UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

This form should be sent to the state board you are applying to, NOT to FSMB.

Applicant:

Securely tape or glue a recent (less than 6 month old) front-view 2" x 2" passport-type color photo of yourself in the square below.

Sign this form with attached photo in the presence of a notary public.

Send the notarized form to the board you are applying to for licensure.

DO NOT SEND THIS FORM TO FSMB.

Doing so will cause a delay with your state board application.

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

Please see the instructions above.

_____
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 (must correspond to date of notarization)

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: _____

(NOTARY PUBLIC SEAL)

My Notary Commission Expires: _____

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401
(802) 657- 4223

CERTIFICATE OF PHYSICIAN ASSISTANT EDUCATION

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

_____ Physician Assistant

Program in _____ on _____
(City and State) (Date)

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

A _____ was granted on _____
(Specify certificate/diploma/degree) (Date)

Is this program CAHEA/ARC-PA agency approved? _____ Yes _____ No

(AFFIX SEAL)

Date: _____

Signed: _____
(Authorized Officer of the School)

TO PROGRAM: Return to above address

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
(802) 657- 4223

VERIFICATION OF PHYSICIAN ASSISTANT LICENSURE OR CERTIFICATION

This section must be completed by the regulatory authority in the states in which **you now hold or have ever held** a license or certification to practice as a physician assistant.

I, _____ Secretary of the _____

State Board of _____, certify that

_____ was granted Certificate Number _____

to practice as a physician assistant in the State of _____

on the _____ day of _____ 19 _____

and that said certificate has never been revoked, suspended or conditioned in any way, or the licensee has never been disciplined by the Board in any way.

NOTE: If licensed by written examination the secretary should further certify:

I further certify that the aforesaid _____ in his/her written

Examination before this Board, obtained a general average of _____ percent in the

Following branches:

(The subjects of the examination and rating of each must be stated in full.)

_____

_____

_____

(AFFIX SEAL) _____ _____
(Secretary/Director) (Date)

Vermont Department of Health
Board of Medical Practice
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
802-657-4220 or 800-745-7371

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER

Name of applicant: _____
The Applicant named above has applied to the Vermont Board of Medical Practice for a license to practice medicine. 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.

Name (applicant) _____was at (Institution)_____

From _____to _____. During that time, he/she

Was (list Position at 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.

The basic medical knowledge:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Professional judgement:	_____ 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
Patient management:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Case presentations:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Physician-Patient relationship:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Participation in Medical Staff Affairs::	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Competence in being able to communicate in reading, writing and speaking the English language:	_____ Poor	_____ Fair	_____ Average	_____ Above Average

Return Directly to the Board

Name of applicant: _____

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?	____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 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 concern (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 of the applicant to complete a residency training program(s)?	____Yes	____ No
Does the applicant call upon consults when needed?	____Yes	____ No

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicants medical education. Please check the appropriate response. If you answer yes to any of these questions, please enclose an explanation.

Did the applicant take any leaves of absence or breaks from his/her medical education?	____Yes	____ No
Were any limitations or special requirements imposed on the applicant because of questions of academic or technical competence?	____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 evaluating this applicant. Of particular value to us in evaluating any applicant 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 previous evaluations
_____ Other – Specify: _____

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

I recommend (Applicant)_____ for licensure in Vermont.

Signed: _____ Date: _____

Print or Type Name and Title: _____

Return Directly to the Board