Yakima River Basin Water Enhancement Project, Yakima, Washington, established by the Secretary of the Interior, will hold a public meeting. The purpose of the Conservation Advisory Group is to provide technical advice and counsel to the Secretary of the Interior and Washington State on the structure, implementation, and oversight of the Yakima River Basin Water Conservation Program.

DATES: Tuesday, October 26, 2004, 9 a.m.–4 p.m.

ADDRESSES: Bureau of Reclamation Office, 1917 Marsh Road, Yakima, Washington.

FOR FURTHER INFORMATION CONTACT: Mr. James Esget, Manager, Yakima River Basin Water Enhancement Project, 1917 Marsh Road, Yakima, Washington, 98901; 509–575–5848, extension 267.

SUPPLEMENTARY INFORMATION: The purpose of the meeting will be to review the option of using the acquired habitat lands to mitigate the impacts that occur from the planned conservation measures and develop recommendations. This meeting is open to the public.

Dated: September 29, 2004,

James A. Esget,

Program Manager, Pacific Northwest Region.

[FR Doc. 04–22458 Filed 10–5–04; 8:45 am]

BILLING CODE 4310–MN–M

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

[Docket No. 02–10]

Kathy A. Morall, M.D.; Revocation of Registration

I. Background

On September 28, 2001, the Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration issued an Order to Show Cause to Kathy A. Morall, M.D., (Respondent), proposing to revoke her DEA Certificate of Registration. The Basis for the Order to Show Cause was that Respondent's registration would be inconsistent with the public interest as that term is used 21 U.S.C. 823(f). More specifically, the OTSC alleged that in November 1998, DEA was alerted that Respondent had ordered large amounts of phentermine and Meridia (Schedule IV controlled substances) for delivery to her home address. DEA notified the Respondent that she could not have controlled substances delivered to her home because she was registered elsewhere. Respondent then asked for a change of address on her registration.

In December 1998, DEA investigators conducted an inspection of Respondent's registered location—her home. When the investigators arrived and asked Respondent where she kept the controlled substances, she initially denied having any controlled substances at home. When the investigators asked her about the whereabouts of the phentermine and Meridia that she had recently ordered, she admitted that the drugs were in her home. When shown the location of the drugs, the investigators noted that the drugs were in a box in a closet, and were not stored in a securely locked, substantially constructed cabinet, as required.

When the investigators asked for the Respondent's dispensing records, she said that they were in her former office in Denver. She agreed to send them to the investigators, but later changed her mind, explaining that she wanted to talk to an attorney first. When finally received, the dispensing records were incomplete. The Respondent failed to provide any records of inventories, theft/loss reports or drug destruction reports.

On January 5, 1999, during the execution of an administration inspection warrant, the Respondent admitted that her record keeping was inadequate and that she had failed to maintain any inventories of controlled substances. She also admitted that the dispensing records that she provided had been created from memory. The Respondent was also unable to provide patient charts, because she had been evicted from her offices and no longer had access.

During the inspection, the investigators found two phentermine vials, one empty and one partially full. Both were issued in the name of a purported patient. The Respondent told the investigators that the drugs were prescribed for her uncle. The Respondent's husband told the investigators, however, that the ''uncle'' was really just a friend of the family.

Accountability audits of the Respondent's handling of phentermine and Meridia form 1997 to 1999 showed various overages and/or underages of the drugs. The investigators also learned that Respondent had filed a report with the police concerning the theft from her offices of controlled substances, but she had not notified DEA, as required by regulation.

The Respondent requested a hearing on the issues raised in the Order to Show Cause and the matter was placed on the docket of Administrative Law Judge Mary Ellen Bittner (the ALJ). Following prehearing procedures, testimony was presented before the ALJ on June 19 and 20, 2002, in Arlington, Virginia. The Government presented testimony from one witness and had admitted several exhibits into evidence. In addition to her own testimony, the Respondent presented two witnesses and also had several exhibits admitted into evidence. After the hearing, both parties submitted Proposed Findings of Fact, Conclusions of Law and Argument.

On July 24, 2003, the ALJ certified and transmitted the record to the Acting Administrator of DEA. The record included, among other things, the Opinion and Recommended Rulings, Findings of Fact, Conclusions of Law and Decision of the Administrative Law Judge, the findings of fact and conclusions of law proposed by all parties, all of the exhibits and affidavits, and the transcript of the hearing sessions. In her opinion, the ALJ recommended that Respondent's DEA registration not be revoked.

II. Final Order

The Deputy Administrator does not adopt the Opinion and Recommended Ruling, Findings of Fact, Conclusions of Law, and Decision of the Administrative Law Judge. The Deputy Administrator has carefully reviewed the entire record in this matter, as defined above, and hereby issues this final rule and final order prescribed by 21 CFR 1316.67 and 21 CFR 1301.46, based upon the following findings of fact and conclusions of law.

A. Findings of Fact

On July 9, 1997, the Respondent was assigned DEA Certificate of Registration number BM5412868, in Schedules II through V. The registration was issued to the Respondent at 128 Steele Street, Suite 200, Denver, Colorado (the Denver clinic). That registered location was known as the Life-Plan Weight Loss Center and was affiliated with the Holland Center for Family Health, and Arizona professional corporation. The Life-Plan Weight Loss Center was owned by Joshua Holland, M.D., and Arizona based medical practitioner, who was also registered with DEA in the State of Arizona. Dr. Holland had previously operated a successful weight loss clinic in Arizona and he sought to open a similar clinic in the Denver area. To that end, he placed an advertisement in a newspaper, seeking a physician to run the Denver clinic. The Respondent was ultimately hired for the position. As the only physician at the Denver clinic, the Respondent was responsible for ordering controlled substances under her DEA registration number.

The Respondent's business arrangement with Dr. Holland dissolved sometime during November 1997 based upon financial differences between the two. Sometime after November 1997, the Respondent left the employ of Dr. Holland and relocated from Suite 200 to Suite 202 of the 128 Steele Street location, where she intended to maintain her own clinic under the name Total Health Care Systems.

At the hearing, a DEA Diversion Investigator (DI) testified about the instigation of the investigation of the Respondent. She introduced a swore statement from a registration technician (RT) at DEA's Denver Division. In the statement, the RT stated that on November 12, 1998, she received a voice mail message from the Respondent. In the message, the Respondent stated that she needed to obtain the controlled substance phentermine as soon as possible. Before returning the Respondent's call, the RT was instructed by her supervisor to return a previous call from a representative of Horizon Wholesale (Horizon) concerning a request by the Respondent to have controlled substances delivered to an unregistered address.

On the same day, the RT placed a call to Horizon. The Horizon representative expressed concern that when the Respondent placed an order for controlled substances, the return telephone number that she gave was for an answering service. He expressed further concern that Horizon could not obtain a business telephone number for the Respondent. The RT instructed the Horizon representative not to ship controlled substances to the Respondent at an address different from her registered address. The RT also requested the telephone number to the answering service that was provided by the Respondent.

After a number of attempts, the RT was able to get in touch with the Respondent. The Respondent informed the RT that she needed to order drugs so that they could be shipped to her home address. When asked whether she was storing controlled substances at her home, the Respondent replied in the affirmative and told the RT that she had a safe at the location to store the controlled substances. The DI also testified that the Respondent also informed another DEA employee that she had a safe at her home.

The RT informed the Respondent that she was not allowed to store controlled substances at her home for the sake of convenience, and could only store controlled substances at a registered location. The Respondent further added that she did not store or dispense controlled substances from the Steele Street location.

Following discussions on the proper manner to modify a DEA registration, the Respondent faxed to the DEA Denver office a request to modify her registration to reflect her home address, 8285 South Marion Way, Littleton, Colorado (the South Marion Way location). The Respondent's request to have controlled substances delivered to her home triggered DEA's investigation.

Following the modification of the Respondent's DEA registration, the DEA investigators received information from Horizon that the Respondent ordered approximately 3000 dosage units of phentermine and 200 dosage units of Meridia to be delivered to the Respondent's home. In the interest of assessing the security of the ordered drugs, and to seek accountability and justification for their use, DEA investigators went to the Respondent's home on December 1, 1998.

When they arrived at the Respondent's home, the DEA investigators asked to review records of the Respondent's handling of controlled substances. Specifically, the investigators requested dispensing records, records of theft or losses, records of drug destructions or any disposals of controlled substances. The Respondent did not provide any of the requested records, including inventories. The Respondent informed the investigators that all of her records were still at her Steele Street office location. The Respondent further stated that she was in the process of moving her practice from the Steele Street location to her home address. When asked if she was seeing patients at her home location, the Respondent answered in the negative.

The investigators then asked to see the controlled substances that were ordered by the Respondent. She told the investigators that the controlled substances were at the Steele Street location. When reminded that controlled substances were to be stored at a registered premise, the Respondent changed her story, claiming that she was not in possession of any controlled substances at any location. When the investigators asked about the 3,000 dosage units of controlled substances that were shipped to her home by Horizon, the Respondent finally admitted that the controlled substances ere in her home, and retrieved them out of an open box in a closet.

The box was small and made of cardboard. In addition to the bottles of pills, it contained trash, cotton, candy wrappers and loose pills. The Respondent informed the investigators that the loose pills came from a previous shipment. Approximately half of the controlled substances that Respondent had ordered were gone, and some of the bottles of phentermine were opened. There were also empty bottles of Meridia in the box. Investigators then asked to see the Respondent's safe. Although she had told RT that she had a safe in her home, she admitted that she did not have one, but intended to get one.

The Respondent told the investigators that she dispensed the missing drugs to her patients but that she had not seen any patients in the previous few weeks. The Respondent then admitted that she had not any patients in here home at all, but had dispensed the medications by mailing them to patients. The Respondent also informed investigators that her husband and son had access to various areas of the house. The DI testified that the controlled substances were not stored or secured as required by DEA laws and regulations.

The investigators had a discussion with the Respondent about the need for maintaining proper records, and the Respondent agreed that any controlled substance records remaining at the Steele Street location were to be transferred to the new registered location. The investigators then conducted a physical count of controlled substances on hand. According to physical count, there were 735 15mg. phentermine tablets and 785 30mg. phentermine tablets.

With respect to controlled substance records that were not provided, arrangements were made with the Respondent to provide the requested records the following day. The DI further requested that the Respondent provide records dating back two years. On December 2, 1998, the mail message from the Respondent saying that she had the requested records and that they were in the mail. However, on December 4, the DI received a second voice mail from the Respondent in which the Respondent stated that she wished to consult with an attorney before turning over the records.

The Respondent eventually sent what she called controlled substance records to DEA on December 21, 1998. Although DEA requested records dating back two years, the Respondent only provided records dating back two months, and only covering the shipments from Horizon. The investigators found that some of the records sent by Respondent appeared to have been ''manufactured.''For example, they found that receipt date of the drugs was incorrect and that the dates of dispensation were in chronological

order up until December 11, 1998, when the next entry reflected a date of December 3, 1998. In addition, the totals of the drugs on the date of the December 1, 1998, inventory did not match the records provided by the Respondent on December 21. Again, the Respondent failed to provide an initial inventory, and her controlled substance records were incomplete and inaccurate.

Upon receipt and inspection of the copied records received from the Respondent, the DI called the Respondent and requested original records. When the Respondent did not respond to the request, the DI applied for an administrative inspection warrant to inspect the Respondent's new registered location. The DI sought the inspection warrant in order to verify the correctness of inventories, records, reports and other documents required to be kept under the CSA.

On January 5, 1999, the DEA investigators returned to the Respondent's registered location to execute the administrative inspection warrant. The investigators found that Respondent's records were intermingled; patient sheets were found among personal papers, financial data, and the like. The investigators also found a yellow notepad where Respondent had apparently attempted to reconcile the quantities of drugs given to patients.

The investigators also found loose pieces of paper entitled ''Medication Accountability'' in a desk, and in a box in the closet. These records were not part of the patient charts. The investigators also collected 15 patient charts for inspection. Two of the charts had no information in them. In many of the other charts, the last entry for the patients was either September or October 1997. In addition, these records were not of patients who purportedly received dispensations over the previous two months.

The investigators also found a prescription bottle for phentermine for Carl Ousley, which listed the Respondent as the prescribing physician. When the investigators asked the identity of Mr. Ousley, the Respondent said he was her uncle. The Respondent's husband, however, stated that Mr. Ousley was only a friend.

In the garage of the Respondent's home, the investigators found an empty bulk manufacturer's bottle of 100-count tablets of phentermine. Although the investigators attempted to obtain from the Respondent the name of the supplier of the drugs, they were never able to determine its origins. The Respondent could not even provide the names of wholesalers from whom she purchased controlled substances. Although the Respondent informed the investigators that she had dispensed these medications to patients, she could not provide documentation to support this claim. There were no original receipts for drug purchases and the Respondent did not know where they could be located.

The DEA investigators found prescription vials for various controlled substances in different parts of the Respondent's home. Investigators also inspected a filing cabinet in which controlled substances were stored. The cabinet was not locked and it contained two empty bottles of Meridia and three opened bottles of phentermine. The investigators also found an empty prescription vial in the master bedroom closet. The investigators could not determine the identity of the drug, the patient or the prescriber because the label had been peeled off.

DEA investigators asked the Respondent if she personally used phentermine. The Respondent acknowledged that she had been given a prescription from her previous business partner, Dr. Holland, and had taken the drug during the previous holiday. The Respondent further stated that she didn't have any more pills from that prescription, but doubted that Dr. Holland would vouch for the prescription because of the bad breakup of their business arrangement. The Respondent further denied any personal use of any phentermine from bottles and vials found around her home.

The DEA investigators also discussed with the Respondent the last time she dispensed controlled substances from her new registered locations. The Respondent informed investigators that she had not dispensed from that location since December 1, 1998. The Respondent also informed investigators that they were free to inspect the Steele Street location because that was where the remainder of her dispensing records were maintained.

The Respondent was asked about inconsistencies in the records that she had previously mailed to DEA. When asked how she planned to reconcile these inconsistencies, the Respondent stated that she could do it from memory. As noted above, during the January 5 inspection, the Respondent informed DEA investigators that she had not dispensed controlled substances from her new registered location since December 1, 1998. However, the results of the physical count performed during that inspection revealed different totals: for example, the December 1, 1998, physical count for phentermine 735 tables; on January 5, 1999, the physical count was 542. The physical count for December 1 should have matched that for January 5.

The investigators further noted that when comparing the records mailed by the Respondent to those seized by investigators on January 5, the records did not match as well. For example, the mailed records for phentermine 30mg. showed one full bottle of 1,000 tablets and one partial bottle of 220, for a balance of 1,220 on hand. However, the physical count that day was 735 tablets.

Following the January 5 inspection, DEA performed two accountability audits of controlled substances handled by the Respondent. The first audit period chosen was from November 1, 1998 to December 1, 1998, and covered the drugs phentermine (30mg. and 15mg.) and Meridia (15mg. and 10mg.). The audit resulted in a shortage of 740 dosage units of phentermine products. DEA investigators performed a second accountability audit, covering the period of November 1, 1998 to January 5, 1999. The audit for that time period reflected shortages and overages of phentermine products.

The investigators had ongoing discussions with the Respondent to inspect the Steele Street location, in order to acquire the remaining dispensing records that Respondent said were there, and reconcile the discrepancies found in DEA's audits. However, the Respondent failed to inform the DEA investigators that she had been evicted from that location. Some time in January 1999, the building manager of the Steele Street location informed DEA that Respondent had been evicted for ''nonpayment.'' Despite the Respondent's assurances that she was agreeable to a meeting at that location, she never actually agreed to a meeting there on a set date.

In light of the Respondent's refusal to cooperate with the investigators, they applied for a search warrant for the Steele Street location (Suite 202). The warrant was executed on May 6, 1999. During the inspection of Suite 202, the investigators took photos of the premises. Various controlled substances were found at that location as well as miscellaneous records.

The investigators generated an inventory of controlled substances found in Suite 202. These drugs were found on a cart, which had been secured by the building manager. The cart had no locking mechanism, and the drugs in the cart were not secured in any fashion when found by the building manager. The Investigators also determined that these controlled substances were ordered under the Respondent's DEA registration number from Quality Care

Pharmaceuticals, a controlled substance distributor. The investigators found that these drugs had expired. They were counted, treated as abandoned, and put aside for destruction. These drug products were identified as phentermine 30mg. in various quantities and number of containers.

Copies of ''Dispense-Quick-Log'' sheets (labels) had been provided with vials of drugs from Quality Care Pharmaceuticals. The labels did not meet DEA record keeping requirements because they did not list which drug was dispensed or the quantity dispensed. These log sheets were found tossed in miscellaneous boxes throughout the office.

The DEA investigators also seized patient files from Suite 202. The investigators tried but failed to find current dispensing records of what drugs the Respondent had purchased from Horizon. An example in this regard was the patient record for patient S.S. The patient file did not contain dispensing information for controlled substances, i.e., quantities, etc. The other patient files seized were fairly representative of the record keeping in all of the files, in that the last entries in the files were dates in 1997 and early 1998.

Following the execution of the search warrant, further accountability audits were conducted. These audits covered the period of November 25, 1997 and January 5, 1999, and again, the controlled substances audited were phentermine (30mg. and 15 mg.) and Meridia (5, 10 and 15mg.). [*Id.*] The revised audits were designed to include information obtained from the inspection of the Steele Street location, the Respondent's new registered location, and information obtained from a second drug supplier, Quality Care Pharmaceuticals. These audits were also conducted to give the Respondent credit for the miscellaneous papers, receipts, and dispensation notes, even though these items did not meet DEA record keeping requirements.

The results of DEA's initial audit (excluding records that were not maintained pursuant to DEA requirements) revealed that the Respondent was unable to account for 11,148 dosage units of controlled substances. Through the use of the records that the Respondent supplied, DEA found that Respondent was unable to account for 7,154 dosage units of controlled substances.

DEA's investigation also revealed that Respondent did not maintain a record of the transfer of controlled substances. In a call to Quality Care Pharmaceuticals, DEA investigators learned that quantities of Redux and Pondimin (both Schedule IV controlled substances) were transferred from Respondent's Steele Street office to Quality Care. The Respondent had previously told investigators that she had not destroyed or returned any drugs.

B. Conclusions of Law

Pursuant to 21 U.S.C. 823(f) and section 824(a)(4) the Deputy Administrator of the Drug Enforcement Administration may revoke a DEA Certificate of Registration if she determines that the continued registration of the registrant would be inconsistent with the public interest. Pursuant to 21 U.S.C. 823(f), in determining the public interest, the following factors will be considered:

(1) The recommendation of the appropriate state licensing board or professional disciplinary authority.

(2) The applicant's experience in dispensing controlled substances.

(3) The applicant's conviction record under Federal or State laws relating to the distribution, or dispensing of controlled substances.

(4) Compliance with applicable State, Federal, or local laws relating to controlled substances.

(5) Such other conduct which may threaten the public health and safety.

These factors are to be considered in the disjunctive; the Deputy Administrator may relay on any one or combination of factors and may give each factor the weight she deems appropriate in determining whether a registration should be revoked or application for registration be denied. See Henry J. Schwarz, Jr., M.D., 54 FR 16,422 (1989).

In this case, factors two, four and five are relevant in determining whether Respondent's DEA Certificate of Registration should be revoked and her pending application for renewal of that registration should be denied.

1. Factors Two and Four—Experience in Dispensing Controlled Substances and Compliance With Applicable State and Federal Law [1]

Factors two and four are also relevant with respect to Respondent's: (1) Failure to maintain a record of her return of Schedule IV controlled substances to a supplier, as required by 21 CFR 1307.12; (2) failure to obtain a DEA registration for the South Marion location prior to dispensing controlled substances from that location, as required by 21 CFR 1301.11 and 1301.12; (3) failure to store Schedule IV controlled substances in a securely locked, substantially constructed cabinet at her former registered location at 128 Steele Street location, Suite 202, as well as the modified registered location at South Marion Way, as required by 21 CFR 1301.75(a); (4) failure to maintain complete and accurate records with respect to the receipt and dispensing of controlled substances, as required by 21 U.S.C. 827(a)(3), and 21 CFR 1304.03, 1304.04 and 1304.21(a) (these statutory provisions are further relevant to Respondent's failure to account for between 7,000 to over 11,000 dosage units of Schedule IV controlled substances); (5) failure to take an initial inventory of controlled substances on hand on the date she engaged in the dispensing of controlled substances as required by 21 U.S.C. 827(a)(1) and 21 CFR 1304.11; and (6) failure to maintain inventories and records of controlled substances, either separately from all other records, and in a readily retrievable fashion, as required by 21 CFR 1304.04(f)(2) and (g).

Thus, the Respondent committed numerous violations of the Controlled Substances Act by failing to adhere to proper record-keeping. The importance of the DEA system of record-keeping is well settled. The purpose of the enactment of the 1970 Uniformed Controlled Substances Act (the ''Act'') was to provide a system for the control of drug traffic and to prevent the abuse of drugs. The statutory scheme envisioned by the Act is one of control through record-keeping. *United States* v. *Stidham,* 938 F. Supp. 808, 814 (S.D. Ala. 1996). Congress sought measures to monitor the drug transactions of registrants, who, with authority to dispense drugs, have the greatest access to controlled substances, and therefore the greatest opportunity for diversion. *United States* v. *Moore,* 423 U.S. 122, 135, (1975).

In some cases, revocation of a DEA registration is an appropriate measure for failure to maintain adequate controlled substance records and inventories. Compliance with Federal laws and regulations relating to the handling, record keeping, reporting, and security of controlled substances are essential to assure that adequate control is maintained to prevent the diversion of controlled substances from legitimate channels. North American Medical, Inc., 53 FR 39,543 (1988). DEA has also found grounds for revocation of a DEA

[1] Most of the conduct at issue regarding the Respondent's experience dispensing controlled substances while not complying with DEA recordkeeping requirements also involve and further demonstrate Respondent's history of failing to comply with state and federal laws concerning controlled substances. Therefore, the Government's analysis under 21 U.S.C. § 823(f)(2) and (4) has been combined. *See* Service Pharmacy, Inc., 61 FR 10,791, 10,795 (1996).

registration in situations involving poor record keeping practices, even where no personal use or criminal convictions involving controlled substances were determined. RX Returns, Inc., 61 FR 37081 (1996).[2]

2. Factor Five—Conduct Which May Threaten the Public Health and Safety

The Respondent testified at the hearing concerning the reasons for her very poor record-keeping. She had no assistance to help with record-keeping and during the period at issue, she was going through extremely stressful circumstances. She developed a condition involving her pituitary gland that lowered her voice, caused her to grow a beard and lose hair. She thought that she might have to have brain surgery. At the same time, her son had a seizure and was diagnosed with a disease related to sickle cell anemia. Several friends died, included one suicide. She was very depressed during this period, and as a result, her recordkeeping suffered.

These circumstances may very well partly excuse some of the Respondent's record-keeping failures. The Deputy Administrator is particularly disturbed, however, by the numerous occasions that the Respondent provided false information to DEA investigators and repeatedly frustrated their attempts to conduct their investigation. At the hearing, the Respondent claimed that she had never meant to mislead the investigators and denied making false statements. The Deputy Administrator finds, however, that the Respondent has no credibility, because it is absolutely clear that she lied to the investigators on numerous occasions.

The Respondent lied about possessing controlled substances at her house. She lied about having a safe in her house in which to store controlled substances. She lied about treating patients from her home. She lied about the true identity of a friend for whom she had written prescriptions for controlled substances. She misled the investigators about the existence of patient records. She continually maintained that she had controlled substance records at her office, when in truth she did not. She later admitted that she had tried to create the records from memory. The Respondent's refusal to cooperate with DEA investigators led DEA to request the issuance of an administrative inspection warrant of her South Marion Way location and subsequently, the Steele Street location.

Moreover, the Respondent agreed to assist DEA investigators in their inspection of the Steele Street location, without telling them that she had been evicted from that location. The Respondent's failure to cooperate with the investigators in their efforts to inspect the former registered location necessitated the execution of a search warrant. The Respondent also made false statements regarding the transfer of drugs. Despite her denials the investigators discovered that the Respondent had transferred Schedule IV controlled substances to Quality Care Pharmaceuticals.

The circumstances surrounding the Respondent's treatment of patients from her home is also troubling. As noted above, the Respondent was unable to account for between 7,000 and 11,000 dosage units of controlled substances. While the Respondent asserted that the controlled substances were legitimately dispensed to patients, she had no records to support her assertion. The Respondent's attempts at creating controlled substance records could not reconcile the shortages. Even the Respondent's own patient records did not bear out her assertions that she continued to dispense drugs to patients throughout 1998, as many of the records showed entries which ended in 1997 and early 1998.

The Deputy Administrator does not necessarily find that these controlled substances were diverted. Nevertheless, the lack of proper documentation to account for the shortage of large quantities of drugs; the Respondent's admission to the use of phentermine; her demonstrated lack of candor; empty drug vials around her home of which she was unable to account for their origins or disposition, all suggest possible drug use on the Respondent's part, or by someone close to her.

III. Conclusion

The preponderance of evidence demonstrates that the Respondent's continued registration would be contrary to the public interest. If the Respondent's only failures involved record-keeping, the Deputy Administrator might find it appropriate to impose a lesser sanction than revocation of the Respondent's DEA registration. The Respondent's false and misleading statements, however, cannot be excused. DEA cannot maintain the integrity of its regulatory system if its registrants, when asked to provide information required by law, provide false information. Accordingly, the Deputy Administrator, pursuant to the authority vested in her by 21 U.S.C. 823 and 824 and 28 CFR 0.100 and 0.104, hereby orders that the Respondent's DEA Registration be, and it hereby is, revoked, and that any requests for renewal or modification be, and hereby are, denied. This order is effective November 5, 2004.

Dated: September 28, 2004.

Michele M. Leonhart,

Deputy Administrator.

[FR Doc. 04–22422 Filed 10–5–04; 8:45 am]

BILLING CODE 4410–09–M

[2] While the Deputy Administrator in *RX Returns* found revocation appropriate, the revocation was stayed and a one year period of probation was imposed. [*Id.* at 37,090]

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

Michael J. Schwartz, MD.; Revocation of Registration

On January 5, 2004, the Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration (DEA), issued an Order to Show Cause to Michael J. Schwartz, M.D. (Dr. Schwartz) who was notified of an opportunity to show cause as to why DEA should not revoke his DEA Certificate of Registration, BS5860590, pursuant to 21 U.S.C. 824(a)(3). Specifically, the Order to Show Cause alleged that Dr. Schwartz was without State license to handle controlled substances in the State of Louisiana. The Order to Show Cause also notified Dr. Schwartz that should no request for a hearing be filed within 30 days, his hearing right would be deemed waived.

The Order to Show Cause was sent by certified mail to Dr. Schwartz at his registered location in Kenner, Louisiana, with a second copy sent to Dr. Schwartz' legal counsel in New Orleans. The order sent to Dr. Schwartz' address of record was subsequently returned to DEA by the United States Postal Service with a stamped notation: ''attempted, not known.'' According to the return receipt of the second order sent to the registrant's attorney, it was accepted on Dr. Schwartz' behalf on or around January 15, 2004. DEA has not received a request for hearing or any other reply from Dr. Schwartz or anyone purporting to represent him in this matter.

Therefore, the Deputy Administrator of DEA, finding that (1) thirty days having passed since the attempted delivery of the Order to Show Cause to the registrant's address of record, as well as to a second address, and (2) no request for hearing having been received, concludes that Dr. Schwartz is deemed to have waived his hearing right. *See David W. Linder,* 67 FR 12579 (2002). After considering material from the investigative file in this matter, the