UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Affidavit and Authorization for Release of Information

Applicant: In the presence of a notary public, sign this form with attached photo. If you are using FCVS for credentials verification, consider having that form notarized at the same time. Send the separate notarized FCVS form to FCVS. **Do not send this form to FCVS** as doing so will delay your licensure.

Please return to the Vermont Board of Medical Practice, 280 State Drive, Waterbury, VT 05671-8320
AHS.VDHMedicalBoard@vermont.gov

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Applicant Photograph

Securely tape or glue a recent (per the board's instructions) front-view 2" x 2" passport-type color photo of yourself in this square.

_____
Applicant's signature (must be signed in the presence of a notary)

_____
Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)

_____
Date of signature (must correspond to date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left.]

NOTARY

State of _____, County of _____,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this _____ day of _____, 20____.

Notary Public Signature _____ My Notary Commission Expires _____

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Licensure Verification Form (Form #1)

Applicant: Most boards require verification of each professional license ever held. Refer to the licensure verification resource at http://www.fsmb.org/licensure/uniform-application/ to determine fees and preferred verification method(s) for each state medical and osteopathic verifying board. You may use this form for each board that requires a written request for verification. In Section 1, list the board you are applying to for licensure, using the directory at http://www.fsmb.org/policy/contacts to ensure you list the correct name and address. Mail this completed form and any required fee to the verifying board.

Verifying Board: Unless using electronic verification, complete Section 2 below and email or mail this form to the board at the address listed in Section 1. Use an additional sheet of paper if needed for explanation(s).

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type ☐ MD ☐ DO ☐ ____

Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Authorization for Verifying Board: I am applying for a license to practice medicine. The board that I am applying to for licensure requires that this form or an otherwise accepted method of verification be completed by all boards through which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of _____ to provide any and all information pertaining to my license number _____ to the board at the address listed below.

Board name	Vermont Board of Medical Practice
Mailing address	280 State Drive, Waterbury, VT 05671-8320
Email Address	AHS.VDHMedicalBoard@vermont.gov

Applicant signature _____ Date _____

Section 2: Board Verification of Licensure

Name of issuing board or license entity _____

Name of licensee (last, first, middle, suffix) _____

License type _____ License number _____ Issue date _____ Expiration date _____

1. Is this license current? If not current, please explain: ☐ Yes ☐ No

2. Have formal disciplinary proceedings been initiated against this applicant's license by a disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form. ☐ Yes ☐ No ☐ Cannot answer under state law

3. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant's license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form. ☐ Yes ☐ No ☐ Cannot answer under state law

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature _____

Print name _____

Title _____ Date _____

Phone number _____ Fax number _____

Email _____

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

Please email or mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

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

CERTIFICATE OF MEDICAL EDUCATION

To be completed by an **officer of your school of medicine**

I hereby certify that _____ was admitted to the
(Name)

_____ School of Medicine in

_____ on _____
(City, State)

And completed all requirements for graduation on _____.
(Date)

A _____ was granted/will be granted on
(Specify Certificate/Diploma/Degree)

_____.
(Date)

Date: _____

Signed: _____

[AFFIX SEAL]

Printed Name: _____

Title:_____

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.

Vermont Department of Health
Board of Medical Practice
280 State Drive, Waterbury, VT 05671-8320
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802-657-4220

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

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