

1 **BEFORE THE ARIZONA REGULATORY BOARD**  
2 **OF PHYSICIAN ASSISTANTS**

3 In the Matter of:

4 **ROBERT J. STRONG, P.A.**

5 Holder of License No. 2242  
6 For the Performance of Healthcare Tasks  
In the State of Arizona

Case No. PA-22-0090A, PA-22-0098A

**FINDINGS OF FACT, CONCLUSIONS  
OF LAW AND ORDER FOR LETTER  
OF REPRIMAND AND PROBATION;  
AND CONSENT TO SAME**

7 The Arizona Regulatory Board of Physician Assistants (“Board”) considered this  
8 matter at its public meeting on May 29, 2024. Robert J. Strong, P.A. (“Respondent”),  
9 appeared before the Board for a Formal Interview pursuant to the authority vested in the  
10 Board by A.R.S. § 32-2551(G). The Board voted to issue Findings of Fact, Conclusions of  
11 Law and Order after due consideration of the facts and law applicable to this matter.

12 **FINDINGS OF FACT**

13 1. The Board is the duly constituted authority for the regulation and control of  
14 physician assistants in the State of Arizona.

15 2. Respondent is the holder of license number 2242 for the performance of  
16 health care tasks in the State of Arizona.

17 PA-22-0090A

18 3. The Board initiated case number PA-22-0090A on October 23, 2022 after  
19 receiving a complaint regarding Respondent’s care and treatment of a 31 year-old female  
20 patient (“JM”) alleging failure to perform a Bartholin cyst drainage.

21 4. On December 23, 2022, Board staff sent a notice letter requested the  
22 records and a response from Respondent by January 6, 2023. Board staff sent a Re-  
23 notice letter on March 21, 2023 due to Respondent’s failure to provide the response or  
24 records. Respondent provided a response on April 20, 2023.

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1 the patient and her significant other became agitated and would not allow the examination  
2 to be performed. With regard to the delay in responding to the Board's investigation,  
3 Respondent stated that he does not frequently check his physical mailbox, and receives  
4 many emails, and therefore, did not timely see the Board's notice letters.

5 11. Also during the Formal Interview, Respondent testified that the office practice  
6 was for a medical assistant to perform a swab while taking vitals when COVID was  
7 suspected. Respondent stated that he did not know that a test had not been performed  
8 and would not normally need to provide a specific order. Respondent stated that the tests  
9 are sent out for processing and would not normally be available for 1-2 days. Respondent  
10 stated that CD reported that she had been symptomatic for 5 days and was outside the  
11 time frame for prescribing antivirals. Respondent stated he discussed this with CD, but  
12 agreed that he did not document the discussion in the medical record. Respondent stated  
13 that he did prescribe a ZPak either later that day or the next day. Respondent stated that  
14 it should have been documented in the record, but he could not recall doing so.  
15 Respondent noted that the prescription order is included in the medication chart.  
16 Respondent testified that he no longer works at the clinic, and left in part because of the  
17 high patient volume required by the clinic. Respondent noted that this volume might have  
18 also contributed to documentation deficiencies.

19 12. During that same Formal Interview, Board members discussed whether  
20 Respondent deviated from the standard of care, and agreed that no deviation was  
21 apparent in either case due to extenuating circumstances. However, Board members  
22 agreed that his documentation was insufficient and that Respondent failed to timely  
23 respond to the Board's notice letters in PA-22-0090A. Board members agreed that the  
24 case rose to the level of discipline and warranted completion of continuing medical  
25 education ("CME") in medical recordkeeping and patient communication.

1 **CONCLUSIONS OF LAW**

2 1. The Board possesses jurisdiction over the subject matter hereof and over  
3 Respondent.

4 2. The conduct and circumstances described above constitute unprofessional  
5 conduct pursuant to A.R.S. § 32-2501(20)(p) (“Failing or refusing to maintain adequate  
6 records on a patient.”).

7 3. The conduct and circumstances described in PA-22-0090A above  
8 constitutes unprofessional conduct pursuant to A.R.S. § 32-2501(20)(aa) (“Failing to  
9 furnish legally requested information to the board or its investigator in a timely manner.”).

10 **ORDER**

11 IT IS HEREBY ORDERED THAT:

12 1. Respondent is issued a Letter of Reprimand;

13 2. Respondent is placed on Probation for a period of 6 months with the  
14 following terms and conditions:

15 a. **Continuing Medical Education**

16 Respondent shall within 6 months of the effective date of this Order obtain no less  
17 than 10 hours of Board staff pre-approved Category I Continuing Medical Education  
18 (“CME”) in an intensive in-person/virtual course regarding medical recordkeeping and no  
19 less than 11 hours of Board staff pre-approved Category I CME in an intensive in-  
20 person/virtual course regarding patient communication. Respondent shall within thirty days  
21 of the effective date of this Order submit his request for CME to the Board for pre-  
22 approval. Upon completion of the CME, Respondent shall provide Board staff with  
23 satisfactory proof of attendance. The CME hours shall be in addition to the hours required  
24 for the biennial renewal of licensure. The Probation shall terminate upon Respondent’s  
25 proof of successful completion of the CME.



1 EXECUTED COPY of the foregoing  
2 mailed this 28th day of August, 2024 to:

3 Robert J. Strong, P.A.  
4 Address of Record

5 ORIGINAL of the foregoing filed  
6 this 28th day of August, 2024 with:

7 Arizona Regulatory Board  
8 of Physician Assistants  
9 1740 West Adams, Suite 4000  
10 Phoenix, Arizona 85007

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13 Board staff  
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