DOCKET NO. 2012-59

IN THE MATTER OF § TEXAS BOARD OF
THE LICENSE OF § VETERINARY
DAVID J. SNYDER, D.V.M. § MEDICAL EXAMINERS

AGREED ORDER

On this the 27th of March, 2012, came to be considered by the Texas Board of Veterinary Medical Examiners ("Board") the matter of the license of David J. Snyder, D.V.M. A meeting of the Board's Executive Disciplinary Committee occurred on January 26, 2012, at which the Executive Disciplinary Committee temporarily suspended Dr. Snyder's veterinary license pursuant to Rule 575.35. A temporary suspension hearing before the Board's Enforcement Committee was held on February 7, 2012. The Respondent appeared at the hearing after receiving sufficient notice. The Board was represented at the hearing by the Board's Enforcement Committee.

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, David J. Snyder, D.V.M., of Terrell, Texas holds Texas veterinary license 5560.

2. The Board has jurisdiction over the subject matter and Respondent. Respondent received all notice and due process required by law and by the rules of the Board. All jurisdictional requirements have been satisfied under TEX. OCC. CODE ANN. Title 4 (the "Act"). By executing this Order, Respondent waives any judicial review, defect in notice, hearing and/or due process and/or any further right to judicial review, notice, hearing and/or due process under the Act, TEX. GOV'T CODE ANN. §§ 2001.051 through .054, and the Rules of the Texas Board of Veterinary Medical Examiners (22 TEX. ADMIN. CODE Chapter 575).

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3. On December 12, 2007, Daniel Nitschke presented his pregnant three-year-old female Chihuahua named “Huey” to David Snyder, D.V.M. at the Highway 34 Animal Hospital ("Clinic") in Terrell, Texas to perform a caesarian procedure. Dr. Snyder performed the procedure on December 12, 2007, and delivered three puppies. That afternoon, Dr. Snyder informed Mr. Nitschke that “Huey” did not survive the operation. That afternoon, Mr. Nitschke and his daughter-in-law, Becky Nitschke, saw the puppies, which Dr. Snyder was allowing to suckle on another lactating bitch in his clinic. Daniel and Becky Nitschke visited the puppies on December 13, 2007, but the staff of the Clinic informed them that they could not visit on Sunday, December 14, 2007 because the Clinic was closed. On Monday, December 15, 2007, Ms. Nitschke went to the Clinic to see the puppies, but was informed by Clinic staff that all of the puppies had died. When Ms. Nitschke asked to see the puppies’ bodies, the Clinic staff refused her request, and informed her that the puppies were already buried.

4. On November 8, 2011, an investigator for the Texas Board of Veterinary Medical Examiners (“Board”) sent a letter to Dr. Snyder, requesting a written response to Ms. Nitschke’s complaint and a copy of the relevant records within 21 days. Dr. Snyder did not respond. On January 24, 2012, an investigator for the Board went to the Clinic and requested records for any animals under the last name “Nitschke.” Clinic staff informed the Board investigator that the hospital’s database did not show any such records.

5. On April 24, 2011, Respondent was arrested for possession of a controlled substance after a DPS officer found crystal methamphetamine and drug paraphernalia in the back seat of a truck that Respondent was driving. Respondent failed to report his arrest to the Board. On June 23, 2011, Respondent was indicted by a grand jury for possession of a controlled substance of more than four grams but less than 200 grams. Rule of Professional Conduct 575.50, Criminal Convictions, states that a misdemeanor or felony offense involving diversion or abuse of controlled substances, dangerous drugs, or narcotics is a crime related to the practice of veterinary medicine.

6. On the evening of May 19, 2011, Mr. Bunch presented his three month-old male puppy named “Shaggy Jr.” to Respondent at the Highway 34 Animal Hospital for neutering surgery. Before beginning the surgery, Respondent sedated “Shaggy Jr.” Once the sedation had taken effect, Respondent placed a mask over “Shaggy Jr.’s” nose and mouth to assist him in breathing while under sedation. Respondent performed the neuter surgery on “Shaggy Jr.” in approximately ten minutes. About an hour after the completion of the surgery, “Shaggy Jr.” had not regained consciousness and was not able to breathe on his own. Respondent gave “Shaggy Jr.” several injections in an attempt to revive him, but “Shaggy Jr.” did not regain consciousness.

7. When another client came in to the clinic, Respondent had his assistant, Melanie Snyder, who is not licensed to practice veterinary medicine, relieve him in caring for “Shaggy Jr.” so that he could go attend to the other client. Ms. Snyder removed the breathing support and placed
"Shaggy Jr." in a cage under some towels, and asked Mr. Bunch to leave the puppy overnight for observation. The next morning, on May 20, 2011, Mr. Bunch returned to the clinic and went to the cage where he had last seen the puppy. The puppy was dead and cold, still inside the cage. Respondent was not available to answer Mr. Bunch's questions regarding “Shaggy Jr.’s” death at that time, so Mr. Bunch left the clinic. When Mr. Bunch returned that afternoon to speak with Respondent and retrieve “Shaggy Jr.’s” body for burial, Mr. Bunch was informed by staff at the Highway 34 Animal Hospital that “Shaggy Jr.” had already been sent for cremation without Mr. Bunch’s permission.

8. On June 17, 2011, after Respondent received notice from the Board of Mr. Bunch’s complaint against him, Respondent went to Mr. Bunch’s residence, and confronted him regarding Mr. Bunch’s complaint to the Board on Respondent’s treatment of “Shaggy Jr.” Respondent was hostile and aggressive to Mr. Bunch and refused to leave when Mr. Bunch requested that he go, even when Mr. Bunch offered to call the police. Respondent failed to respond to the Board’s request for relevant patient records and a written response to the complaint.

9. On July 22, 2011 at around 5:00 pm, Billy Langwell presented his four year old Schnauzer named “Alex” to Respondent at the Highway 34 Animal Hospital for treatment of vomiting and severe bloody diarrhea. Respondent did not perform any blood tests on “Alex,” but told Mr. Langwell that he diagnosed “Alex” as having pancreatitis. Respondent then administered three injections to “Alex”—.5cc of Dexamethasone, .3cc of Naxcell, and 500cc of subcutaneous fluids. Respondent told Mr. Langwell that he would keep “Alex” hospitalized, and report back to Mr. Langwell on “Alex’s” condition later that night. Respondent did not call Mr. Langwell that night.

10. The next morning, on July 23, 2011 at 7:51 am, Mr. Langwell attempted to reach Respondent by phone, and had to leave a message. Mr. Langwell left another message for Respondent at 9:51 am. At approximately 10:48 am, a member of Respondent’s office staff called Mr. Langwell to tell him that Respondent wanted to keep “Alex” hospitalized overnight. That same afternoon, Lesley Snyder, Respondent’s wife and veterinary office assistant, stopped by Mr. Langwell’s place of business, told him that “Alex” did not look good, and suggested that he continue to try to contact Respondent. Mr. Langwell then called Respondent at 2:08 pm and again at 6:13 pm, but did not reach him. According to Respondent’s records, on July 23, 2011, he noted that “Alex” was “a little dehydrated” and gave him 500cc of subcutaneous fluids, .5cc of Naxcell, and .2cc of banamine.

11. From the notes in his records, Respondent appears to have left town on July 23, 2011, sometime before 2:30 pm. At 2:30 pm, notes reflect that Respondent received notification from his staff that “Alex” had died. Respondent’s records suggest that he did not return to town until late on July 24, 2011.
12. Mr. Langwell and Dan Bodziak went to the Highway 34 Animal Hospital around 7:00 pm on July 23, 2011, but found that the clinic was closed and no one was there. Mr. Langwell called Respondent three more times on July 23, 2011, at 7:45 pm, 8:30 pm, and 9:44 pm, and left urgent messages each time. Between each call, Mr. Langwell drove by the Highway 34 Animal Hospital to see if anyone had arrived, but never found anyone there.

13. On July 24, 2011, Mr. Langwell again attempted to contact Respondent at 8:37 am, and left another urgent message. Mr. Langwell then drove to the Highway 34 Animal Hospital, and when no one answered the door, called Respondent again from the parking lot at 12:46 pm, but did not reach anyone. Mr. Langwell called again from the clinic parking lot at 12:55 pm, and a clinic employee opened the door and allowed Mr. Langwell to enter the clinic. Inside, Mr. Langwell found “Alex” dead and bloated, lying unattended in a kennel.

14. Respondent did not respond to the Board’s request for a response to Mr. Langwell’s complaint. On August 10-11, 2011, investigators from the Board conducted an onsite investigation at Respondent’s clinic. At that time, they received Respondent’s patient records on “Alex.” The patient records lack the client’s address or telephone number, the patient’s species and breed, and details necessary to substantiate Respondent’s examination and diagnosis of “Alex.”

15. On August 10-11, 2011, investigators from the Board performed an onsite inspection of Respondent at the Highway 34 Animal Hospital in Terrell, Texas. During the inspection, a Board investigator noted that Respondent’s controlled substances were not kept in sufficiently secured cabinets, which the Board’s investigator pointed out to Respondent during the inspection. Respondent was also unable to produce a controlled substances log when the Board’s investigator requested it. At an informal conference of the Enforcement Committee on November 10, 2011, Respondent admitted that he had failed to maintain his controlled substance log because he had gotten behind on entries for 2010, and did not have a drug log for the Board to inspect for the year 2011.

16. On August 29, 2011, Leslie Snyder, an employee at the Highway 34 Animal Hospital, reported to the Terrell Police Department that a burglary had occurred. The inadequately secured cabinet that Board investigator had noted during the investigation had been pried open and ten ten-milliliter bottles of ketamine were reported stolen from the cabinet. Respondent told the Terrell Police Department that he had failed to properly secure a door to the Highway 34 Animal Clinic when he left the clinic at approximately 11:30 pm on August 28, 2011.

17. On or about November 10, 2011, agents from the U.S. Drug Enforcement Agency reported to the Board’s investigator that they had met with Respondent at the Highway 34 Animal Hospital to discuss Respondent’s failure to report the stolen bottles of ketamine, and that Respondent had voluntarily surrendered his DEA controlled substance certification to the agents at that time.
18. On September 15, 2011, Charlene Knight presented a six-month old Chihuahua puppy named “Bella” and a six-month old Jack Russell Terrier puppy named “Harley” to Respondent for spay procedures. On September 16, 2011, Respondent anesthetized “Bella” and “Harley” and performed spay surgery on both of them. Later that day, Respondent informed Ms. Knight that “Bella” had choked on a large piece of dog food that became lodged in her throat during surgery, and that Respondent had euthanized “Bella” because she had been deprived of oxygen so long that if “Bella” regained consciousness, she would be severely brain damaged. Ms. Knight denied allowing “Bella” to eat after midnight the day before surgery.

19. While “Harley” survived the surgery and was released by Respondent on September 16, 2011, Ms. Knight had to return to Respondent’s hospital when she noticed that “Harley’s” stomach was hard. Respondent informed Ms. Knight that he had inadvertently used the wrong type of stitches on “Harley,” and had failed to use dissolving stitches. Ms. Knight believes that “Harley” had major personality changes after the surgery by Respondent, and believes that those changes are due to brain damage caused by anesthesia that “Harley” received during surgery.

20. On November 30, 2011, Board Investigator Barker presented Respondent with the Ms. Knight’s complaint regarding “Bella” and “Harley,” along with a written request that Respondent provide a written response and relevant patient records to the Board within 21 days. Respondent did not provide any such response.

21. On January 24, 2012, a Board investigator went to the Highway 34 Animal Hospital and requested copies of records for “Bella” and “Harley.” Respondent’s employee informed the investigator that no such records existed in the hospital’s database for “Harley.” The record for “Bella” did not list her weight; the names, dosages, concentration and routes of administration of each drug prescribed, administered, and/or dispensed; a description of the spay procedure; the diagnosis of “Bella’s” condition following the spay; or the euthanasia procedure.

22. On September 16, 2011, Edward and Linda Erwin presented their nine-month old female Chihuahua, “Sugar,” to Respondent at the Highway 34 Animal Hospital in Terrell, Texas for a spay procedure. Respondent told Mr. and Mrs. Erwin that they could pick up “Sugar” the next day. On September 17, 2011, Mr. and Mrs. Erwin returned to pick up “Sugar.” Respondent told them that “Sugar” had been stolen from the clinic the day before by a family that was at the Highway 34 Animal Hospital to tend to their own hospitalized Chihuahua. Respondent had not called Mr. and Mrs. Erwin to inform them of the theft, but claimed that he had called animal control. Respondent stated that he had not spayed “Sugar” prior to her disappearance.

23. Respondent gave Mr. and Mrs. Erwin the name, address and phone number of Maria Delarosa, and informed them that Ms. Delarosa was the person he suspected of stealing “Sugar.” Mr. and Mrs. Erwin reported the theft to the Terrell Police Department. Mr. and Mrs. Erwin learned that Respondent had not previously reported the theft of “Sugar” to either the Terrell police or to animal control. Detectives from the Terrell Police Department questioned Ms.
Delarosa regarding the theft of “Sugar,” and searched the Delarosa residence, but did not find “Sugar.” Ms. Delarosa told the police that “Sugar” was not in a cage at the Highway 34 Animal Hospital when they visited their dog there on September 16, 2011.

24. At an informal conference with the Enforcement Committee on November 30, 2011, Respondent admitted that he allows animal control officers to use xylazine that Respondent purchases to fill the darts they use to sedate stray animals. Respondent does not establish a veterinarian-client-patient relationship with the animals that the animal control officers dart with the xylazine Respondent provides them.

25. On December 1, 2011, Respondent was stopped by the Texas Highway Patrol and found to have an unopened bottle of ketamine in his possession, despite the fact that Respondent surrendered his controlled substances certification to the Drug Enforcement Administration on November 10, 2011. Respondent was arrested for possession of a controlled substance. The Board requested a response from Dr. Snyder regarding his arrest, but he did not provide one.

26. On January 2, 2012, Diane Mitchell presented a six-year-old Chihuahua named “Skippy” to Respondent at the Highway 34 Animal Hospital for a teeth cleaning. Respondent did not inform Ms. Mitchell that “Skippy” would have to be sedated for the teeth cleaning, or that he intended to do extractions on “Skippy,” although Respondent extracted two of “Skippy’s” teeth. When Ms. Mitchell arrived to pick “Skippy” up at approximately 3:45 pm that afternoon after the cleaning was completed, “Skippy’s” tongue was hanging out of his mouth, was dark colored, and looked stiff. Ms. Mitchell inquired about “Skippy’s” condition to a member of Respondent’s staff, who told her that “Skippy’s” tongue was hanging out because he was “very relaxed.” According to Respondent’s records, “Skippy” was sedated with propofol, a short-acting sedative with a fast recovery time, giving Respondent a reason to know that something was wrong with “Skippy” when he did not recover quickly from the sedation.

27. Ms. Mitchell returned home with “Skippy,” and attempted to remove him from his carrier at around 4:30 pm, but “Skippy” would not move. At approximately 8:00 pm, Ms. Mitchell heard “Skippy” snoring very loudly. At around 9:15 pm, she noticed that she had not heard “Skippy” snoring recently, and attempted to shake “Skippy” awake. It was then that she noticed “Skippy” was dead.

28. On September 10, 2010, the Board entered Agreed Order 2010-88, disciplining Respondent and ordering him to complete an additional nine hours of continuing education prior to September 10, 2011. Respondent failed to complete the additional nine hours of continuing education prior to September 10, 2011.
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 Finding of Fact 3-4, 6-7, 9-13, 18-19, and 26-27, Respondent has violated Rule 573.22, PROFESSIONAL STANDARD OF HUMANE TREATMENT, of the Board’s Rules of Professional Conduct by administering excessive anesthesia, leaving the patient to meet with another client while the patient was in a critical health crisis, by failing to maintain breathing support while the patient was unable to breathe on its own, allowing a patient to leave his care while still appearing to be under anesthesia, by failing to adequately diagnose and treat “Alex’s” illness, by failing to communicate appropriately with the client regarding the patient’s condition, by leaving an acutely ill dog without veterinary treatment, by using the wrong material for stitches to close a surgical incision, by failing to perform a caesarian procedure properly, and by failing to care for newborn puppies appropriately—none of which is in keeping with 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 Terrell, Texas, or in similar communities.

3. Based on Finding of Fact 5, Respondent has violated Rule 573.69, REPORTING OF CRIMINAL ACTIVITY, of the Board’s Rules of Professional Conduct, by failing to report to the Board an arrest for a crime related to the practice of veterinary medicine within 30 days of the arrest.

4. Based on Findings of Fact 7 and 22-23, Respondent violated Rule 573.26, Honesty, Integrity and Fair Dealing, of the Board’s Rules of Professional Conduct by cremating a patient without notice to or permission from the client, and by failing to inform his client of their animal’s disappearance in a timely manner.

5. Based on Findings of Fact 8 and 25, Respondent violated Rule 573.4, Adherence to the Law, of the Board’s Rules of Professional Conduct by attempting to intimidate a witness into dropping a complaint against him, in violation of Texas Penal Code §36.05, and by possessing a controlled substance after voluntarily surrendering his controlled substances registration to the U.S. Drug Enforcement Administration.

6. Based on Findings of Fact 4, 8, 14 and 20, Respondent violated Rule 573.74, Duty to Cooperate with the Board, of the Board’s Rules of Professional Conduct by failing to respond to the Board investigator’s request for a response to the complaint and copies of relevant medical records.

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7. Based on Findings of Fact 9-13, Respondent has violated Rule 573.23, Board Certified Specialists and Duty of Licensee to Refer a Case, of the Board’s Rules of Professional Conduct by failing to refer “Alex” to another veterinary clinic when “Alex” was acutely ill and in need of immediate veterinary care while Respondent left town and was unavailable to administer such care.

8. Based on Findings of Fact 4, 14 and 21, Respondent has violated Rule 573.52, Patient Recordkeeping, of the Board’s Rules of Professional Conduct by failing to create patient records for “Huey” and her puppies, by failing to record the client’s address or telephone number, the patient’s species and breed, and details necessary to substantiate Respondent’s examination and diagnosis of “Alex,” failing to create a patient record for “Harley,” and failing to record for “Bella” weight, the names, dosages, concentration and routes of administration of each drug prescribed, administered, and/or dispensed, a description of the spay procedure, the diagnosis of “Bella’s” condition following the spay, or the euthanasia procedure.

9. Based on Finding of Fact 15-17, Respondent has violated Rule 573.61, MINIMUM SECURITY FOR CONTROLLED SUBSTANCES, of the Board’s Rules of Professional Conduct by failing to store his controlled substances in a substantially constructed cabinet capable of resisting entry by tools such as pry bars.

10. Based on Findings of Fact 15, Respondent violated Rule 513.50, CONTROLLED SUBSTANCES RECORDS KEEPING FOR DRUGS ON HAND, of the Board’s Rules of Professional Conduct by failing to maintain at his place of business records of all controlled substances in his possession.

11. Based on Finding of Fact 23, Respondent has violated Rule 573.27, OBSERVANCE OF CONFIDENTIALITY, of the Board’s Rules of Professional Conduct by releasing confidential client information without a waiver from the client or an appropriate court order or subpoena.

12. Based on Finding of Fact 24, Respondent has violated Rule 573.41, Use of Prescription Drugs, of the Board’s Rules of Professional Conduct by dispensing prescription drugs without first having established a veterinarian-client-patient relationship.

13. Based on Finding of Fact 28, Respondent has violated Rule 573.62, VIOLATION OF BOARD ORDERS/NEGOTIATED SETTLEMENTS, of the Board’s Rules of Professional Conduct by failing to provide proof of having completed nine additional hours of continuing education as ordered by the Board.

14. Based on Finding of Facts 1-28 and Conclusions of Law 1-13, Respondent has violated Section 801.402 (6) 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:

(3) is chronically or habitually intoxicated, chemically dependent, or addicted to drugs; or
(4) engages in dishonest or illegal practices, in or connected with, the practice of veterinary medicine; or
(6) engages in practices or conduct that violates the board’s rules of professional conduct; or
(12) performs or prescribes unnecessary or unauthorized treatment.; or
(16) commits gross malpractice or a pattern of acts that indicate consistent malpractice, negligence, or incompetence in the practice of veterinary medicine.

15. Based on Conclusions of Law 1-14, 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:

(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.

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

Based on the above Findings of Fact and Conclusions of Law, in lieu of any administrative penalties or reprimands associated with a finding of a violation of the Board’s rules and the Veterinary Licensing Act, Respondent agrees to voluntarily surrender his veterinary license and not seek reinstatement by the Board for five years from the date of this Order.

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 Order.

3. Failure by Respondent to comply with the terms of this Agreed Order or with any

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other provisions of the Licensing Act or the Board Rules, may result in further disciplinary action.

Respondent, by signing this Agreed Order, acknowledges his understanding of the Agreed Order, the notice, and Findings of Fact and Conclusions of Law herein 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. NOTHING IN THIS ORDER SHALL BE DEEMED A WAIVER OF RESPONDENT'S RIGHTS UNDER STATUTE OR UNDER THE UNITED STATES OR TEXAS CONSTITUTIONS TO APPEAL AN ORDER OR ACTION OF THE BOARD SUBSEQUENT TO THIS AGREED ORDER EXCEPT AS RESPONDENT MAY HAVE OTHERWISE AGREED TO HEREIN. 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, DAVID J. SNYDER, 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.

[Signature]
David J. Snyder, D.V.M.

8-1-2012
Date
STATE OF TEXAS

COUNTY OF Edwards

BEFORE ME, on this day, personally appeared David J. Snyder, 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 15th day of March, 2012.

DENNIS LEE BARKER, JR.
Notary Public
STATE OF TEXAS
Commission Exp. 11-18-2013
Notary without Bond

SIGNED AND ENTERED by the TEXAS BOARD OF VETERINARY MEDICAL EXAMINERS on this the 27th day of March, 2012.

Bud E. Allredge, Jr., D.V.M., President

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