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COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 2218

IN RE: THE LICENSE TO PRACTICE OSTEOPATHY IN THE COMMONWEALTH OF KENTUCKY HELD BY STEPHEN P. MEESE, D.O., LICENSE NO. 02536, 500 WAYNOKA DRIVE, SARDINIA, OHIO 45171

AGREED ORDER OF PERMANENT SURRENDER

Come now the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Hearing Panel A, and Stephen P. Meese, D.O. ("the licensee"), and, based upon their mutual desire to resolve this pending case, hereby ENTER INTO the following **AGREED ORDER OF PERMANENT SURRENDER**:

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Agreed Order of Permanent Surrender:

1. At all relevant times, Stephen P. Meese, D.O., was licensed by the Board to practice osteopathy within the Commonwealth of Kentucky.
2. The licensee's osteopathic specialty is general medicine.
3. In or around June 2018, the licensee entered into an Agreed Order, Case No. 1862, in which he stipulated to facts including the following:
   - The licensee's medical specialty is Obstetrics and Gynecology.
   - On or about January 8, 2018, the Board received a grievance filed by Patient A, who alleged that the licensee made sexually explicit comments during her appointments and after a surgery.
   - Patient A was interviewed by a Board investigator following receipt of the grievance. Patient A stated that she saw the licensee at his office in Stanford at the end of May 2017 to schedule a hysterectomy and she requested to schedule it after her birthday. Patient A stated that the licensee offered to be her designated driver for her birthday

party if there would be alcohol and nudity involved. She stated that no one else was present in the room when he made the statement.

- Patient A stated that her next appointment was in early June, at which she had an ultrasound. She stated that while she was laying on the exam table with her feet in stirrups (fully clothed), the licensee made a "camera" or "framing sign" with his hands and pointed it toward her vaginal area and stated "best view ever." Patient A stated that the licensee made a statement about pubic hair and expressed his personal preference regarding women with pubic hair. Patient A stated she was alone in the room with the licensee when the statements were made.

- Patient A stated that her surgery was on June 20, 2017 at Ephraim McDowell Hospital. She stated that following the surgery, the licensee came into her hospital room, sat on her bed, and made comments about bruises on her thighs and grabbed each area in turn. She stated that when her boyfriend arrived, the licensee left the room.

- Patient A stated that later that afternoon on the same day, she was preparing to leave. She stated that the licensee came into her room and advised that she should not have penetrative sex for six weeks but that she could have oral sex. Patient A stated that the licensee then made statements about his personal preference regarding oral sex. She stated that no one else was in the room when he made the statements.

- Patient A stated that she did not return to the licensee for follow up after her surgery. She stated that she saw her gynecologist, APRN Crystal Brown, at Ephraim McDowell Specialty Clinic in August 2017, where she told Ms. Brown and the office manager, Kristi Poynter, about the comments made by the licensee. She stated that she met with Ephraim McDowell Hospital Risk Assessment sometime in August or September 2017.

- A Board investigator interviewed Ms. Brown and Ms. Pointer, who both stated that Patient A provided the same account regarding the licensee to them.

- A Board investigator interviewed Marilyn Peterson, Director of Risk Management for Ephraim McDowell Hospital. She stated that in August 2017 Patient A came to Ephraim McDowell to give her complaint through an interview. When Peterson was asked any questions about what transpired after the meeting, she was instructed not to answer by attorneys for Ephraim McDowell.

- A Board investigator contacted attorney Amy Johnson, who was hired by Ephraim McDowell Hospital to investigate the allegation against the licensee. She stated that she conducted an investigation and that it was concluded, but she declined to comment or share the investigation.

- The licensee submitted a letter of resignation to Ephraim McDowell on September 1, 2017.

- During interview of witnesses by a Board investigator, each was asked if they knew where the licensee went after leaving Ephraim McDowell Hospital. Locations of Elizabethtown or Bardstown were suggested. The Board investigator checked hospitals in those locations and could not find the licensee practicing at either. Ms. Poynter advised that the licensee may have moved to Bardstown or Lebanon. The Board investigator learned that the licensee was working in Lebanon at the Lebanon Physicians for Women, which is part of the Lebanon Hospital.

- During an interview with the Board investigator, the licensee stated he recalled making the designated driver remark to Patient A as she told him she was having a birthday and planned to do some wild partying. He stated he probably made statements such as she did not need to shave prior to surgery as studies showed it was healthier. He stated that he has had patients ask about sex after surgery and that six weeks is a long time without sex and he tells them that while they can't have any penetration they can have oral sex or masturbation. He stated that he had a chaperone in the room with him but could not remember who it was. He stated that he had switched from Ephraim McDowell Hospital to Lebanon in January 2018. He stated that obtaining the position was in the works for two years and that Patient A's complaint was not the cause of his resignation from Ephraim McDowell.

- In a written response to the grievance dated February 9, 2018, the licensee acknowledged making a designated driver comment during the scheduling of Patient A's hysterectomy. He denied making any gestures or commentary toward Patient A's vaginal area. The licensee acknowledged that he discussed Patient A shaving her pubic hair in the context of pre-operative instructions and stated that her prefers women do not completely shave prior to surgery due to increased risk of infection associated with complete shaving. The licensee stated that he did observe bruising to Patient A's thighs and body while positioning her after the administration of anesthetic and had concern for possible abuse. He stated that he sat on the edge of her bed, discussed the procedure with her, and questioned the bruising. He denied any physical contact with Patient A. The licensee stated that he provided Patient A with discharge instructions, including avoidance of penetrative sex for six weeks. He stated that he advised that masturbation and oral sex were permissible, but denied expressing any personal preferences for such activities.

4. Pursuant to the Agreed Order, Case No. 1862, the licensee was required to utilize chaperones during female patient encounters and to undergo an assessment at Vanderbilt's Comprehensive Assessment Program for Professionals ("VCAP") and implement any recommendations made by VCAP.

5. In or around August 2019, VCAP recommended that the licensee engage in therapy for himself and complete a Boundaries course.

6. In or around March 2020, the licensee completed the *Maintaining Proper Boundaries* course at Vanderbilt University Medical Center.
7. In or around November 2020, the Agreed Order, Case No. 1862, was terminated.
8. On or about May 23, 2024, Detective Marcus Harlow, Boone Co. Sheriff's Office, reported to the Board that he was investigating a sexual assault complaint in which Patient 1 alleged that the licensee sexually assaulted her under the guise of conducting an exam at an urgent care center.
9. An interview was conducted with Merissa Kerish, former MA for the licensee, and she stated substantially as follows: Ms. Kerish swabbed Patient 1 for COVID and strep based upon her presenting complaints; she witnessed the licensee ask Patient 1 and other female patients "are you having trouble using the restroom?"; Ms. Kerish recalled the licensee asking Patient 1 if she was constipated and the licensee offered to perform an "internal vaginal exam" to see if she was impacted; Ms. Kerish had never seen or heard of that in her experience and does not believe it is normal procedure; Ms. Kerish recalled Patient 1 stating "I don't know what that has to do with COVID" and that she did not want a vaginal exam; Ms. Kerish recalled the licensee asking two other female patients the same line of questioning the same day; Ms. Kerish stepped out of the room and left the licensee alone with Patient 1 and then the licensee came out of the room and told Ms. Kerish that Patient 1 was going to have the vaginal exam; and Ms. Kerish stated that it was clear that Patient 1 was very uncomfortable and that she too felt the same "vibe," recalling that Patient 1 was whispering due to the level of uncomfortableness.
10. An interview was conducted with Patient 1, who stated substantially as follows: she had been seen by the licensee two (2) days before the incident complaining of symptoms related

to her chest and throat and received a z-pack (antibiotic); on the day of the incident, she presented with complaints of pain in her stomach; a nurse swabbed Patient 1 for COVID prior to examination by the licensee; the licensee asked Patient 1 if she was constipated which she denied having; the licensee still offered to check her for constipation; the licensee also asked "if she wanted to do a 'vaginal thing,' " which she declined because "I knew that nothing was going on down there. He tried to say 'you could have an infection down there with poop or something' which is what he was trying to explain to me to justify it"; during the examination, the licensee grabbed Patient 1 on her butt and dragged her to the edge of the examination table and the nurse then grabbed the black stirrups and placed her feet in them; the licensee inserted one finger into Patient 1's vagina and then another for approximately ten seconds; the licensee then placed his fingers into her rectum for approximately 5-7 seconds; after the vaginal and rectal examination, the licensee informed Patient 1 that she was positive for COVID and wanted to listen to her stomach for gurgling; the licensee had Patient 1 lean back in a chair and listened to her stomach at the sternum area and then moved further down toward her waist and genital area and rested his hand on her thigh; the licensee asked Patient 1 if she was on birth control and whether she had frequent urinary tract infections (UTIs) but did not prescribe any medication or advise her on how to address the COVID; and after the encounter Patient 1 reported the incident to the police.

11. On or about April 4, 2025, the licensee provided a written response to the allegations, including reference to the medical records. He states that he emphatically denies the allegations of Patient 1. He states that she complained of generalized and crampy abdominal pain of moderate severity. He offered Patient 1 a rectal or vaginal exam to check

for fecal impaction. He asserts he did not perform the vaginal exam since she did not consent, but did perform the rectal exam with her consent. He disputes the suggestion that he tries to "set up unnecessary vaginal or rectal exams" and is merely attempting to obtain a full clinical picture to best treat the patient. Ultimately, he stands behind his medical decision-making regarding Patient 1.

12. On May 15, 2025, the licensee, with counsel, appeared before Inquiry Panel B, and stated substantially as follows: the licensee palpitated the patient's abdomen which caused pain and increased guarding; there was some rebound but no fever; he informed Patient 1 that he could conduct a vaginal or rectal exam to determine if she was impacted; Patient 1 chose the rectal exam; the licensee determined that Patient 1 was not impacted and discharged her home with a diagnosis of constipation.
13. On or about June 3, 2025, the Board issued a Complaint as well as an Emergency Order of Restriction, prohibiting the licensee from being in the presence of any patient unless accompanied by a Board-approved chaperone, who is able to be present and to hear and see all interactions between the licensee and the patient at all times.
14. On or about December 16, 2025, the Board received a letter from Anthony J. Bucher, Esq. He informed the Board that his firm has recently been retained by Employee K. L. (the "grievant") regarding her very brief employment with Bluegrass Urgent Care ("BUC") and her claims related to her interaction with the licensee at the Walton, Kentucky, location on September 13, 2025.
15. The grievant stated that on September 13, 2025 she worked at the Walton location with the licensee. The grievant alleged that the licensee kept flirting with her. He made a comment about her breasts, asking if she had implants and suggesting that she could be a model. He

commented that he would like to see the grievant in a bikini. The licensee asked the grievant if she wanted to see a "jack off video" and proceeded to show her a video of a man, believed to be himself, masturbating to ejaculation. He also called her into a room later and when she entered, he was naked from the waist down. He asked her to examine his pelvic area because he had "chaffing" around his scrotum.

16. After work, the grievant went to the Mexican restaurant next door. The licensee followed her over. She used her phone to record their conversation. In the video, the licensee described his case with the Board regarding Patient 1, the civil lawsuit filed by Patient 1, and his dissatisfaction with Dr. So. He described what sexual acts he would like to do to the grievant. They discussed the placement of the office security cameras. He acknowledged showing the grievant the masturbation video, noting that he moved where they were standing so that the video could not be seen on the security camera. He also told her he was "just feeling her out" earlier at the office to see if she was someone he could trust. He wanted her to be a third chaperone for him. But he told her that if they become sexual, she needs to "just lie" on the chaperone form that the investigator will ask her to sign. He also admitted to having sex in the office, but will not name who with. He further admitted to trying to have sex with another employee for 2 years, but that employee would never agree.

17. The grievant alleged that the licensee reached out to her several times by phone and/or text after September 13, 2025. Then, on Friday, November 21, 2025, he showed up at her house. There had been a discussion at work on September 13, 2025, in which the grievant indicated that she had never had a Bengal's jersey and had wanted one. The licensee came to her home on November 21, 2025, under the pretense of giving her a Bengal's jersey.

When the grievant informed the licensee that she was not happy that he had come to her home, he returned to the car. She states this is on her Ring Camera video. She followed him to his car to further confront him about coming to her home. When she arrived at his car, the grievant alleges that the licensee was massaging his groin area on the outside of his pants.

18. The licensee provided a written response to the grievance. He contends that the grievant engaged him in a very sexual conversation and asked for pictures or videos, to which he downloaded a video randomly sent to him to show her. He admits that he had the grievant examine an area in his inguinal fold that was irritated and becoming painful, but states it was professional. He states they then went to the Mexican restaurant together, and she spoke to him very explicitly. He admits he discussed making her a third chaperone. He stated he was in contact with the grievant and that she questioned him several times about the jersey. He admits to going to her home with the jersey but maintains that she was the one making sexually explicit comments. He ends by stating that everything was consensual and that nothing proceeded to any sexual activity.
19. The licensee was given notice of the Panel meeting conducted on January 15, 2026, and did not appear.
20. On or about January 20, 2026, the Board issued an Amended Complaint and an Emergency Order of Suspension pursuant to which the licensee became prohibited from performing any act which constitutes the "practice of medicine," as that term is defined by KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities - until the resolution of the Amended Complaint.

21. The licensee now agrees to enter into this Agreed Order of Permanent Surrender to resolve the pending case.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Agreed Order of Permanent Surrender:

1. The licensee's Kentucky medical license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact, the licensee has engaged in conduct which violates the provisions of KRS 311.595(9), as illustrated by KRS 311.597(4). Accordingly, there are legal grounds for the parties to enter into this Agreed Order of Permanent Surrender.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this pending case by entering into an informal resolution such as this Agreed Order of Permanent Surrender.

AGREED ORDER OF PERMANENT SURRENDER

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon their mutual desire to fully and finally resolve the pending case, the parties hereby ENTER INTO the following **AGREED ORDER OF PERMANENT SURRENDER:**

1. The licensee, Stephen P. Meese, D.O., hereby SURRENDERS his Kentucky osteopathic license indefinitely and permanently, effective immediately upon the filing of this Agreed Order of Permanent Surrender and subject to the following terms:
    a. From the date of filing of this Agreed Order of Permanent Surrender forward, the licensee SHALL never perform any act which would constitute the "practice of medicine," as that term is defined in KRS 311.550(10) - the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities – within the Commonwealth of Kentucky.

b. The licensee understands and agrees that any violation of the terms of this Agreed Order of Permanent Surrender may provide a legal basis for additional disciplinary action and a legal basis for criminal prosecution for practicing medicine without a license. If the Board should receive information that, after the date of filing of this Agreed Order of Permanent Surrender, the licensee has performed an act which would constitute the "practice of medicine" within the Commonwealth of Kentucky, it will aggressively pursue the criminal prosecution of the licensee for such acts, to the full extent of the law.

c. As an express condition for the entry of this Agreed Order of Permanent Surrender, and in light of the licensee's pattern of conduct, each party understands and agrees that neither the Board nor its Panels will ever consider any petition for reinstatement of license, any motion or request for modification or change of the terms of this Agreed Order of Permanent Surrender or special request for consideration for relief filed by the licensee. This Agreed Order of Permanent Surrender is expressly designed to serve as the complete and final termination of the legal relationship between this Board and this licensee. Any communication by the licensee and/or his agents to the Board attempting to revive that legal relationship will be returned without being provided or forwarded to any Board member.

2. The licensee expressly agrees that if he should violate any term or condition of the Agreed Order of Permanent Surrender, the licensee's practice SHALL constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Agreed Order, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Agreed Order of Permanent Surrender.

3. The licensee understands and agrees that any violation of the terms of this Agreed Order of Permanent Surrender would provide a legal basis for additional disciplinary action pursuant to KRS 311.595(13) or criminal action.

SO AGREED on this 5 day of FEBr, 2026.

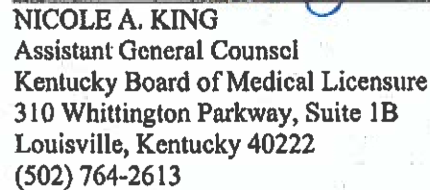
FOR THE LICENSEE:

STEPHEN P. MEESE, D.O

JENNIFER WINTERGERST
COUNSEL FOR THE LICENSEE

FOR THE BOARD:

WAQAR SALEEM, M.D.
CHAIR, HEARING PANEL A



NICOLE A. KING
Assistant General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 764-2613

WAIVER OF RIGHTS

I, Stephen P. Meese, D.O., have read and understand the foregoing Agreed Order of Permanent Surrender, Case No. 2218. I have been given sufficient time and opportunity to consider the Agreed Order of Permanent Surrender, and I understand the effect it will have upon my license to practice medicine in the Commonwealth of Kentucky and elsewhere.

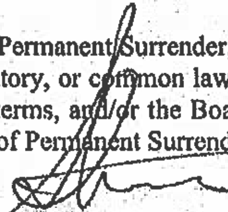
I understand that the foregoing Agreed Order of Permanent Surrender is a legally binding final order of the Kentucky Board of Medical Licensure that affects my rights and privileges. I also understand that the foregoing Agreed Order of Permanent Surrender is a public document which will be available for public inspection, may be accessible through the Board's website, and will be

a permanent part of my historical file with the Board. I understand that the foregoing Agreed Order of Permanent Surrender will be reported to the National Practitioner Data Bank and the Federation of State Medical Boards. I understand that it may be my responsibility to report the foregoing Agreed Order of Permanent Surrender directly to other jurisdictions.

I understand that I have a right to legal representation in this matter, at my own expense, and I have been afforded sufficient time and opportunity to exercise my right to consult with counsel regarding the legal effect of the foregoing Agreed Order of Permanent Surrender.

I understand that, without my consent as stated in the foregoing Agreed Order of Permanent Surrender, no legal action may be taken against my license except after a hearing held in accordance with KRS Chapter 13B. In such a formal hearing, I understand that I would have a right to be represented by counsel at my own expense; the right to call and confront witnesses and cross-examine witnesses; the right to present evidence and testify on my own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to appeal a final order or decision adverse to me; and the right to raise constitutional challenges.

By entering into the foregoing Agreed Order of Permanent Surrender, I expressly and voluntarily waive my right to raise any constitutional, statutory, or common law objection(s) I may have to the Agreed Order of Permanent Surrender, its terms, and/or the Board's conduct in conformity with it and/or enforcement of the Agreed Order of Permanent Surrender.



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EMERGENCY ORDER OF SUSPENSION

On January 15, 2026, the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel B, considered: a Panel Memorandum prepared by Jon Marshall, Medical Investigator, dated January 7, 2026; a grievance filed by Anthony J. Bucher, esq., dated December 16, 2025; the Emergency Order of Restriction, dated June 3, 2025; and the licensee's response, undated. The licensee was given notice and did not appear before the Panel.

Having considered this information and being sufficiently advised, Inquiry Panel B enters the following EMERGENCY ORDER OF SUSPENSION, in accordance with KRS 311.592(1) and 13B.125(1):

FINDINGS OF FACT

Pursuant to KRS 13B.125(2) and based upon the information available, Inquiry Panel B concludes there is probable cause to make the following Findings of Fact, which support this Emergency Order of SUSPENSION:

1. At all relevant times, Stephen P. Meese, D.O. ("the licensee"), was licensed by the Board to practice osteopathy within the Commonwealth of Kentucky.
2. The licensee's osteopathic specialty is general medicine.
3. In or around June 2018, the licensee entered into an Agreed Order, Case No. 1862, in which he stipulated to facts including the following:

- The licensee's medical specialty is Obstetrics and Gynecology.

- On or about January 8, 2018, the Board received a grievance filed by Patient A, who alleged that the licensee made sexually explicit comments during her appointments and after a surgery.

- Patient A was interviewed by a Board investigator following receipt of the grievance. Patient A stated that she saw the licensee at his office in Stanford at the end of May 2017 to schedule a hysterectomy and she requested to schedule it after her birthday. Patient A stated that the licensee offered to be her designated driver for her birthday party if there would be alcohol and nudity involved. She stated that no one else was present in the room when he made the statement.

- Patient A stated that her next appointment was in early June, at which she had an ultrasound. She stated that while she was laying on the exam table with her feet in stirrups (fully clothed), the licensee made a "camera" or "framing sign" with his hands and pointed it toward her vaginal area and stated "best view ever." Patient A stated that the licensee made a statement about pubic hair and expressed his personal preference regarding women with pubic hair. Patient A stated she was alone in the room with the licensee when the statements were made.

- Patient A stated that her surgery was on June 20, 2017 at Ephraim McDowell Hospital. She stated that following the surgery, the licensee came into her hospital room, sat on her bed, and made comments about bruises on her thighs and grabbed each area in turn. She stated that when her boyfriend arrived, the licensee left the room.

- Patient A stated that later that afternoon on the same day, she was preparing to leave. She stated that the licensee came into her room and advised that she should not have penetrative sex for six weeks but that she could have oral sex. Patient A stated that the licensee then made statements about his personal preference regarding oral sex. She stated that no one else was in the room when he made the statements.

- Patient A stated that she did not return to the licensee for follow up after her surgery. She stated that she saw her gynecologist, APRN Crystal Brown, at Ephraim McDowell Specialty Clinic in August 2017, where she told Ms. Brown and the office manager, Kristi Poynter, about the comments made by the licensee. She stated that she met with Ephraim McDowell Hospital Risk Assessment sometime in August or September 2017.

- A Board investigator interviewed Ms. Brown and Ms. Pointer, who both stated that Patient A provided the same account regarding the licensee to them.

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- A Board investigator contacted attorney Amy Johnson, who was hired by Ephraim McDowell Hospital to investigate the allegation against the licensee. She stated that she conducted an investigation and that it was concluded, but she declined to comment or share the investigation.

- The licensee submitted a letter of resignation to Ephraim McDowell on September 1, 2017.

- During interview of witnesses by a Board investigator, each was asked if they knew where the licensee went after leaving Ephraim McDowell Hospital. Locations of Elizabethtown or Bardstown were suggested. The Board investigator checked hospitals in those locations and could not find the licensee practicing at either. Ms. Poynter advised that the licensee may have moved to Bardstown or Lebanon. The Board investigator learned that the licensee was working in Lebanon at the Lebanon Physicians for Women, which is part of the Lebanon Hospital.

- During an interview with the Board investigator, the licensee stated he recalled making the designated driver remark to Patient A as she told him she was having a birthday and planned to do some wild partying. He stated he probably made statements such as she did not need to shave prior to surgery as studies showed it was healthier. He stated that he has had patients ask about sex after surgery and that six weeks is a long time without sex and he tells them that while they can't have any penetration they can have oral sex or masturbation. He stated that he had a chaperone in the room with him but could not remember who it was. He stated that he had switched from Ephraim McDowell Hospital to Lebanon in January 2018. He stated that obtaining the position was in the works for two years and that Patient A's complaint was not the cause of his resignation from Ephraim McDowell.

- In a written response to the grievance dated February 9, 2018, the licensee acknowledged making a designated driver comment during the scheduling of Patient A's hysterectomy. He denied making any gestures or commentary toward Patient A's vaginal area. The licensee acknowledged that he discussed Patient A shaving her pubic hair in the context of pre-operative instructions and stated that her prefers women do not completely shave prior to surgery due to increased risk of infection associated with complete shaving. The licensee stated that he did observe bruising to Patient A's thighs

and body while positioning her after the administration of anesthetic and had concern for possible abuse. He stated that he sat on the edge of her bed, discussed the procedure with her, and questioned the bruising. He denied any physical contact with Patient A. The licensee stated that he provided Patient A with discharge instructions, including avoidance of penetrative sex for six weeks. He stated that he advised that masturbation and oral sex were permissible, but denied expressing any personal preferences for such activities.

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5. In or around August 2019, VCAP recommended that the licensee engage in therapy for himself and complete a Boundaries course.
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impacted; Ms. Kerish had never seen or heard of that in her experience and does not believe it is normal procedure; Ms. Kerish recalled Patient 1 stating "I don't know what that has to do with COVID" and that she did not want a vaginal exam; Ms. Kerish recalled the licensee asking two other female patients the same line of questioning the same day; Ms. Kerish stepped out of the room and left the licensee alone with Patient 1 and then the licensee came out of the room and told Ms. Kerish that Patient 1 was going to have the vaginal exam; and Ms. Kerish stated that it was clear that Patient 1 was very uncomfortable and that she too felt the same "vibe," recalling that Patient 1 was whispering due to the level of uncomfortableness.

10. An interview was conducted with Patient 1, who stated substantially as follows: she had been seen by the licensee two (2) days before the incident complaining of symptoms related to her chest and throat and received a z-pack (antibiotic); on the day of the incident, she presented with complaints of pain in her stomach; a nurse swabbed Patient 1 for COVID prior to examination by the licensee; the licensee asked Patient 1 if she was constipated which she denied having; the licensee still offered to check her for constipation; the licensee also asked "if she wanted to do a 'vaginal thing,' " which she declined because "I knew that nothing was going on down there. He tried to say 'you could have an infection down there with poop or something' which is what he was trying to explain to me to justify it"; during the examination, the licensee grabbed Patient 1 on her butt and dragged her to the edge of the examination table and the nurse then grabbed the black stirrups and placed her feet in them; the licensee inserted one

finger into Patient 1's vagina and then another for approximately ten seconds; the licensee then placed his fingers into her rectum for approximately 5-7 seconds; after the vaginal and rectal examination, the licensee informed Patient 1 that she was positive for COVID and wanted to listen to her stomach for gurgling; the licensee had Patient 1 lean back in a chair and listened to her stomach at the sternum area and then moved further down toward her waist and genital area and rested his hand on her thigh; the licensee asked Patient 1 if she was on birth control and whether she had frequent urinary tract infections (UTIs) but did not prescribe any medication or advise her on how to address the COVID; and after the encounter Patient 1 reported the incident to the police.

11. On May 15, 2025, the licensee, with counsel, appeared before Inquiry Panel B, and stated substantially as follows: the licensee palpitated the patient's abdomen which caused pain and increased guarding; there was some rebound but no fever; he informed Patient 1 that he could conduct a vaginal or rectal exam to determine if she was impacted; Patient 1 chose the rectal exam; the licensee determined that Patient 1 was not impacted and discharged her home with a diagnosis of constipation.

12. On or about June 3, 2025, the Board issued a Complaint as well as an Emergency Order of Restriction, prohibiting the licensee from being in the presence of any patient unless accompanied by a Board-approved chaperone, who is able to be present and to hear and see all interactions between the licensee and the patient at all times.

13. On or about December 16, 2025, the Board received a letter from Anthony J. Bucher, Esq. He informed the Board that his firm has recently been retained by Employee K. L. (the "grievant") regarding her very brief employment with Bluegrass Urgent Care ("BUC") and her claims related to her interaction with the licensee at the Walton, Kentucky, location on September 13, 2025.

14. The grievant stated that on September 13, 2025 she worked at the Walton location with the licensee. The grievant alleged that the licensee kept flirting with her. He made a comment about her breasts, asking if she had implants and suggesting that she could be a model. He commented that he would like to see the grievant in a bikini. The licensee asked the grievant if she wanted to see a "jack off video" and proceeded to show her a video of a man, believed to be himself, masturbating to ejaculation. He also called her into a room later and when she entered, he was naked from the waist down. He asked her to examine his pelvic area because he had "chaffing" around his scrotum.

15. After work, the grievant went to the Mexican restaurant next door. The licensee followed her over. She used her phone to record their conversation. In the video, the licensee described his earlier complaint with the Board, the civil lawsuit filed by Patient 1, and his dissatisfaction with Dr. So. He described what sexual acts he would like to do to the grievant. They discussed the placement of the office security cameras. He acknowledged showing the grievant the masturbation video, noting that he moved where they were standing so that the video could not be seen on the security camera. He also told her he was "just feeling her out" earlier at the office to see if she was someone he could trust. He wanted her to be

a third chaperone for him. But he told her that if they become sexual, she needs to "just lie" on the chaperone form that the investigator will ask her to sign. He also admitted to having sex in the office, but will not name who with. He further admitted to trying to have sex with another employee for 2 years, but that employee would never agree.

16. The grievant alleged that the licensee reached out to her several times by phone and/or text after September 13, 2025. Then, on Friday, November 21, 2025, without an invitation or any advance notice, he showed up at her house. There had been a discussion at work on September 13, 2025, in which the grievant indicated that she had never had a Bengal's jersey and had wanted one. The licensee came to her home on November 21, 2025, under the pretense of giving her a Bengal's jersey. The grievant asked how he had gotten her address. He confirmed he had gotten her address from BUC records. When the grievant informed the licensee that she was not happy that he had come to her home, he returned to the car. She states this is on her Ring Camera video. She followed him to his car to further confront him about coming to her home. When she arrived at his car, the grievant alleges that the licensee was massaging his groin area on the outside of his pants.

17. The licensee provided a written response to the grievance. He contends that the grievant engaged him in a very sexual conversation and asked for pictures or videos, to which he downloaded a video randomly sent to him to show her. He admits that he had the grievant examine an area in his inguinal fold that was irritated and becoming painful, but states it was professional. He states they then

went to the Mexican restaurant together, and she spoke to him very explicitly. He admits he discussed making her a third chaperone. He stated he was in contact with the grievant and that she questioned him several times about the jersey. He admits to going to her home with the jersey but maintains that she was the one making sexually explicit comments. He ends by stating that everything was consensual and that nothing proceeded to any sexual activity.

18. The licensee was given notice of the Panel meeting conducted on January 15, 2026, and did not appear.

CONCLUSIONS OF LAW

Pursuant to KRS 13B.125(2) and based upon the information available, Inquiry Panel B finds there is probable cause to support the following Conclusions of Law, which serve as the legal bases for this Emergency Order of Suspension:

1. The licensee's Kentucky medical license is subject to regulation and discipline by this Board.
2. KRS 311.592(1) provides that the Board may issue an emergency order suspending, limiting, or restricting a physician's license at any time an inquiry panel has probable cause to believe that a) the physician has violated the terms of an order placing him on probation; or b) a physician's practice constitutes a danger to the health, welfare and safety of his patients or the general public.
3. There is probable cause to believe that the licensee has violated KRS 311.595(9), as illustrated by KRS 311.597(4).

4. Inquiry Panel B concludes there is probable cause to believe this licensee's practice constitutes a danger to the health, welfare and safety of his patients or the general public.

5. The Board may draw logical and reasonable inferences about a licensee's practice by considering certain facts about a licensee's practice. If there is proof that a licensee has violated a provision of the Kentucky Medical Practice Act in one set of circumstances, the Board may infer that the licensee will similarly violate the Medical Practice Act when presented with a similar set of circumstances. Similarly, the Board concludes that proof of a set of facts about a licensee's practice presents representative proof of the nature of that licensee's practice in general. Accordingly, probable cause to believe that the licensee has committed certain violations in the recent past presents probable cause to believe that the licensee will commit similar violations in the near future, during the course of the licensee's medical practice.

6. The United States Supreme Court has ruled that it is no violation of the federal Due Process Clause for a state agency to temporarily suspend a license, without a prior evidentiary hearing, so long as 1) the immediate action is based upon a probable cause finding that there is a present danger to the public safety; and, 2) the statute provides for a prompt post-deprivation hearing. *Barry v. Barchi*, 443 U.S. 55, 61 L.Ed.2d 365, 99 S.Ct. 2642 (1979); *FDIC v. Mallen*, 486 U.S. 230, 100 L.Ed.2d 265, 108 S.Ct. 1780 (1988) and *Gilbert v. Homar*, 520 U.S. 924 (1997), 117 S.Ct. 1807 (1997). Cf. KRS 13B.125(1).

KRS 13B.125(3) provides that the Board shall conduct an emergency hearing on this emergency order within ten (10) working days of a request for such a hearing by

the licensee. The licensee has been advised of his right to a prompt post-deprivation hearing under this statute.

EMERGENCY ORDER OF SUSPENSION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Chair of Inquiry Panel B, on behalf of Inquiry Panel B, hereby ORDERS that the license to practice osteopathy in the Commonwealth of Kentucky held by Stephen P. Meese, D.O., is SUSPENDED and Dr. Meese is prohibited from performing any act which constitutes the "practice of medicine," as that term is defined by KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities - until the resolution of the Amended Complaint setting forth the allegations discussed in this pleading or until such further Order of the Board.

The Chair of Inquiry Panel B further declares that this is an EMERGENCY ORDER, effective upon receipt by the licensee.

SO ORDERED this 20th day of January, 2026.

DALE E. TONEY, M.D.
CHAIR, INQUIRY PANEL B

CERTIFICATE OF SERVICE

I certify that the original of this Emergency Order of Suspension was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; and copies were mailed via certified mail return-receipt requested to the licensee, Stephen Meese, D.O., License No. 02536, 500 Waynoka Drive, Sardinia, Ohio 45171; and to counsel for the licensee, Jennifer Wintergerst, Esq., Bricker Graydon Wyatt, LLP, 400 West Market, Suite 200, Louisville, Kentucky 40202, and via email to jwintergerst@bricker.com on this 20th day of January, 2026.

NICOLE A. KING
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FILED OF RECORD

JAN 20 2026

K.B.M.L.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 2218

IN RE: THE LICENSE TO PRACTICE OSTEOPATHY IN THE COMMONWEALTH OF KENTUCKY HELD BY STEPHEN P. MEESE, D.O., LICENSE NO. 02536, 500 WAYNOKA DRIVE, SARDINIA, OHIO 45171

AMENDED COMPLAINT

Comes now the Complainant, Chair of the Kentucky Board of Medical Licensure's Inquiry Panel B, and on behalf of the Panel which met on January 15, 2026, states for its Amended Complaint against the licensee, Stephen P. Meese D.O., as follows:

1. At all relevant times, Stephen P. Meese, D.O., was licensed by the Board to practice osteopathy within the Commonwealth of Kentucky.
2. The licensee's osteopathic specialty is general medicine.
3. In or around June 2018, the licensee entered into an Agreed Order, Case No. 1862, in which he stipulated to facts including the following:

   - The licensee's medical specialty is Obstetrics and Gynecology.
   - On or about January 8, 2018, the Board received a grievance filed by Patient A, who alleged that the licensee made sexually explicit comments during her appointments and after a surgery.
   - Patient A was interviewed by a Board investigator following receipt of the grievance. Patient A stated that she saw the licensee at his office in Stanford at the end of May 2017 to schedule a hysterectomy and she requested to schedule it after her birthday. Patient A stated that the licensee offered to be her designated driver for her birthday party if there would be alcohol and nudity involved. She stated that no one else was present in the room when he made the statement.
   - Patient A stated that her next appointment was in early June, at which she had an ultrasound. She stated that while she was laying on the exam table with her feet in stirrups (fully clothed), the licensee made a "camera" or "framing sign" with his hands and pointed it toward her vaginal area and stated "best view ever." Patient A stated that the licensee made a statement about pubic hair and expressed his personal preference regarding women

with pubic hair. Patient A stated she was alone in the room with the licensee when the statements were made.

- Patient A stated that her surgery was on June 20, 2017 at Ephraim McDowell Hospital. She stated that following the surgery, the licensee came into her hospital room, sat on her bed, and made comments about bruises on her thighs and grabbed each area in turn. She stated that when her boyfriend arrived, the licensee left the room.

- Patient A stated that later that afternoon on the same day, she was preparing to leave. She stated that the licensee came into her room and advised that she should not have penetrative sex for six weeks but that she could have oral sex. Patient A stated that the licensee then made statements about his personal preference regarding oral sex. She stated that no one else was in the room when he made the statements.

- Patient A stated that she did not return to the licensee for follow up after her surgery. She stated that she saw her gynecologist, APRN Crystal Brown, at Ephraim McDowell Specialty Clinic in August 2017, where she told Ms. Brown and the office manager, Kristi Poynter, about the comments made by the licensee. She stated that she met with Ephraim McDowell Hospital Risk Assessment sometime in August or September 2017.

- A Board investigator interviewed Ms. Brown and Ms. Pointer, who both stated that Patient A provided the same account regarding the licensee to them.

- A Board investigator interviewed Marilyn Peterson, Director of Risk Management for Ephraim McDowell Hospital. She stated that in August 2017 Patient A came to Ephraim McDowell to give her complaint through an interview. When Peterson was asked any questions about what transpired after the meeting, she was instructed not to answer by attorneys for Ephraim McDowell.

- A Board investigator contacted attorney Amy Johnson, who was hired by Ephraim McDowell Hospital to investigate the allegation against the licensee. She stated that she conducted an investigation and that it was concluded, but she declined to comment or share the investigation.

- The licensee submitted a letter of resignation to Ephraim McDowell on September 1, 2017.

- During interview of witnesses by a Board investigator, each was asked if they knew where the licensee went after leaving Ephraim McDowell Hospital. Locations of Elizabethtown or Bardstown were suggested. The Board investigator checked hospitals in those locations and could not find the

licensee practicing at either. Ms. Poynter advised that the licensee may have moved to Bardstown or Lebanon. The Board investigator learned that the licensee was working in Lebanon at the Lebanon Physicians for Women, which is part of the Lebanon Hospital.

- During an interview with the Board investigator, the licensee stated he recalled making the designated driver remark to Patient A as she told him she was having a birthday and planned to do some wild partying. He stated he probably made statements such as she did not need to shave prior to surgery as studies showed it was healthier. He stated that he has had patients ask about sex after surgery and that six weeks is a long time without sex and he tells them that while they can't have any penetration they can have oral sex or masturbation. He stated that he had a chaperone in the room with him but could not remember who it was. He stated that he had switched from Ephraim McDowell Hospital to Lebanon in January 2018. He stated that obtaining the position was in the works for two years and that Patient A's complaint was not the cause of his resignation from Ephraim McDowell.

- In a written response to the grievance dated February 9, 2018, the licensee acknowledged making a designated driver comment during the scheduling of Patient A's hysterectomy. He denied making any gestures or commentary toward Patient A's vaginal area. The licensee acknowledged that he discussed Patient A shaving her pubic hair in the context of pre-operative instructions and stated that her prefers women do not completely shave prior to surgery due to increased risk of infection associated with complete shaving. The licensee stated that he did observe bruising to Patient A's thighs and body while positioning her after the administration of anesthetic and had concern for possible abuse. He stated that he sat on the edge of her bed, discussed the procedure with her, and questioned the bruising. He denied any physical contact with Patient A. The licensee stated that he provided Patient A with discharge instructions, including avoidance of penetrative sex for six weeks. He stated that he advised that masturbation and oral sex were permissible, but denied expressing any personal preferences for such activities.

4. Pursuant to the Agreed Order, Case No. 1862, the licensee was required to utilize chaperones during female patient encounters and to undergo an assessment at Vanderbilt's Comprehensive Assessment Program for Professionals ("VCAP") and implement any recommendations made by VCAP.

5. In or around August 2019, VCAP recommended that the licensee engage in therapy for himself and complete a Boundaries course.

6. In or around March 2020, the licensee completed the *Maintaining Proper Boundaries* course at Vanderbilt University Medical Center.
7. In or around November 2020, the Agreed Order, Case No. 1862, was terminated.
8. On or about May 23, 2024, Detective Marcus Harlow, Boone Co. Sheriff's Office, reported to the Board that he was investigating a sexual assault complaint in which Patient 1 alleged that the licensee sexually assaulted her under the guise of conducting an exam at an urgent care center.
9. An interview was conducted with Merissa Kerish, former MA for the licensee, and she stated substantially as follows: Ms. Kerish swabbed Patient 1 for COVID and strep based upon her presenting complaints; she witnessed the licensee ask Patient 1 and other female patients "are you having trouble using the restroom?"; Ms. Kerish recalled the licensee asking Patient 1 if she was constipated and the licensee offered to perform an "internal vaginal exam" to see if she was impacted; Ms. Kerish had never seen or heard of that in her experience and does not believe it is normal procedure; Ms. Kerish recalled Patient 1 stating "I don't know what that has to do with COVID" and that she did not want a vaginal exam; Ms. Kerish recalled the licensee asking two other female patients the same line of questioning the same day; Ms. Kerish stepped out of the room and left the licensee alone with Patient 1 and then the licensee came out of the room and told Ms. Kerish that Patient 1 was going to have the vaginal exam; and Ms. Kerish stated that it was clear that Patient 1 was very uncomfortable and that she too felt the same "vibe," recalling that Patient 1 was whispering due to the level of uncomfortableness.

10. An interview was conducted with Patient 1, who stated substantially as follows: she had been seen by the licensee two (2) days before the incident complaining of symptoms related to her chest and throat and received a z-pack (antibiotic); on the day of the incident, she presented with complaints of pain in her stomach; a nurse swabbed Patient 1 for COVID prior to examination by the licensee; the licensee asked Patient 1 if she was constipated which she denied having; the licensee still offered to check her for constipation; the licensee also asked "if she wanted to do a 'vaginal thing,' " which she declined because "I knew that nothing was going on down there. He tried to say 'you could have an infection down there with poop or something' which is what he was trying to explain to me to justify it"; during the examination, the licensee grabbed Patient 1 on her butt and dragged her to the edge of the examination table and the nurse then grabbed the black stirrups and placed her feet in them; the licensee inserted one finger into Patient 1's vagina and then another for approximately ten seconds; the licensee then placed his fingers into her rectum for approximately 5-7 seconds; after the vaginal and rectal examination, the licensee informed Patient 1 that she was positive for COVID and wanted to listen to her stomach for gurgling; the licensee had Patient 1 lean back in a chair and listened to her stomach at the sternum area and then moved further down toward her waist and genital area and rested his hand on her thigh; the licensee asked Patient 1 if she was on birth control and whether she had frequent urinary tract infections (UTIs) but did not prescribe any medication or advise her on how to address the COVID; and after the encounter Patient 1 reported the incident to the police.

11. On May 15, 2025, the licensee, with counsel, appeared before Inquiry Panel B, and stated substantially as follows: the licensee palpitated the patient's abdomen which caused pain and increased guarding; there was some rebound but no fever; he informed Patient 1 that he could conduct a vaginal or rectal exam to determine if she was impacted; Patient 1 chose the rectal exam; the licensee determined that Patient 1 was not impacted and discharged her home with a diagnosis of constipation.
12. On or about June 3, 2025, the Board issued a Complaint as well as an Emergency Order of Restriction, prohibiting the licensee from being in the presence of any patient unless accompanied by a Board-approved chaperone, who is able to be present and to hear and see all interactions between the licensee and the patient at all times.
13. On or about December 16, 2025, the Board received a letter from Anthony J. Bucher, Esq. He informed the Board that his firm has recently been retained by Employee K. L. (the "grievant") regarding her very brief employment with Bluegrass Urgent Care ("BUC") and her claims related to her interaction with the licensee at the Walton, Kentucky, location on September 13, 2025.
14. The grievant stated that on September 13, 2025 she worked at the Walton location with the licensee. The grievant alleged that the licensee kept flirting with her. He made a comment about her breasts, asking if she had implants and suggesting that she could be a model. He commented that he would like to see the grievant in a bikini. The licensee asked the grievant if she wanted to see a "jack off video" and proceeded to show her a video of a man, believed to be

himself, masturbating to ejaculation. He also called her into a room later and when she entered, he was naked from the waist down. He asked her to examine his pelvic area because he had "chaffing" around his scrotum.

15. After work, the grievant went to the Mexican restaurant next door. The licensee followed her over. She used her phone to record their conversation. In the video, the licensee described his earlier complaint with the Board, the civil lawsuit filed by Patient 1, and his dissatisfaction with Dr. So. He described what sexual acts he would like to do to the grievant. They discussed the placement of the office security cameras. He acknowledged showing the grievant the masturbation video, noting that he moved where they were standing so that the video could not be seen on the security camera. He also told her he was "just feeling her out" earlier at the office to see if she was someone he could trust. He wanted her to be a third chaperone for him. But he told her that if they become sexual, she needs to "just lie" on the chaperone form that the investigator will ask her to sign. He also admitted to having sex in the office, but will not name who with. He further admitted to trying to have sex with another employee for 2 years, but that employee would never agree.
16. The grievant alleged that the licensee reached out to her several times by phone and/or text after September 13, 2025. Then, on Friday, November 21, 2025, without an invitation or any advance notice, he showed up at her house. There had been a discussion at work on September 13, 2025, in which the grievant indicated that she had never had a Bengal's jersey and had wanted one. The licensee came to her home on November 21, 2025, under the pretense of giving

her a Bengal's jersey. The grievant asked how he had gotten her address. He confirmed he had gotten her address from BUC records. When the grievant informed the licensee that she was not happy that he had come to her home, he returned to the car. She states this is on her Ring Camera video. She followed him to his car to further confront him about coming to her home. When she arrived at his car, the grievant alleges that the licensee was massaging his groin area on the outside of his pants.

17. The licensee provided a written response to the grievance. He contends that the grievant engaged him in a very sexual conversation and asked for pictures or videos, to which he downloaded a video randomly sent to him to show her. He admits that he had the grievant examine an area in his inguinal fold that was irritated and becoming painful, but states it was professional. He states they then went to the Mexican restaurant together, and she spoke to him very explicitly. He admits he discussed making her a third chaperone. He stated he was in contact with the grievant and that she questioned him several times about the jersey. He admits to going to her home with the jersey but maintains that she was the one making sexually explicit comments. He ends by stating that everything was consensual and that nothing proceeded to any sexual activity.
18. The licensee was given notice of the Panel meeting conducted on January 15, 2026, and did not appear.
19. Simultaneous with the Amended Complaint and in accordance with KRS 311.592, the Board's Inquiry Panel B authorized the issuance of an Emergency Order of Suspension pursuant to which licensee shall become prohibited from

performing any act which constitutes the "practice of medicine," as that term is defined by KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities - until the resolution of the Amended Complaint.

20. By his conduct, the licensee has violated KRS 311.595(9), as illustrated by KRS 311.597(4). Accordingly, legal grounds exist for disciplinary action against his license to practice medicine in the Commonwealth of Kentucky.

21. The licensee is directed to respond to the allegations delineated in paragraphs 13 through 18 of the Amended Complaint within thirty (30) days of service thereof and is further given notice that:

    (a) His failure to respond may be taken as an admission of the charges; and

    (b) He may appear alone or with counsel, may cross-examine all prosecution witnesses and offer evidence in his defense.

22. NOTICE IS HEREBY GIVEN that a hearing on this Amended Complaint is to be scheduled during the Prehearing Conference on January 27, 2026, at 9:00 a.m., Eastern Standard Time. The hearing will be held at the Kentucky Board of Medical Licensure, Hurstbourne Office Park, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222. Said hearing shall be held pursuant to the Rules and Regulations of the Kentucky Board of Medical Licensure and pursuant to KRS Chapter 13B. This hearing shall proceed as scheduled and the hearing date shall only be modified by leave of the Hearing Officer upon a showing of good cause.

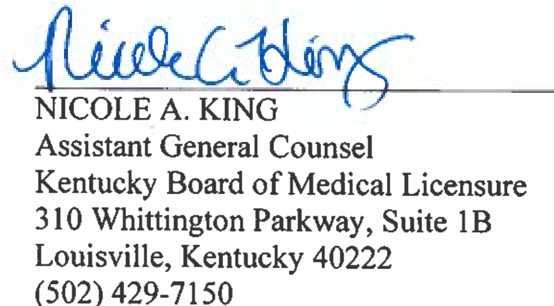
WHEREFORE, Complainant prays that appropriate disciplinary action be taken against the license to practice osteopathy in the Commonwealth of Kentucky held by Stephen P. Meese, D.O.

This 20th day of January, 2026.

DALE E. TONEY, M.D.
CHAIR, INQUIRY PANEL B

CERTIFICATE OF SERVICE

I certify that the original of this Amended Complaint was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; a copy was mailed to Thomas J. Hellmann, Esq., 810 Hickman Hill Road, Frankfort, Kentucky 40601; and copies were mailed via certified mail return-receipt requested to the licensee, Stephen Meese, D.O., License No. 02536, 500 Waynoka Drive, Sardinia, Ohio 45171; and to counsel for the licensee, Jennifer Wintergerst, Esq., Bricker Graydon Wyatt, LLP, 400 West Market, Suite 2000, Louisville, Kentucky 40202, and via email to jwintergerst@bricker.com on this 20th day of January, 2026.



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K.B.M.L.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 2218

IN RE: THE LICENSE TO PRACTICE OSTEOPATHY IN THE COMMONWEALTH OF KENTUCKY HELD BY STEPHEN P. MEESE, D.O., LICENSE NO. 02536, 500 WAYNOKA DRIVE, SARDINIA, OHIO 45171

EMERGENCY ORDER OF RESTRICTION

On May 15, 2025, the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel B, considered: a Panel Memorandum prepared by Jon Marshall, Medical Investigator, dated April 18, 2025; a grievance filed by Det. Marcus Harlow, Boone County Sheriff's Office, dated May 23, 2024; the Investigation Narrative in Case No. 24-000268, undated; the Victim/Complainant Interview Notes in Case No. 24-000268, dated January 9, 2024; the Witness Interview Notes in Case No. 24-000268, dated January 16, 2024; the licensee's response to the grievance, dated April 4, 2025; Patient 1 Bluegrass Urgent Care records provided by the licensee, dated January 4, 2025; Patient 1 Bluegrass Urgent Care records provided by the licensee, dated January 6, 2025; and the Agreed Order, filed of record June 7, 2018. The licensee was given notice and appeared before and was heard by the Panel before it chose to issue this emergency order.

Having considered this information and being sufficiently advised, Inquiry Panel B enters the following EMERGENCY ORDER OF RESTRICTION, in accordance with KRS 311.592(1) and 13B.125(1):

FINDINGS OF FACT

Pursuant to KRS 13B.125(2) and based upon the information available, Inquiry Panel B concludes there is probable cause to make the following Findings of Fact, which support this Emergency Order of Restriction:

1. At all relevant times, Stephen P. Meese, D.O., was licensed by the Board to practice osteopathy within the Commonwealth of Kentucky.
2. The licensee's osteopathic specialty is general medicine.
3. In or around June 2018, the licensee entered into an Agreed Order, Case No. 1862, in which he stipulated to facts including the following:
   - The licensee's medical specialty is Obstetrics and Gynecology.
   - On or about January 8, 2018, the Board received a grievance filed by Patient A, who alleged that the licensee made sexually explicit comments during her appointments and after a surgery.
   - Patient A was interviewed by a Board investigator following receipt of the grievance. Patient A stated that she saw the licensee at his office in Stanford at the end of May 2017 to schedule a hysterectomy and she requested to schedule it after her birthday. Patient A stated that the licensee offered to be her designated driver for her birthday party if there would be alcohol and nudity involved. She stated that no one else was present in the room when he made the statement.
   - Patient A stated that her next appointment was in early June, at which she had an ultrasound. She stated that while she was laying on the exam table with her feet in stirrups (fully clothed), the licensee made a "camera" or "framing sign" with his hands and pointed it toward her vaginal area and stated "best view ever." Patient A stated that the licensee made a statement about pubic hair and expressed his personal preference regarding women with pubic hair. Patient A stated she was alone in the room with the licensee when the statements were made.
   - Patient A stated that her surgery was on June 20, 2017 at Ephraim McDowell Hospital. She stated that following the surgery, the licensee came into her hospital room, sat on her bed, and made comments about bruises on her thighs and grabbed each area in turn. She stated that when her boyfriend arrived, the licensee left the room.

- Patient A stated that later that afternoon on the same day, she was preparing to leave. She stated that the licensee came into her room and advised that she should not have penetrative sex for six weeks but that she could have oral sex. Patient A stated that the licensee then made statements about his personal preference regarding oral sex. She stated that no one else was in the room when he made the statements.

- Patient A stated that she did not return to the licensee for follow up after her surgery. She stated that she saw her gynecologist, APRN Crystal Brown, at Ephraim McDowell Specialty Clinic in August 2017, where she told Ms. Brown and the office manager, Kristi Poynter, about the comments made by the licensee. She stated that she met with Ephraim McDowell Hospital Risk Assessment sometime in August or September 2017.

- A Board investigator interviewed Ms. Brown and Ms. Pointer, who both stated that Patient A provided the same account regarding the licensee to them.

- A Board investigator interviewed Marilyn Peterson, Director of Risk Management for Ephraim McDowell Hospital. She stated that in August 2017 Patient A came to Ephraim McDowell to give her complaint through an interview. When Peterson was asked any questions about what transpired after the meeting, she was instructed not to answer by attorneys for Ephraim McDowell.

- A Board investigator contacted attorney Amy Johnson, who was hired by Ephraim McDowell Hospital to investigate the allegation against the licensee. She stated that she conducted an investigation and that it was concluded, but she declined to comment or share the investigation.
- The licensee submitted a letter of resignation to Ephraim McDowell on September 1, 2017.

- During interview of witnesses by a Board investigator, each was asked if they knew where the licensee went after leaving Ephraim McDowell Hospital. Locations of Elizabethtown or Bardstown were suggested. The Board investigator checked hospitals in those locations and could not find the licensee practicing at either. Ms. Poynter advised that the licensee may have moved to Bardstown or Lebanon. The Board investigator learned that the licensee was working in Lebanon at the Lebanon Physicians for Women, which is part of the Lebanon Hospital.

- During an interview with the Board investigator, the licensee stated he recalled making the designated driver remark to Patient A as she told him she was having a birthday and planned to do some wild partying. He stated he probably made statements such as she did not need to shave prior to surgery

as studies showed it was healthier. He stated that he has had patients ask about sex after surgery and that six weeks is a long time without sex and he tells them that while they can't have any penetration they can have oral sex or masturbation. He stated that he had a chaperone in the room with him but could not remember who it was. He stated that he had switched from Ephraim McDowell Hospital to Lebanon in January 2018. He stated that obtaining the position was in the works for two years and that Patient A's complaint was not the cause of his resignation from Ephraim McDowell.

- In a written response to the grievance dated February 9, 2018, the licensee acknowledged making a designated driver comment during the scheduling of Patient A's hysterectomy. He denied making any gestures or commentary toward Patient A's vaginal area. The licensee acknowledged that he discussed Patient A shaving her pubic hair in the context of pre-operative instructions and stated that her prefers women do not completely shave prior to surgery due to increased risk of infection associated with complete shaving. The licensee stated that he did observe bruising to Patient A's thighs and body while positioning her after the administration of anesthetic and had concern for possible abuse. He stated that he sat on the edge of her bed, discussed the procedure with her, and questioned the bruising. He denied any physical contact with Patient A. The licensee stated that he provided Patient A with discharge instructions, including avoidance of penetrative sex for six weeks. He stated that he advised that masturbation and oral sex were permissible, but denied expressing any personal preferences for such activities.

4. Pursuant to the Agreed Order, Case No. 1862, the licensee was required to utilize chaperones during female patient encounters and to undergo an assessment at Vanderbilt's Comprehensive Assessment Program for Professionals ("VCAP") and implement any recommendations made by VCAP.
5. In or around August 2019, VCAP recommended that the licensee engage in therapy for himself and complete a Boundaries course.
6. In or around March 2020, the licensee completed the *Maintaining Proper Boundaries* course at Vanderbilt University Medical Center.
7. In or around November 2020, the Agreed Order, Case No. 1862, was terminated.

8. On or about May 23, 2024, Detective Marcus Harlow, Boone Co. Sheriff's Office, reported to the Board that he was investigating a sexual assault complaint in which Patient 1 alleged that the licensee sexually assaulted he under the guise of conducting an exam at an urgent care center.
9. An interview was conducted with Merissa Kerish, former MA for the licensee, and she stated substantially as follows: Ms. Kerish swabbed Patient 1 for COVID and strep based upon her presenting complaints; she witnessed the licensee ask Patient 1 and other female patients "are you having trouble using the restroom?"; Ms. Kerish recalled the licensee asking Patient 1 if she was constipated and the licensee offered to perform an "internal vaginal exam" to see if she was impacted; Ms. Kerish had never seen or heard of that in her experience and does not believe it is normal procedure; Ms. Kerish recalled Patient 1 stating "I don't know what that has to do with COVID" and that she did not want a vaginal exam; Ms. Kerish recalled the licensee asking two other female patients the same line of questioning the same day; Ms. Kerish stepped out of the room and left the licensee alone with Patient 1 and then the licensee came out of the room and told Ms. Kerish that Patient 1 was going to have the vaginal exam; and Ms. Kerish stated that it was clear that Patient 1 was very uncomfortable and that she too felt the same "vibe," recalling that Patient 1 was whispering due to the level of uncomfortableness.
10. An interview was conducted with Patient 1, who stated substantially as follows: she had been seen by the licensee two (2) days before the incident complaining of symptoms related to her chest and throat and received a z-pack (antibiotic); on

the day of the incident, she presented with complaints of pain in her stomach; a nurse swabbed Patient 1 for COVID prior to examination by the licensee; the licensee asked Patient 1 if she was constipated which she denied having; the licensee still offered to check her for constipation; the licensee also asked "if she wanted to do a 'vaginal thing,' " which she declined because "I knew that nothing was going on down there. He tried to say 'you could have an infection down there with poop or something' which is what he was trying to explain to me to justify it"; during the examination, the licensee grabbed Patient 1 on her butt and dragged her to the edge of the examination table and the nurse then grabbed the black stirrups and placed her feet in them; the licensee inserted one finger into Patient 1's vagina and then another for approximately ten seconds; the licensee then placed his fingers into her rectum for approximately 5-7 seconds; after the vaginal and rectal examination, the licensee informed Patient 1 that she was positive for COVID and wanted to listen to her stomach for gurgling; the licensee had Patient 1 lean back in a chair and listened to her stomach at the sternum area and then moved further down toward her waist and genital area and rested his hand on her thigh; the licensee asked Patient 1 if she was on birth control and whether she had frequent urinary tract infections (UTIs) but did not prescribe any medication or advise her on how to address the COVID; and after the encounter Patient 1 reported the incident to the police.

11. On May 15, 2025, the licensee, with counsel, appeared before Inquiry Panel B, and stated substantially as follows: the licensee palpitated the patient's abdomen which caused pain and increased guarding; there was some rebound but no fever;

he informed Patient 1 that he could conduct a vaginal or rectal exam to determine if she was impacted; Patient 1 chose the rectal exam; the licensee determined that Patient 1 was not impacted and discharged her home with a diagnosis of constipation.

CONCLUSIONS OF LAW

Pursuant to KRS 13B.125(2) and based upon the information available, Inquiry Panel B finds there is probable cause to support the following Conclusions of Law, which serve as the legal bases for this Emergency Order of Restriction:

1. The licensee's Kentucky medical license is subject to regulation and discipline by this Board.
2. KRS 311.592(1) provides that the Board may issue an emergency order suspending, limiting, or restricting a physician's license at any time an inquiry panel has probable cause to believe that a) the physician has violated the terms of an order placing him on probation; or b) a physician's practice constitutes a danger to the health, welfare and safety of his patients or the general public.
3. There is probable cause to believe that the licensee has violated KRS 311.595(9), as illustrated by KRS 311.597(4).
4. Inquiry Panel B concludes there is probable cause to believe this licensee's practice constitutes a danger to the health, welfare and safety of his patients or the general public.
5. The Board may draw logical and reasonable inferences about a licensee's practice by considering certain facts about a licensee's practice. If there is proof that a licensee has violated a provision of the Kentucky Medical Practice Act in one set of

circumstances, the Board may infer that the licensee will similarly violate the Medical Practice Act when presented with a similar set of circumstances. Similarly, the Board concludes that proof of a set of facts about a licensee's practice presents representative proof of the nature of that licensee's practice in general. Accordingly, probable cause to believe that the licensee has committed certain violations in the recent past presents probable cause to believe that the licensee will commit similar violations in the near future, during the course of the licensee's medical practice.

6. The United States Supreme Court has ruled that it is no violation of the federal Due Process Clause for a state agency to temporarily suspend a license, without a prior evidentiary hearing, so long as 1) the immediate action is based upon a probable cause finding that there is a present danger to the public safety; and, 2) the statute provides for a prompt post-deprivation hearing. *Barry v. Barchi*, 443 U.S. 55, 61 L.Ed.2d 365, 99 S.Ct. 2642 (1979); *FDIC v. Mallen*, 486 U.S. 230, 100 L.Ed.2d 265, 108 S.Ct. 1780 (1988) and *Gilbert v. Homar*, 520 U.S. 924 (1997), 117 S.Ct. 1807 (1997). Cf. KRS 13B.125(1).

KRS 13B.125(3) provides that the Board shall conduct an emergency hearing on this emergency order within ten (10) working days of a request for such a hearing by the licensee. The licensee has been advised of his right to a prompt post-deprivation hearing under this statute.

EMERGENCY ORDER OF RESTRICTION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Chair of Inquiry Panel B, on behalf of Inquiry Panel B, hereby ORDERS that the license to practice osteopathy in the Commonwealth of Kentucky held by Stephen P. Meese, D.O.,

is RESTRICTED and Dr. Meese is prohibited from being in the presence of any patient unless accompanied by a Board-approved chaperone, who is able to be present and to hear and see all interactions between the licensee and the patient at all times, until the Board's Hearing Panel has finally resolved the Complaint or until such further Order of the Board.

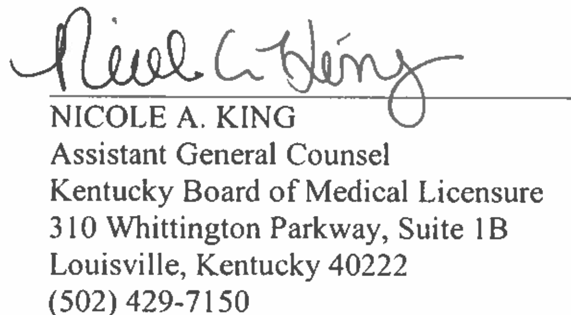
The Chair of Inquiry Panel B further declares that this is an EMERGENCY ORDER, effective upon receipt by the licensee.

SO ORDERED this 3rd day of June, 2025.

DALE E. TONEY, M.D.
CHAIR, INQUIRY PANEL B

CERTIFICATE OF SERVICE

I certify that the original of this Emergency Order of Restriction was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; and copies were mailed via certified mail return-receipt requested to the licensee, Stephen Meese, D.O., License No. 02536, 500 Waynoka Drive, Sardinia, Ohio 45171; and to counsel for the licensee, Jennifer Wintergerst, Esq., Wyatt, Tarrant & Combs, PLLC, 400 West Market, Suite 200, Louisville, Kentucky 40202, and via email to jwintergerst@wyattfirm.com on this 3rd day of June, 2025.



NICOLE A. KING
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Kentucky Board of Medical Licensure
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FILED OF RECORD

JUN - 3 2025

K.B.M.L.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 2218

IN RE: THE LICENSE TO PRACTICE OSTEOPATHY IN THE COMMONWEALTH OF KENTUCKY HELD BY STEPHEN P. MEESE, D.O., LICENSE NO. 02536, 500 WAYNOKA DRIVE, SARDINIA, OHIO 45171

COMPLAINT

Comes now the Complainant, Chair of the Kentucky Board of Medical Licensure's Inquiry Panel B, and on behalf of the Panel which met on May 15, 2025, states for its Complaint against the licensee, Stephen P. Meese D.O., as follows:

1. At all relevant times, Stephen P. Meese, D.O., was licensed by the Board to practice osteopathy within the Commonwealth of Kentucky.
2. The licensee's osteopathic specialty is general medicine.
3. In or around June 2018, the licensee entered into an Agreed Order, Case No. 1862, in which he stipulated to facts including the following:

   - The licensee's medical specialty is Obstetrics and Gynecology.
   - On or about January 8, 2018, the Board received a grievance filed by Patient A, who alleged that the licensee made sexually explicit comments during her appointments and after a surgery.
   - Patient A was interviewed by a Board investigator following receipt of the grievance. Patient A stated that she saw the licensee at his office in Stanford at the end of May 2017 to schedule a hysterectomy and she requested to schedule it after her birthday. Patient A stated that the licensee offered to be her designated driver for her birthday party if there would be alcohol and nudity involved. She stated that no one else was present in the room when he made the statement.
   - Patient A stated that her next appointment was in early June, at which she had an ultrasound. She stated that while she was laying on the exam table with her feet in stirrups (fully clothed), the licensee made a "camera" or "framing sign" with his hands and pointed it toward her vaginal area and stated "best view ever." Patient A stated that the licensee made a statement about pubic hair and expressed his personal preference regarding women

with pubic hair. Patient A stated she was alone in the room with the licensee when the statements were made.

- Patient A stated that her surgery was on June 20, 2017 at Ephraim McDowell Hospital. She stated that following the surgery, the licensee came into her hospital room, sat on her bed, and made comments about bruises on her thighs and grabbed each area in turn. She stated that when her boyfriend arrived, the licensee left the room.

- Patient A stated that later that afternoon on the same day, she was preparing to leave. She stated that the licensee came into her room and advised that she should not have penetrative sex for six weeks but that she could have oral sex. Patient A stated that the licensee then made statements about his personal preference regarding oral sex. She stated that no one else was in the room when he made the statements.

- Patient A stated that she did not return to the licensee for follow up after her surgery. She stated that she saw her gynecologist, APRN Crystal Brown, at Ephraim McDowell Specialty Clinic in August 2017, where she told Ms. Brown and the office manager, Kristi Poynter, about the comments made by the licensee. She stated that she met with Ephraim McDowell Hospital Risk Assessment sometime in August or September 2017.

- A Board investigator interviewed Ms. Brown and Ms. Pointer, who both stated that Patient A provided the same account regarding the licensee to them.

- A Board investigator interviewed Marilyn Peterson, Director of Risk Management for Ephraim McDowell Hospital. She stated that in August 2017 Patient A came to Ephraim McDowell to give her complaint through an interview. When Peterson was asked any questions about what transpired after the meeting, she was instructed not to answer by attorneys for Ephraim McDowell.

- A Board investigator contacted attorney Amy Johnson, who was hired by Ephraim McDowell Hospital to investigate the allegation against the licensee. She stated that she conducted an investigation and that it was concluded, but she declined to comment or share the investigation.
- The licensee submitted a letter of resignation to Ephraim McDowell on September 1, 2017.

- During interview of witnesses by a Board investigator, each was asked if they knew where the licensee went after leaving Ephraim McDowell Hospital. Locations of Elizabethtown or Bardstown were suggested. The Board investigator checked hospitals in those locations and could not find the licensee practicing at either. Ms. Poynter advised that the licensee may have

moved to Bardstown or Lebanon. The Board investigator learned that the licensee was working in Lebanon at the Lebanon Physicians for Women, which is part of the Lebanon Hospital.

- During an interview with the Board investigator, the licensee stated he recalled making the designated driver remark to Patient A as she told him she was having a birthday and planned to do some wild partying. He stated he probably made statements such as she did not need to shave prior to surgery as studies showed it was healthier. He stated that he has had patients ask about sex after surgery and that six weeks is a long time without sex and he tells them that while they can't have any penetration they can have oral sex or masturbation. He stated that he had a chaperone in the room with him but could not remember who it was. He stated that he had switched from Ephraim McDowell Hospital to Lebanon in January 2018. He stated that obtaining the position was in the works for two years and that Patient A's complaint was not the cause of his resignation from Ephraim McDowell.

- In a written response to the grievance dated February 9, 2018, the licensee acknowledged making a designated driver comment during the scheduling of Patient A's hysterectomy. He denied making any gestures or commentary toward Patient A's vaginal area. The licensee acknowledged that he discussed Patient A shaving her pubic hair in the context of pre-operative instructions and stated that her prefers women do not completely shave prior to surgery due to increased risk of infection associated with complete shaving. The licensee stated that he did observe bruising to Patient A's thighs and body while positioning her after the administration of anesthetic and had concern for possible abuse. He stated that he sat on the edge of her bed, discussed the procedure with her, and questioned the bruising. He denied any physical contact with Patient A. The licensee stated that he provided Patient A with discharge instructions, including avoidance of penetrative sex for six weeks. He stated that he advised that masturbation and oral sex were permissible, but denied expressing any personal preferences for such activities.

4. Pursuant to the Agreed Order, Case No. 1862, the licensee was required to utilize chaperones during female patient encounters and to undergo an assessment at Vanderbilt's Comprehensive Assessment Program for Professionals ("VCAP") and implement any recommendations made by VCAP.

5. In or around August 2019, VCAP recommended that the licensee engage in therapy for himself and complete a Boundaries course.

6. In or around March 2020, the licensee completed the *Maintaining Proper Boundaries* course at Vanderbilt University Medical Center.
7. In or around November 2020, the Agreed Order, Case No. 1862, was terminated.
8. On or about May 23, 2024, Detective Marcus Harlow, Boone Co. Sheriff's Office, reported to the Board that he was investigating a sexual assault complaint in which Patient 1 alleged that the licensee sexually assaulted her under the guise of conducting an exam at an urgent care center.
9. An interview was conducted with Merissa Kerish, former MA for the licensee, and she stated substantially as follows: Ms. Kerish swabbed Patient 1 for COVID and strep based upon her presenting complaints; she witnessed the licensee ask Patient 1 and other female patients "are you having trouble using the restroom?"; Ms. Kerish recalled the licensee asking Patient 1 if she was constipated and the licensee offered to perform an "internal vaginal exam" to see if she was impacted; Ms. Kerish had never seen or heard of that in her experience and does not believe it is normal procedure; Ms. Kerish recalled Patient 1 stating "I don't know what that has to do with COVID" and that she did not want a vaginal exam; Ms. Kerish recalled the licensee asking two other female patients the same line of questioning the same day; Ms. Kerish stepped out of the room and left the licensee alone with Patient 1 and then the licensee came out of the room and told Ms. Kerish that Patient 1 was going to have the vaginal exam; and Ms. Kerish stated that it was clear that Patient 1 was very uncomfortable and that she too felt the same "vibe," recalling that Patient 1 was whispering due to the level of uncomfortableness.

10. An interview was conducted with Patient 1, who stated substantially as follows: she had been seen by the licensee two (2) days before the incident complaining of symptoms related to her chest and throat and received a z-pack (antibiotic); on the day of the incident, she presented with complaints of pain in her stomach; a nurse swabbed Patient 1 for COVID prior to examination by the licensee; the licensee asked Patient 1 if she was constipated which she denied having; the licensee still offered to check her for constipation; the licensee also asked "if she wanted to do a 'vaginal thing,' " which she declined because "I knew that nothing was going on down there. He tried to say 'you could have an infection down there with poop or something which is what he was trying to explain to me to justify it' "; during the examination, the licensee grabbed Patient 1 on her butt and dragged her to the edge of the examination table and the nurse then grabbed the black stirrups and placed her feet in them; the licensee inserted one finger into Patient 1's vagina and then another for approximately ten seconds; the licensee then placed his fingers into her rectum for approximately 5-7 seconds; after the vaginal and rectal examination, the licensee informed Patient 1 that she was positive for COVID and wanted to listen to her stomach for gurgling; the licensee had Patient 1 lean back in a chair and listened to her stomach at the sternum area and then moved further down toward her waist and genital area and rested his hand on her thigh; the licensee asked Patient 1 if she was on birth control and whether she had frequent urinary tract infections (UTIs) but did not prescribe any medication or advise her on how to address the COVID; and after the encounter Patient 1 reported the incident to the police.

11. On May 15, 2025, the licensee, with counsel, appeared before Inquiry Panel B, and stated substantially as follows: the licensee palpitated the patient's abdomen which caused pain and increased guarding; there was some rebound but no fever; he informed Patient 1 that he could conduct a vaginal or rectal exam to determine if she was impacted; Patient 1 chose the rectal exam; the licensee determined that Patient 1 was not impacted and discharged her home with a diagnosis of constipation.

12. Simultaneous with this Complaint and in accordance with KRS 311.592, the Chair of the Board's Inquiry Panel B authorized the issuance of an emergency order of restriction pursuant to which licensee will become prohibited from being in the presence of any patient unless accompanied by a Board approved chaperone, who is able to be present and to hear and see all interactions between the licensee and the patient at all times, in the Commonwealth of Kentucky pending resolution of this Complaint.

13. By his conduct, the licensee has violated KRS 311.595(9), as illustrated by KRS 311.597(4). Accordingly, legal grounds exist for disciplinary action against his license to practice medicine in the Commonwealth of Kentucky.

14. The licensee is directed to respond to the allegations delineated in the Complaint within thirty (30) days of service thereof and is further given notice that:

    (a) His failure to respond may be taken as an admission of the charges; and

    (b) He may appear alone or with counsel, may cross-examine all prosecution witnesses and offer evidence in his defense.

15. NOTICE IS HEREBY GIVEN that a hearing on this Complaint is scheduled for **January 22-23, 2026**, at 9:00 a.m., Eastern Standard Time, at the Kentucky Board of Medical Licensure, Hurstbourne Office Park, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222. Said hearing shall be held pursuant to the Rules and Regulations of the Kentucky Board of Medical Licensure and pursuant to KRS Chapter 13B. This hearing shall proceed as scheduled and the hearing date shall only be modified by leave of the Hearing Officer upon a showing of good cause.

WHEREFORE, Complainant prays that appropriate disciplinary action be taken against the license to practice osteopathy in the Commonwealth of Kentucky held by Stephen P. Meese, D.O.

This 30th day of June, 2025.

DALE E. TONEY, M.D.
CHAIR, INQUIRY PANEL B

CERTIFICATE OF SERVICE

I certify that the original of this Complaint was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; a copy was mailed to Thomas J. Hellmann, Esq., 810 Hickman Hill Road, Frankfort, Kentucky 40601; and copies were mailed via certified mail return-receipt requested to the licensee, Stephen Meese, D.O., License No. 02536, 500 Waynoka Drive, Sardinia, Ohio 45171; and to counsel for the licensee, Jennifer Wintergerst, Esq., Wyatt, Tarrant & Combs, LLP, 400 West Market, Suite 2000, Louisville, Kentucky 40202, and via email to jwintergerst@wyattfirm.com on this 30th day of June, 2025.

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