BEFORE THE BOARD OF DISCIPLINARY APPEALS
APPOINTED BY THE SUPREME COURT OF TEXAS

IN THE MATTER OF:
MARTIN S WOZNIAK,
RESPONDENT

BODA Cause No. 73113
State Bar Case No. 202400162

RESPONDENT'S EMERGENCY MOTION FOR STAY OF SUSPENSION PENDING APPEAL AND MOTION FOR RECONSIDERATION DUE TO INVOLUNTARY MEDICAL ABSENCE

TO THE HONORABLE BOARD OF DISCIPLINARY APPEALS:

Respondent, Martin S Wozniak, respectfully files this Emergency Motion for Stay of Suspension Pending Appeal and Motion for Reconsideration. Respondent urgently requests that this Board stay the active suspension imposed by the Evidentiary Panel pending the resolution of the merits of the underlying appeal. In support thereof, Respondent respectfully shows the following:

I. INTRODUCTION & UNUSUAL CIRCUMSTANCES

1. This is an emergency matter. On June 8, 2026 the Evidentiary Panel held a hearing knowing I was in the hospital under general anesthesia.
2. On June 8, 2026, the Evidentiary Panel held a hearing on Respondent's Motion for New Trial and Emergency Stay of Suspension.
3. Respondent was entirely unable to participate in or attend the hearing due to a previously unexpected and severe medical emergency requiring surgery that the Evidentiary Panel had been informed about. Respondent is still currently confined to the hospital recovering from surgery. Proof of this involuntary medical absence—the official Operative Report documenting Respondent's surgical procedure and ongoing hospitalization—is attached hereto as **Exhibit A**. Respondent remains hospitalized.
4. Consequently, the Evidentiary Panel denied the stay without Respondent's input, participation, or presentation of evidence regarding the merits of the stay or the irreparable harm to clients.

II. ARGUMENT: DUE PROCESS VIOLATIONS AND PLENARY POWER ABUSE

5. **Denial of Due Process:** A lawyer facing disciplinary suspension has a constitutionally protected property interest in their license to practice law. Holding a dispositive stay hearing while the Respondent is physically incapacitated in a hospital following surgery constitutes a severe deprivation of due process.
6. **Infringement on Plenary Power:** The Evidentiary Panel signed the underlying Amended Judgment of Suspension on April 14, 2026. However, the Panel ordered the active suspension to take effect a mere 2 days later, on April 16, 2026.
7. This timeline is a severe abuse of discretion. Under Texas disciplinary procedure, an Evidentiary Panel retains full plenary power over its judgment for at least 30 days after signing. This 30-day window is constitutionally and procedurally protected to allow a Respondent to file post-judgment motions, such as a Motion for New Trial or Motion to Modify the Judgment.
8. By triggering the active suspension on Day 14, the Panel effectively forced the execution of a punitive sanction before its own judgment was final and while it still held active jurisdiction to vacate or amend the order. Forcing a lawyer into active suspension while the trial-level panel still retains plenary power—compounded by Respondent's medical absence—constitutes a distinct failure of due process.

III. ARGUMENT: IMMEDIATE AND IRREPARABLE HARM

IRREPARABLE HARM

9. If an emergency stay is not granted immediately, the active suspension will take effect during a period when Respondent is physically compromised.
10. This will result in immediate, catastrophic, and irreparable harm to Respondent's active clients, who will suddenly be left without counsel while Respondent is physically incapacitated and unable to properly transition files, file necessary motions to withdraw, or protect their legal interests.
11. Conversely, granting a temporary stay to allow Respondent to recover and properly present this matter will cause zero prejudice to the Commission for Lawyer Discipline.

IV. PRAYER FOR RELIEF

WHEREFORE, PREMISES CONSIDERED, Respondent respectfully prays that this Board:

1. **GRANT** this Emergency Motion and immediately **STAY** the active suspension pending the final determination of the underlying appeal;

2. In the alternative, **REMAND** the issue of the stay to the Evidentiary Panel with instructions to conduct a new hearing where Respondent can meaningfully participate upon release from the hospital; and
3. Grant Respondent all other relief to which he may be justly entitled.

Dated: July 6, 2026.

Respectfully submitted,
/S/ MARTIN S. WOZNIAK
State Bar No. 22013550
Baylor Scott White / Room Number 3314
Grapevine, TX 76051

5549 Davis Blvd. Suite 59
North Richland Hills, TX 76180
(214) 417-0520
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wozniak640@gmail.com
RESPONDENT PRO SE

CERTIFICATE OF CONFERENCE

I hereby certify that on July 6, 2026, I conferred (or attempted to confer via email/phone from my hospital bed) with opposing counsel for the Commission for Lawyer Discipline, Sara Tate, regarding this emergency motion. Opposing counsel states they oppose.

/S/ MARTIN S. WOZNIAK

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document was served electronically via the electronic filing manager on this 7th day of July, 2026, upon the Commission for Lawyer Discipline.

/S/ MARTIN S. WOZNIAK

Exhibit A

Op Report signed by Nathan Edward Williams II at 06/08/26 1745

Operative Report

PATIENT: WOZNIAK, MARTIN STANLEY

DATE OF BIRTH: 11/10/1951

ACCOUNT: 9610971389

MRN: 2000028047

ADMISSION: 06/08/2026

DISCHARGE:

AUTHOR: Nathan Williams, MD

DATE OF PROCEDURE:

June 8, 2026

SURGEON:

Nathan Williams, MD

LOCATION:

THE Southlake Hospital.

PREOPERATIVE DIAGNOSIS:

Right knee severe osteoarthritis.

POSTOPERATIVE DIAGNOSIS:

Right knee severe osteoarthritis.

PROCEDURE PERFORMED:

Right primary total knee arthroplasty.

ASSISTANT:

Tony Volponi, physician assistant.

ANESTHESIA:

General endotracheal with regional block.

ANESTHESIOLOGIST:

Dr. Shawn Nguyen.

COMPLICATIONS:

None.

ESTIMATED BLOOD LOSS:

50 cc.

SPECIMENS:

None.

DRAINS PLACED:

None.

ANTIBIOTIC PROPHYLAXIS:

Ancef 2 g IV given prior to incision.

TIME OF TOURNIQUET:

48 minutes at 300 mmHg.

OPERATIVE IMPLANT:

Smith and Nephew Legion knee system consisting of

1. A size 7 right posterior stabilized Oxinium femoral component.

2. A size 6 right tibial baseplate.

3. A size 9 mm posterior-stabilized high flexion articular insert.

4. A size 35 mm oval resurfacing patella.

5. Rally medium-viscosity gentamicin cement.

OPERATIVE FINDINGS:

Intraoperative evaluation revealed severe medial compartment chondral loss with bone eburnation and peripheral compartment spurring. He also had high-grade scattered anterior and lateral compartment lesions. A limited deep MCL release was performed for ligament protection. Also, additional 2 mm was taken off the distal femur to correct mild presenting fixed flexion contracture. Overall bone quality was good.

OPERATIVE PROCEDURE:

The patient was taken back to the operative suite where they were situated in a supine position on the operating room table. Following induction of general anesthesia, the operative site was confirmed with history as well as films and prophylactic antibiotics were administered. Sequential compression device was utilized on the non-operative limb. The lower extremity was then double prepped and draped in a typical manner. Following limb exsanguination and tourniquet inflation, an anterior midline longitudinal incision was made followed by a medial parapatellar arthrotomy. Examination of the knee revealed severe arthritis with associated bone eburnation and peripheral compartment spurring. The patella was first addressed utilizing a measured resection technique, obtaining a parallel resection. The patella was sized and a shield was placed. Attention was turned to the femoral side where the intramedullary canal was opened and suctioned, followed by placement of an intramedullary guide set for a valgus resection. The expected distal cut was then made. The femur was sized in the anteroposterior direction and rotation was set parallel to the epicondylar axis. The anterior, posterior, and chamfer cuts were then made, taking the expected resections. A good transition was obtained across the anterior femur and also a good external-rotation cut

pattern was achieved. Attention was turned to the tibial side where extramedullary alignment was utilized, obtaining a nice perpendicular cut to the tibial axis and the tibia was sized. Tibial rotation was based off the junction of the medial third of the tibial tubercle and then the central keel was punched. Attention was then turned to the posterior aspect of the knee for posterior condylar osteophytes and meniscal remnants. The stability of the PCL was also assessed. Multiple tibial insert sizes were trailed to optimize motion and stability. Well-balanced medial and lateral gaps were achieved throughout the arc of motion as well as full knee flexion and extension. Also achieved was a central tracking extensor mechanism with the no-thumbs technique, and a stable anterior and posterior drawer exam. At this point, I was satisfied with soft tissue balancing as well as implant position and sizing, and attention was turned to final implants. All trials were removed. The bone was prepared with pulse lavage and gauze drying. Then utilizing third generation cementing techniques, the tibia, femur, and patella were all cemented and impacted into position, removing excess cement from the knee. A good capture was also obtained on the articular insert. Once the cement had dried, final physical exam remained unchanged and satisfactory. The knee was irrigated with normal saline. Tourniquet was let down and excellent hemostasis was obtained and no drain was placed. The extensor mechanism was then closed with a series of figure-of-eight #1Vicryls and oversewn with #2 Quill. Irrigation of the knee was repeated. The skin was then closed in multilayered fashion with interrupted 0 Vicryl in the deep Scarpa layer, 2-0 Vicryl in the dermis, and final closure was with a running subcuticular 3-0 barbed suture as well as Dermabond. A Xeroform sterile gauze dressing was applied. The patient tolerated the procedure well without any operative complications. Postoperative counts were performed and were correct.

Nathan Williams, MD

NW/MODL

D: 06/08/2026 11:04:41

T: 06/08/2026 11:38:06

Job #: 748871/1092806405

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https://mychart.texashealth.org/MyChart/app/visits/note?csn=WP-246K6AJUa2uiJ39Gu-2BXlnkBQ-3D-3D-24jLjPNERsNVL6i-2B0SU0xRycOtrPAUWTiGgsMVCL2a1n4-3D&lrpID=WP-24IuB5PVWXLdwHaD3aqdxWyA-3D-3D-24A6qRYr9VXvSdTlyeW6xdBkZ1bl9gAQH0EWMPNy2ttac-3D&hnoID=WP-24P0VF-2FN6G0zi1zGyirALpZQ-3D-3D-24DVHEdWy3JcbIuTmiXICT9CTOBbClzuhM86FMHOdsiXs-3D&hnoDAT=WP-24B2so31-2Bpclr-2FXGsuEH-2FSvA-3D-3D-24-2BwT-2BKdfbsBBcEawjw2TYgGDQRudXil354XgufN31V24-3D&fromPvdPage=1&fromVisitNotesPage=0#:~:text=Op%20Report%20signed%20by%20Nathan%20Edward%20Williams%20II%20at%2006/08/26%201745

Op Note signed by Nathan Williams, MD at 6/28/2026 8:19 AM
Baylor Scott and White
Baylor Scott and White Medical Center - Grapevine

DATE OF SERVICE: 06/25/2026
LOCATION: Baylor Grapevine Hospital.
PREOPERATIVE DIAGNOSIS: Right knee arthroplasty, persistent postoperative incisional drainage.
POSTOPERATIVE DIAGNOSES:
1. Right knee arthroplasty, persistent postoperative incisional drainage.
2. Right knee arthrotomy, partial rupture.
PROCEDURE: Right knee incision and drainage of deep draining sinus as well as repair of partial capsule rupture.
ORTHOPEDIC ATTENDING: Nathan Williams, MD
ASSISTANT: Tony Valponi, Physician Assistant.
ANESTHESIA: General endotracheal.
COMPLICATIONS: None.
ESTIMATED BLOOD LOSS: 20 mL.
SPECIMENS: Three sets of deep aerobic and anaerobic swab cultures, as well as 2 sets of synovial biopsies sent for
aerobic, anaerobic, AFB, and fungal cultures.
DRAINS PLACED: None.
ANTIBIOTIC PROPHYLAXIS: Ancef 2 g IV given after specimen acquisition.
TOURNIQUET TIME: 50 minutes at 300 mmHg.
OPERATIVE IMPLANTS: Smith and Nephew Legion Knee System consisting of:
1. Size 9 mm posterior stabilized high flexion articular insert.
OPERATIVE PROCEDURE: The patient was taken back to the OR suite where he was situated in the supine position on
the OR table. Following induction of general anesthesia, the operative site was confirmed with history as well as
exam. Exam revealed a 3 cm distal skin incisional full-thickness dehiscence. He did have expressible
serosanguineous fluid as well as some spotting on his bed sheets. There was no surrounding erythema. Knee exam
revealed a motion arc of 0/5/90 degrees with stiff endpoints. The right lower extremity was then double prepped and
draped in the typical manner with ChloraPrep solution. Following limb exsanguination and tourniquet inflation, the
inferior most aspect of the incision was opened on either side of the skin dehiscence. A finger sweep was made
medially and a partial deep arthrotomy defect was appreciated. Therefore, the entire incision line was then opened.
The subcuticular layer was elevated medial to reveal the arthrotomy. The distal most 2 inches of the arthrotomy had
opened. The upper majority aspect was still approximated. The arthrotomy was now opened in its entirety. All deep
and superficial suture burden was then removed. The above-mentioned cultures were then taken. Intraarticular
appearance was benign with serosanguineous fluid. A modest amount of fibrinous tissue was present, most
prominent around the infrapatellar pouch. The fibrinous tissue was removed with rongeur as well as manually. Given
the sinus communication with the implants, the plan was for implant washout. The polyethylene was a 9 mm PS poly

was removed giving better access to all implants. Copious irrigation with pulsatile lavage was then done. Then, a
complete implant scrub was performed with chlorhexidine. Irrigation was performed again. Another Betadine scrub
was performed throughout the implant surfaces as well as soft tissue surfaces and then irrigated again. And then a
hydrogen peroxide scrub was performed as a third scrub and then irrigated once again. Tissue surfaces all appeared
viable without contaminated or devascularized tissue. All foreign material had been removed from the knee as far as
suture material. Attention was turned towards final implants. A 9 poly was then selected and impacted obtaining a
good capture in the articular tray. Physical exam with extension stretching revealed 0 degrees of extension to 120
degrees of flexion with the arthrotomy open. The knee was then held in extension. 1 g of powdered vancomycin and
1.2 g of powdered tobramycin was placed intraarticular. The arthrotomy was then closed with multiple figure-of-eight
#1 Vicryls using a total of 10. The most inferior aspect of the arthrotomy, though, could not obtain complete
approximation due to poor tissue quality as well as tissue gapping. However, subcuticular tissue bites on the inferior
aspect of the closure and then closing down to the edge of the patellar tendon. It did provide a nice soft tissue
overlay over the inferior 2 cm of the arthrotomy. This was oversewed with a #2 StrataFix suture obtaining a watertight
closure. Irrigation was performed again. The subcutaneous layers were then closed with interrupted 0 Vicryl deep, 2-0
Vicryl in the dermis and final closure was the skin clips. A Xeroform gauze compressive dressing was applied. The
patient was also placed in a knee immobilizer with anticipated postoperative plan for 4 weeks of knee rest and knee
extension for arthrotomy protection prior to initiating a gentle range of motion regimen. The patient tolerated the
procedure well without any perioperative complications. Postoperative counts were correct.