DISCIPLINE COMMITTEE OF THE ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

Citation: Royal College of Dental Surgeons of Ontario v. Pawluk, 2026 ONRCDSO 4

Date: 2026-04-13

File No.: 24-0246

BETWEEN:

Royal College of Dental Surgeons of Ontario

-and-

Yuriy Pawluk
Registration No: 9707

FINDING AND PENALTY REASONS

RESTRICTION ON PUBLICATION

In the matter of the Royal College of Dental Surgeons of Ontario and Dr. Pawluk the Discipline Panel ordered, under ss 45(3) of the Health Professions Procedural Code, that no person shall publish or broadcast the identity of any patients of the Registrant, or any information that could disclose the identity of any patients who are named in the Notice of Hearing and/or the Agreed Statement of Facts in this matter.

PANEL MEMBERS:
Judy Welikovitch, Public Member (Chair)
Noha Gomaa, Professional Member
Andrea Gonsalves, Subject Matter Expert

APPEARANCES:
Carly Waisglass, for the College
Rebecca Young, for Dr. Yuriy Pawluk

Heard: February 6, 2026, by video conference

REASONS FOR DECISION

1. This matter came on for a hearing before a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario (the "**College**") on February 6, 2026, by video conference. Dr. Yuriy Pawluk (the "**Registrant**") admitted to the acts of professional misconduct alleged by the College. The hearing proceeded by way of an agreed statement of facts. The panel made findings of professional misconduct and imposed a penalty in accordance with the parties' joint submission on penalty.

2. These are the panel's reasons for decision.

THE ALLEGATIONS

3. In a notice of hearing dated April 2, 2024, the College made seven allegations of professional misconduct against Dr. Pawluk pursuant to s. 51(1)(c) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*,[1] (the "**Code**"). The allegations and related particulars are as follows:

1. Dr. Pawluk signed or issued a certificate, report or similar document that he knew or ought to have known contained a false, misleading or improper statement in relation to one or more of the following patients during one or more years specified below, contrary to s 2.28 of Ontario Regulation 853/93 under the *Dentistry Act, 1991*,[2] as amended (the "**Misconduct Regulation**").

   Particulars:

   - During the years 2017-2020, he submitted claims for services that were not provided, including restorations, radiographs, examinations, nitrous oxide and oxygen sedation.
     - During the years 2019 and 2020, he submitted claims for restorations that were not provided, for three patients (AB, EB, MB).
     - During the year 2018, he submitted claims for radiographs that were not provided, for three patients (AB, DS, VS).
     - During the year 2020, he submitted claims for examinations that were not provided, for three patients (MB, FD, DS).
     - During the years 2017-2019, he submitted claims for nitrous oxide and oxygen saturation that were not provided, for one patient (NK).
   - During the years 2016-2021, he submitted claims for services with insufficient information to support the claims, including periodontal surgery, apicotectomy/apical curettage and nitrous oxide and oxygen sedation.
     - During the years 2016-2021, he submitted claims for periodontal surgery with insufficient information to support the claims, for three patients (AB, EB, MB).
     - During years 2018 and 2019, he submitted claims for apicotectomy/apical curettage with insufficient information to support the claims, for two patients (EB, DK).
     - During the year 2020, he submitted claims for nitrous oxide and oxygen sedation with insufficient information to support the claims, for three patients (VN, DS, VS).

[1] SO 1991, c 18.
[2] SO 1991, c 24.

- During the years 2019-2021, he submitted claims for scaling for three patients (AB, EB, MB) only a short period after the patients had received scaling;
- His chart entries during the year 2020 for one patient (MB) indicate that COVID-19 screening was done before the College first directed registrants to screen patients on March 13, 2020, which calls into question the accuracy of his records.

2. He submitted an account or charge for dental services that he knew or ought to have known was false or misleading relative to one or more of the following patients during one or more of the years specified below, contrary to s. 2.33 of the Misconduct Regulation.

   Particulars:

   - During the years 2017-2020, he submitted claims for services that were not provided, including restorations, radiographs, examinations, nitrous oxide and oxygen sedation.
     - During the years 2019 and 2020, he submitted claims for restorations that were not provided, for three patients (AB, EB, MB).
     - During the year 2018, he submitted claims for radiographs that were not provided, for three patients (AB, DS, VS);
     - During the year 2020, he submitted claims for examinations that were not provided, for three patients (MB, FD, DS).
     - During the years 2017-2019, he submitted claims for nitrous oxide and oxygen saturation that were not provided, for one patient (NK).
   - During the years 2016-2021, he submitted claims for services with insufficient information to support the claims, including periodontal surgery, apicotectomy/apical curettage and nitrous oxide and oxygen sedation.
     - During the years 2016-2021, he submitted claims for periodontal surgery with insufficient information to support the claims, for three patients (AB, EB, MB).
     - During years 2018, 2019, he submitted claims for apicotectomy/apical curettage with insufficient information to support the claims, for two patients (EB, DK).
     - During the year 2020, he submitted claims for nitrous oxide and oxygen sedation with insufficient information to support the claims, for three patients (VN, DS, VS).
   - During the years 2019-2021, he submitted claims for scaling for three patients (AB, EB, MB) only a short period after the patients had received scaling.

3. He charged a fee that was excessive or unreasonable in relation to the service performed relative to one or more of the following patients during one or more of the years specified below, contrary to s. 2.31 of the Misconduct Regulation.

Particulars:

- During the years 2017-2020, he submitted claims for services that were not provided, including restorations, radiographs, examinations, nitrous oxide and oxygen sedation.
    - During the years 2019 and 2020, he submitted claims for restorations that were not provided, for three patients (AB, EB, MB).
    - During the year 2018, he submitted claims for radiographs that were not provided, for three patients (AB, DS, VS).
    - During the year 2020, he submitted claims for examinations that were not provided, for three patients (MB, FD, DS).
    - During the years 2017-2019, he submitted claims for nitrous oxide and oxygen saturation that were not provided, for one patient (NK).
- During the years 2016-2021, he submitted claims for services with insufficient information to support the claims, including periodontal surgery, apicotectomy/apical curettage and nitrous oxide and oxygen sedation.
    - During the years 2016-2021, he submitted claims for periodontal surgery with insufficient information to support the claims, for three patients (AB, EB, MB).
    - During years 2018 and 2019, he submitted claims for apicotectomy/apical curettage with insufficient information to support the claims, for two patients (EB, DK).
    - During the year 2020, he submitted claims for nitrous oxide and oxygen sedation with insufficient information to support the claims, for three patients (VN, DS, VS).
- During the years 2019-2021, he submitted claims for scaling for three patients (AB, EB, MB) only a short period after the patients had received scaling.

4. He contravened a standard of practice or failed to maintain the standards of practice of the profession relative to one or more of the following patients during one or more of the years specified below, contrary to s. 2.1 of the Misconduct Regulation.

    Particulars:

    - During the years 2016-2021, he provided aggressive periodontal surgery without adequate investigation or a sanative phase, for three patients (AB, EB, MB).

5. He failed to keep records as required by the Regulations relative to one or more of the following patients during one or more of the years specified below, contrary to s. 2.25 of the Misconduct Regulation.

Particulars:

- His clinical recordkeeping was seriously deficient during the years 2019-2021, including failing to document a diagnosis and the placement of restorations, for three patients (AB, MB, VN);
- He failed to document pre-operative instructions and sedation procedure details during the year 2020, for three patients (AB, EB, MB);
- He failed to retain the financial ledgers for 19 patients (AB, EB, MB, FD, VG, SH, EH, GH, AI, DK, MKo, MKu, NK, VN, BR, MS, DS, VS, OZ) and related appointment schedules.

6. During the year(s) 2022 and/or 2023, he failed to reply appropriately or within a reasonable time to a written enquiry made by the College, contrary to s. 2.58 of the Misconduct Regulation.

   Particulars:

   - He failed to reply appropriately or within a reasonable time to the College's written request for patient records;
   - He failed to comply with a request from the College to provide the financial ledgers for 19 patients (AB, EB, MB, FD, VG, SH, EH, GH, AI, DK, MKo, MKu, NK, VN, BR, MS, DS, VS, OZ) and related appointment schedules.

7. He engaged in conduct or performed an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical contrary to s. 2.59 of the Misconduct Regulation.[3]

   Particulars:

   - He failed to advise the College in 2021 that a flood had destroyed patient ledgers and he did not take appropriate steps to recover the ledgers or notify patients about their loss, as required by College guidance;
   - During the years 2017-2020, he submitted claims for services that were not provided including: restorations, radiographs, examinations, nitrous oxide and oxygen sedation, for five patients (AB, EB, MB, DS, FD);
   - During the years 2016-2021, he submitted claims for services with insufficient information to support the claims, including: periodontal surgery, apicotectomy/apical curettage and nitrous oxide and oxygen sedation, for seven patients (AB, EB, MB, DK, VN, DS, VS);

[3] During the hearing, the parties jointly requested an amendment to allegation 7 in the notice of hearing to remove the words "during the year(s) 2022 and/or 2023". The parties advised the panel that the words had been included inadvertently. The panel granted the amendment pursuant to s. 40 of the Code. The amendment was minor and clerical in nature, and it was just and equitable to grant the amendment.

- During the years 2019-2021, he submitted claims for scaling for three patients (AB, EB, MB) only a short period after the patients had received scaling;
- His chart entries during the year 2020 for one patient (MB) indicate that COVID-19 screening was done before the College first directed registrants to screen patients on March 13, 2020, which calls into question the accuracy of his records.

THE REGISTRANT'S PLEA

4. The Registrant admitted to each of the allegations in the notice of hearing. The Chair conducted an oral plea inquiry to confirm that the Registrant's admissions of professional misconduct were voluntary, informed and unequivocal. The agreed statement of facts entered into evidence and signed by the parties also confirmed Dr. Pawluk's understanding of the nature of the allegations and the consequences of admitting to the alleged acts of professional misconduct, and that he voluntarily decided to admit the allegations against him.

5. The panel was satisfied that Dr. Pawluk's plea was voluntary, informed and unequivocal.

THE EVIDENCE

6. The parties provided the panel with an agreed statement of facts, which was made an exhibit at the hearing. The relevant facts set out in the agreed statement are as follows (attachments referred to in the agreed statement of facts have been omitted):

Background

1. At the material times, the Registrant Dr. Yuriy Pawluk ("Dr. Pawluk" or the "Registrant") was a registered member of the Royal College of Dental Surgeons of Ontario (the "College") practising at 9 Madawaska Ave. #202, Willowdale, ON, M2M 2R1 (the "Clinic"). Attached as Tab A is a copy of the Registrant's profile from the Dentist Register.

The Complaint

2. On February 23, 2022, the College received a complaint concerning anomalous billing patterns occurring at the Registrant's dental practice. The complaint expressed specific concerns regarding the Registrant's billing of code 42421 (periodontal services – flap approach procedure); billing of core build-ups and crowns; billing for nitrous oxide sedation and oral sedation; billing of apicoectomy/apical curettage, root amputation; recordkeeping; and collection of co-payments. Attached as Tab B is a copy of the Memorandum of Information Received, the Complaint and supporting documents.

The Investigation

3. On June 2, 2022, the College initiated an investigation into the Registrant's conduct. The Registrant was provided notice of the complaint on June 14, 2022. On July 15, August 18, and September 7, 2022, the Registrant was asked to provide records for the relevant patients with additional requests for outstanding records being made on November 17, and December 9, 2022.

4. On July 12, 2022, the College investigator received production summaries from the Registrant, and on October 31, and December 8, 2022, the Registrant provided records to the College investigator. On February 1, 2023, the Registrant notified the College that the outstanding records were damaged due to a flood.

5. On April 12, 2023, the College investigator prepared a records analysis, which contained an analysis of the records provided by the Registrant to the College. Attached as Tab C is a copy of the Records Analysis, which shows:

    a. In the years 2017, 2019 and 2020, it was unclear whether the restorative code claimed was appropriate or whether the amalgam was placed or replaced, for two patients (AB, EB);

    b. In the years 2015-2021, there were no records provided for radiographic claims, for five patients (AB, DS, FD, MK, VS);

        i. While the Registrant subsequently provided records documenting additional bitewings for DS, FD, and MK, there still remain outstanding x-rays for AB, DS, FD, and VS. In particular:

            1. AB: The Registrant did not provide bitewings records for October 29, 2015;

    c. DS: The Registrant only provided bitewing records for November 1, 2018; the Registrant did not provide bitewing records for January 18, 2016, March 12, 2016 and March 21, 2017;

            1. FD: The Registrant only provided bitewing records for January 16, 2020; the Registrant did not provide bitewing records for September 26, 2020;

            2. VS: The Registrant did not provide bitewing or PAN records.

    d. In the year 2020 and 2021, chart entries indicated the recall examinations code, but did not reference a DDS' exam, for three patients (MB, FD, DS);

        i. While the Registrant subsequently provided notes referencing a DDS exam for these patients, the supplemental records were still missing the following information:

1. MB: The Registrant did not provide notations about exams in the records for January 5, 2020;

e. FD: The Registrant did not provide notations about exams in the records for the January 16, 2020, September 20, 2020 or June 28, 2021 appointments;

1. DS: The Registrant did not provide notations about exams in the records for July 23, 2020.

f. The supplemental records referred to above are attached at Tab D;

g. In the years 2017-2019, nitrous oxide sedation was not documented in the chart entries, for one patient (NK);

h. With respect to flap approach, with curettage of osseus defect surgery claims:

i. records were not provided for surgeries that took place in 2016 and 2017, for one patient (AB);

ii. records were provided but diagnoses were not documented for surgeries that took place in 2018-2021, for three patients (AB, EB, MB). The Registrant subsequently provided additional records, but they did not indicate that a diagnosis was provided for each of AB, EB and MB.

i. With respect to apicoectomy/apical curettage claims:

i. chart notes were not provided for surgeries that took place in 2014, for one patient (EB);

ii. chart notes were provided but no pre-operative radiographs were documented for procedures that took place in 2018-2019, for two patients (EB, DK);

j. In the year 2020, either the number of units of nitrous oxide and oxygen were not found or documented, or no chart notes regarding sedation were found or documented, even though codes for oral sedation were claimed, for two patients (VN, DS);

k. In the years 2019-2021, units of scaling were claimed and documented as performed shortly after units of scaling and selective prophylaxis were previously claimed, for three patients (AB, EB, MB);

i. If the Registrant were to testify, he would state that these three patients had gingival concerns, warranting additional scaling.

l. The College's initial advice to registrants to screen patients for COVID-19 was dated March 13, 2020, however, for one patient (MB), three hygiene chart entries indicated that COVID-19 screenings were performed before that date;

m. In the years 2019-2020, there was no diagnosis found or documented and/or it was unclear how and where the MOVL composite was placed on a crowned tooth, for two patients (AB, VN);

i. The Registrant subsequently provided records, but they did not provide the diagnosis or observations about the decay on all surfaces.

n. In 2020, pre-operative instructions and sedation procedure notations were not fully documented in accordance with the College's Standards, for three patients (AB, EB, MB);

o. Despite the College's requests, the Registrant did not provide ledgers and related appointment schedules for 19 patients (AB, EB, MB, FD, VG, SH, EH, GH, AI, DK, MKo, MKu, NK, VN, BR, MS, DS, VS, OZ); and,

p. In 2021, the Registrant failed to advise the College that a flood had destroyed patient ledgers, and the Registrant did not take appropriate steps to recover the records according to guidelines.

6. On April 25, 2023, the Registrant was provided with the results of the College's investigation and was later notified of the intention to refer allegations of professional misconduct to the Discipline Committee of the College ("Discipline Committee"). The Registrant was invited to provide a response.

7. On March 5, 2024, the Registrant provided his response.

8. On March 26, 2024, the specified allegations of professional misconduct were referred to the Discipline Committee.

Professional Misconduct Admitted

9. It is admitted that during the years 2017-2020, the Registrant submitted claims for services with insufficient information to support the claims, including restorations, radiographs, examinations, nitrous oxide and oxygen sedation, for seven patients, particularly:

a. during the years 2019 and 2020, the Registrant submitted claims for restorations without sufficient information to support the claims, for two patients (AB, EB);
b. during the year 2018, the Registrant submitted claims for radiographs without sufficient information to support the claims, for three patients (AB, DS, VS);
c. during the year 2020, the Registrant submitted claims for examinations without sufficient information to support the claims, for three patients (MB, FD, DS); and,
d. during the years 2017-2019, the Registrant submitted claims for nitrous oxide and oxygen saturation without sufficient information to support the claims, for one patient (NK).

10. It is admitted that during the years 2016-2021, the Registrant submitted claims for services with insufficient information to support the claims,

including periodontal surgery, apicoectomy/apical curettage and nitrous oxide and oxygen sedation, for seven patients, particularly:

a. during the years 2016-2021, the Registrant submitted claims for periodontal surgery with insufficient information to support the claims, for three patients (AB, EB, MB);
b. during the years 2018 and 2019, the Registrant submitted claims for apicoectomy/apical curettage with insufficient information to support the claims, for two patients (EB, DK); and,
c. during the year 2020, the Registrant submitted claims for nitrous oxide and oxygen sedation with insufficient information to support the claims, for three patients (VN, DS, VS).

11. It is admitted that during the years 2019-2021, the Registrant submitted claims for scaling for three patients (AB, EB, MB) only a short period after the patients had received scaling. If the Registrant were to testify, he would state that these three patients had gingival concerns, warranting additional scaling.

12. It is admitted that the Registrant's chart entries during the year 2020 for one patient (MB) indicate that COVID-19 screening was done before the College first directed registrants to screen patients on March 13, 2020, which called into question the accuracy of the Registrant's records.

13. It is admitted that during the years 2016-2021, the Registrant provided aggressive periodontal surgery without adequate investigation or a sanative phase, for three patients (AB, EB, MB).

14. It is admitted that the Registrant's clinical recordkeeping was seriously deficient during the years 2019-2021, including failing to document a diagnosis and the placement of restorations, for three patients (AB, MB, VN).

15. It is admitted that the Registrant failed to document pre-operative instructions and sedation procedure details during the year 2020, for three patients (AB, EB, MB).

16. It is admitted that the Registrant failed to retain the financial ledgers for 19 patients (AB, EB, MB, FD, VG, SH, EH, GH, AI, DK, MKo, MKu, NK, VN, BR, MS, DS, VS, OZ) and related appointment schedules.

17. It is admitted that the Registrant failed to reply appropriately or within a reasonable time to the College's written request for patient records.

18. It is admitted that the Registrant failed to comply with a request from the College to provide the financial ledgers for 19 patients (AB, EB, MB, FD, VG, SH, EH, GH, AI, DK, MKo, MKu, NK, VN, BR, MS, DS, VS, OZ) and related appointment schedules.

19. It is admitted that the Registrant failed to advise the College in 2021 that a flood had destroyed patient ledgers and the Registrant did not take appropriate steps to recover the ledgers or notify patients about their loss, as required by College guidance.

20. The Registrant admits and acknowledges that his conduct described above constitutes professional misconduct pursuant to section 51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the Regulated Health Professions Act, 1991, SO 1991, c 18 and as defined in the following paragraphs of section 2 of Ontario Regulation 853/93:

    a. Paragraph 1: Contravening a standard of practice or failing to maintain the standards of practice of the profession;
    b. Paragraph 28: Signing or issuing a certificate, report or similar document that the member knew or ought to have known contained a false, misleading or improper statement;
    c. Paragraph 25: Failing to keep records as required by the Regulations;
    d. Paragraph 31: Charging a fee that was excessive or unreasonable;
    e. Paragraph 33: Submitting an account or charge that the member knew or ought to have known was false or misleading;
    f. Paragraph 58: Failing to reply appropriately or within a reasonable time to a written enquiry made by the College; and,
    g. Paragraph 59: Engaging in conduct or performing an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical.

DECISION

7. After deliberating, the panel found that the College had proven the allegations of professional misconduct against Dr. Pawluk. The Chair announced the panel's decision on the record.

REASONS FOR DECISION

8. The College bears the onus of proving the allegations against the Registrant on a balance of probabilities through clear, cogent and convincing evidence. The Registrant's admissions of professional misconduct are material but must be supported by evidence. The evidence in the agreed statement of facts supports the Registrant's admissions and satisfies the College's burden of proof.

9. We will first deal with allegations 1, 2 and 3 together, as they are all related. The evidence establishes that during the years 2017-2020, the Registrant submitted claims to an insurer for services with insufficient information to support the claims, including restorations, radiographs, examinations, nitrous oxide and oxygen sedation, for seven patients. In addition, during the years 2016-2021, the Registrant submitted claims for services with insufficient information to support the claims in respect of periodontal surgery, apicoectomy/apical curettage and nitrous oxide and oxygen sedation, for seven patients. During the years 2019-

2021, the Registrant submitted claims for scaling for three patients only a short period after the patients had already received scaling. These facts prove on a balance of probabilities:

(a) Allegation 1: that Dr. Pawluk signed or issued a certificate, report or similar document that he knew or ought to have known contained a false, misleading or improper statement, which constitutes professional misconduct under s. 2.28 of the Misconduct Regulation.

(b) Allegation 2: that Dr. Pawluk submitted an account or charge for dental services that he knew or ought to have known was false or misleading, which is professional misconduct under s. 2.33 of the Misconduct Regulation.

(c) Allegation 3: that Dr. Pawluk charged a fee that was excessive or unreasonable in relation to the service performed, which is professional misconduct under s. 2.31 of the Misconduct Regulation.

10. With respect to allegation 4, the panel was satisfied on a balance of probabilities that Dr. Pawluk contravened a standard of practice or failed to maintain the standards of practice of the profession. During the years 2016-2021, the Registrant provided aggressive periodontal surgery without adequate investigation or a sanative phase, for three patients. The Registrant's records for these patients did not contain documented findings or a rationale before proceeding to aggressive periodontal treatment. The College's Dental Recordkeeping Guidelines, which reflect standards of the profession, provide that:

> A diagnosis should be formulated, based on the collected clinical and radiographic findings from the dentist's examination, as well as the patient's medical and dental history, and supplemented when necessary with clinical photographs, diagnostic study models and/or the results of any tests or consultations. A diagnosis should be clearly documented in the patient record, as it forms the foundation for a treatment plan.
>
> It is particularly important to record a diagnosis when the reason for proposed treatment is not readily apparent from the patient's history or the documentation of the clinical and/or radiographic examination.

11. The Registrant admits that without the necessary investigation or sanative phase, he failed to maintain the standards of practice.

12. In allegation 5, the College alleges that the Registrant failed to keep records as required by the Regulations relative to several patients. The Registrant admitted to multiple recordkeeping deficiencies. Section 38 of RRO 1990, Regulation 547 under the *Drug and Pharmacies Regulation Act*[4] requires dentists to:

> (b) make and keep clinical and financial records respecting his or her patients and the record for each patient shall contain not less than,
>
> (i) the patient's history,

[4] RSO 1990, c H.4

(ii) the examination procedures used,
(iii) the clinical findings obtained,
(iv) the treatment prescribed and provided, and
(v) the member's fees and charges;

(c) keep the records required under clause (b) in a systematic manner and such records shall be retained for a period of at least ten years after the date of the last entry in the record or until two years following the death of the member, whichever first occurs.

13. The evidence establishes that Dr. Pawluk failed to document a diagnosis and the placement of restorations, for three patients. He also failed to document pre-operative instructions and sedation procedure details for three patients. Further, the Registrant failed to retain the financial ledgers and related appointment schedules for 19 patients. The panel found that these deficiencies constitute a failure to keep records as required by the Regulations. The College proved allegation 5.

14. The College alleges in allegation 6 that the Registrant failed to reply appropriately or within a reasonable time to a written enquiry made by the College. Dr. Pawluk admitted that he failed to reply appropriately or within a reasonable time to the College's written request for patient records. Specifically, on July 15, August 18, and September 7, 2022, the College investigator asked the Registrant to provide records for the relevant patients. Additional requests for outstanding records were made on November 17, and December 9, 2022. On July 12, 2022, the Registrant sent production summaries to the investigator but it was not until October 31, and December 8, 2022, that the Registrant provided records.

15. The Registrant failed to comply with a request from the College to provide the financial ledgers and related appointment schedules for 19 patients. It was only on February 1, 2023—more than seven months after the initial request—that the Registrant notified the College that the outstanding records were damaged due to a flood.

16. Those admitted facts prove allegation 6 on a balance of probabilities.

17. Finally, with respect to allegation 7, the panel found that the Registrant engaged in conduct or performed acts that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical. The admitted facts demonstrate a serious and persistent disregard for the Registrant's obligations as a member of this College, and a lack of candour with the College.

18. This is not a situation of a single isolated incident of poor judgment—for multiple patients over an extended period of time, the Registrant submitted inaccurate, incomplete, false and/or misleading insurance claims, failed to comply with recordkeeping requirements, and failed to respond appropriately or in a timely manner to inquiries from the College in an investigation of a complaint from an insurance provider. The misconduct was compounded by the fact that the Registrant did not advise the College in 2021 that a flood had destroyed patient ledgers, and he failed to take steps to recover ledgers as required by College guidance.

19. The Registrant's conduct undermines the relationship of trust that exists between dentists, patients, insurance providers, the College and the public.

20. The College proved allegation 7.

PENALTY SUBMISSIONS

21. The parties presented the panel with a joint submission on penalty and costs, asking the panel to impose an order with the following terms:

a. requiring the Registrant to appear before the panel of the Discipline Committee to be reprimanded within ninety (90) days of this Order becoming final or on a date fixed by the Registrar;

b. directing the Registrar to suspend the Registrant's certificate of registration for a period of six (6) months, or such further time until the Registrant complies with paragraph (d)(ii), commencing immediately. The suspension shall run without interruption;

c. that the Registrar impose the following terms, conditions and limitations on the Registrant's certificate of registration (the "Suspension Conditions"), which conditions shall continue until the suspension of the Registrant's certificate of registration as referred to in paragraph 1(b) above has been fully served:

(i) while the Registrant's certificate of registration is under suspension, the Registrant shall immediately inform the following people about the suspension:

- staff in the offices or practices in which the Registrant works, including other regulated professionals and administrative staff;
- dentists with whom the Registrant works, whether the Registrant is a principal in the practice or otherwise associated with the practice;
- dentists or other individuals who routinely refer patients to the Registrant;
- faculty members at Faculties of Dentistry, if the Registrant is affiliated with the Faculty in an academic or professional capacity;
- owners of a practice or office in which the Registrant works;
- patients who ask to book an appointment during the suspension, or whose previously booked appointment has been rescheduled due to the suspension. The Registrant may assign administrative staff to inform patients about the suspension. All communications with patients must be truthful and honest;

(ii) while suspended, the Registrant must not engage in the practice of dentistry, including but not limited to:

- acting in any manner that suggests the Registrant is entitled to practice dentistry. This includes communicating diagnoses or offering clinical advice in social settings. The Registrant must ensure that

administrative or office staff do not suggest to patients in any way that the Registrant is entitled to engage in the practice of dentistry;
- giving orders or standing orders to dental hygienists;
- supervising work performed by others;
- working in the capacity of a dental assistant or performing laboratory work;
- acting as a clinical instructor;

(iii) while suspended, the Registrant must not be present in offices or practices where the Registrant works when patients are present, except for emergencies that do not involve patients. The Registrant must immediately advise the Registrar in writing about any such emergencies;

(iv) while suspended, the Registrant must not benefit or profit, directly or indirectly from the practice of dentistry and

- the Registrant may arrange for another dentist to take over their practice during the suspension period. If another dentist assumes the practice, all of the billings of the practice during the suspension period belong to that dentist. The Registrant may be reimbursed for actual out-of-pocket expenses incurred in respect of the practice during the suspension period;
- the Registrant is permitted to sign and/or submit insurance claims for work that was completed prior to the suspension;
- the Registrant must not sign insurance claims for work that has been completed by others during the suspension period;

(v) the Registrant shall cooperate with any office monitoring which the Registrar thinks is needed to ensure that the Registrant has complied with the Suspension Conditions. The Registrant must provide the College with access to any records associated with the practice that the College may require to verify that the Registrant has not engaged in the practice of dentistry or profited during the suspension; and

(vi) the Suspension Conditions imposed by virtue of subparagraphs 1(c)(i)-(v) above shall be removed at the end of the period that the Registrant's certificate of registration is suspended.

d. directing that the Registrar also impose the following additional terms, conditions and limitations on the Registrant's Certificate of Registration, namely:

(i) The Registrant shall successfully complete, at his own expense, the following courses approved by the College within six (6) months of this Order becoming final or such further time as may be permitted by the Registrar:

1. The College's Fundamentals of Dental Recordkeeping course with written proof of same provided to the College;

2. A course on billing, pre-approved by the College, with written proof of the same provided to the College;

3. The PROBE Program for Professional/Problem-Based Ethics (must obtain an “unconditional pass” grade); and,

(ii) The Registrant shall retain a qualified dentist, approved by the College to act as the Registrant’s Clinical Supervisor (the “Clinical Supervisor”).

(iii) As soon as the Registrant has been notified, in writing, that the Clinical Supervisor is approved, and following the completion of the suspension of the Registrant’s certificate of registration, the Registrant will practise under Clinical Supervision at Level 2, as specified in the Clinical Supervision Framework attached as “Appendix A” to this Joint Submission on Penalty and Costs.

(iv) The level of Clinical Supervision will not be reduced and the Clinical Supervision will not end without the recommendation of the Clinical Supervisor and the College’s prior approval in writing. If the College approves a reduction in the level of supervision, the Registrant will continue to practise under the Clinical Supervision at the prescribed level as specified in the Clinical Supervision Framework.

(v) The Registrant will ensure that the Clinical Supervisor completes all the requirements of the Clinical Supervision set out below, including providing required reports to the College in a timely manner.

(vi) During Level 2 Clinical Supervision, the Clinical Supervisor will:

- be accessible to the Registrant by telephone or other electronic means, and/or available at scheduled times to discuss or observe the Registrant’s treatment.
- directly observe the Registrant’s general dental practice in-person related to billings and recordkeeping at least once every month.
- review at least 15 of the Registrant’s chart entries each month and discuss with the Registrant any recommendations with respect to the Registrant’s area of practice. If fewer than 15 chart entries are available for any given month, the Clinical Supervisor will review all the Registrant’s chart entries for that month. If the Registrant does not provide any treatment in a given month, no chart review is required, and the supervision will be extended until such time that the Registrant has seen 15 patients, the charts of which are able to be reviewed by the Clinical Supervisor.
- provide a report to the College every month in the format specified by the College; and
- prior to recommending that the Registrant progress to Level 1 Clinical Supervision:

1. conduct chart reviews for at least 15 patient visits over at least one month; and

2. confirm that both the Clinical Supervisor and the Registrant are confident that the Registrant can practise dentistry autonomously without regular input from the Clinical Supervisor.

(vii) During Level 1 Clinical Supervision, the Clinical Supervisor will:

- Be available to me at scheduled times, in-person or electronically, to discuss the Registrant's area of practice;
- review at least 15 of my chart entries for the Registrant's area of practice each month and discuss with the Registrant any recommendations with respect to the Registrant's area of practice. If fewer than 15 chart entries are available for any given month, the Clinical Supervisor will review all the Registrant's chart entries for that month. If the Registrant does not provide any treatment in a given month, no chart review is required.
- Provide a report to the College every three months in the format specified by the College; and
- Prior to recommending that the Registrant practise without Clinical Supervision:

    1. conduct chart reviews for at least 15 patient visits over at least a three-month period; and

    2. confirm that both the Clinical Supervisor and the Registrant are confident that the Registrant can practise dentistry autonomously without a Clinical Supervisor.

(viii) At any time during Clinical Supervision, the Clinical Supervisor will report to the College immediately if:

- the Clinical Supervisor believes that my conduct or treatment is likely to expose the Registrant's patients to harm or injury;
- the Registrant has breached the terms of this Undertaking or any terms, conditions or limitations on my certificate of registration;
- the Clinical Supervisor suspects that that the Registrant has engaged in professional misconduct related to the Registrant's area of practice;
- if any patient or staff member expresses concerns to the Clinical Supervisor about improper care or conduct by the Registrant;
- a breakdown or conflict of interest has occurred in the Registrant's relationship with the Clinical Supervisor; or
- The Clinical Supervisor no longer wishes or is no longer able to supervise the Registrant.

(ix) If the Clinical Supervisor is no longer able to supervise the Registrant, the Registrant will notify the College immediately and cease performing cease

practising dentistry until the Registrant is able to retain a new Clinical Supervisor, approved by the College, to continue the Clinical Supervision.

(x) The Registrant will abide by all recommendations of the Clinical Supervisor, including recommendations for changes to the Registrant's practices, recommended courses, and review of recommended resources.

Practice Monitoring

(xi) The Registrant will submit to practice monitoring for twenty-four months after the Registrant completes the Clinical Supervision. The monitoring may be conducted by way of unannounced visits, which may be conducted virtually or in-person at the discretion of the College.

(xii) The Registrant will pay the monitoring fee of $1,000 per visit to the College within two weeks of the invoice date for each monitoring visit.

Costs

(xiii) that the Registrant pay costs to the College in the amount of $10,000.00 in respect of this discipline hearing, within twelve (12) months of the date this Order becomes final, which must be paid in four (4) consecutive quarterly installments of $2,500 each, with the first payment due within three (3) months of the date this Order becomes final.

22. During the penalty phase, the parties informed the panel of Dr. Pawluk's prior complaint history. Although the complaints history does not constitute a prior disciplinary history, it is relevant that in 2017 the College's Inquiries Complaints and Reports Committee directed Dr. Pawluk to complete a Specified Continuing Education or Remediation Program ("SCERP") which included a recordkeeping course. In addition, in 1999 the College's then-Complaints Committee directed the Registrant to appear before a panel to be cautioned for deficient record-keeping. Dr. Pawluk's conduct in the current discipline proceeding occurred after those remedial measures, which is relevant to the appropriate penalty in this case.

PENALTY DECISION

23. The panel accepted the parties' joint submission as to penalty and costs, and made an order in accordance with the terms set out in paragraph 21 above

REASONS FOR PENALTY DECISION

24. Once this Discipline Committee makes findings of professional misconduct, an order should be imposed that protects the public, maintains public confidence in the College's ability to regulate its members, and upholds high professional standards. A discipline penalty should provide general and specific deterrence, remediation where appropriate; reflect the aggravating and mitigating factors, as well as proportionality; and fall within a range of reasonable penalties. In addition, where the parties have reached a joint submission on

penalty, the panel must accept the joint submission unless doing so would bring the administration of justice into disrepute or be otherwise contrary to the public interest.

25. Stated in simple terns, the penalty jointly proposed by the parties comprises a reprimand, a six-month suspension of Dr. Pawluk's certificate of registration, completion of courses in recordkeeping, billing and professional ethics, clinical supervision and practice monitoring by the College. The panel was satisfied that these components serve the objectives of penalty. The reprimand and suspension achieve specific and general deterrence. The courses, practice supervision and practice monitoring provide remediation. Together, the terms protect the public and maintain public confidence in the College's ability to regulate the profession.

26. The penalty as a whole is proportionate to the severity of Dr. Pawluk's misconduct and his circumstances. It reflects the relevant mitigating and aggravating factors. The most important mitigating factor is that Dr. Pawluk took responsibility for his actions by admitting to the misconduct allegations and working with the College to reach an agreed statement of facts and a joint submission on penalty. The number of patients involved and the length of time over which the misconduct occurred are relevant aggravating factors. In addition, the specific terms, conditions and limitations requiring Dr. Pawluk to complete three different remedial courses and undertake clinical supervision and practice monitoring are appropriate given the Registrant's complaints history and the fact that the misconduct occurred despite prior remedial measures imposed by the Complaints Committee and the ICRC.

27. The panel was also satisfied that the penalty falls within a reasonable range having regard to prior cases involving similar misconduct. College counsel brought several cases to the panel's attention, some with shorter periods of suspension and some with longer periods, while several involved similar six-month suspensions. The cases generally involved similar terms, conditions and limitations. Having regard to the similarities and differences between this case and the cases cited by the College, the panel accepted that the joint submission is within the appropriate range for this type of misconduct.

28. Finally, the panel accepted the parties' agreement on costs. An order for costs in the amount of $10,000.00 is in line with costs orders in other one-day uncontested matters that come before this Discipline Committee.

THE REPRIMAND

29. At the conclusion of the hearing, Dr. Pawluk confirmed through his counsel that he was waiving his right to appeal and wished to receive the reprimand immediately. Accordingly, the panel delivered an oral reprimand as required by paragraph 1 of the panel's order.

I, Judy Welcovitch, sign these Reasons for Decision as Chairperson of this Discipline Panel.

April 13, 2026

Judy Welicovitch — Date

Chair, Discipline Committee Panel

APPENDIX "A"

RCDSO v. Dr. Yuriy Pawluk

Dr. Pawluk, as you know, this Discipline panel has ordered you be given an oral reprimand as part of the sanction imposed upon you. The reprimand should impress upon you the seriousness of your misconduct.

The fact that you have received this reprimand will be part of the public portion of the Register and, as such, part of your record with the College.

You will be given an opportunity to make a statement at the end of the reprimand if you wish.

The panel has found that you have engaged in multiple acts of professional misconduct over a lengthy period of time in respect of multiple patients. This protracted and recurring misconduct related to

- Issuing documents and submitting claims that you know, or ought to have known, were false, misleading or inaccurate, including submitting insurance claims for services without sufficient documentation to support those claims;
- Failing to keep records as required by the Regulations, including serious deficiencies and inaccuracies in your patient records;
- Failing to follow College guidelines when patient financial ledgers were lost in a flood;
- Contravening or failing to maintain standards of the dentistry profession;
- Charging excessive and unreasonable fees for services; and
- Failing to respond reasonably to inquiries from the College.

The cumulative effect of your conduct would reasonably be regarded by Registrants as disgraceful, dishonourable, unprofessional and unethical.

Your professional misconduct is a matter of profound concern. It is completely unacceptable to your fellow dentists and to the public. You have brought discredit to the entire profession and to yourself. Public confidence in this profession has been put in jeopardy.

Of special concern to us is the fact that the professional misconduct in which you engaged occurred over an extended period of time and involved many patients. The conduct represents a

serious breach of trust with the public, the College, your patients, and insurance providers. You engaged in this pattern of conduct despite having received guidance from the College in the past as a result of your complaints history. You were given the opportunity to correct your practice and avoid this misconduct, which you failed to heed. The circumstances of this case could have justified a more severe penalty than the one we imposed.

As I advised earlier, you will now be given an opportunity to make a comment if you wish to do so. This is **not** an opportunity for you to debate the merits or the correctness of the decisions we have made.