Vermont Department of Health – Board of Medical Practice
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
medicalboard@vdh.state.vt.us
802-657-4220 or 800-745-7371

Dear Doctor:

The Board of Medical Practice is pleased that you have chosen to apply for licensure in Vermont. This packet contains all the materials you will need to complete your application for licensure.

Uniform Application for Physician Licensure (UA):

The Board has adopted the Uniform Application for Physician Licensure (UA) into its Medical Licensing Application. This form will make it easier for physicians to apply for licensure in states that utilize this form (UA). The Vermont Board of Medical Practice is one of the first boards to incorporate the UA into its state license application.

Please utilize the Instructions & Helpful Hints to complete the application. It is recommended that you review the Board's rules to ensure that you meet the eligibility requirements on our website at http://www.healthvermont.gov/hc/med_board/bmp.aspx. The following factors may negatively impact the application process: illegibility, incomplete or inaccurate information, failure to enclose the required fee, and failure to arrange for the required direct source verifications. Failure to answer all questions completely or accurately, or the omission or falsification of materials or facts may be cause for denial of your application, disciplinary action after licensure, or delay your license from being issued. If you have questions about the application or attached forms, please contact this office before you return the application.

The Federation Credentials Verification Service (FCVS):

The Board accepts the use of FCVS to primary source verify core physician credentials as part of the licensure process. If using FCVS, the Federation of State Medical Boards (FSMB) credential verification service, the Board recommends completing the FCVS application first or simultaneously with the Vermont Board of Medical Practice Application for License.

FCVS is a service of the (FSMB) and was created to help license portability for physicians. FSMB is a national not-for-profit organization that provides this service for state medical licensing authorities in the United States, Guam, Puerto Rico and the Virgin Islands, (contact FCVS for a complete state listing of requiring and accepting licensing authorities).

By using FCVS to verify your credentials, you will establish a permanent repository of primary source-verified documents. Once your file is established, these documents will be available for your use at any time. The documents that FCVS verifies and stores for you fall into the following categories:

- Identity
- Medical Education
- Postgraduate Training
- Examination History (state licensing authorities only)
- Board Action/Disciplinary History
- ECFMG Certification (if applicable)
- ABMS Board Certification

You pay FCVS a fee for gathering and forwarding your Initial or Subsequent Profile, and can also forward additional Profiles to other licensing boards and health care entities of your choice. Average processing time to collect and forward your initial Profile is approximately 8-12 weeks. Once your permanent file is established, updated Subsequent Profiles are typically forwarded within 2-3 weeks. Most physicians will benefit greatly throughout their career by having their credentials permanently stored and easily accessible.

Contact FCVS at 888-ASK-FCVS (or outside the U.S. at 1-817- 868-5000) for additional information regarding the service and its fees. If your credentials are already on file with FCVS, contact FCVS directly at the above number to have them forwarded to the Vermont Board of Medical Practice.

Sincerely,

Vermont Board of Medical Practice

Instructions for completing the Application for Licensure to Practice Medicine in Vermont

Application Fees. Enclose the $625 fee (Payable to the Vermont Department of Health). This fee is non-refundable.

Examination Transcript. Request that a transcript of your exam scores be sent directly to the Vermont Department of Health – Board of Medical Practice from the appropriate examining agency. **If you are using FCVS, they will obtain your exam score transcripts based on the information you provide in the FCVS application.** For those that have taken any component of the NBME in conjunction with another exam (USMLE/FLEX), you must request the transcripts from the NBME.

- USMLE/FLEX/SPEX – Request transcripts online at www.fsmb.org or call (817)868-4000.
- NBME – Download the request form at www.nbme.org/pdf/endorse.pdf or call (215)590-9500.
- State Exam – Contact the state licensing board in which you took the exam.
- LMCC – Call (613)521-6012

ECFMG (if applicable): Request that a Confirmation Report of ECFMG Certification be sent directly to the Vermont Department of Health – Board of Medical Practice from the ECFMG. **If you are using FCVS, you do not need to contact the ECFMG. You will complete the ECFMG release forms included in the FCVS application and FCVS will coordinate with the ECFMG to obtain your certification.**

- ECFMG – Download the request form at www.ecfmg.org/cvs/forms/282asb.pdf or call (215)-386-5900

American Medical Association Profile. Request an American Medical Association Profile. You will need to complete the AMA Physician Profile Service Order Form.. This form must be sent by the applicant directly to the AMA. Download the requests forms at:

- Physician Profile Service Form: https://profiles.ama-assn.org/amaprofiles/info/pdf/profileorderform.pdf
- AMA – Call at (800) 665-2882

National Practitioner Data Bank Self Query. Effective September 1, 1990, the Federal government opened the National Practitioner Data Bank. This data bank, mandated by Congress, tracks regulatory board disciplinary actions, certain actions resulting from peer review and malpractice payments. **You must self query this data bank on your own as part of the application process for a Vermont medical license**. Simply query the data bank using the instructions below and when you receive the response, **SEND THE ORIGINAL, UNALTERED** response to the Board. You may keep a photocopy if you wish.

- Log –on to web site for NPDB: www.npdb-hipdb.com
- Select "Report to and Query the Data Banks"
- Click on "Perform a Self-Query"
- Select the type of self-query you wish to perform, "Individual or Organization"
- Provide ALL required information and credit card information (Checks and Cash are not accepted)
- Once all information is complete, click CONTINUE. A formatted copy of the self-query is generated immediately with a Data Bank Control Number (DCN) listed at the top of the page. Print this formatted copy, and keep the DCN to monitor the processing status of your self-query. To print a query from the IQRS, you must have Adobe Acrobat Reader version 4.0 or higher installed on your computer.
- To complete the self-query process, you must sign the formatted self-query application in the presence of a notary public and mail it to the NPDB-HIPDB. Self-queries received without notarization or with an incomplete notarization are rejected. Notarized forms that are missing credit card information will be rejected.

Application Instructions. Complete the application as instructed in each section. Please see below for additional instructions and documents that need to be submitted to the Board.

Additional Instructions – Please see below additional instructions for completing specific sections of the Uniform Application (UA).

- Malpractice Claims (UA, Section 11, Page 10) – Please **DO NOT** complete this section. You will complete malpractice claims information in Addendum 2 (Addendum Pages 3-5).
- Application for Physician Licensure Instructions Checklist (UA Checklist) – The checklist states that you must submit a certified birth certificate or a current, valid passport. **You must submit a certified (NOT NOTARIZED) Birth Certificate, the Board will not accept a current, valid passport.**

Additional Documents – submit the following documents to the Board along with the completed application (if applicable):

- Certified Copy of Birth Certificate. **If you are using FCVS, you do not need to submit this document to the Board. This will be collected by FCVS as part of your FCVS Physician Profile.**

  ****A passport is NOT Acceptable****
- Copy of American Specialty Board Certificate(s).
- Curriculum vitae (CV/Resume).

Addendum Instructions. Complete the addendums as instructed below. If anything in not applicable, please state N/A as a response.

Addendum 1 (Addendum 1 Pages 1-4). These questions must be completed by the applicant. Please either type or print your responses. If additional space is required, please attach a separate sheet referencing the question number. Return this form to the Board along with the completed application.

Addendum 2 (Addendum 2 Pages 1-5). These questions must be completed by the applicant. Please either type or print your responses. If additional space is required, please attach a separate sheet referencing the question number. Return this form to the Board along with the completed application.

Addendum 3 (Addendum 3 Pages 1 and 2). This question must be completed by the applicant. Please either type or print your responses. If additional space is required, please attach a separate sheet referencing the question number. Return this form to the Board along with the completed application. This information is confidential and is exempt from public disclosure.

Addendum 4 and 4A .

Addendum 4 (Addendum 4 Page 1) – This form must be completed by the physician. Please list three references of licensed physicians that can attest to you character and professional abilities. Return this form to the Board along with the completed application.

Addendum 4A (Addendum 4A Pages 1 and 2) – This form must be completed by the individual providing the reference. Make three (3) copies of this Reference Form and mail a copy to each individual that you have listed as a reference. The completed reference form must be returned directly to the board.

Addendum 5 (Addendum 5 Page 1). This form must be completed by the applicant. Please complete this form as instructed in each section. Please include requested documents if applicable. Return this form to the Board along with the completed application.

Addendum 6 (Addendum 6 Pages 1-2). This form must be completed by the applicant. Return this form to the Board along with the completed application.

Addendum 7 (Addendum 7 Page 1). This form must be completed by the applicant. Return this form to the Board along with the completed application.

Additional Instructions and Helpful Hints:

- Please print legibly or type
- Answer all questions completely
- Make a copy of the completed application and addendums for your records
- Please be sure to write your name on each attachment
- Do not delegate this important task to an employee. False statements on this form are grounds for unprofessional conduct
- Personal Interview. Once your application is complete, you will receive the name, address, and telephone number of a member of the Board of Medical Practice to contact and schedule your interview. The personal interview cannot be conducted by telephone.
- **PUBLIC ADDRESS: The Board can only enter ONE address into the system. Please be sure to provide a mailing address that the Board can contact you at and that you do not mind being public record.**

Specialty Codes List

(primary care specialties in boldface)

0101	Allergy and Immunology	1501	Anatomic & Clinical Pathology	2201	Surgery
0102	Clinical & Laboratory Immunology	1502	Anatomic Pathology	2202	Surgery of the Hand
0201	Anesthesiology	1503	Clinical Pathology	2203	Pediatric Surgery
0202	Critical Care Medicine	1504	Blood Banking/Transfusion Medicine	2204	Surgical Critical Care
0203	Pain Management	1505	Chemical Pathology	2205	General Vascular Surgery
0301	Colon & Rectal Surgery	1506	Cytopathology	2301	Thoracic Surgery
0401	Dermatology	1507	Dermatopathology	2401	Urology
0402	Dermatopathology	1508	Forensic Pathology	4001	Abdominal Surgery
0403	Clinical & Laboratory Dermatology	1509	Hematology	4002	Acupuncture
0404	Dermatological Immunology	1510	Immunopathology	4003	Addiction Medicine
0501	Emergency Medicine	1511	Medical Microbiology	4004	Adult Reconstructive Orthopedics
0502	Medical Toxicology	1512	Neuroathology	4005	Allergy
0503	Pediatric Emergency Medicine	1513	Pediatric Pathology	4006	Cardiovascular Surgery
0504	Sports Medicine	1601	Pediatrics	4007	Clinical Pharmacology
0601	Family Practice	1602	Adolescent Medicine	4008	Diabetes
0602	Geriatric Medicine	1603	Clinical & Laboratory Immunology	4009	Facial Plastic Surgery
0603	Sports Medicine	1604	Medical Toxicology	4010	General Practice
0701	Internal Medicine	1605	Neonatal-Perinatal Medicine	4011	Gynecology
0702	Adolescent Medicine	1606	Pediatric Cardiology	4012	Head & Neck Surgery
0703	Cardiac Electrophysiology	1607	Pediatric Critical Care Medicine	4013	Hepatology
0704	Cardiovascular Disease	1608	Pediatric Emergency Medicine	4014	Homeopathic Medicine
0705	Critical Care Medicine	1609	Pediatric Endocrinology	4015	Immunology
0706	Clinical & Lab Immunology	1610	Pediatric Gastroenterology	4016	Legal Medicine
0707	Endocrinology Diabetes & Metabolism	1611	Pediatric Hematology-Oncology	4017	Musculoskeletal Oncology
0708	Gastroenterology	1612	Pediatric Infectious Disease	4018	Neuroradiology
0709	Geriatric Medicine	1613	Pediatric Nephrology	4019	Nutrition
0710	Hematology	1614	Pediatric Pulmonology	4020	Obstetrics
0711	Infectious Disease	1615	Pediatric Rheumatology	4021	Oral & Maxillofacial Surgery
0712	Medical Oncology	1616	Pediatric Sports Medicine	4022	Orthopedic Surgery of the Spine
0713	Nephrology	1617	Children with Special Health Needs	4023	Orthopedic Trauma
0714	Pulmonary Disease	1701	Physical Medicine & Rehabilitation	4024	Pain Medicine
0715	Rheumatology	1801	Plastic Surgery	4025	Pediatric Allergy
0716	Sports Medicine	1802	Hand Surgery	4026	Pediatric Ophthalmology
0801	Medical Genetics	1901	Preventive Medicine	4027	Pediatric Orthopedics
0802	Clinical Biochemical Genetics	1902	Aerospace Medicine	4028	Pediatric Surgery (Neurology)
0803	Clinical Biochemical/Molecular Genetics	1903	Occupational Medicine	4029	Pediatric Urology
0804	Clinical Cytogenetics	1904	Public Health & General Preventive	4030	Psychoanalysis
0805	Clinical Genetics (Md)	1905	Medical Toxicology	4031	Radioisotopic Pathology
0806	Clinical Molecular Genetics	1906	Underseas Medicine	4032	Sports Medicine (Orthopedic Surgery)
0901	Neurological Surgery		Psychiatry & Neurology (Board Name – Not A Specialty)	4033	Traumatic Surgery
0902	Critical Care Medicine	2001	Psychiatry	4034	Sleep Medicine
1001	Nuclear Medicine	2002	Neurology	9001	Rotating Internship (Residency)
1101	Obstetrics & Gynecology	2003	Neurology With Special Qualifications in Child Neurology	9999	Other – Please Specify
1102	Critical Care Medicine	2004	Addiction Psychiatry		
1103	Gynecologic Oncology	2005	Child & Adolescent Psychiatry		
1104	Maternal & Fetal Medicine	2006	Forensic Psychiatry		
1105	Reproductive Endocrinology	2007	Geriatric Psychiatry		
1201	Ophthalmology	2008	Clinical Neurophysiology		
1301	Orthopaedic Surgery	2101	Radiology		
1302	Hand Surgery	2102	Diagnostic Radiology		
1401	Otolaryngology	2103	Radiation Oncology		
1402	Otology/Neurotology	2104	Radiological Physics		
1403	Pediatric Otolaryngology	2105	Nuclear Radiology		
		2106	Pediatric Radiology		
		2107	Vascular & Interventional Radiology		

Application for Physician Licensure Instructions

Checklist

After completing the enclosed application, you are responsible for submitting the application along with certain documents. There are two different checklists below; one when you are using the Federation Credentials Verification Service (FCVS) and one when you are not using FCVS. Please use the checklist that applies to you.

	State does not require FCVS and you choose not to use FCVS	State requires or accepts FCVS and you are using FCVS
Completed Application (including state addendums)	☐	☐
State Licensure Verification form sent to the Board from all states in which you have ever held any healthcare license	☐	☐
Enclose the completed "Affidavit and Authorization for Release of Information" form with this application when submitting it to the Board	☐	☐
Notarized copy of birth certificate or current, valid passport	☐	completed via FCVS
Medical Education Verification form sent to the Board by all medical schools attended – include a copy of your diploma (must be sealed by your school)	☐	completed via FCVS
Medical school transcripts sent to the Board by your medical school	☐	completed via FCVS
Fifth Pathway (if applicable) form sent to the Board from the medical school and institution – include a copy of your diploma (must be sealed by your school)	☐	completed via FCVS
Postgraduate Training Verification form sent to the Board from all programs you attended	☐	completed via FCVS
Enclose a copy of your postgraduate training certificate with this application when submitting it to the Board	☐	completed via FCVS
Examination transcripts sent to the Board	☐	completed via FCVS
ECFMG (if applicable) Status Report sent to the Board	☐	completed via FCVS

It is your responsibility to 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 being granted to you by the board.

Application for Physician Licensure

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name _____

First Name _____

Middle Name _____

Suffix _____

Maiden Name _____

M.D. ☐ D.O. ☐

_____

All other names used

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website; therefore, you should consider what your preferred address is for these purposes.

Practice Address
☐ Public Access
☐ Mailing

Street _____

_____

_____

City _____ State/Province _____ ZIP Code _____

Telephone _____ Fax _____

E-mail address _____

Alternate Phone (e.g. pager or cell phone) _____

Home Address
☐ Public Access
☐ Mailing

Street _____

_____

_____

City _____ State/Province _____ ZIP Code _____

Telephone _____ Fax _____

E-mail address _____

Alternate Phone (e.g. pager or cell phone) _____

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

/ /
Date of Birth (mm/dd/yyyy) | Birth City | Birth State/Province | Birth Country

Gender | Social Security Number | NPI Number | Are you a U.S. Citizen? ☐ Yes ☐ No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI , please go to http://www.cms.hhs.gov/NationalProvIdentStand/.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School (attach additional pages if necessary)

1. School Name _____
Address _____
City _____ State/Province _____ ZIP Code _____
Country _____
Attendance Dates (From – To) _____
Graduation Date _____ Degree _____

2. School Name _____
Address _____
City _____ State/Province _____ ZIP Code _____
Country _____
Attendance Dates (From – To) _____
Graduation Date _____ Degree _____

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

1. Medical School Name _____

Address _____

City _____ State/Province _____ ZIP Code _____

Country _____

Attendance Dates (From – To) _____

Graduation Date _____ Degree _____

2. Medical School Name _____

Address _____

City _____ State/Province _____ ZIP Code _____

Country _____

Attendance Dates (From – To) _____

Graduation Date _____ Degree _____

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. Additionally, the postgraduate program must provide this Board with the Program Director's recommendation letter. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training (copy and attach additional pages if necessary)

Complete name and address of hospital where training was conducted (Do Not Abbreviate)

1.Hospital Name_____

Hospital Address_____

City _____

State/Province _____

ZIP Code _____

Country _____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Accredited by: ☐ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other_____

Department/Specialty:_____

From: / To: / Successfully Completed? Yes☐ No☐ In Progress☐

Month Year Month Year

2.Hospital Name_____

Hospital Address_____

City _____

State/Province _____

ZIP Code_____

Country _____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Accredited by: ☐ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other_____

Department/Specialty:_____

From: / To: / Successfully Completed? Yes☐ No☐ In Progress☐

Month Year Month Year

Applicant Name: _____ Date: _____

6. Postgraduate Training (continued)

3.Hospital Name_____

Hospital Address_____

City_____

State/Province_____

ZIP Code_____

Country_____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Accredited by: ☐ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other_____

Department/Specialty:_____

From: ____/____ To: ____/____ Successfully Completed? Yes☐ No☐ In Progress☐

Month Year Month Year

4.Hospital Name_____

Hospital Address_____

City_____

State/Province_____

ZIP Code_____

Country_____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐Other

Accredited by: ☐ ACGME ☐AOA ☐ RCPSC ☐ None ☐ Other_____

Department/Specialty:_____

From: ____/____ To: ____/____ Successfully Completed? Yes ☐ No ☐ In Progress ☐

Month Year Month Year

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.). If additional space is necessary, please enclose a separate sheet with your application and include all the information below.

Examination	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)	Number of attempts
State Board Exam _____ State	_____	☐ P ☐ F	_____
FLEX Pre-1985	_____	☐ P ☐ F	_____
FLEX Component 1	_____	☐ P ☐ F	_____
FLEX Component 2	_____	☐ P ☐ F	_____
LMCC – Single	_____	☐ P ☐ F	_____
LMCC – Part I	_____	☐ P ☐ F	_____
LMCC – Part II	_____	☐ P ☐ F	_____
NBME Part I	_____	☐ P ☐ F	_____
NBME Part II	_____	☐ P ☐ F	_____
NBME Part III	_____	☐ P ☐ F	_____
SPEX	_____	☐ P ☐ F	_____
NBOME Part I	_____	☐ P ☐ F	_____
NBOME Part II	_____	☐ P ☐ F	_____
NBOME Part III	_____	☐ P ☐ F	_____
COMLEX-USA Level 1	_____	☐ P ☐ F	_____
COMLEX-USA Level 2, CE	_____	☐ P ☐ F	_____
COMLEX-USA Level 2, PE	_____	☐ P ☐ F	_____
COMLEX-USA Level 3	_____	☐ P ☐ F	_____
COMVEX	_____	☐ P ☐ F	_____
USMLE Step I	_____	☐ P ☐ F	_____
USMLE Step II, CS	_____	☐ P ☐ F	_____
USMLE Step II, CK	_____	☐ P ☐ F	_____
USMLE Step III	_____	☐ P ☐ F	_____

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG website at www.ecfmg.org.

8. ECFMG (if applicable)

Certificate Number _____ Issue Date _____ Valid Through Date _____

9. State/Province Professional Licensure whether temporary or permanent: List all states and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license or certification. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states or provinces in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure – MD or DO only – attach additional pages if necessary

1. State/Province _____ Type _____ (MD, DO) License Number _____ Status _____ Issue Date _____
2. State/Province _____ Type _____ (MD, DO) License Number _____ Status _____ Issue Date _____
3. State/Province _____ Type _____ (MD, DO) License Number _____ Status _____ Issue Date _____
4. State/Province _____ Type _____ (MD, DO) License Number _____ Status _____ Issue Date _____
5. State/Province _____ Type _____ (MD, DO) License Number _____ Status _____ Issue Date _____
6. State/Province _____ Type _____ (MD, DO) License Number _____ Status _____ Issue Date _____
7. State/Province _____ Type _____ (MD, DO) License Number _____ Status _____ Issue Date _____
8. State/Province _____ Type _____ (MD, DO) License Number _____ Status _____ Issue Date _____
9. State/Province _____ Type _____ (MD, DO) License Number _____ Status _____ Issue Date _____
10. State/Province _____ Type _____ (MD, DO) License Number _____ Status _____ Issue Date _____

Applicant Name: _____ Date: _____

All Other Health Care Licensure/Certification (e.g., RN, PA, etc.) - attach additional pages if necessary.

1. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
2. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
3. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
4. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
5. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____

10. Chronology of Activities: List ALL activities (medical, non-medical and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM**. Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities (copy and attach additional pages if necessary)

Dates: From/To	Practice/Employment
1. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
2. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____

Dates: From/To	Practice/Employment
3. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
4. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
5. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
6. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____

Applicant Name: _____ Date: _____

11. Malpractice Liability Claims Information (copy this form to report multiple claims)

Name of patient involved: _____

In which state did the action take place? _____ Case number (if applicable) _____

Which court? _____
(If private compromise or settled before initiation of civil action, state here)

Current status of claim: _____

☐ Open (pending) ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out)
☐ Other _____

Amount of judgment or settlement $ _____ Amount paid on your behalf $ _____

Month and year of event precipitating claim: _____

Month and year of lawsuit: _____

Insurance carrier at time: _____

What is/or was your status? ☐ Primary defendant ☐ Co-defendant ☐ Other _____

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit
And
Authorization For Release of Information

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 Application for Physician 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's Signature (must be signed in the presence of a notary)

_____
Applicant's Printed Last Name

_____
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

_____
Date of Signature

Applicant Photograph

Securely tape or glue in this square a current front-view 2" x 2" passport-type color photograph of yourself.

NOTARY

Dated_____ Signed_____

State of_____ County of _____

SUBSCRIBED AND SWORN TO before me this_____ day of, _____ 20____.

My commission expires:_____ (NOTARY PUBLIC SIGNATURE & SEAL)

Applicant Name: _____ Date: _____

Licensure Verification Form **Form #1**
(Copy this form for multiple licenses)

I am applying for a license to practice medicine. The Board requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the following Board: _____

TO BE COMPLETED BY APPLICANT

Applicant Name: _____
Last First Middle Suffix

Date of Birth: _____ Social Security Number: _____ License Number: _____
(From State/Province you are sending this form to)

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

I hereby authorize the licensing agency of the State/Province of _____ to furnish the information to the Board indicated below.

Signature of Applicant _____ Date _____

Board Name: _____

Address: _____
Street City State/Province ZIP Code

TO BE COMPLETED BY STATE LICENSING BOARD OR CANADIAN PROVINCE

Name of Licensee: _____
Last First Middle Suffix

License Type: _____ License #: _____ Issue Date: _____ Expiration Date: _____

Is this license current? ☐Yes ☐No If No, please explain: _____

1) Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?
☐Yes ☐No ☐Cannot answer under state law
If Yes, please explain: _____

2) 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?
☐ Yes ☐ No ☐ Cannot answer under state law
If Yes, please explain: _____

Affix Board Seal Here

Board Authorized Signature: _____

Title: _____

Date: _____

Please return this form to the Board listed at the top of this form.

Applicant Name: _____ Date: _____

Medical School Verification – Page 1 of 4

(Copy this form for multiple schools)

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to your medical school along with a copy of your diploma. Request the Dean or designated official to complete Section 3 of this form and return this form, the sealed copy of your diploma (to be sealed by your medical school) and a copy of your official transcripts directly to this Board.

Section 1: Applicant Information

Last Name: _____

First Name: _____

Middle Name: _____

Suffix: _____

Name if different when diploma awarded: _____

Social Security Number: _____

Date of Birth: _____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the medical school below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

_____ _____

Applicant's Signature Date

Section 2: Instructions to the Dean or designated official of medical school

Please complete Section 3 of this form, certify the enclosed copy of the above named applicant's diploma by placing your school seal on it, enclose an offical copy of the transcripts of the above named physician and forward all of this information directly to this Board to the following address:

Board Name: _____

Address _____

City _____

State/Province _____

ZIP Code _____

Medical School Verification – Page 2 of 4
(Copy this form for multiple schools)

Section 3: Medical School Verification

Medical School Name: _____

School name if different when the above applicant attended: _____

Medical School Address: _____

Street City State/Province ZIP Code

Hours of undergraduate education required for admission into your school: _____

Applicant's Attendance Dates: From _____ To _____ Graduation Date: _____ Degree: _____

(Indicate N/A if not applicable) (Indicate N/A if not applicable)

Total weeks of education applicant attended your school: _____

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: _____

AFFIX INSTITUTIONAL SEAL HERE Title: _____

(If no seal is available, this form must be notarized) Date: _____

Phone number: _____ Fax: _____

E-mail: _____

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

Medical School Verification – Page 3 of 4
(Copy this form for multiple schools)

1. Does this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?

Response ☐ YES ☐ NO

If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

Please Specify: _____

2. Does this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response ☐YES ☐NO

If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
☐ Academic Probation		
☐ Probation for unprofessional conduct/behavioral reasons		
☐ Probation for other reason		

Please specify reason: _____

3. Does this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response ☐ YES ☐ NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s): _____

Medical School Verification – Page 4 of 4

(Copy this form for multiple schools)

4. Does this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? Response ☐ YES ☐ NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Does this individual's official records reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?
Response ☐ YES ☐ NO

If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

Postgraduate Training Verification - Page 1 of 3

(Copy this form for multiple programs)

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to your training program. Request the Program Director or designated official to complete Section 3 of this form and return this form and the Program Director's recommendation letter directly to this Board.

Section 1: Applicant Information

Last Name: _____

First Name: _____

Middle Name: _____

Suffix: _____

Name if different when diploma awarded: _____

Social Security Number: _____

Date of Birth: _____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

_____ _____

Applicant's Signature Date

Section 2: Instructions to the PROGRAM DIRECTOR or designated official of POSTGRADUATE TRAINING PROGRAM.

Please complete Section 3 of this form and attach a recommendation letter from the Program Director and forward this information directly to this Board at the following address:

Board Name: _____

Address _____

City _____

State/Province _____

ZIP Code _____

Postgraduate Training Verification - Page 2 of 3
(Copy this form for multiple programs)

Section 3: Postgraduate Training Verification

Institution Name: _____

Institution Address: _____

Street _____

City _____

State/Province _____

ZIP Code _____

Affiliated Medical School Name: _____

Program Type/Specialty: _____

Postgraduate Year: _____

☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Chief Resident

Other: _____

From Date: _____/_____/_____ To Date: _____/_____/_____

Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
(The definition of Successfully Completed is: In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?)

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Did this individual ever take a leave of absence or break from his/her training?	☐ Yes	☐ No
Was this individual ever placed on probation?	☐ Yes	☐ No
Was this individual ever disciplined or placed under investigation?	☐ Yes	☐ No
Were any negative reports for behavioral reasons ever filed by instructors?	☐ Yes	☐ No
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	☐ Yes	☐ No

Please explain any "Yes" response from above (attach additional pages if necessary): _____

_____

_____

_____

Postgraduate Training Verification - Page 3 of 3

(Copy this form for multiple programs)

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: _____

E-mail: _____

AFFIX INSTITUTIONAL SEAL HERE (If no seal is available, this form must be notarized)

If you completed Section 5 of the application, you must complete this form

Fifth Pathway Verification

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to the director of your 5th Pathway Program. Request the Program Director or designated official to complete Section 3 of this form and return this form and the Program Director's recommendation letter directly to this Board.

Section 1: Applicant Information

Last Name: _____ Suffix: _____

First Name: _____ Middle Name: _____

Name if different when diploma awarded: _____

Social Security Number: _____

Date of Birth: _____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

_____ _____

Applicant's Signature Date

Section 2: Instructions to the PROGRAM DIRECTOR or designated official

Please complete Section 3 of this form and attach a recommendation letter from the Program Director and forward this information directly to this Board at the following address:

Board Name: _____

Address _____

City _____

State/Province _____ ZIP Code _____

Section 3: Medical School Verification

Medical School Name: _____

School name if different when the above applicant attended: _____

Applicant's Attendance Dates: From _____ To _____ Program Completion Date: _____
(Indicate N/A if not applicable)

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: _____

AFFIX INSTITUTIONAL SEAL HERE

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

Title: _____

Date: _____

Phone number: _____

Fax: _____

E-mail: _____

Addendum 1

Application for License to Practice Medicine in Vermont
Physician – Medical Doctor

1. Were you in active clinical practice in the past 12 months? _____Yes _____No

2. Years of Practice [See 26 VSA § 1368(a)(10)]

Month and year you started practicing as a physician (excluding residency/fellowship training)?

_____

3. Have you ever held a Vermont Limited Temporary License: _____Yes _____No

If yes, License Number:_____

4. Premedical Education

Please provide the names of premedical schools you attended and the dates of attendance.

Name and location of institution Degree From To

_____

_____

If necessary, please use an additional sheet and check this box: .....☐

5. Specialty Board Certification

Enter up to three specialty codes from the ***Specialty Codes List*** on Instructions page 3. List your primary specialty first. If you cannot locate a specialty, please write the specialty name in the space provided.

Specialty Code				Specialty Name (if code unknown)	Name of Board	Board Certified	Year Certified	Year Recertified
						❑ yes ❑ no		
						❑ yes ❑ no		
						❑ yes ❑ no		

6. Practice

Do you have hospital privileges?_____Yes_____No

List all hospitals where you have, or previously have had, staff privileges. Include name, address, and dates.

Name Address From/To Specialty/Subspecialty

_____

_____

_____

Statutory Profile Questions

Vermont law, 26 VSA § 1368, creates a data repository within the Department of Health. Under this law, the Department must collect certain information to create individual profiles on all health care professionals licensed, certified, or registered by the Department pursuant to Title 26 of the VSA. Please try to answer the following questions as best as you can. You will receive a copy of your profile prior to its initial release to the public and each time the profile is modified or amended. You will be given a reasonable time to correct factual inaccuracies that appear in such profile. As noted below, certain questions do not need to be answered.

It is very important for us to receive photostatic copies of court papers, licensing authority decisions, and other documents relevant to the questions below in order to have a true and accurate description of actions taken.

7. Criminal Convictions [See 26 VSA § 1368(a)(1)]

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted. For purposes of this question, "convicted" means that you pleaded guilty or that you were found or adjudged guilty by a court of competent jurisdiction. Please provide copies of papers fully documenting the convictions.

(Conviction Date)	(Court)	(City/State)	(Crime)
(Conviction Date)	(Court)	(City/State)	(Crime)

If necessary, please use an additional sheet and check this box: .....☐

8. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)]

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without finding by a court of competent jurisdiction. Please provide copies of papers fully documenting these matters.

(Conviction Date)	(Court)	(City/State)	(Charge)
(Conviction Date)	(Court)	(City/State)	(Charge)

If necessary, please use an additional sheet and check this box: .....☐

9. Vermont Board of Medical Practice Matters [See 26 VSA § 1368(a)(3)]

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed.

(Date)	(Final Disposition – Summary)

If necessary, please use an additional sheet and check this box: .....☐

10. Licensing Authority Matters in Other States [See 26 VSA § 1368(a)(4)]

Please provide a description of all formal charges served by licensing authorities of other states, the findings, conclusions, and orders of such licensing authorities, and final disposition of such matters by the courts, if appealed, in those states. Please provide copies of papers fully documenting these matters.

(Date of Final Disposition)	(Licensing or Certification Authority)	(Court)	(City/State)	(Nature of Charge)

If necessary, please use an additional sheet and check this box: .....☐

11. Restriction of Hospital Privileges [See 26 VSA § 1368(a)(5)]

A. Revocation/Involuntary Restrictions

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you. Please provide copies of papers fully documenting these matters.

(Date) (Hospital) (State) (Nature of Restriction) (Reason for Restriction)

If necessary, please use an additional sheet and check this box: .....☐

B. Other Restrictions

Please provide a description of all resignations from, or nonrenewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital. Please provide copies of papers fully documenting these matters.

(Date) (Hospital) (State)

(Nature of Action) (Action) (Reason for Action)

☐ In Lieu ☐ In Settlement

If necessary, please use an additional sheet and check this box: .....☐

12. Appointments/Teaching [See 26 VSA § 1368(a)(12)]

Note: Answering #12 is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. Appointments

Please provide information about your appointments to medical school or professional school faculties.

(School) (City) (State) (Nature of Appointment) From (year) To (year)

(School) (City) (State) (Nature of Appointment) From (year) To (year)

If necessary, please use an additional sheet and check this box: .....☐

B. Teaching

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years.

(School/Institution) (City) (State) (Nature of Teaching) From (year) To (year)

(School/Institution) (City) (State) (Nature of Teaching) From (year) To (year)

If necessary, please use an additional sheet and check this box: .....☐

13. Publications [See 26 VSA § 1368(a)(13)]

Note: Answering #13 is optional. By answering, you are granting permission to have this information posted on the web.

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years.

(Title) (Publication) (Year)

(Title) (Publication) (Year)

If necessary, please use an additional sheet and check this box: .....☐

14. Activities [See 26 VSA § 1368(a)(14)]

Note: Answering #14 is optional. By answering, you are granting permission to have this information posted on the web.

Please provide information regarding your professional or community service activities and awards.

(Activities or Awards)

If necessary, please use an additional sheet and check this box: .....☐

15. Interview

A. In which part of Vermont would you prefer to be interviewed? Northern-Burlington/St. Albans area, Southern-Rutland, Springfield, Central-Montpelier/Randolph, or using webcam (Please be specific)?

B. When are you scheduled to begin work in Vermont?

C. What is going to be the primary location of your practice setting?

D. Provide a brief description of your anticipated practice:

E. What has been your physical residence (city, state) in the past ten years?

Addendum 2

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

16. Have you ever applied for and been denied a license to practice medicine or any other healing art? _____Yes_____No

17. Have you ever withdrawn an application for a license to practice medicine or any other healing art? _____Yes_____No

Withdrawal or denial of License – Attach documents

State_____Year_____

Circumstances under which license was withdrawn, denied, revoked, not renewed, or otherwise terminated_____

_____

_____

18. Have you ever voluntarily surrendered or resigned a license to practice medicine or any other healing art in lieu of disciplinary action or for any other reason? _____Yes_____No

Voluntarily surrendered or resigned a license to practice medicine or any healing art – Attach documents

State_____Year_____

Circumstances_____

_____

_____

19. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local?) _____Yes_____No

Disciplinary charges or action – Attach documents

Name of organization involved_____Date_____

Duration_____

Action taken (circle all that apply)

01 Revocation of right or privilege	12 Leave of absence
02 Suspension of right or privilege	13 Withdrawal of an application
03 Censure	14 Termination or non-renewal of contract
04 Written reprimand or admonition	15 Medical Records Suspension
05 Restriction of right or privilege	16 Probation
06 Non-renewal of right or privilege	17 Assurance of Discontinuances
07 Fine	18 Consent Agreement
08 Required performance of public service	19 Letter of Agreement
09 Education/Training/Counseling/Monitoring	20 Expulsion from Membership
10 Denial of rights or privileges	21 Reprimand
11 Resignation	22 Other (specify)_____

Circumstances_____

_____

_____

_____

20. Have you ever been denied the privilege of taking an examination before any state medical examining board? _____Yes_____No

Denial of examination privileges – Attach documents

State_____

Circumstances under which examination privileges denied_____

_____

_____

21. Have you ever discontinued your education, training, or clinical practice for a period of more than three months? NOT including premedical education. _____Yes_____No

If yes, Please explain:_____

_____

_____

22. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion? _____Yes_____No

Residency Training Program(s) not completed – discontinued education, training, practice – Attach documents

Residency Training Program(s)_____

Location of Programs_____Year_____

Circumstances_____

_____

_____

_____

23. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you? _____Yes_____No

Affecting Health Care Institution Staff Privileges, Employment or Appointment – Attach documents

Institution Involved_____

Location_____Year_____

Circumstances_____

_____

24. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time? _____Yes_____No

Privilege to prescribe controlled substances – Attach documents

Name of organization involved_____

Type of restriction_____Date_____

Circumstances of restriction_____

_____

_____

_____

_____

25. Are you presently or have you ever been a defendant in a criminal proceeding? _____Yes_____No

Court_____

City and State_____

Charge_____

Description_____

_____

_____

Status_____

_____

Date_____

26. Do you currently or have you ever prescribed any prescription medication over the Internet? This does NOT include prescribing you would do using electronic medical records in your practice. _____Yes_____No

Please provide a general description of your practice of Internet prescribing_____

_____

_____

27. Medical Malpractice Court Judgments/Settlements [See 26 VSA § 1368(a)(6A)]

A. Judgments

Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you, and any pending malpractice cases; complete the below information and provide copies of papers fully documenting these matters.

☐ Judgment ☐ Arbitration

_____

(Date) (Court) (State) (Nature of Case) (Amount Assessed Against You)

If necessary, please use an additional sheet and check this box: .....☐

B. Settlements

Please provide a description of all pending settlements and settlements of medical malpractice claims against you.

Please complete the below information and provide copies of papers fully documenting these matters.

_____

(Date) (Court) (State) (Amount Assessed Against You)

If necessary, please use an additional sheet and check this box: .....☐

Medical Malpractice Claim

Please provide the following information regarding each instance of alleged malpractice. This section should be photo copied and filled out separately for each claim. Additional sheets may be obtained/used if necessary.

Insurer_____

Claimant Name_____

Description of alleged claim (allegations only): This does not constitute an admission of fault or liability.

Please indicate:

1. Patient's condition at point of your involvement;

2. Patient's condition at end of treatment;
3. The nature and extent of your involvement with the patient;
4. Your degree of responsibility for the course of treatment in leading to the claim; and
5. Narrative of event.

_____

_____

_____

_____

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

_____

Your role (circle one):

01 Anesthesiologist	11 PGY 4
02 Primary Care Physician	12 PGY 5
03 Referring Physician	13 PGY 6
04 Attending Physician	14 PGY 7
05 Consultant Specialist	15 Workman's Compensation Evaluator
06 Surgeon	16 Court Psychiatrist
07 Fellow	17 On-Call Physician
08 PGY 1	18 Group Practitioner/Partner
09 PGY 2	19 Other: Specify_____
10 PGY 3	20 Unknown

Your Legal Representative in this matter (include name, address and telephone number)

Name_____

Firm_____

Address_____

City, State, Zip_____

Phone_____

Indicate Decision, Appeal, Settlement, Dismissal:

If a Court or Arbitration Panel heard your case, indicate the following:

Court_____

Court's location_____

Docket number_____

Date the action was filed_____

Decision determined by (check one):_____Judge_____Jury_____Arbitration Panel

Decision:_____Award:_____

If your case was appealed, indicate the following: Date appeal filed (month, day, year) _____/_____/_____

Date appeal decided: (month, day, year) _____/_____/_____

If your case was settled, indicate the following:

Settlement amount paid on your behalf: _____

Total settlement amount: _____

Date of settlement: (month, day, year) _____/_____/_____

_____Case dismissed against you _____ Against all defendants

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any: _____

_____

_____

_____

Addendum 3

Return this form to the Board along with the completed application.
This information is confidential and is exempt from public disclosure.

28. To your knowledge, are you presently the subject of a criminal investigation under which you have not been charged? _____Yes_____No

Criminal Investigation – Proceeding – Attach documents

Court_____

City and State_____

Charge_____

Description_____

_____

_____

_____

_____

_____

_____

_____

_____

Status_____

_____

Date_____

29. To your knowledge, are you the subject of an investigation by any other licensing board under which you have not been charged as of the date of this application? _____Yes_____No

Investigation by any other licensing board – Attach documents

Name of Licensing Board_____Date_____

Location of Licensing Board_____

Circumstances_____

MEDICAL QUESTIONS

Please answer "Yes" or "No" to the questions below. Definitions are provided to assist you in answering. Please explain any "Yes" answers.

DEFINITIONS

In answering the questions above, please use these definitions:

"**Ability to practice medicine**" – This term includes:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"**Medical condition**" – Includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"**Currently**" – This term means recently enough to have a real or perceived impact on one's functioning as a licensee.

"**Chemical substances**" – This term is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"**Controlled substances**" – This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"**Illegal use of controlled substances**" – This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

30. Do you have a medical condition that in any way impairs or potentially impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety? _____Yes_____No

In explaining a "Yes" answer, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

31. Are you currently engaged in the use of alcohol or other chemical substances that in any way impairs or potentially impairs your ability to practice medicine in your field of practice with reasonable skill and safety? _____Yes_____No

In explaining a "Yes" answer, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

32. Are you currently engaged in the illegal use of controlled substances? _____Yes_____No

In explaining a "Yes" answer, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine.

Medical condition, treatment, use of chemical or illegal substances

Treating organization_____

Address_____Telephone_____

Type of diagnosis, condition or treatment – field of practice – use of chemical substances_____

_____

_____

Dates of illness or dependency_____to_____

Dates of treatment_____to_____

Name of Rehabilitation/Professional Assistance or Monitoring Program_____

Address_____Telephone_____

Contact person at Program_____

Addendum 4

List of Three (3) References

List a total of three (3) references in the space below. The individuals listed must be a fully licensed physician attesting to your character and professional abilities. Return this sheet to the Board with your application.

Make three (3) copies of the attached Reference Form (Addendum 4A) and mail a copy to each individual listed below, along with a copy of the signed Affidavit and Authorization for Release of Information (UA Page 11). All completed Reference forms must be returned directly to the Board.

***NOTE**: Program Director should be substituted for Chief of Service for applicants who are applying for a license while still in residency training or have completed a residency within the last year.

Reference #1: Chief of Service (See Program Director Note* above):

Name: _____

Address: _____

City, State, Zip: _____

Telephone: (_____)_____

How long and at what capacity has this individual known you? _____

_____

Reference #2: Active physician staff member at the hospital where you have a current or recent appointment:

Name: _____

Address: _____

City, State, Zip: _____

Telephone: (_____)_____

How long and at what capacity has this individual known you? _____

_____

Reference #3: Active physician staff member at the hospital where you have a current of recent appointment:

Name: _____

Address: _____

City, State, Zip: _____

Telephone: (_____)_____

How long and at what capacity has this individual known you? _____

_____

NOTE: If you are unable to provide references from these individuals because you have never held hospital privileges, attach such an explanation to this form when you submit your application. Three other references from physicians you have worked with most recently will then be required.

Addendum 4A

Reference Form

Substitute forms are not acceptable. This form may be duplicated as needed.

This form is to be completed by the individual providing the reference.
Please return the completed form directly to the Board at:

Vermont Department of Health
Board of Medical Practice
108 Cherry Street, P.O. Box 70
Burlington, VT 05401

Name of Applicant:_____

The physician named above has applied to the Vermont Board of Medical Practice for a license to practice medicine in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following reference form. Thank you for your cooperation.

Please complete all parts of this form. If more room is needed, please attach additional information.

Dr._____was at_____

From_____to_____. During that time, he/she was (List status in the Institution):_____

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

Basic medical knowledge:	_____Poor	_____Fair	_____Average	_____Above Average
Professional judgment:	_____Poor	_____Fair	_____Average	_____Above Average
Sense of responsibility:	_____Poor	_____Fair	_____Average	_____Above Average
Moral character/ ethical conduct:	_____Poor	_____Fair	_____Average	_____Above Average
Competence and skill:	_____Poor	_____Fair	_____Average	_____Above Average
Cooperativeness, ability to work with others:	_____Poor	_____Fair	_____Average	_____Above Average
History & physical exam taking:	_____Poor	_____Fair	_____Average	_____Above Average
Record keeping:	_____Poor	_____Fair	_____Average	_____Above Average
Case presentations:	_____Poor	_____Fair	_____Average	_____Above Average
Patient management:	_____Poor	_____Fair	_____Average	_____Above Average
Physician-Patient Relationship:	_____Poor	_____Fair	_____Average	_____Above Average
Competence in being able to communicate in reading, writing and speaking the English language:	_____Poor	_____Fair	_____Average	_____Above Average
Participation in Medical Staff Affairs	_____Poor	_____Fair	_____Average	_____Above Average

Addendum 4A, Continued

Name of Applicant:_____

How long have you known the applicant and in what capacity?_____

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner? _____Yes_____No

Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine? _____Yes_____No

Do you know of any pending professional misconduct proceedings or medical malpractice claims? _____Yes_____No

Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is not minor.) _____Yes_____No

Do you know of any suspension, restriction, or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice? _____Yes_____No

Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures? _____Yes_____No

Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? _____Yes_____No

Do you know of a failure to complete a residency training program(s)? _____Yes_____No

Does the applicant call upon consults when needed? _____Yes_____No

In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluation this applicant. Of particular value to us in evaluating any candidate are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

The above report is based on:

_____ Close personal observation

_____ General impression

_____ A composite of faculty/staff evaluations

_____ Other – Specify:_____

I further certify that at the time of completion of the above training, or during my association with the physician, he/she was competent to practice medicine and he/she was not the subject of any disciplinary action.

I recommend_____ for licensure in Vermont.
Name of Physician

Signed:_____Date:_____

Print or Type Name and Title:_____

Addendum 5

Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions

You **must** answer questions 1, 2, and 3.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good Standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship (15 V.S.A. § 795).

1. You must check one of the two statements below regarding child support regardless whether or not you have children:
   - ☐ I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

   -OR-

   - ☐ I hereby certify that I am NOT in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application of Hardship".

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business shall not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes. "Good Standing" means that no taxes are due and payable and all returns have been filed, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxed would impose an unreasonable hardship (32 V.S.A. § 3113).

2. You must check on of the two statements below regarding taxes:
   - ☐ I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a $10,000. fine or both).

   -OR-

   - ☐ I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application of Hardship".

Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

3. You must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment contribution:
   - ☐ I hereby certify, under the pains of penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a $10,000 fine or both).

   -OR-

   - ☐ I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an "Application of Hardship".

   -OR-

   - ☐ I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____

*The disclosure of your social security number is mandatory. It is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by the Department of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

Statement of Applicant

I certify that the information stated by me in this application is true and accurate to the best of my knowledge and that I understand providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant: _____ Date: _____

Addendum 6

Consent to Disclosure of Prescriber-Identifiable Information for Marketing or Promoting Prescription Drugs

Under Vermont law, a prescriber may give consent so that his or her identifiable data in prescription drug records may be used for marketing or promoting prescription drugs. If a prescriber chooses not to consent, the use of prescriber-identifiable data in prescription drug records is restricted as provided for in the law. The text of the law is found at 18 V.S.A. § 4631, and a copy of the law appears on the next page.

If you choose to consent to the use of your identifiable data in prescription drug records for marketing or promoting prescription drugs, please check the "I consent" box below and sign next to it. Your consent is effective for this licensing or certification period.

If you wish not to consent, you do not need to complete this consent form.

If you do complete this form, please return it to the Board of Medical Practice with your completed license or certification application of renewal form.

You may revoke your consent at any time by signing the Revocation of Consent form and sending it to the Board of Medical Practice. The Revocation form may be obtained directly from the Board or on the Board's website.

☐ I consent

_____ _____

Signature Date

_____ _____

Print Name Vermont License or Certification Number

Mailing Address (please print): _____

_____

_____

_____

Telephone Number: _____

The Vermont Statutes Online

Title 18: Health

Chapter 91: Prescription Drug Cost Containment

4631. Confidentiality of prescription information

§ 4631. Confidentiality of prescription information

(a) It is the intent of the general assembly to advance the state's interest in protecting the public health of Vermonters, protecting the privacy of prescribers and prescribing information, and to ensure costs are contained in the private health care sector, as well as for state purchasers of prescription drugs, through the promotion of less costly drugs and ensuring prescriber's receive unbiased information.

(b) As used in this section:

(1) "Electronic transmission intermediary" means an entity that provides the infrastructure that connects the computer systems or other electronic devices used by health care professionals, prescribers, pharmacies, health care facilities and pharmacy benefit managers, health insurers, third-party administrators, and agents and contractors of those persons in order to facilitate the secure transmission of an individual's prescription drug order, refill, authorization request, claim, payment, or other prescription drug information.

(2) "Health care facility" shall have the same meaning as in section 9402 of this title.

(3) "Health care professional" shall have the same meaning as in section 9402 of this title.

(4) "Health insurer" shall have the same meaning as in section 9410 of this title.

(5) "Marketing" shall include advertising, promotion, or any activity that is intended to be used or is used to influence sales or the market share of a prescription drug, influence or evaluate the prescribing behavior of an individual health care professional to promote a prescription drug, market prescription drugs to patients, or evaluate the effectiveness of a professional pharmaceutical detailing sales force.

(6) "Pharmacy" means any individual or entity licensed or registered under chapter 36 of Title 26.

(7) "Prescriber" means an individual allowed by law to prescribe and administer prescription drugs in the course of professional practice.

(8) "Promotion" or "promote" means any activity or product the intention of which is to advertise or publicize a prescription drug, including a brochure, media advertisement or announcement, poster, free sample, detailing visit, or personal appearance.

(9) "Regulated records" means information or documentation from a prescription dispensed in Vermont and written by a prescriber doing business in Vermont.

(c)(1) The department of health and the office of professional regulation, in consultation with the appropriate licensing boards, shall establish a prescriber data-sharing program to allow a prescriber to give consent for his or her identifying information to be used for the purposes described under subsection (d) of this section.

The department and office shall solicit the prescriber's consent on licensing applications or renewal forms and shall provide a prescriber a method for revoking his or her consent. The department and office may establish rules for this program.

(2) The department or office shall make available the list of prescribers who have consented to sharing their information. Entities who wish to use the information as provided for in this section shall review the list at minimum every six months.

(d) A health insurer, a self-insured employer, an electronic transmission intermediary, a pharmacy, or other similar entity shall not sell, license, or exchange for value regulated records containing prescriber-identifiable information, not permit the use of regulated records containing prescriber-identifiable information for marketing or promoting a prescription drug, unless the prescriber consents as provided in subsection (c) of this section. Pharmaceutical manufacturers and pharmaceutical marketers shall not use prescriber-identifiable information for marketing or promoting a prescription drug unless the prescriber consents as provided in subsection (c) of this section.

(e) The prohibitions set forth in subsection (d) of this section shall not apply to the following:

(1) the sale, license, exchange for value, or use, of regulated records for the limited purposes of pharmacy reimbursement, prescription drug formulary compliance; patient care management; utilization review by a health care professional, the patient's health insurer, or the agent of either; or health care research;

(2) the dispensing of prescription medications to a patient or to the patient's authorized representative;

(3) the transmission of prescription information between an authorized prescriber and a licensed pharmacy, between licensed pharmacies, or that may occur in the event a pharmacy's ownership is changed or transferred;

(4) care management educational communications provided to a patient about the patient's health conditions, adherence to a prescribed course of therapy and other information relating to the drug being dispensed, treatment options, recall or patient safety notices, or clinical trials;

(5) the collection, use, or disclosure of prescription information or other regulatory activity as authorized by chapter 84, chapter 84A, or section 9410 of this title, or as otherwise provided by law;

(6) the collection and transmission of prescription information to a Vermont or federal law enforcement officer engaged in his or her official duties as otherwise provided by law; and

(7) the sale, license, exchange for value, or use of patient and prescriber data for marketing or promoting if the data do not identify a prescriber, and there is no reasonable basis to believe that the data provided could be used to identify a prescriber.

(f) In addition to any other remedy provided by law, the attorney general may file an action in superior court for a violation of this section or of any rules adopted under this section by the attorney general. The attorney general shall have the same authority to investigate and to obtain remedies as if the action were brought under the Vermont consumer fraud act, chapter 63 of Title 9. Each violation of this section or of any rules adopted under this section by the attorney general constitutes a separate civil violation for which the attorney general may obtain relief. (Added 2007, No. 80, § 17; amended 2007, No. 89 (Adj. Sess), § 3, eff. March 5, 2008.)

State of Vermont
Department of Health
Board of Medical Practice

Statement of Good Standing

Regarding Any Unpaid Judgment Issued by the Judicial Bureau or District Court for Fines or Penalties for a Violation or Criminal Offense

I hereby state that I am in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense.

I understand that a license may not be issued or renewed without such a statement.

I further understand that, for the purposes of this section, a person is in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense if:

(1) 60 days or fewer have elapsed since the date a judgment was issued; or

(2) the person is in compliance with a repayment plan approved by the judiciary.

_____ _____

Signature Date