

1                                   **BEFORE THE BOARD OF MEDICAL EXAMINERS**  
2                                   **OF THE STATE OF NEVADA**

3                                   \* \* \* \* \*

4  
5   **In the Matter of Charges and Complaint**

Case No. 26-32772-1

6   **Against:**

**FILED**

7   **SHAHAB MOKHTARE, M.D.,**

FEB 20 2026

8   **Respondent.**

NEVADA STATE BOARD OF  
MEDICAL EXAMINERS

By: \_\_\_\_\_

9  
10                                   **COMPLAINT**

11                               The Investigative Committee<sup>1</sup> (IC) of the Nevada State Board of Medical Examiners (Board),  
12 by and through Ian J. Cumings, Senior Deputy General Counsel and attorney for the IC, having a  
13 reasonable basis to believe that Shahab Mokhtare, M.D. (Respondent) violated the provisions of  
14 Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630  
15 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's charges and  
16 allegations as follows:

17                               1.       Respondent was at all times relative to this Complaint a medical doctor holding an  
18 active license to practice medicine in the State of Nevada (License No. 13663). Respondent was  
19 originally licensed by the Board on August 5, 2010.

20                               2.       Patient A<sup>2</sup> is an immediate family member of Respondent.

21                               3.       During the events in question, Patient A resided in Oregon at an assisted care facility  
22 and had a relevant medical history of hypertension, diabetes mellitus, coronary artery disease,  
23 peripheral artery disease, and dementia.

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27                               <sup>1</sup> The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal  
28 Complaint was authorized for filing, was composed of Board members Bret W. Frey, M.D., Joseph Olivarez, P.A.-C.  
and Apeksha Desai, M.D., MBA.

<sup>2</sup> Patient A's true identity is not disclosed herein to protect his or her privacy, but is disclosed in the Patient  
Designation served upon Respondent along with a copy of this Complaint.

1           4.       Between 2021 and 2024, while practicing medicine in Nevada, Respondent  
2 prescribed to Patient A controlled substances on more than thirty-four (34) occasions, including  
3 eleven (11) separate prescriptions for Tramadol, a schedule IV opioid analgesic, totaling two  
4 thousand three hundred and ninety-six tablets (2,396). Additionally, Respondent prescribed to  
5 Patient A: twelve (12) prescriptions for Xanax, a benzodiazepine, totaling one thousand six hundred  
6 and twenty (1,620) tablets; eight (8) prescriptions for Armodafinil, a stimulant anti-narcolepsy drug,  
7 totaling six hundred sixty (660) tablets; two (2) prescriptions for Zolpidem, a hypnotic drug used to  
8 treat insomnia; and one (1) prescription for Phentermine, a stimulant used to treat obesity.

9           5.       NAC 639.945(3) and NRS 639.235(4) provide that, for the purposes of applying  
10 Pharmacy Board regulations, a bona fide therapeutic relationship between the patient and  
11 practitioner shall be deemed to exist if the patient was examined in person, electronically,  
12 telephonically, or by fiber optics, by the practitioner within six (6) months immediately preceding  
13 the date the practitioner dispenses or prescribes a drug to the patient as a result of the examination,  
14 the practitioner diagnosed a condition for which a given drug therapy is prescribed.

15           6.       NRS 639.23911(1)(a) provides that before issuing an initial prescription for a  
16 controlled substance listed in schedule II, III, or IV for the treatment of pain, a practitioner must  
17 have established a bona fide physician-patient relationship.

18           7.       Respondent issued the aforementioned prescriptions without ever having formed a  
19 bona fide physician-patient relationship with Patient A or first checking Patient A's Prescription  
20 Monitoring Report (PMP) and every 90 days thereafter as required by Nevada Law.

21           8.       The concurrent prescriptions for opioid analgesics, benzodiazepines, and zolpidem  
22 are contraindicated. Respondent failed to document a single record of a visit with Patient A prior  
23 to prescribing any medications, or any medical reasoning justifying the medical necessity for  
24 concurrent prescriptions of contraindicated medications. Additionally, the prescription for  
25 Phentermine is contraindicated in Patient A who had established diagnosis of heart disease.

26           9.       Respondent did not order any studies, evaluations, consultations or referrals for  
27 Patient A to justify the prescription of any of the medications he prescribed, nor did Respondent

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1 document any discussions regarding Patient A’s prescriptions with Patient A’s medical providers in  
2 Oregon.

3 10. All of the prescriptions written by Respondent were filled by another member of his  
4 immediate family at a Southern Nevada pharmacy. Staff at the Oregon assisted care facility  
5 overseeing the care of Patient A never received any medications for Patient A which were prescribed  
6 by Respondent.

7 **COUNT I**

8 **NRS 630.301(4) - Malpractice**

9 11. All of the allegations contained in the above paragraphs are hereby incorporated by  
10 reference as though fully set forth herein.

11 12. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating  
12 disciplinary action against a licensee.

13 13. NAC 630.040 defines malpractice as “the failure of a physician, in treating a patient,  
14 to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.”

15 14. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed  
16 to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when  
17 rendering medical services to Patient A for prescribing multiple controlled and contraindicated  
18 drugs without having first conducted an examination of Patient A or checking Patient A’s PMP  
19 report.

20 15. By reason of the foregoing, Respondent is subject to discipline by the Board as  
21 provided in NRS 630.352.

22 **COUNT II**

23 **NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records**

24 16. All of the allegations contained in the above paragraphs are hereby incorporated by  
25 reference as though fully set forth herein.

26 17. NRS 630.3062(1)(a) provides that the “failure to maintain timely, legible, accurate  
27 and complete medical records relating to the diagnosis, treatment and care of a patient” constitute  
28 grounds for initiating discipline against a licensee.

1 18. Respondent failed to maintain proper medical records relating to the diagnosis,  
2 treatment and care of Patient A, by failing to document his actions when he treated Patient A.

3 19. By reason of the foregoing, Respondent is subject to discipline by the Board as  
4 provided in NRS 630.352.

5 **COUNT III**

6 **NRS 630.306(1)(b)(3) – Engaging in Conduct That Violates Pharmacy Board Regulations**

7 20. All of the allegations contained in the above paragraphs are hereby incorporated by  
8 reference as though fully set forth herein.

9 21. NRS 630.306(1)(b)(3) provides that engaging in conduct that violates a regulation  
10 adopted by the Pharmacy Board is ground for initiating disciplinary action against a licensee.

11 22. By the conduct described herein, Respondent engaged in conduct that violates  
12 regulations adopted by the Pharmacy Board, specifically but no limited to NRS 639.23911(1)(a).

13 23. By reason of the foregoing, Respondent is subject to discipline by the Board as  
14 provided in NRS 630.352.

15 **COUNT IV**

16 **NRS 630.306(1)(b)(2) - Violation of Standards of Practice**

17 24. All of the allegations in the above paragraphs are hereby incorporated by reference  
18 as though fully set forth herein.

19 25. Violation of a standard of practice adopted by the Board is grounds for disciplinary  
20 action pursuant to NRS 630.306(1)(b)(2).

21 26. The Board adopted by reference the Model Policy in NAC 630.187.

22 27. Pursuant to NAC 630.230(1)(k), a licensee shall not engage in the practice of writing  
23 prescriptions for controlled substances to treat acute pain or chronic pain in a manner that deviates  
24 from the standards set forth in the Model Policy.

25 28. As demonstrated by, but not limited to, the above-outlined facts, Respondent wrote  
26 prescriptions to Patient A for opioid analgesics to treat chronic pain in a manner that deviated from  
27 the Model Policy.

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1 benzodiazepines, narcoleptic medications, hypnotic medications, and weight loss medications in a  
2 manner that deviated from the professional standards for the prescription of these medications.

3 39. Respondent's conduct was unsafe and unprofessional.

4 40. By reason of the foregoing, Respondent is subject to discipline by the Board as  
5 provided in NRS 630.352.

6 **WHEREFORE**, the IC prays:

7 1. That the Board give Respondent notice of the charges herein against him and give  
8 him notice that he may file an answer to the Complaint herein as set forth in  
9 NRS 630.339(2) within twenty (20) days of service of the Complaint;

10 2. That the Board set a time and place for a formal hearing after holding an Early Case  
11 Conference pursuant to NRS 630.339(3);

12 3. That the Board determine what sanctions to impose if it determines there has been a  
13 violation or violations of the Medical Practice Act committed by Respondent;

14 4. That the Board award fees and costs for the investigation and prosecution of this case  
15 as outlined in NRS 622.400;

16 5. That the Board make, issue and serve on Respondent its findings of fact, conclusions  
17 of law and order, in writing, that includes the sanctions imposed; and

18 6. That the Board take such other and further action as may be just and proper in these  
19 premises.

20 DATED this 20<sup>th</sup> day of February, 2026.

21 INVESTIGATIVE COMMITTEE OF THE  
22 NEVADA STATE BOARD OF MEDICAL EXAMINERS

23 By: \_\_\_\_\_

24 IAN J. CUMINGS  
25 Senior Deputy General Counsel  
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*Attorney for the Investigative Committee*

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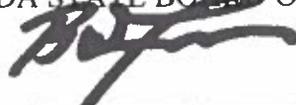
VERIFICATION

STATE OF NEVADA        )  
                                  : ss.  
COUNTY OF WASHOE    )

Bret W. Frey, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

DATED this 20th day of February, 2026.

INVESTIGATIVE COMMITTEE OF THE  
NEVADA STATE BOARD OF MEDICAL EXAMINERS



By: \_\_\_\_\_

BRET W. FREY, M.D.  
*Chairman of the Investigative Committee*