of the Veterinary Licensing Act, Texas Occupations Code:

801.401. DISCIPLINARY POWERS OF BOARD. (a) If an applicant or license holder is subject to denial of a license or to disciplinary action under Section 801.402, the Board may: (a)

(1) refuse to examine an applicant or to issue or renew a license;

(2) revoke or suspend a license;

- (3) place on probation a license holder or person whose license has been suspended;
- (4) reprimand a license holder; or
- (5) impose an administrative penalty.

11. Based on the above Conclusions of Law, Respondent may be disciplined in the manner set out in Section 801.451, IMPOSITION OF ADMINISTRATIVE PENALTY, of the Veterinary Licensing Act, which authorizes an administrative penalty for violations of the Act and Board rules.

NOW, THEREFORE, THE BOARD AND RESPONDENT AGREE AS FOLLOWS:

Based on the above Findings of Fact and Conclusions of Law, the Board ORDERS that Respondent's license be **SUSPENDED** for **FIVE YEARS** beginning on April 30, 2014. Respondent agrees to voluntarily not seek reinstatement by the Board for five years from the date of this Order. Respondent further agrees that his veterinary license will remain suspended until the Board meets and decides whether to adopt this Agreed Order.

Respondent also agrees to provide the Board with an opinion, stemming from at least a psychological evaluation, stating that Respondent is safe to practice veterinary medicine. That psychological evaluation must be from a qualified mental health professional that is approved by the Board's Peer Assistance Program to provide that opinion and must be completed within the three preceding months prior to April 29, 2019. If Respondent is not able to provide the Board with a psychological opinion in accordance with those requirements before April 29, 2019, then Respondent's suspension from the practice of veterinary medicine shall remain in place after April 29, 2019, until Respondent is able to provide the Board with a psychological evaluation that conforms to those requirements.

In addition, the Board ORDERS that Respondent complete a combined **TWENTY (20)** hours of continuing education in practice management and recordkeeping every year that his license is suspended in addition to the continuing education hours required for Respondent to renew his license. Documentation of the completion of the continuing education penalty shall be received within thirty (30) days of the end of the period to complete the continuing education. Therefore, Respondent has to provide proof that he completed the additional 20 hours in practice management and recordkeeping every year of his five year suspension. If Respondent fails to provide documentation of completion within forty-five (45) days of the end of the period to complete the continuing education, further enforcement action will be taken.

The Board further ORDERS that Respondent pay, within forty-five (45) days of the date of this Order, and administrative penalty in the amount of **ONE THOUSAND DOLLARS (\$1000.00)**. If Respondent fails to pay the restitution within forty-five (45) days of the date of this Order,

enforcement action will be taken.

The Board further ORDERS that Respondent shall take and pass the Texas veterinary jurisprudence examination within 90 days from the date of this Agreed Order.

Respondent agrees to attend mental health counseling from a qualified mental health professional approved by the Board's Peer Assistance Program until that mental health professional declares in that mental health professional's opinion that Respondent no longer needs counseling. Respondent also agrees to follow all recommendations of the mental health professional. The Board further ORDERS that Respondent shall provide the Board with documentation every six (6) months of the dates Respondent attended regular counseling during the preceding six (6) months along with the name of the mental health professional Respondent is seeking assistance from.

The Board further ORDERS that:

1. Respondent shall abide by the Rules of Professional Conduct, the Texas Veterinary Licensing Act, and the laws of the State of Texas and the United States.
2. Respondent shall cooperate with the Board's attorneys, investigators, compliance officers and other employees and agents investigating Respondent's compliance with this Agreed Order.
3. Failure by Respondent to comply with the terms of this Agreed Order or with any other provisions of the Licensing Act or the Board Rules, may result in further disciplinary action. The disciplinary action is including, but not limited to, license revocation.

Respondent, by signing this Agreed Order, acknowledges his understanding of the Agreed Order, the notice, and Findings of Fact and Conclusions of Law set forth herein, and agrees that he will satisfactorily comply with the mandates of the Agreed Order in a timely manner or be subject to appropriate disciplinary action by the Board.

Respondent, by signing this Agreed Order, waives his right to a formal hearing and any right to seek judicial review of this Agreed Order. Respondent acknowledges that he had the right to be represented by legal counsel in this matter.

RESPONDENT WAIVES ANY FURTHER HEARINGS OR APPEALS TO THE BOARD OR TO ANY COURT IN REGARD TO ALL TERMS AND CONDITIONS OF THIS AGREED ORDER. RESPONDENT AGREES THAT THIS IS A FINAL ORDER.

The effective date of this Agreed Order shall be the date it is adopted by the Board.

I, MILLARD LUCIEN TIERCE, III, D.V.M., HAVE READ AND UNDERSTAND THE FOREGOING AGREED ORDER. I UNDERSTAND BY SIGNING IT, I WAIVE CERTAIN RIGHTS. I SIGN IT VOLUNTARILY. I UNDERSTAND THAT THIS ORDER CONTAINS THE ENTIRE AGREEMENT AND THERE IS NO OTHER AGREEMENT OF ANY KIND, VERBAL, WRITTEN OR OTHERWISE.

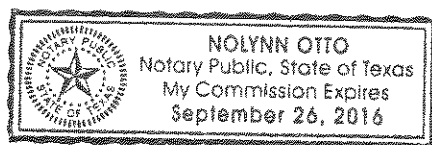
M. L. Tierce III
MILLARD LUCIEN TIERCE, III, D.V.M.

1 Oct. 2014
DATE

STATE OF TEXAS §
COUNTY OF Tarrant §

BEFORE ME, on this day, personally appeared Millard Lucien Tierce, III, D.V.M., known to me as the person whose name is subscribed to the foregoing document, and acknowledged to me that he executed the same for the purposes stated therein.

Given under the hand and seal of office this 1st day of October, 2014.



[Signature]
Notary Public

SIGNED AND ENTERED by the TEXAS BOARD OF VETERINARY MEDICAL EXAMINERS on this the 21 October, 2014.

[Signature]
Bud E. Alldredge, Jr., D.V.M., President