

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 2238

FILED OF RECORD

APR 16 2026

K.B.M.L
IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF
KENTUCKY HELD BY PETER B. HARDIN, M.D., LICENSE NO. 42374, 430 LAKE
FOREST DRIVE, CAMPBELLSVILLE, KENTUCKY 42718

AGREED ORDER OF PERMANENT SURRENDER

Come now the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Hearing Panel A, and Peter B. Hardin, M.D. ("the licensee"), and, based upon their mutual desire to fully and finally 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, Peter B. Hardin, M.D. ("the licensee"), was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is radiation oncology.
3. On or about August 15, 2024, the licensee entered into an Agreed Order in Case No. 2147 to resolve a Complaint and Emergency Order of Suspension. He stipulated to certain facts, including:
 - On or about October 1, 2008, the licensee applied for a full medical license in the Commonwealth of Kentucky. At that time, he informed the Board that he was admitted to a residential treatment program in March 2008 for treatment of alcohol use. The Board approved his request for a full medical license contingent upon him entering into a Letter of Agreement.
 - On or about December 22, 2008, the licensee entered into a five-year Letter of Agreement agreeing to abstain from alcohol, be subjected to random drug testing, and be an active participant in the activities of the Kentucky Physicians Health

Foundation ("the Foundation"). He successfully completed the terms of the Agreement.

- On or about November 30, 2023, the licensee was arrested and charged with operating a motor vehicle under the influence of alcohol in Adair County. Pursuant to the Citation, an officer was dispatched to a reckless driver due to a caller complaint advising the vehicle was running off the road into the grass median and back onto the road. The caller advised that the licensee ran off the road into the grass. When the officer arrived, he observed a male subject sitting in the driver's seat with the motor running. The licensee advised that he was having blood sugar problems, so the officer called EMS. EMS arrived and informed the officer that the licensee's blood sugar was good and that was not the issue. The officer administered a PBT for the presence of alcohol, which produced a read of .312. The officer asked the licensee to step out of the vehicle. He refused several sobriety tests, citing knee problems. The officer moved on to the eye test, but the licensee was unable to follow directions.
- On or about November 30, 2023, the Columbia Police Department collected a blood sample from the licensee. Laboratory testing showed a 0.336g/100mL alcohol content in the blood.
- On or about January 5, 2024, the licensee was arrested and charged with operating a vehicle under the influence of alcohol in Metcalfe County. The Kentucky Uniform Police Traffic Collision Report states substantially as follows:

Unit #1 was traveling westbound on KY HWY 80 near intersection with Jack Sparks Road. Unit #1 stated that he struck a deer approximately .5 miles east of current location. Unit #1 stated that he continued westbound on KY HWY 80 until the vehicle lost all fluids. Unit #1 operator was awaiting on AAA to tow the vehicle.

Upon arriving to the scene the operator of Unit #1 was sitting in the operator seat of the vehicle on the westbound shoulder of KY HWY 80. The operator of Unit #1 had a strong odor of alcoholic beverage. I immediately suspected him of being under the influence. I instructed Unit #1 operator to exit the vehicle. While exiting the vehicle the operator of Unit #1 was using the vehicle for balance. Unit #1 operator was very unsteady on his feet and using the vehicle for balance. I conducted SFST [Standardized Field Sobriety Test], horizontal gaze nystagmus. Unit #1 operator displayed lack of smooth pursuit in both eyes. The operator of Unit #1 also had distinct and sustained nystagmus at maximum deviation in both the left and right eyes. Unit #1 operator could not complete the walk and turn or the one leg stand. Unit #1 operator stated that he had both knees replaced in the past three months. The operator of Unit #1 was placed under arrest for driving under

the influence and later administered a breath test. The breath tests results were .221 [...].

It appeared that unit #1 had struck something other than a deer. I traveled east on KY HWY 80 for approximately a mile and did not see any visible signs of a collision. I did see fluids from Unit #1 vehicle approximately .5 miles from Unit #1 current location.

- On or about January 11, 2024, Taylor Regional Hospital summarily suspended the licensee pending the completion of an investigation by the Medical Executive Committee.
- On or about January 12, 2024, the Board received correspondence from Rick Morris, Medical Physicist at Taylor Regional Radiation Oncology. Mr. Morris stated substantially as follows:

On January 3, 2024, I was working remote. Early in the day, I asked Dr. Hardin whether a patient who was scheduled to start treatment the next day would require a PET/CT fusion. Due to the patient starting treatment the next day, I would consider this an urgent inquiry. When Dr. Hardin failed to respond after several hours, I called Dr. Hardin. This was a typical question for me to ask Dr. Hardin in the scope of our professional relationship. Dr. Hardin responded that the PET/CT fusion was needed for treatment planning. I explained to Dr. Hardin that the PET data would need to be transferred to certain computer software for use by the physics/dosimetry team. Dr. Hardin attempted to move the PET data while on the phone with me, but he became agitated and stated the process was not working. When it became clear my oral instructions on how to move the PET data to the necessary software were not helping, I offered to Face Time Dr. Hardin to walk him through what to do. Upon initiating the video call, I noticed Dr. Hardin was clicking the incorrect tab even though he was adamant he was correct. This encounter was strange, as Dr. Hardin has transferred the fusion data in the exact same matter many times in the past without confusion or the need for step-by-step instruction.

On January 4, 2024, I was working on-site. When I arrived at work, radiation therapist, Marie, told me she suspected Dr. Hardin was drunk at work the previous day. This explained his delayed reaction to my inquiry and his difficulty transferring the file the day before. When I arrived, I spoke with Dr. Hardin regarding the PET/CT fusion plan we worked on the day before, and he replied he had not seen it and did not have time to look at it because he was about to see another patient. Knowing, Dr. Hardin is a diabetic, I initially thought his erratic behavior this morning may be due to his glucose levels being at an unsafe level. Soon after, I heard someone ask Dr. Hardin about his blood sugar and Dr. Hardin replied it had recently been tested and it was okay. However, Dr. Hardin did not seem okay as his speech was slurred and he visibly had difficulty walking and trouble navigating the

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Later in the afternoon, Marie asked me if I noticed anything wrong with Dr. Hardin. She told me she thought he was drunk. As the day went on, Dr. Hardin's physical/ cognitive abilities appeared to continue to decline. I left the facility at approximately 1:30pm. Before I left, I went to Dr. Hardin's office to see if he needed anything else from Medical Physics that day. When I entered his office, he was slouched over in his chair with his eyes closed. When I spoke, he raised his head slightly, but he never replied to me or opened his eyes. As I was leaving, Tammy at the front desk stopped me and told me Dr. Hardin was drunk. While suspected of being drunk, Dr. Hardin finally approved the new patient's PET/ CT fusion plan and started her treatment.

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- On or about January 15, 2024, the licensee requested a hearing regarding his suspended privileges pursuant to the Taylor Regional Hospital Medical Staff Bylaws.
- On or about January 19, 2024, the Hearing Committee recommended to the Medical Executive Committee that it affirm the summary suspension of the licensee's clinical privileges at Taylor Regional Hospital.
- On or about February 15, 2024, Taylor Regional Hospital informed the licensee that the Medical Executive Committee affirmed the recommendation, summarily suspending his privileges.
- On or about February 22, 2024, in accordance with KRS 311.592, the Chair of the Board's Inquiry Panel B authorized the issuance of an Emergency Order of Suspension based upon the above facts.
- On or about March 4, 2024, counsel for the licensee notified the Board that the licensee pled guilty to a charge of DUI in Adair County District Court (Case No.

23-T-02444) on February 28, 2024, and pled guilty to a charge of DUI in Metcalfe County District Court (Case No. 24-T-00017) on February 28, 2024. He also informed the Board that the licensee had met with the Foundation and was complying with its determination that he obtain a 96-hour evaluation.

- On or about March 14, 2024, the Board ratified the Emergency Order of Suspension and issued a Complaint based upon the above facts.
 - On or about March 30, 2024, the licensee enrolled in a 12-week residential treatment program at Bradford Health Services ("Bradford"). He made good progress while in treatment and was discharged on or about June 17, 2024. His Axis I diagnosis included alcohol use disorder, severe. Bradford provided numerous recommendations, including engaging in individual therapy; attending 90 recovery meetings in 90 days followed by a minimum of 3 meetings per week thereafter; following up with his primary care physician within six months post-discharge; continuing wearing his CPAP machine, taking his recommended dose of Trazodone and to see an addictionologist; and complying with all requirements of the Foundation monitoring agreement. Bradford advocated for his return to medical practice two weeks post-discharge, on July 1, 2024. It also recommended that the number of hours he work not exceed forty hours.
 - On or about June 25, 2024, the licensee entered into an aftercare and monitoring contract with the Foundation. The components are as follows:
 - i. Documented attendance at no less than 12 recovery meetings per month;
 - ii. Ongoing relationship with a 12-Step sponsor;
 - iii. Individual therapy;
 - iv. Medication management with a Foundation-approved provider, if indicated;
 - v. Random, observed drug screens and alcohol determinations; and
 - vi. Once he has been approved to return to clinical practice, we will also obtain interval reports from a contact at his primary worksite confirming his appropriate professional behavior within the workplace setting.
 - By her letter of July 2, 2024, Dr. Simpson explained that the licensee has entered into a contract with the Foundation. With the above-noted parameters in place, the Foundation does not believe he poses any undue risk to his patients or the public.
4. Pursuant to the Agreed Order in Case No. 2147, the licensee agreed that he violated KRS 311.595(7), (8), and (21).

5. Pursuant to the terms of Agreed Order in Case No. 2147, the licensee was placed on probation for no more than five years and he agreed to maintain a contractual relationship with the Foundation; not to work in excess of forty (40) hours per week; comply with all June 2024 Bradford Health Services Recommendations regarding testing, monitoring, therapy, medical care and support meetings; and to not violate any provision of KRS 311.595 and/or 311.597.
6. On or about September 17, 2024, the Board received a grievance from Dr. John Cox, Dr. Meredith Angel, and Dr. James Watkins. The grievance alleges that the licensee treated a patient with prostate cancer in 2023 in an incompetent and grossly negligent manner. The patient had no evidence of his prostate cancer having extra-prostatic extension and no evidence of rectal involvement. However, when Dr. Cox reviewed the treatment plan that the licensee had created and implemented, the delivered radiation therapy treatment plan included the patient's full rectum. Dr. Cox believes that the licensee overexposed the area of treatment to include the patient's prostate, bladder, and rectum, despite the fact that the rectum and bladder had no signs of cancer. The patient was also treated by Dr. Meredith Angel and by Dr. James Watkins, who noted significant concerns.
7. On or about September 17, 2024, Dr. Cox filed a separate grievance in which he provided additional details about the licensee's practice. He described the licensee's treatment of three other patients, which he believes falls below the standard of care. The concerns include the licensee not treating the correct area, resulting in radiation therapy being applied to healthy tissue. Dr. Cox also noted that at least one of the patients discussed in his grievance was treated prior to the licensee's most recent substance abuse issues. This

patient received only radiation therapy and was refused chemotherapy, which should have also been offered.

8. Dr. Cox also alleged in his grievance that the licensee is prescribing medication to a staff member who does not have a patient chart in the clinic's electronic medical records (EMR) and is also the licensee's romantic interest.
9. Dr. Cox provided an analysis regarding the age and capabilities of the radiation machine used in the licensee's practice, stating it was 15-20 years old with outdated software. He believes that the licensee last upgraded the equipment four years ago. In July 2024, the machine malfunctioned, and the licensee contacted IT for assistance while he was not present at the office. Although he made the machine operable again, no significant upgrades were made due to concerns about potential software fragility. Dr. Cox noted that the equipment could not provide the latest treatments and referred many patients to other facilities for better care, unlike the licensee, who treated all patients referred to him without making any referrals.
10. Dr. Cox also described billing concerns and forwarded a complaint to the Attorney General's Office, Medicaid Investigation Branch.
11. On or about November 27, 2024, the Board's investigator learned that the patient in the grievance from Drs. Cox, Angel and Watkins (the prostate cancer patient) had passed away due to radiation exposure. His rectum had deteriorated and become necrotic, which caused him to develop sepsis, and his white blood count skyrocketed. Dr. Angel stated that the patient died an agonizing death and was moaning in his sleep even after receiving medication.

12. During the course of the investigation, the Board's investigator spoke to Kelly Rucker, R.N, a former employee of the licensee. She discussed the licensee's tendency to downplay patients' symptoms, attributing them to chemotherapy rather than his radiation treatments. She recounted an incident where she sent a patient with chest pain to the ER, leading to the discovery of a heart attack, despite the licensee's insistence on continuing treatment. Ms. Rucker noted that the licensee discouraged referrals to hospice to maximize billing and never referred patients to other clinics. She criticized him for mismanaging patient care and prioritizing profit over patients' well-being, stating that he should not be caring for cancer patients. Ms. Rucker observed that he was rarely present at the clinic, especially on Fridays, and claimed that his radiation technicians could administer treatments without his supervision.
13. A KASPER Report for staff member VH showed three prescriptions for Tramadol written by Dr. Peter Hardin; the prescriptions were filled a total of 7 times in 2024.
14. On or about February 11, 2025, the licensee provided a response to the grievance, including a summary of his treatment for each of the four patients referenced in the grievances. He contends that he treated those patients within professional standards.
15. Pursuant to his response, through counsel, the licensee acknowledged prescribing limited amounts of controlled medications to a staff member VH with whom he has a romantic relationship. He asserts they were for a legitimate medical need in conjunction with her primary care physician. He provided a detailed explanation of his prescribing, noting that she was not an oncology patient and so, his treatment of her was not in the EMR.

16. A subpoena was provided to the licensee for 19 patient charts. There was no patient chart for staff member VH. The remaining 18 patient charts were provided to a Board Consultant for review.
17. After submitting the requested information to the Board Consultant, the licensee provided an independent expert review from Dr. James Jacob of Denver, CO, of the four patient charts specifically listed in the grievance, finding that the care was generally appropriate in his opinion. This was also provided to the Board Consultant for consideration.
18. On or about April 11, 2024, two months later, the licensee submitted a 2nd independent expert review, by Dr. Amtullah Kahn of Somerset, KY, who also generally found that the licensee's care was appropriate. This was also sent to the Board Consultant for consideration.
19. The Board Consultant completed a review of the patient charts and found that eight charts were considered Below Minimum Standards; six charts were considered Borderline; and four charts were determined to be within Minimum Standards. He also found gross negligence in four charts; two charts that required immediate attention, imminent danger in two charts, malpractice in one chart, gross incompetence in one chart, and gross ignorance in one chart.
20. On or about July 29, 2025, the licensee provided a response to the Board Consultant's review, noting that he is currently not practicing and would agree not to do so until the Board deems it appropriate. He also provided more comments defending his care of the patients that the Board consultant found to be below minimum standards.
21. On or about August 5, 2025, the Board Consultant provided a Consultant Final Review, considering the licensee's response to his review, but still noting significant concerns.

22. On September 18, 2025, the licensee, with counsel, appeared before Inquiry Panel B. He informed the Panel that he is not currently working. This is due, in part, to acute renal failure requiring dialysis.
23. On or about October 16, 2025, the Board issued a 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 Complaint.
24. 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(8) and (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, Peter B. Hardin, M.D., hereby SURRENDERS his Kentucky medical 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 11 day of March, 2026.

FOR THE LICENSEE:


PETER B. HARDIN, M.D.


LUKE MORGAN
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

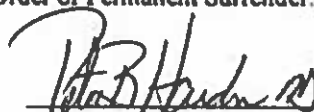
I, Peter B. Hardin, M.D., have read and understand the foregoing Agreed Order of Permanent Surrender, Case No. 2238. I have been given sufficient time and opportunity to consider the Agreed Order of Permanent Surrender, and I understand the effect it will have upon my license to practice medicine in 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.



PETER B. HARDIN, M.D.
LICENSE NO. 42374

DEC 12 2025

K.B.M.L.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
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AMENDED COMPLAINT

Comes now the Complainant, Acting Chair of the Kentucky Board of Medical Licensure's Inquiry Panel B, and on behalf of the Panel which met on September 18, 2025, states for its Amended Complaint against the licensee, Peter B. Hardin, M.D., as follows:

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 - On or about June 25, 2024, the licensee entered into an aftercare and monitoring contract with the Foundation. The components are as follows:
 - i. Documented attendance at no less than 12 recovery meetings per month;
 - ii. Ongoing relationship with a 12-Step sponsor;
 - iii. Individual therapy;
 - iv. Medication management with a Foundation-approved provider, if indicated;
 - v. Random, observed drug screens and alcohol determinations; and
 - vi. Once he has been approved to return to clinical practice, we will also obtain interval reports from a contact at his primary worksite confirming his appropriate professional behavior within the workplace setting.
 - By her letter of July 2, 2024, Dr. Simpson explained that the licensee has entered into a contract with the Foundation. With the above-noted parameters in place, the Foundation does not believe he poses any undue risk to his patients or the public.
4. Pursuant to the Agreed Order in Case No. 2147, the licensee agreed that he violated KRS 311.595(7), (8), and (21).
 5. Pursuant to the terms of Agreed Order in Case No. 2147, the licensee was placed on probation for no more than five years and he agreed to maintain a contractual relationship with the Foundation; not to work in excess of forty (40) hours per week; comply with all June 2024 Bradford Health Services Recommendations regarding testing, monitoring,

therapy, medical care and support meetings; and to not violate any provision of KRS 311.595 and/or 311.597.

6. On or about September 17, 2024, the Board received a grievance from Dr. John Cox, Dr. Meredith Angel, and Dr. James Watkins. The grievance alleges that the licensee treated a patient with prostate cancer in 2023 in an incompetent and grossly negligent manner. The patient had no evidence of his prostate cancer having extra-prostatic extension and no evidence of rectal involvement. However, when Dr. Cox reviewed the treatment plan that the licensee had created and implemented, the delivered radiation therapy treatment plan included the patient's full rectum. Dr. Cox believes that the licensee overexposed the area of treatment to include the patient's prostate, bladder, and rectum, despite the fact that the rectum and bladder had no signs of cancer. The patient was also treated by Dr. Meredith Angel and by Dr. James Watkins, who noted significant concerns.
7. On or about September 17, 2024, Dr. Cox filed a separate grievance in which he provided additional details about the licensee's practice. He described the licensee's treatment of three other patients, which he believes falls below the standard of care. A concern includes the licensee not treating the correct area, resulting in radiation therapy being applied to healthy tissue. Dr. Cox also noted that at least one of the patients discussed in his grievance was treated prior to the licensee's most recent substance abuse issues. This patient received radiation therapy and was refused chemotherapy, despite the fact that Dr. Cox believed it should have been offered.
8. Dr. Cox also alleged in his grievance that the licensee is prescribing medication to a staff member who does not have a patient chart in the clinic's electronic medical records (EMR) and is also the licensee's romantic interest.

9. Dr. Cox provided an analysis regarding the age and capabilities of the radiation machine used in the licensee's practice, stating it was 15-20 years old with outdated software. He believes that the licensee last upgraded the equipment four years ago. In July 2024, the machine malfunctioned, and the licensee contacted IT for assistance while he was not present at the office. Although he made the machine operable again, Dr. Cox believes no significant upgrades were made due to concerns about potential software fragility. Dr. Cox noted that the equipment could not provide the latest treatments and referred many patients to other facilities for better care, unlike the licensee, who treated all patients referred to him without making any referrals.
10. Dr. Cox also described billing concerns and forwarded a complaint to the Attorney General's Office, Medicaid Investigation Branch.
11. On or about November 27, 2024, the Board's investigator learned that the patient in the grievance from Drs. Cox, Angel and Watkins (the prostate cancer patient) had passed away due to radiation exposure. His rectum had deteriorated and become necrotic, which caused him to develop sepsis, and his white blood count skyrocketed. Dr. Angel stated that the patient died an agonizing death and was moaning in his sleep even after receiving medication.
12. During the course of the investigation, the Board's investigator spoke to Kelly Rucker, R.N, a former employee of the licensee. She discussed the licensee's tendency to downplay patients' symptoms, attributing them to chemotherapy rather than his radiation treatments. Ms. Rucker believes that the licensee discouraged referrals to hospice to maximize billing and never referred patients to other clinics. She criticized him for mismanaging patient care and prioritizing profit over patients' well-being. Ms. Rucker observed that he was rarely

present at the clinic, especially on Fridays, and claimed that his radiation technicians were allowed to administer treatments without his supervision.

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16. A subpoena was provided to the licensee for nineteen patient charts. There was no patient chart for staff member V.H. The remaining eighteen patient charts were provided to a Board Consultant for review.
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18. On or about April 11, 2025, two months later, the licensee submitted a 2nd expert review, by Dr. Amtullah Kahn of Somerset, KY, who also generally found that the licensee's care was appropriate. This was also sent to the Board Consultant for consideration.
19. The Board Consultant completed a review of the patient charts and found that eight charts were considered Below Minimum Standards; six charts were considered Borderline; and

four charts were determined to be within Minimum Standards. He also found gross negligence in four charts; two charts that required immediate attention, imminent danger in two charts, malpractice in one chart, gross incompetence in one chart, and gross ignorance in one chart.

20. On or about July 29, 2025, the licensee provided a response to the Board Consultant's review, noting that he is currently not practicing and would agree not to do so until the Board deems it appropriate. He also provided more comments on the patient care that was found to be below minimum standards.
21. On or about August 5, 2025, the Board Consultant provided a Consultant Final Review, considering the licensee's response to his review, but still noting significant concerns.
22. On September 18, 2025, the licensee, with counsel, appeared before Inquiry Panel B. He informed the Panel that he is not currently working. He states that this is due to a billing error with Medicaid, which resulted in his suspension for one year. Additionally, he said he is currently unable to work because of acute renal failure due to Type I diabetes and is receiving dialysis.
23. Simultaneous with the original Complaint and in accordance with KRS 311.592, the Acting Chair of the Board's Inquiry Panel B authorized the issuance of 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 – in the Commonwealth of Kentucky pending resolution of the Complaint.

24. By his conduct, the licensee has violated KRS 311.595(8) and (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.

25. The licensee is directed to respond to the allegations delineated in paragraph 24 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, cross-examine all prosecution witnesses, and offer evidence in his defense.

26. NOTICE IS HEREBY GIVEN that a hearing on this Amended Complaint is scheduled for **April 22-24, 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 medicine in the Commonwealth of Kentucky held by Peter B. Hardin, M.D.

This 12th day of December, 2025.


WILLIAM C. THORNBURY, JR., M.D.
ACTING 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 via email to thellmann@mac.com; and copies were sent via certified mail return-receipt requested to the licensee, Peter B. Hardin, M.D., License No. 42374, 430 Lake Forest Dr., Campbellsville, Kentucky 42718 and via email to phardin4@twc.com and to counsel for the licensee, Lisa English Hinkle, Esq. and Luke Morgan, Esq., McBrayer, PLLC, 201 East Main Street, Suite 900, Lexington, Kentucky 40507, and via email to lhinkle@mcbayerfirm.com and lmorgan@mcbayerfirm.com on this 12th day of December, 2025.



Nicole A. King
Assistant General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150

FILED OF RECORD

OCT 16 2025

K.B.M.L

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 2238

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY PETER B. HARDIN, M.D., LICENSE NO. 42374, 430 LAKE FOREST DRIVE, CAMPBELLSVILLE, KENTUCKY 42718

EMERGENCY ORDER OF SUSPENSION

On September 18, 2025, the Kentucky Board of Medical Licensure (“the Board”), acting by and through its Inquiry Panel B, considered Panel Memoranda from Kevin Payne, Medical Investigator, dated August 12, 2025; Grievance by Dr. Cox, Dr. Watkins, Dr. Meredith, dated September 17, 2024; Dr. Cox’s Grievance, dated September 17, 2024; Dr. Cox’s Analysis of Equipment at TRRO, undated; Letter from RN Kelly Rucker, dated March 3, 2024; List of Prescriptions by Dr. Hardin for staff member V.H., undated; Dr. Hardin’s Response to Grievances, dated January 31, 2025; Profile/Background form and CV, undated; Dr. Hardin’s expert review by Dr. James Jacob, Denver, CO, undated; Dr. Hardin’s 2nd expert review by Dr. Amtullah Kahn, Somerset, emailed May 11, 2025; Consultant Review, undated; Rebuttal to Consultant Review, dated July 29, 2025; and Consultant Final Review, dated August 5, 2025. 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 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, Peter B. Hardin, M.D. (“the licensee”), was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee’s medical specialty is radiation oncology.
3. On or about August 15, 2024, the licensee entered into an Agreed Order in Case No. 2147 to resolve a Complaint and Emergency Order of Suspension. He stipulated to certain facts, including:
 - On or about October 1, 2008, the licensee applied for a full medical license in the Commonwealth of Kentucky. At that time, he informed the Board that he was admitted to a residential treatment program in March 2008 for treatment of alcohol use. The Board approved his request for a full medical license contingent upon him entering into a Letter of Agreement.
 - On or about December 22, 2008, the licensee entered into a five-year Letter of Agreement agreeing to abstain from alcohol, be subjected to random drug testing, and be an active participant in the activities of the Kentucky Physicians Health Foundation (“the Foundation”). He successfully completed the terms of the Agreement.
 - On or about November 30, 2023, the licensee was arrested and charged with operating a motor vehicle under the influence of alcohol in Adair County. Pursuant to the Citation, an officer was dispatched to a reckless driver due to a caller complaint advising the vehicle was running off the road into the grass median and back onto the road. The caller advised that the licensee ran off the road into the grass. When the officer arrived, he observed a male subject sitting in the driver's seat with the motor running. The licensee advised that he was having blood sugar problems, so the officer called EMS. EMS arrived and informed the officer that the licensee’s blood sugar was good and that was not the issue. The officer administered a PBT for the presence of alcohol, which produced a read of .312. The officer asked the licensee to step out of the vehicle. He refused several sobriety tests, citing knee problems. The officer moved on to the eye test, but the licensee was unable to follow directions.

- On or about November 30, 2023, the Columbia Police Department collected a blood sample from the licensee. Laboratory testing showed a 0.336g/100mL alcohol content in the blood.
- On or about January 5, 2024, the licensee was arrested and charged with operating a vehicle under the influence of alcohol in Metcalfe County. The Kentucky Uniform Police Traffic Collision Report states substantially as follows:

Unit #1 was traveling westbound on KY HWY 80 near intersection with Jack Sparks Road. Unit #1 stated that he struck a deer approximately .5 miles east of current location. Unit #1 stated that he continued westbound on KY HWY 80 until the vehicle lost all fluids. Unit #1 operator was awaiting on AAA to tow the vehicle.

Upon arriving to the scene the operator of Unit #1 was sitting in the operator seat of the vehicle on the westbound shoulder of KY HWY 80. The operator of Unit #1 had a strong odor of alcoholic beverage. I immediately suspected him of being under the influence. I instructed Unit #1 operator to exit the vehicle. While exiting the vehicle the operator of Unit #1 was using the vehicle for balance. Unit #1 operator was very unsteady on his feet and using the vehicle for balance. I conducted SFST [Standardized Field Sobriety Test], horizontal gaze nystagmus. Unit #1 operator displayed lack of smooth pursuit in both eyes. The operator of Unit #1 also had distinct and sustained nystagmus at maximum deviation in both the left and right eyes. Unit #1 operator could not complete the walk and turn or the one leg stand. Unit #1 operator stated that he had both knees replaced in the past three months. The operator of Unit #1 was placed under arrest for driving under the influence and later administered a breath test. The breath tests results were .221 [...].

It appeared that unit #1 had struck something other than a deer. I traveled east on KY HWY 80 for approximately a mile and did not see any visible signs of a collision. I did see fluids from Unit #1 vehicle approximately .5 miles from Unit #1 current location.

- On or about January 11, 2024, Taylor Regional Hospital summarily suspended the licensee pending the completion of an investigation by the Medical Executive Committee.
- On or about January 12, 2024, the Board received correspondence from Rick Morris, Medical Physicist at Taylor Regional Radiation Oncology. Mr. Morris stated substantially as follows:

On January 3, 2024, I was working remote. Early in the day, I asked Dr. Hardin whether a patient who was scheduled to start treatment the next day would require a PET/CT fusion. Due to the patient starting treatment the next day, I would consider this an urgent inquiry. When Dr. Hardin failed

to respond after several hours, I called Dr Hardin. This was a typical question for me to ask Dr. Hardin in the scope of our professional relationship. Dr. Hardin responded that the PET/CT fusion was needed for treatment planning. I explained to Dr. Hardin that the PET data would need to be transferred to certain computer software for use by the physics/dosimetry team. Dr. Hardin attempted to move the PET data while on the phone with me, but he became agitated and stated the process was not working. When it became clear my oral instructions on how to move the PET data to the necessary software were not helping, I offered to Face Time Dr. Hardin to walk him through what to do. Upon initiating the video call, I noticed Dr. Hardin was clicking the incorrect tab even though he was adamant he was correct. This encounter was strange, as Dr. Hardin has transferred the fusion data in the exact same matter many times in the past without confusion or the need for step-by-step instruction.

On January 4, 2024, I was working on-site. When I arrived at work, radiation therapist, Marie, told me she suspected Dr. Hardin was drunk at work the previous day. This explained his delayed reaction to my inquiry and his difficulty transferring the file the day before. When I arrived, I spoke with Dr. Hardin regarding the PET/CT fusion plan we worked on the day before, and he replied he had not seen it and did not have time to look at it because he was about to see another patient. Knowing, Dr. Hardin is a diabetic, I initially thought his erratic behavior this morning may be due to his glucose levels being at an unsafe level. Soon after, I heard someone ask Dr. Hardin about his blood sugar and Dr. Hardin replied it had recently been tested and it was okay. However, Dr. Hardin did not seem okay as his speech was slurred and he visibly had difficulty walking and trouble navigating the computer software he regularly used. While I was onsite, Dr. Hardin saw one new patient, three follow up patients, oversaw one patient starting radiation, and oversaw one breast CT simulation procedure. While I was working back by the treatment machine, Marie pulled Dr. Hardin aside and I overheard her tell Dr. Hardin that everyone knew he was drunk, which Dr. Hardin denied.

Later in the afternoon, Marie asked me if I noticed anything wrong with Dr. Hardin. She told me she thought he was drunk. As the day went on, Dr. Hardin's physical/ cognitive abilities appeared to continue to decline. I left the facility at approximately 1:30pm. Before I left, I went to Dr. Hardin's office to see if he needed anything else from Medical Physics that day. When I entered his office, he was slouched over in his chair with his eyes closed. When I spoke, he raised his head slightly, but he never replied to me or opened his eyes. As I was leaving, Tammy at the front desk stopped me and told me Dr. Hardin was drunk. While suspected of being drunk, Dr. Hardin finally approved the new patient's PET/ CT fusion plan and started her treatment.

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CONCLUSIONS OF LAW

Pursuant to KRS 13B.125(2) and based upon the information available to him, the Chair of 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/her on probation; or b) a physician's practice constitutes a danger to the health, welfare and safety of his/her patients or the general public.
3. There is probable cause to believe that the licensee has violated KRS 311.595(8) and (9), as illustrated by KRS 311.597(4).

4. Inquiry Panel B concludes there is probable cause to believe this physician'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 physician's practice by considering certain facts about a physician's practice. If there is proof that a physician has violated a provision of the Kentucky Medical Practice Act in one set of circumstances, the Board may infer that the physician 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 physician's practice presents representative proof of the nature of that physician's practice in general. Accordingly, probable cause to believe that the physician has committed certain violations in the recent past presents probable cause to believe that the physician will commit similar violations in the near future, during the course of the physician's medical practice.
6. The United States Supreme Court has ruled that it is not a 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*, 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 medicine in the Commonwealth of Kentucky held by Peter Hardin, M.D., is SUSPENDED and Dr. Hardin 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 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 16th day of October, 2025.



WILLIAM C. THORNBURY, JR., M.D.
ACTING 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 copies were sent via certified mail return-receipt requested to the licensee, Peter B. Hardin, M.D., License No. 42374, 430 Lake Forest Dr., Campbellsville, Kentucky 42718 and via email to phardin4@twc.com on this 16th day of October, 2025.



Nicole A. King
Assistant General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
Tel. (502) 429-7150

FILED OF RECORD

OCT 16 2025

K.B.M.L.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 2238

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY PETER B. HARDIN, M.D., LICENSE NO. 42374, 430 LAKE FOREST DRIVE, CAMPBELLSVILLE, KENTUCKY 42718

COMPLAINT

Comes now the Complainant, Acting Chair of the Kentucky Board of Medical Licensure's Inquiry Panel B, and on behalf of the Panel which met on September 18, 2025, states for its Complaint against the licensee, Peter B. Hardin, M.D., as follows:

1. At all relevant times, Peter B. Hardin, M.D. (the "licensee"), was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Radiation Oncology.
3. On or about August 15, 2024, the licensee entered into an Agreed Order in Case No. 2147 to resolve a Complaint and Emergency Order of Suspension. He stipulated to certain facts, including:

- On or about October 1, 2008, the licensee applied for a full medical license in the Commonwealth of Kentucky. At that time, he informed the Board that he was admitted to a residential treatment program in March 2008 for treatment of alcohol use. The Board approved his request for a full medical license contingent upon him entering into a Letter of Agreement.
- On or about December 22, 2008, the licensee entered into a five-year Letter of Agreement agreeing to abstain from alcohol, be subjected to random drug testing, and be an active participant in the activities of the Kentucky Physicians Health Foundation ("the Foundation"). He successfully completed the terms of the Agreement.
- On or about November 30, 2023, the licensee was arrested and charged with operating a motor vehicle under the influence of alcohol in Adair County. Pursuant to the Citation, an officer was dispatched to a reckless driver due to a caller complaint advising the vehicle was running off the road into the grass median and back onto the road. The caller advised that the licensee ran off the road into the

grass. When the officer arrived, he observed a male subject sitting in the driver's seat with the motor running. The licensee advised that he was having blood sugar problems, so the officer called EMS. EMS arrived and informed the officer that the licensee's blood sugar was good and that was not the issue. The officer administered a PBT for the presence of alcohol, which produced a read of .312. The officer asked the licensee to step out of the vehicle. He refused several sobriety tests, citing knee problems. The officer moved on to the eye test, but the licensee was unable to follow directions.

- On or about November 30, 2023, the Columbia Police Department collected a blood sample from the licensee. Laboratory testing showed a 0.336g/100mL alcohol content in the blood.
- On or about January 5, 2024, the licensee was arrested and charged with operating a vehicle under the influence of alcohol in Metcalfe County. The Kentucky Uniform Police Traffic Collision Report states substantially as follows:

Unit #1 was traveling westbound on KY HWY 80 near intersection with Jack Sparks Road. Unit #1 stated that he struck a deer approximately .5 miles east of current location. Unit #1 stated that he continued westbound on KY HWY 80 until the vehicle lost all fluids. Unit #1 operator was awaiting on AAA to tow the vehicle.

Upon arriving to the scene the operator of Unit #1 was sitting in the operator seat of the vehicle on the westbound shoulder of KY HWY 80. The operator of Unit #1 had a strong odor of alcoholic beverage. I immediately suspected him of being under the influence. I instructed Unit #1 operator to exit the vehicle. While exiting the vehicle the operator of Unit #1 was using the vehicle for balance. Unit #1 operator was very unsteady on his feet and using the vehicle for balance. I conducted SFST [Standardized Field Sobriety Test], horizontal gaze nystagmus. Unit #1 operator displayed lack of smooth pursuit in both eyes. The operator of Unit #1 also had distinct and sustained nystagmus at maximum deviation in both the left and right eyes. Unit #1 operator could not complete the walk and turn or the one leg stand. Unit #1 operator stated that he had both knees replaced in the past three months. The operator of Unit #1 was placed under arrest for driving under the influence and later administered a breath test. The breath tests results were .221 [...].

It appeared that unit #1 had struck something other than a deer. I traveled east on KY HWY 80 for approximately a mile and did not see any visible signs of a collision. I did see fluids from Unit #1 vehicle approximately .5 miles from Unit #1 current location.

- On or about January 11, 2024, Taylor Regional Hospital summarily suspended the licensee pending the completion of an investigation by the Medical Executive Committee.
- On or about January 12, 2024, the Board received correspondence from Rick Morris, Medical Physicist at Taylor Regional Radiation Oncology. Mr. Morris stated substantially as follows:

On January 3, 2024, I was working remote. Early in the day, I asked Dr. Hardin whether a patient who was scheduled to start treatment the next day would require a PET/CT fusion. Due to the patient starting treatment the next day, I would consider this an urgent inquiry. When Dr. Hardin failed to respond after several hours, I called Dr. Hardin. This was a typical question for me to ask Dr. Hardin in the scope of our professional relationship. Dr. Hardin responded that the PET/CT fusion was needed for treatment planning. I explained to Dr. Hardin that the PET data would need to be transferred to certain computer software for use by the physics/dosimetry team. Dr. Hardin attempted to move the PET data while on the phone with me, but he became agitated and stated the process was not working. When it became clear my oral instructions on how to move the PET data to the necessary software were not helping, I offered to Face Time Dr. Hardin to walk him through what to do. Upon initiating the video call, I noticed Dr. Hardin was clicking the incorrect tab even though he was adamant he was correct. This encounter was strange, as Dr. Hardin has transferred the fusion data in the exact same matter many times in the past without confusion or the need for step-by-step instruction.

On January 4, 2024, I was working on-site. When I arrived at work, radiation therapist, Marie, told me she suspected Dr. Hardin was drunk at work the previous day. This explained his delayed reaction to my inquiry and his difficulty transferring the file the day before. When I arrived, I spoke with Dr. Hardin regarding the PET/CT fusion plan we worked on the day before, and he replied he had not seen it and did not have time to look at it because he was about to see another patient. Knowing, Dr. Hardin is a diabetic, I initially thought his erratic behavior this morning may be due to his glucose levels being at an unsafe level. Soon after, I heard someone ask Dr. Hardin about his blood sugar and Dr. Hardin replied it had recently been tested and it was okay. However, Dr. Hardin did not seem okay as his speech was slurred and he visibly had difficulty walking and trouble navigating the computer software he regularly used. While I was onsite, Dr. Hardin saw one new patient, three follow up patients, oversaw one patient starting radiation, and oversaw one breast CT simulation procedure. While I was working back by the treatment machine, Marie pulled Dr. Hardin aside and I overheard her tell Dr. Hardin that everyone knew he was drunk, which Dr. Hardin denied.

Later in the afternoon, Marie asked me if I noticed anything wrong with Dr. Hardin. She told me she thought he was drunk. As the day went on, Dr. Hardin's physical/ cognitive abilities appeared to continue to decline. I left the facility at approximately 1:30pm. Before I left, I went to Dr. Hardin's office to see if he needed anything else from Medical Physics that day. When I entered his office, he was slouched over in his chair with his eyes closed. When I spoke, he raised his head slightly, but he never replied to me or opened his eyes. As I was leaving, Tammy at the front desk stopped me and told me Dr. Hardin was drunk. While suspected of being drunk, Dr. Hardin finally approved the new patient's PET/ CT fusion plan and started her treatment.

After I left, Marie called me and told me that after I left Dr. Hardin seemed alert for a later breast simulation that afternoon and that he placed the field wires on the patient, but did not speak to the patient. Marie confided in me that she had found four water bottles full of alcohol in Dr. Hardin's office since he was arrested for a DUI. Dr. Hardin was arrested for a DUI between November 25, 2023 and December 7, 2023. I personally smelled one of these bottles that Marie brought to my attention and observed the smell of vodka.

- On or about January 15, 2024, the licensee requested a hearing regarding his suspended privileges pursuant to the Taylor Regional Hospital Medical Staff Bylaws.
- On or about January 19, 2024, the Hearing Committee recommended to the Medical Executive Committee that it affirm the summary suspension of the licensee's clinical privileges at Taylor Regional Hospital.
- On or about February 15, 2024, Taylor Regional Hospital informed the licensee that the Medical Executive Committee affirmed the recommendation, summarily suspending his privileges.
- On or about February 22, 2024, in accordance with KRS 311.592, the Chair of the Board's Inquiry Panel B authorized the issuance of an Emergency Order of Suspension based upon the above facts.
- On or about March 4, 2024, counsel for the licensee notified the Board that the licensee pled guilty to a charge of DUI in Adair County District Court (Case No. 23-T-02444) on February 28, 2024, and pled guilty to a charge of DUI in Metcalfe County District Court (Case No. 24-T-00017) on February 28, 2024. He also informed the Board that the licensee had met with the Foundation and was complying with its determination that he obtain a 96-hour evaluation.
- On or about March 14, 2024, the Board ratified the Emergency Order of Suspension and issued a Complaint based upon the above facts.

- On or about March 30, 2024, the licensee enrolled in a 12-week residential treatment program at Bradford Health Services (“Bradford”). He made good progress while in treatment and was discharged on or about June 17, 2024. His Axis I diagnosis included alcohol use disorder, severe. Bradford provided numerous recommendations, including engaging in individual therapy; attending 90 recovery meetings in 90 days followed by a minimum of 3 meetings per week thereafter; following up with his primary care physician within six months post-discharge; continuing wearing his CPAP machine, taking his recommended dose of Trazodone and to see an addictionologist; and complying with all requirements of the Foundation monitoring agreement. Bradford advocated for his return to medical practice two weeks post-discharge, on July 1, 2024. It also recommended that the number of hours he work not exceed forty hours.
 - On or about June 25, 2024, the licensee entered into an aftercare and monitoring contract with the Foundation. The components are as follows:
 - i. Documented attendance at no less than 12 recovery meetings per month;
 - ii. Ongoing relationship with a 12-Step sponsor;
 - iii. Individual therapy;
 - iv. Medication management with a Foundation-approved provider, if indicated;
 - v. Random, observed drug screens and alcohol determinations; and
 - vi. Once he has been approved to return to clinical practice, we will also obtain interval reports from a contact at his primary worksite confirming his appropriate professional behavior within the workplace setting.
 - By her letter of July 2, 2024, Dr. Simpson explained that the licensee has entered into a contract with the Foundation. With the above-noted parameters in place, the Foundation does not believe he poses any undue risk to his patients or the public.
4. Pursuant to the Agreed Order in Case No. 2147, the licensee agreed that he violated KRS 311.595(7), (8), and (21).
 5. Pursuant to the terms of Agreed Order in Case No. 2147, the licensee was placed on probation for no more than five years and he agreed to maintain a contractual relationship with the Foundation; not to work in excess of forty (40) hours per week; comply with all June 2024 Bradford Health Services Recommendations regarding testing, monitoring,

therapy, medical care and support meetings; and to not violate any provision of KRS 311.595 and/or 311.597.

6. On or about September 17, 2024, the Board received a grievance from Dr. John Cox, Dr. Meredith Angel, and Dr. James Watkins. The grievance alleges that the licensee treated a patient with prostate cancer in 2023 in an incompetent and grossly negligent manner. The patient had no evidence of his prostate cancer having extra-prostatic extension and no evidence of rectal involvement. However, when Dr. Cox reviewed the treatment plan that the licensee had created and implemented, the delivered radiation therapy treatment plan included the patient's full rectum. Dr. Cox believes that the licensee overexposed the area of treatment to include the patient's prostate, bladder, and rectum, despite the fact that the rectum and bladder had no signs of cancer. The patient was also treated by Dr. Meredith Angel and by Dr. James Watkins, who noted significant concerns.
7. On or about September 17, 2024, Dr. Cox filed a separate grievance in which he provided additional details about the licensee's practice. He described the licensee's treatment of three other patients, which he believes falls below the standard of care. A concern includes the licensee not treating the correct area, resulting in radiation therapy being applied to healthy tissue. Dr. Cox also noted that at least one of the patients discussed in his grievance was treated prior to the licensee's most recent substance abuse issues. This patient received radiation therapy and was refused chemotherapy, despite the fact that Dr. Cox believed it should have been offered.
8. Dr. Cox also alleged in his grievance that the licensee is prescribing medication to a staff member who does not have a patient chart in the clinic's electronic medical records (EMR) and is also the licensee's romantic interest.

9. Dr. Cox provided an analysis regarding the age and capabilities of the radiation machine used in the licensee's practice, stating it was 15-20 years old with outdated software. He believes that the licensee last upgraded the equipment four years ago. In July 2024, the machine malfunctioned, and the licensee contacted IT for assistance while he was not present at the office. Although he made the machine operable again, Dr. Cox believes no significant upgrades were made due to concerns about potential software fragility. Dr. Cox noted that the equipment could not provide the latest treatments and referred many patients to other facilities for better care, unlike the licensee, who treated all patients referred to him without making any referrals.
10. Dr. Cox also described billing concerns and forwarded a complaint to the Attorney General's Office, Medicaid Investigation Branch.
11. On or about November 27, 2024, the Board's investigator learned that the patient in the grievance from Drs. Cox, Angel and Watkins (the prostate cancer patient) had passed away due to radiation exposure. His rectum had deteriorated and become necrotic, which caused him to develop sepsis, and his white blood count skyrocketed. Dr. Angel stated that the patient died an agonizing death and was moaning in his sleep even after receiving medication.
12. During the course of the investigation, the Board's investigator spoke to Kelly Rucker, R.N, a former employee of the licensee. She discussed the licensee's tendency to downplay patients' symptoms, attributing them to chemotherapy rather than his radiation treatments. Ms. Rucker believes that the licensee discouraged referrals to hospice to maximize billing and never referred patients to other clinics. She criticized him for mismanaging patient care and prioritizing profit over patients' well-being. Ms. Rucker observed that he was rarely

present at the clinic, especially on Fridays, and claimed that his radiation technicians were allowed to administer treatments without his supervision.

13. A KASPER Report for staff member V.H. showed three prescriptions for Tramadol written by the licensee; the prescriptions were filled a total of seven times in 2024.
14. On or about February 11, 2025, the licensee provided a response to the grievance, including a summary of his treatment for each of the four patients referenced in the grievances.
15. Pursuant to his response, through counsel, the licensee acknowledged prescribing limited amounts of controlled medications to a staff member V.H. with whom he has a romantic relationship. He asserts they were for a legitimate medical need in conjunction with her primary care physician. He provided a detailed explanation of his prescribing, noting that she was not an oncology patient and so, his treatment of her was not in the EMR.
16. A subpoena was provided to the licensee for nineteen patient charts. There was no patient chart for staff member V.H. The remaining eighteen patient charts were provided to a Board Consultant for review.
17. After submitting the requested information to the Board Consultant, the licensee provided an expert review from Dr. James Jacob of Denver, CO, of the four patient charts specifically listed in the grievance, finding that the care was generally appropriate in his opinion. This was also provided to the Board Consultant for consideration.
18. On or about April 11, 2025, two months later, the licensee submitted a 2nd expert review, by Dr. Amtullah Kahn of Somerset, KY, who also generally found that the licensee's care was appropriate. This was also sent to the Board Consultant for consideration.
19. The Board Consultant completed a review of the patient charts and found that eight charts were considered Below Minimum Standards; six charts were considered Borderline; and

four charts were determined to be within Minimum Standards. He also found gross negligence in four charts; two charts that required immediate attention, imminent danger in two charts, malpractice in one chart, gross incompetence in one chart, and gross ignorance in one chart.

20. On or about July 29, 2025, the licensee provided a response to the Board Consultant's review, noting that he is currently not practicing and would agree not to do so until the Board deems it appropriate. He also provided more comments on the patient care that was found to be below minimum standards.
21. On or about August 5, 2025, the Board Consultant provided a Consultant Final Review, considering the licensee's response to his review, but still noting significant concerns.
22. On September 18, 2025, the licensee, with counsel, appeared before Inquiry Panel B. He informed the Panel that he is not currently working. He states that this is due to a billing error with Medicaid, which resulted in his suspension for one year. Additionally, he said he is currently unable to work because of acute renal failure due to Type I diabetes and is receiving dialysis.
23. Simultaneous with this Complaint and in accordance with KRS 311.592, the Acting Chair of the Board's Inquiry Panel B authorized the issuance of an emergency order of suspension pursuant to which the licensee will 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 – in the Commonwealth of Kentucky pending resolution of this Complaint.

24. By his conduct, the licensee has violated KRS 311.595(7), (8) and (21). Accordingly, legal grounds exist for disciplinary action against his license to practice medicine in the Commonwealth of Kentucky.

25. 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, cross-examine all prosecution witnesses, and offer evidence in his defense.

26. NOTICE IS HEREBY GIVEN that a hearing on this Complaint is scheduled for **March 25-27, 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 medicine in the Commonwealth of Kentucky held by Peter B. Hardin, M.D.

This 16th day of October, 2025.



WILLIAM C. THORNBURY, JR., M.D.
ACTING 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 sent via certified mail return-receipt requested to the licensee, Peter B. Hardin, M.D., License No. 42374, 430 Lake Forest Dr., Campbellsville, Kentucky 42718 and via email to phardin4@twc.com on this 16th day of October, 2025.



Nicole A. King
Assistant General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 2147

AUG 15 2024

K.B.M.L.

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY PETER B. HARDIN, M.D., LICENSE NO. 42374, 125 GREENBRIAR DRIVE, CAMPBELLSVILLE, KENTUCKY 42718

AGREED ORDER

Come now the Kentucky Board of Medical Licensure (hereafter “the Board”), acting by and through its Hearing Panel A, and Peter B. Hardin, M.D. (hereafter “the licensee”), and, based upon their mutual desire to resolve this pending case, hereby ENTER INTO the following **AGREED ORDER**:

STIPULATIONS OF FACT

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

1. At all relevant times, Peter B. Hardin, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee’s medical specialty is Radiation Oncology.
3. On or about October 1, 2008, the licensee applied for a full medical license in the Commonwealth of Kentucky. At that time, he informed the Board that he was admitted to a residential treatment program in March 2008 for treatment of alcohol use. The Board approved his request for a full medical license contingent upon him entering into a Letter of Agreement.
4. On or about December 22, 2008, the licensee entered into a five-year Letter of Agreement agreeing to abstain from alcohol, be subjected to random drug testing, and be an active participant in the activities of the Kentucky Physicians Health

Foundation (“the Foundation”). He successfully completed the terms of the Agreement.

5. On or about November 30, 2023, the licensee was arrested and charged with operating a motor vehicle under the influence of alcohol in Adair County. Pursuant to the Citation, an officer was dispatched to a reckless driver due to a caller complaint advising the vehicle was running off the road into the grass median and back onto the road. The caller advised that the licensee ran off the road into the grass. When the officer arrived, he observed a male subject sitting in the driver's seat with the motor running. The licensee advised that he was having blood sugar problems, so the officer called EMS. EMS arrived and informed the officer that the licensee's blood sugar was good and that was not the issue. The officer administered a PBT for the presence of alcohol, which produced a read of .312. The officer asked the licensee to step out of the vehicle. He refused several sobriety tests, citing knee problems. The officer moved on to the eye test, but the licensee was unable to follow directions.
6. On or about November 30, 2023, the Columbia Police Department collected a blood sample from the licensee. Laboratory testing showed a 0.336g/100mL alcohol content in the blood.
7. On or about January 5, 2024, the licensee was arrested and charged with operating a vehicle under the influence of alcohol in Metcalfe County. The Kentucky Uniform Police Traffic Collision Report states substantially as follows:

Unit #1 was traveling westbound on KY HWY 80 near intersection with Jack Sparks Road. Unit #1 stated that he struck a deer approximately .5 miles east of current location. Unit #1 stated that he continued westbound on KY HWY 80

until the vehicle lost all fluids. Unit #1 operator was awaiting on AAA to tow the vehicle.

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8. On or about January 11, 2024, Taylor Regional Hospital summarily suspended the licensee pending the completion of an investigation by the Medical Executive Committee.
9. On or about January 12, 2024, the Board received correspondence from Rick Morris, Medical Physicist at Taylor Regional Radiation Oncology. Mr. Morris stated substantially as follows:

On January 3, 2024, I was working remote. Early in the day, I asked Dr. Hardin whether a patient who was scheduled to start treatment the next day would require a PET/CT fusion. Due to the patient starting treatment the next day, I would consider this an urgent inquiry. When Dr. Hardin failed to respond after several hours, I called Dr Hardin. This was a typical question for me to ask Dr. Hardin in the scope of our professional relationship. Dr. Hardin responded that the PET/CT fusion was needed for treatment planning. I explained to Dr. Hardin that the PET data would need to be transferred to certain computer software for use by the physics/ dosimetry team. Dr. Hardin attempted to move the PET data while on the phone with me, but he became agitated and stated the process was not working. When it became clear my oral instructions on how to move the PET data to the necessary software were not helping, I offered to Face Time Dr.

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Later in the afternoon, Marie asked me if I noticed anything wrong with Dr. Hardin. She told me she thought he was drunk. As the day went on, Dr. Hardin's physical/ cognitive abilities appeared to continue to decline. I left the facility at approximately 1:30pm. Before I left, I went to Dr. Hardin's office to see if he needed anything else from Medical Physics that day. When I entered his office, he was slouched over in his chair with his eyes closed. When I spoke, he raised his head slightly, but he never replied to me or opened his eyes. As I was leaving, Tammy at the front desk stopped me and told me Dr. Hardin was drunk. While suspected of being drunk, Dr. Hardin finally approved the new patient's PET/ CT fusion plan and started her treatment.

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10. On or about January 15, 2024, the licensee requested a hearing regarding his suspended privileges pursuant to the Taylor Regional Hospital Medical Staff Bylaws.

11. On or about January 19, 2024, the Hearing Committee issued a Report and Recommendation to the Medical Executive Committee. It stated substantially as follows:

[...] Dr. Sean Desimone presented information to the Hearing Committee which he gathered during the investigation and on which the Chief Executive Officer and he relied in making the determination to summarily suspend Dr. Hardin's clinical privileges. The information relied upon and presented to the Hearing Committee included the following:

- Witness summaries of interviews of six team members which described multiple occasions wherein Dr. Hardin was impaired while at his office.
- Two Uniform Citations, one from Adair County and one from Metcalfe County relating to recent charges of Dr. Hardin for Driving Under the Influence.
- Photograph of target which was placed by Dr. Hardin on the door of the physicist.
- A video from security camera from the parking lot of the treatment center which depicted Dr. Hardin going to his vehicle at approximately 2:00 pm to take a drink of something.

Thereafter, Dr. Hardin spoke on his own behalf. He explained that he underwent two knee surgeries, one in August, 2023 and one in November 2023. In order to address the pain associated with the recovery, he had the option of taking narcotics or consuming alcohol in combination with over the counter medications. Dr. Hardin explained that he considered the latter to be less addictive. Dr. Hardin acknowledged that he had a problem with alcohol in that he was using it for the wrong reasons and he was drinking to excess. Dr. Hardin explained that his fatigue and drowsiness which was reported by many team members was a result of his failure to be able to sleep rather than impairment from alcohol. Dr. Hardin explained that he was diabetic and some of his symptoms may have been a result of his blood sugar. Dr. Hardin explained the target as being non-threatening to the physicist and merely a demonstration of what a poor shooter he was.

Dr. Hardin agreed that the written statements of team members provided to the Hearing Committee were accurate and he understood why they were concerned

about his behavior. Dr. Hardin also agreed that the decision to summarily suspend his privileges was proper.

Dr. Hardin was asked questions about prior abuse issues which he acknowledged. He explained that he was equipped to address alcohol addiction based upon the tools he had learned from prior treatment.

Dr. Hardin was asked whether he wanted to provide any additional information to the Hearing Committee and he declined although he offered to answer any additional questions. He acknowledged that he felt like the initial investigation had been conducted in a fair manner. He also acknowledged that the hearing before the Hearing Committee was fair and he had been afforded appropriate due process. Thereafter the hearing was concluded.

The Hearing Committee finds that Dr. Hardin has abused alcohol and in so doing has endangered the public at large by driving while impaired and endangered patients by providing services while impaired. Further, the Hearing Committee finds that Dr. Hardin has consumed alcohol during business hours and has attempted to intimidate the physicist who had knowledge of his impairment while seeing patients at his office. Based upon the totality of this conduct, the Hearing Committee recommends to the Medical Executive Committee that it affirm the summary suspension of Dr. Hardin's clinical privileges at Taylor Regional Hospital.

12. On or about February 15, 2024, Taylor Regional Hospital informed the licensee that the Medical Executive Committee affirmed the recommendation, summarily suspending his privileges.
13. On or about February 22, 2024, in accordance with KRS 311.592, the Chair of the Board's Inquiry Panel B authorized the issuance of an Emergency Order of Suspension based upon the above facts.
14. On or about March 4, 2024, counsel for the licensee notified the Board that the licensee pled guilty to a charge of DUI in Adair County District Court (Case No. 23-T-02444) on February 28, 2024, and pled guilty to a charge of DUI in Metcalfe County District Court (Case No. 24-T-00017) on February 28, 2024. He also informed the Board that the licensee had met with the Foundation and was complying with its determination that he obtain a 96-hour evaluation.

15. On or about March 14, 2024, the Board ratified the Emergency Order of Suspension and issued a Complaint based upon the above facts.
16. On or about March 30, 2024, the licensee enrolled in a 12-week residential treatment program at Bradford Health Services (“Bradford”). He made good progress while in treatment and was discharged on or about June 17, 2024. His Axis I diagnosis included alcohol use disorder, severe. Bradford provided numerous recommendations, including engaging in individual therapy; attending 90 recovery meetings in 90 days followed by a minimum of 3 meetings per week thereafter; following up with his primary care physician within six months post-discharge; continuing wearing his CPAP machine, taking his recommended dose of Trazodone and to see an addictionologist; and complying with all requirements of the Foundation monitoring agreement. Bradford advocated for his return to medical practice two weeks post-discharge, on July 1, 2024. It also recommended that the number of hours he work not exceed forty hours.
17. On or about June 25, 2024, the licensee entered into an aftercare and monitoring contract with the Foundation. The components are as follows:
 - a. Documented attendance at no less than 12 recovery meetings per month;
 - b. Ongoing relationship with a 12-Step sponsor;
 - c. Individual therapy;
 - d. Medication management with a Foundation-approved provider, if indicated;
 - e. Random, observed drug screens and alcohol determinations; and
 - f. Once he has been approved to return to clinical practice, we will also obtain interval reports from a contact at his primary worksite confirming his appropriate professional behavior within the workplace setting.

18. By her letter of July 2, 2024, Dr. Simpson explained that the licensee has entered into a contract with the Foundation. With the above-noted parameters in place, the Foundation does not believe he poses any undue risk to his patients or the public.

19. The licensee now agrees to enter into this Agreed Order to resolve this pending case.

STIPULATED CONCLUSIONS OF LAW

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

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(7), (8) and (21). Accordingly, there are legal grounds for the parties to enter into this Agreed Order.
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.

AGREED ORDER

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**:

1. The license to practice medicine held by Peter B. Hardin, M.D., is hereby PLACED ON PROBATION FOR A PERIOD OF FIVE (5) YEARS, with that period of probation to become effective immediately upon the filing of this Agreed Order.


2. During the effective period of this Agreed Order, the licensee's medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS:
- a. The licensee SHALL enter into and maintain a contractual relationship with the Kentucky Physicians Health Foundation and shall fully comply with all requirements of that contractual relationship;
 - i. The licensee SHALL completely abstain from the consumption of mood-altering substances, including alcohol, except as prescribed by a duly licensed practitioner for a documented legitimate medical purpose. The licensee SHALL ensure that any such medical treatment and prescribing is reported directly to the Board in writing by his treating physician within ten (10) days after the date of treatment. The licensee SHALL inform the treating physician of this responsibility and ensure timely compliance. The licensee's failure to inform the treating physician of this responsibility SHALL be considered a violation of this Agreed Order;
 - ii. The licensee SHALL be subject to periodic, unannounced breathalyzer, blood and urine alcohol and/or drug analysis as desired by the Board, and under the conditions specified by the Board's testing agent, the purpose being to ensure that the licensee remain drug and/or alcohol-free. The cost of such breathalyzer, blood and urine alcohol and/or drug analyses and reports SHALL be paid by the licensee, and the licensee SHALL pay those costs under the terms fixed by the Board's agent for testing. The licensee's failure to fully reimburse the Board's agent within that time frame SHALL constitute a violation of this Agreed Order;
 - b. The licensee SHALL NOT work in excess of forty (40) hours per week;
 - c. The licensee SHALL comply with all June 2024 Bradford Health Services Recommendations regarding testing, monitoring, therapy, medical care and support meetings; and
 - d. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.
3. The licensee expressly agrees that if he should violate any term or condition of this Agreed Order, the licensee's practice will 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 a violation of any term or condition of this Agreed Order would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, 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.

4. The licensee understands and agrees that any violation of the terms of this Agreed Order would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13), and may provide a legal basis for criminal prosecution.

SO AGREED on this 16 day of July, 2024.

FOR THE LICENSEE:


PETER B. HARDIN, M.D.


BRIAN R. GOOD
COUNSEL FOR THE LICENSEE

FOR THE BOARD:



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



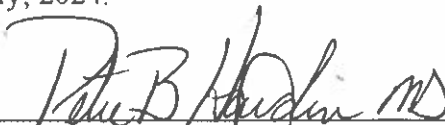
NICOLE A. KING
Assistant General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
Tel. (502) 429-7150

WAIVER OF RIGHTS

I, Peter B. Hardin, M.D., am presently the Respondent in Kentucky Board of Medical Licensure Case No. 2147. I understand that, under 201 KAR 9:082, I must waive certain rights if I wish to resolve this matter by informal dispensation. Accordingly, I WAIVE my right to raise any constitutional, statutory or common law objection(s) I may have to the Hearing Panel rejecting the proposed informal dispensation or to the curtailment of such a settlement by the Board's General Counsel or Assistant General Counsel.

Furthermore, if the Hearing Panel accepts the proposed Agreed Order as submitted, I WAIVE my right to demand an evidentiary hearing or to raise additional constitutional or statutory objections in this matter. However, if the Hearing Panel should reject the proposed Agreed Order, I understand that further proceedings will be conducted in accordance with KRS 311.530 *et seq*, and I will have the right to raise any objections normally available in such proceedings.

Executed this 16 day of July, 2024.



PETER B. HARDIN, M.D.
Respondent



COUNSEL FOR THE RESPONDENT

FILED OF RECORD

MAR 21 2024

K.B.M.L.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 2147

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY PETER B. HARDIN, M.D., LICENSE NO. 42374, 125 GREENBRIAR DRIVE, CAMPBELLSVILLE, KENTUCKY 42718

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 March 21, 2024, states for its Complaint against the licensee, Peter B. Hardin, M.D., as follows:

1. At all relevant times, Peter B. Hardin, M.D. (the "licensee"), was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Radiation Oncology.
3. On or about October 1, 2008, the licensee applied for a full medical license in the Commonwealth of Kentucky. At that time, he informed the Board that he was admitted to a residential treatment program in March 2008 for treatment of alcohol use. The Board approved his request for a full medical license contingent upon him entering into a Letter of Agreement.
4. On or about December 22, 2008, the licensee entered into a five-year Letter of Agreement agreeing to abstain from alcohol, be subjected to random drug testing, and be an active participant in the activities of the Kentucky Physicians Health Foundation ("the Foundation"). He successfully completed the terms of the Agreement.
5. On or about November 30, 2023, the licensee was arrested and charged with operating a motor vehicle under the influence of alcohol in Adair County. Pursuant

to the Citation, an officer was dispatched to a reckless driver due to a caller complaint advising the vehicle was running off the road into the grass median and back onto the road. The caller advised that the licensee ran off the road into the grass. When the officer arrived, he observed a male subject sitting in the driver's seat with the motor running. The licensee advised that he was having blood sugar problems, so the officer called EMS. EMS arrived and informed the officer that the licensee's blood sugar was good, and that was not the issue. The officer administered a PBT for the presence of alcohol, which produced a read of .312. The officer asked the licensee to step out of the vehicle. He refused several sobriety tests, citing knee problems. The officer moved on to the eye test, but the licensee was unable to follow directions.

6. On or about November 30, 2023, the Columbia Police Department collected a blood sample from the licensee. Laboratory testing showed a 0.336g/100mL alcohol content in the blood.
7. On or about January 5, 2024, the licensee was arrested and charged with operating a vehicle under the influence of alcohol in Metcalfe County. The Kentucky Uniform Police Traffic Collision Report states substantially as follows:

Unit #1 was traveling westbound on KY HWY 80 near intersection with Jack Sparks Road. Unit #1 stated that he struck a deer approximately .5 miles east of current location. Unit #1 stated that he continued westbound on KY HWY 80 until the vehicle lost all fluids. Unit #1 operator was awaiting on AAA to tow the vehicle.

Upon arriving to the scene the operator of Unit #1 was sitting in the operator seat of the vehicle on the westbound shoulder of KY HWY 80. The operator of Unit #1 had a strong odor of alcoholic beverage. I immediately suspected him of being under the influence. I instructed Unit #1 operator to exit the vehicle. While exiting the vehicle the operator of Unit #1 was using the vehicle for balance. Unit #1 operator was very unsteady on his feet and using the vehicle for balance. I conducted SFST [Standardized Field Sobriety Test], horizontal

gaze nystagmus. Unit #1 operator displayed lack of smooth pursuit in both eyes. The operator of Unit #1 also had distinct and sustained nystagmus at maximum deviation in both the left and right eyes. Unit #1 operator could not complete the walk and turn or the one leg stand. Unit #1 operator stated that he had both knees replaced in the past three months. The operator of Unit #1 was placed under arrest for driving under the influence and later administered a breath test. The breath tests results were .221 [...].

It appeared that unit #1 had struck something other than a deer. I traveled east on KY HWY 80 for approximately a mile and did not see any visible signs of a collision. I did see fluids from Unit #1 vehicle approximately .5 miles from Unit #1 current location.

8. On or about January 11, 2024, Taylor Regional Hospital summarily suspended the licensee pending the completion of an investigation by the Medical Executive Committee.
9. On or about January 12, 2024, the Board received correspondence from Rick Morris, Medical Physicist at Taylor Regional Radiation Oncology. Mr. Morris stated substantially as follows:

On January 3, 2024, I was working remote. Early in the day, I asked Dr. Hardin whether a patient who was scheduled to start treatment the next day would require a PET/CT fusion. Due to the patient starting treatment the next day, I would consider this an urgent inquiry. When Dr. Hardin failed to respond after several hours, I called Dr Hardin. This was a typical question for me to ask Dr. Hardin in the scope of our professional relationship. Dr. Hardin responded that the PET/CT fusion was needed for treatment planning. I explained to Dr. Hardin that the PET data would need to be transferred to certain computer software for use by the physics/ dosimetry team. Dr. Hardin attempted to move the PET data while on the phone with me, but he became agitated and stated the process was not working. When it became clear my oral instructions on how to move the PET data to the necessary software were not helping, I offered to Face Time Dr. Hardin to walk him through what to do. Upon initiating the video call, I noticed Dr. Hardin was clicking the incorrect tab even though he was adamant he was correct. This encounter was strange, as Dr. Hardin has transferred the fusion data in the exact same matter many times in the past without confusion or the need for step-by-step instruction.

On January 4, 2024, I was working on-site. When I arrived at work, radiation therapist, Marie, told me she suspected Dr. Hardin was drunk at work the previous day. This explained his delayed reaction to my inquiry and his difficulty transferring the file the day before. When I arrived, I spoke with Dr.

Hardin regarding the PET/CT fusion plan we worked on the day before, and he replied he had not seen it and did not have time to look at it because he was about to see another patient. Knowing, Dr. Hardin is a diabetic, I initially thought his erratic behavior this morning may be due to his glucose levels being at an unsafe level. Soon after, I heard someone ask Dr. Hardin about his blood sugar and Dr. Hardin replied it had recently been tested and it was okay. However, Dr. Hardin did not seem okay as his speech was slurred and he visibly had difficulty walking and trouble navigating the computer software he regularly used. While I was onsite, Dr. Hardin saw one new patient, three follow up patients, oversaw one patient starting radiation, and oversaw one breast CT simulation procedure. While I was working back by the treatment machine, Marie pulled Dr. Hardin aside and I overheard her tell Dr. Hardin that everyone knew he was drunk, which Dr. Hardin denied.

Later in the afternoon, Marie asked me if I noticed anything wrong with Dr. Hardin. She told me she thought he was drunk. As the day went on, Dr. Hardin's physical/ cognitive abilities appeared to continue to decline. I left the facility at approximately 1:30pm. Before I left, I went to Dr. Hardin's office to see if he needed anything else from Medical Physics that day. When I entered his office, he was slouched over in his chair with his eyes closed. When I spoke, he raised his head slightly, but he never replied to me or opened his eyes. As I was leaving, Tammy at the front desk stopped me and told me Dr. Hardin was drunk. While suspected of being drunk, Dr. Hardin finally approved the new patient's PET/ CT fusion plan and started her treatment.

After I left, Marie called me and told me that after I left Dr. Hardin seemed alert for a later breast simulation that afternoon and that he placed the field wires on the patient, but did not speak to the patient. Marie confided in me that she had found four water bottles full of alcohol in Dr. Hardin's office since he was arrested for a DUI. Dr. Hardin was arrested for a DUI between November 25, 2023 and December 7, 2023. I personally smelled one of these bottles that Marie brought to my attention and observed the smell of vodka.

10. On or about January 15, 2024, the licensee requested a hearing regarding his suspended privileges pursuant to the Taylor Regional Hospital Medical Staff Bylaws.
11. On or about January 19, 2024, the Hearing Committee issued a Report and Recommendation to the Medical Executive Committee. It stated substantially as follows:

[...] Dr. Sean Desimone presented information to the Hearing Committee which he gathered during the investigation and on which the Chief Executive

Officer and he relied in making the determination to summarily suspend Dr. Hardin's clinical privileges. The information relied upon and presented to the Hearing Committee included the following:

- Witness summaries of interviews of six team members which described multiple occasions wherein Dr. Hardin was impaired while at his office.
- Two Uniform Citations, one from Adair County and one from Metcalfe County relating to recent charges of Dr. Hardin for Driving Under the Influence.
- Photograph of target which was placed by Dr. Hardin on the door of the physicist.
- A video from security camera from the parking lot of the treatment center which depicted Dr. Hardin going to his vehicle at approximately 2:00 pm to take a drink of something.

Thereafter, Dr. Hardin spoke on his own behalf. He explained that he underwent two knee surgeries, one in August, 2023 and one in November 2023. In order to address the pain associated with the recovery, he had the option of taking narcotics or consuming alcohol in combination with over the counter medications. Dr. Hardin explained that he considered the latter to be less addictive. Dr. Hardin acknowledged that he had a problem with alcohol in that he was using it for the wrong reasons and he was drinking to excess. Dr. Hardin explained that his fatigue and drowsiness which was reported by many team members was a result of his failure to be able to sleep rather than impairment from alcohol. Dr. Hardin explained that he was diabetic and some of his symptoms may have been a result of his blood sugar. Dr. Hardin explained the target as being non-threatening to the physicist and merely a demonstration of what a poor shooter he was.

Dr. Hardin agreed that the written statements of team members provided to the Hearing Committee were accurate and he understood why they were concerned about his behavior. Dr. Hardin also agreed that the decision to summarily suspend his privileges was proper.

Dr. Hardin was asked questions about prior abuse issues which he acknowledged. He explained that he was equipped to address alcohol addiction based upon the tools he had learned from prior treatment.

Dr. Hardin was asked whether he wanted to provide any additional information to the Hearing Committee and he declined although he offered to answer any additional questions. He acknowledged that he felt like the initial investigation had been conducted in a fair manner. He also acknowledged that the hearing before the Hearing Committee was fair and he had been afforded appropriate due process. Thereafter the hearing was concluded.

The Hearing Committee finds that Dr. Hardin has abused alcohol and in so doing has endangered the public at large by driving while impaired and endangered patients by providing services while impaired. Further, the Hearing Committee finds that Dr. Hardin has consumed alcohol during business hours and has attempted to intimidate the physicist who had knowledge of his impairment while seeing patients at his office. Based upon the totality of this conduct, the Hearing Committee recommends to the Medical Executive Committee that it affirm the summary suspension of Dr. Hardin's clinical privileges at Taylor Regional Hospital.

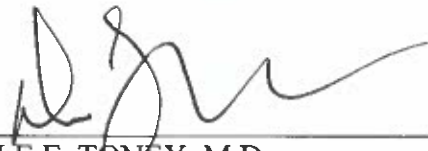
12. On or about February 15, 2024, Taylor Regional Hospital informed the licensee that the Medical Executive Committee affirmed the recommendation, summarily suspending his privileges.
13. On or about February 22, 2024, in accordance with KRS 311.592, the Chair of the Board's Inquiry Panel B authorized the issuance of an Emergency Order of Suspension pending resolution of this Complaint.
14. On or about March 4, 2024, counsel for the licensee notified the Board that the licensee pled guilty to a charge of DUI in Adair County District Court (Case No. 23-T-02444) on February 28, 2024, and pled guilty to a charge of DUI in Metcalfe County District Court (Case No. 24-T-00017) on February 28, 2024. He also informed the Board that the licensee has met with the Foundation and is complying with its determination that he obtain a 96-hour evaluation.
15. By his conduct, the licensee has violated KRS 311.595(7), (8) and (21). Accordingly, legal grounds exist for disciplinary action against his license to practice medicine in the Commonwealth of Kentucky.
16. 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, cross-examine all prosecution witnesses, and offer evidence in his defense.

17. NOTICE IS HEREBY GIVEN that a hearing on this Complaint is scheduled for **September 3, 4, 5, 6 & 7, 2024**, 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 medicine in the Commonwealth of Kentucky held by Peter B. Hardin, M.D.

This 21st day of March 2024.



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 sent via certified mail return-receipt requested to the licensee, Peter B. Hardin, M.D., License No. 42374, 125 Greenbriar Drive, Campbellsville, Kentucky 42718 and to counsel for the licensee, Brian R. Good, Esq., Elder & Good, PLLC, 159 St. Matthews Avenue, Suite 1, Louisville, Kentucky 40207, and via email to bgood@eldergood.com on this 21st day of March, 2024.



Nicole A. King
Assistant General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150

FEB 22 2024

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 2147

K.B.M.L.

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY PETER B. HARDIN, M.D., LICENSE NO. 42374, 125 GREENBRIAR DRIVE, CAMPBELLSVILLE, KENTUCKY 42718

EMERGENCY ORDER OF SUSPENSION

The Kentucky Board of Medical Licensure ("the Board"), acting by and through the Chair of its Inquiry Panel B, considered: notes prepared by Kevin Payne, Medical Investigator, undated; Correspondence from Richard Morris, dated January 8, 2024; Report of suspension of clinical privileges at Taylor Regional Hospital, processed January 12, 2024; Uniform Citation, arrest date of November 30, 2023; Correspondence from KSP Crime Lab, dated February 6, 2024; Citation and crash report, arrest date of January 5, 2024; Taylor Regional Hospital letter to Dr. Hardin, dated January 18, 2024; Witness statements concerning Dr. Peter Hardin, undated; Report and Recommendation of Hearing Committee to Medical Executive Committee, dated January 19, 2024; Photo of target placed on grievant's door, undated; Final Report of drug screen, dated February 8, 2024; Taylor Regional Hospital letter to Dr. Hardin, dated February 15, 2024; and Dr. Hardin's response to grievance and report, dated February 16, 2024.

Having considered this information and being sufficiently advised, the Chair of 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 to him, the Chair of 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, Peter B. Hardin, M.D. (the "licensee"), was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Radiation Oncology.
3. On or about October 1, 2008, the licensee applied for a full medical license in the Commonwealth of Kentucky. At that time, he informed the Board that he was admitted to a residential treatment program in March 2008 for treatment of alcohol use. The Board approved his request for a full medical license contingent upon him entering into a Letter of Agreement.
4. On or about December 22, 2008, the licensee entered into a five-year Letter of Agreement agreeing to abstain from alcohol, be subjected to random drug testing, be an active participant in the activities of the Kentucky Physicians Health Foundation. He successfully completed the terms of the Agreement.
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blood sugar, so the officer called EMS. EMS arrived and informed the officer that the licensee's blood sugar was good and that wasn't the issue. The officer administered a PBT for the presence of alcohol which produced a read of .312. The officer asked the licensee to step out of the vehicle. He refused several sobriety tests, citing knee problems. The officer moved on to the eye test and the licensee was unable to follow directions.

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7. On or about January 5, 2024, the licensee was arrested and charged with operating a vehicle under the influence of alcohol in Metcalfe County. The Kentucky Uniform Police Traffic Collision Report states substantially as follows:

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On January 3, 2024, I was working remote. Early in the day, I asked Dr. Hardin whether a patient who was scheduled to start treatment the next day would require a PET/CT fusion. Due to the patient starting treatment the next day, I would consider this an urgent inquiry. When Dr. Hardin failed to respond after several hours, I called Dr. Hardin. This was a typical question for me to ask Dr. Hardin in the scope of our professional relationship. Dr. Hardin responded that the PET/CT fusion was needed for treatment planning. I explained to Dr. Hardin that the PET data would need to be transferred to certain computer software for use by the physics/ dosimetry team. Dr. Hardin attempted to move the PET data while on the phone with me, but he became agitated and stated the process was not working. When it became clear my oral instructions on how to move the PET data to the necessary software were not helping, I offered to Face Time Dr. Hardin to walk him through what to do. Upon initiating the video call, I noticed Dr. Hardin was clicking the incorrect tab even though he was adamant he was correct. This encounter was strange, as Dr. Hardin has transferred the fusion data in the exact same matter many times in the past without confusion or the need for step-by-step instruction.

On January 4, 2024, I was working on-site. When I arrived at work, radiation therapist, Marie, told me she suspected Dr. Hardin was drunk at work the previous day. This explained his delayed reaction to my inquiry and his difficulty transferring the file the day before. When I arrived, I spoke with Dr. Hardin regarding the PET/CT fusion plan we worked on the day before, and he replied he had not seen it and did not have time to look at it because he was about to see another patient. Knowing, Dr. Hardin is a diabetic, I initially thought his erratic behavior this morning may be due to his glucose levels being at an unsafe level. Soon after, I heard someone ask Dr. Hardin about his blood sugar and Dr. Hardin replied it had recently been tested and it was okay. However, Dr. Hardin did not seem okay as his speech was slurred and he visibly had difficulty walking and trouble navigating the computer software he regularly used. While I was onsite, Dr. Hardin saw one new patient, three follow up patients, oversaw one patient starting radiation, and oversaw one breast CT

simulation procedure. While I was working back by the treatment machine, Marie pulled Dr. Hardin aside and I overheard her tell Dr. Hardin that everyone knew he was drunk, which Dr. Hardin denied.

Later in the afternoon, Marie asked me if I noticed anything wrong with Dr. Hardin. She told me she thought he was drunk. As the day went on, Dr. Hardin's physical/ cognitive abilities appeared to continue to decline. I left the facility at approximately 1:30pm. Before I left, I went to Dr. Hardin's office to see if he needed anything else from Medical Physics that day. When I entered his office, he was slouched over in his chair with his eyes closed. When I spoke, he raised his head slightly, but he never replied to me or opened his eyes. As I was leaving, Tammy at the front desk stopped me and told me Dr. Hardin was drunk. While suspected of being drunk, Dr. Hardin finally approved the new patient's PET/ CT fusion plan and started her treatment.

After I left, Marie called me and told me that after I left Dr. Hardin seemed alert for a later breast simulation that afternoon and that he placed the field wires on the patient, but did not speak to the patient. Marie confided in me that she had found four water bottles full of alcohol in Dr. Hardin's office since he was arrested for a DUI. Dr. Hardin was arrested for a DUI between November 25, 2023 and December 7, 2023. I personally smelled one of these bottles that Marie brought to my attention and observed the smell of vodka.

10. On or about January 15, 2024, the licensee requested a hearing regarding his suspended privileges pursuant to the Taylor Regional Hospital Medical Staff Bylaws.
11. On or about January 19, 2024, the Hearing Committee issued a Report and Recommendation to the Medical Executive Committee. It stated substantially as follows:

[...] Dr. Sean Desimone presented information to the Hearing Committee which he gathered during the investigation and on which the Chief Executive Officer and he relied in making the determination to summarily suspend Dr. Hardin's clinical privileges. The information relied upon and presented to the Hearing Committee included the following:

- Witness summaries of interviews of six team members which described multiple occasions wherein Dr. Hardin was impaired while at his office.
- Two Uniform Citations, one from Adair County and one from Metcalfe County relating to recent charges of Dr. Hardin for Driving Under the Influence.

- Photograph of target which was placed by Dr. Hardin on the door of the physicist.
- A video from security camera from the parking lot of the treatment center which depicted Dr. Hardin going to his vehicle at approximately 2:00 pm to take a drink of something.

Thereafter, Dr. Hardin spoke on his own behalf. He explained that he underwent two knee surgeries, one in August, 2023 and one in November 2023. In order to address the pain associated with the recovery, he had the option of taking narcotics or consuming alcohol in combination with over the counter medications. Dr. Hardin explained that he considered the latter to be less addictive. Dr. Hardin acknowledged that he had a problem with alcohol in that he was using it for the wrong reasons and he was drinking to excess. Dr. Hardin explained that his fatigue and drowsiness which was reported by many team members was a result of his failure to be able to sleep rather than impairment from alcohol. Dr. Hardin explained that he was diabetic and some of his symptoms may have been a result of his blood sugar. Dr. Hardin explained the target as being non-threatening to the physicist and merely a demonstration of what a poor shooter he was.

Dr. Hardin agreed that the written statements of team members provided to the Hearing Committee were accurate and he understood why they were concerned about his behavior. Dr. Hardin also agreed that the decision to summarily suspend his privileges was proper.

Dr. Hardin was asked questions about prior abuse issues which he acknowledged. He explained that he was equipped to address alcohol addiction based upon the tools he had learned from prior treatment.

Dr. Hardin was asked whether he wanted to provide any additional information to the Hearing Committee and he declined although he offered to answer any additional questions. He acknowledged that he felt like the initial investigation had been conducted in a fair manner. He also acknowledged that the hearing before the Hearing Committee was fair and he had been afforded appropriate due process. Thereafter the hearing was concluded.

The Hearing Committee finds that Dr. Hardin has abused alcohol and in so doing has endangered the public at large by driving while impaired and endangered patients by providing services while impaired. Further, the Hearing Committee finds that Dr. Hardin has consumed alcohol during business hours and has attempted to intimidate the physicist who had knowledge of his impairment while seeing patients at his office. Based upon the totality of this conduct, the Hearing Committee recommends to the Medical Executive Committee that it affirm the summary suspension of Dr. Hardin's clinical privileges at Taylor Regional Hospital.

12. On or about February 15, 2024, Taylor Regional Hospital informed the licensee that the Medical Executive Committee affirmed the recommendation, summarily suspending his privileges.

CONCLUSIONS OF LAW

Pursuant to KRS 13B.125(2) and based upon the information available to it, the Chair of 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(7), (8) and (21).
4. The Chair of 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.

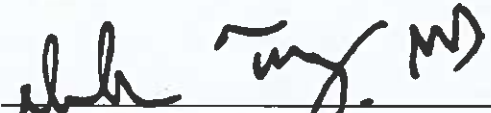
EMERGENCY ORDER OF SUSPENSION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Chair of Inquiry Panel B hereby ORDERS that the license to practice medicine in the Commonwealth of Kentucky held by PETER B. HARDIN, M.D., is SUSPENDED and Dr. Hardin is prohibited from performing any act which constitutes the "practice of medicine

or osteopathy,” as that term is defined by KRS 311.550(11) – 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 such further Order of the Board.

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


SO ORDERED this 22nd day of February, 2024.



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 a copy was mailed via certified mail return-receipt requested to the licensee, Peter B. Hardin, M.D., License No. 42374, 125 Greenbriar Drive, Campbellsville, Kentucky 42718 on this 22nd day of February, 2024.



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