Vermont Department of Health
Board of Medical Practice
280 State Drive, Waterbury, VT 05671-8320
AHS.VDHMedicalBoard@vermont.gov
802-657-4220

APPLICATION FOR LIMITED TEMPORARY LICENSE
STATEMENT OF SUPERVISING PHYSICIAN

This section must be completed by the Program Director/physician who will be supervising your work in Vermont. This licensed physician will be responsible and liable for all negligent and wrongful acts or omissions of the limited temporary license holder. Termination of appointment as an intern, resident, fellow, or medical officer of such designated hospital or institution shall operate as a revocation of such limited temporary license. This limited temporary license shall be revoked upon the death or legal incompetence of the licensed physician or upon ten days written notice of the licensed physician.

I certify that (name of applicant) ___________________________________ is under my direct supervision and control **in a formal ACGME-approved residency program** at:

Hospital or Institution: ____

Department: ____

Address: ____

City, State, Zip Code: ____

For the period __________________________________to ________________________________.

I state that the above applicant is under my direct supervision and control. I further state that I shall be legally responsible and liable for all negligent or wrongful acts or omissions of this limited temporary license holder.

_______________________________________ Signature of Program Director/Supervising Physician

_______________________________________ Program Director/Supervising Physician's Vermont License Number

_______________________________________ Printed Name of Program Director/Supervising Physician

_______________________________________ Date

_______________________________________ Address

_______________________________________ City, State, Zip Code

PLEASE EMAIL OR MAIL COMPLETED FORM TO THE BOARD'S ADDRESS LISTED ABOVE. THANK YOU.

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APPLICATION FOR LIMITED TEMPORARY LICENSE
STATEMENT OF PROGRAM DIRECTOR

(THIS FORM TO BE USED FOR RESIDENTS PARTICIPATING IN AN AWAY ROTATION ONLY)

I certify that (name of applicant) ___________________________________ is engaged as an intern, resident, fellow, or medical officer at:

Hospital or Institution: ____

Department: ____

Address: ____

City, State, Zip Code: ____

For the period __________________________________to _________________________________.

I further state that (name of applicant) ________________________________ is a resident/fellow in good standing and is scheduled to participate in an **away rotation** at:

Hospital or Institution: ____

Department: ____

Address: ____

City, State, Zip Code: ____

For the period __________________________________to _________________________________. This is an approved rotation within the framework of the residency program.

____ ____

Signature of Program Director Date

____

Printed Name of Program Director

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