UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Affidavit and Authorization for Release of Information

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

Please return to the Vermont Board of Medical Practice, 108 Cherry Street, Burlington, VT 05401

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

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

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

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

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

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

Applicant Photograph

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

_____

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

_____

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

_____

Date of signature (must correspond to date of notarization)

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

NOTARY

State of _____, County of _____,

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

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

Notary Public Signature _____ My Notary Commission Expires _____

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE
108 Cherry Street P.O. Box 70
Burlington, VT 50402

CERTIFICATE OF PODIATRIC MEDICAL LICENSURE

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

I, _____ authorized representative of the _____ State Board of Podiatric Medical Examiners or similar authority, certify that _____ was granted license/certificate number _____ to practice podiatric medicine in the state of _____ on the _____ day of _____, _____.

Based on _____ and that said certificate has never been revoked, suspended, or conditioned in any way, or the licensee/certificate holder has never been disciplined by this authority in any way.

NOTE: If licensed/certified by written examination the authorized representative should further certify:

I further certify that the aforesaid _____ in their 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)

_____

_____

_____

_____

_____
(Signature of Authorized Representative)

_____ [AFFIX SEAL]
(Printed Name of Authorized Representative)

_____
(Date)

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

CERTIFICATE OF PODIATRIC MEDICAL EDUCATION

To be completed by an officer of your School of Podiatric Medicine

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

_____ School of Podiatric Medicine in

_____ on _____
(City, State) (Date)

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

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

_____.
(Date)

_____
(Signature of Authorized Officer of the School)

_____
(Printed Name of Authorized Officer of the School)

[AFFIX SEAL]

_____
(Date)

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE
108 Cherry Street P.O. Box 70
Burlington, VT 50402

VERIFICATION OF POSTGRADUATE PODIATRIC MEDICAL EDUCATION

To be completed by the Training Program Director:

Name of Institution: _____

Address: _____

_____

_____

If the name of the Institution was different when applicant attended, please enter name:

_____

I hereby certify that _____ was enrolled in the
(Name of Applicant)

_____
Program Type (Residency, Fellowship)

_____
Department (e.g. Radiology, Internal Medicine)

At this institution from _____ to _____.
mm/dd/yy mm/dd/yy

During the time of the applicant participation, our postgraduate podiatric medical training met the minimum requirements set by the council on Podiatric Medical Education (CPME) of the American Podiatric Medical Association.

Our records indicate that the applicant received a certificate of completion on _____.
mm/dd/yy

Date: _____

Signed: _____
(Official of the Sponsoring Institution) [AFFIX SEAL]

Print Name: _____

Title: _____

Return directly to the Vermont Board of Medical Practice

REQUEST SCORES

- Please complete the Part I/II Score Request Form. Forms are also available at the school registrar's office. Please send the form and $35.00 fee (by credit card, personal check, certified check, cashier check, or money order) made payable to: The National Board of Podiatric Medical Examiners.

Mailing or Express Service Address:

Prometric
ATTN: NBPME
7941 Corporate Drive
Nottingham, MD 21236

Telephone: (877) 302-8952

- Part III scores can be transferred to another state by online ordering with payment by credit card at the Federation of Podiatric Medical Board's (FPMB) website www.fpmb.org. Alternatively, requests may be printed and mailed to the Federation with a check. If you have any questions, you may contact FPMB at:

Federation of Podiatric Medical Boards
12116 Flag Harbor Drive
Germantown, MD 20874-1979

Telephone: (202) 810-3762

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE
108 Cherry Street P.O. Box 70
Burlington, VT 50402

FPMB DISCIPLINARY INQUIRY

To the Applicant: Please fill out the information below and forward it to the following address with a check made payable to:

Federation of Podiatric Medical Boards
1729 Glastonberry Road
Potomac, MD 20854

Telephone: (301) 424-1000
Website: www.fpmb.org

ATTN FPMB: Please return the information to the Board at the above address. The Vermont Board of Medical Practice requests a disciplinary search on the following individual:

Name: _____

Address: _____

City, State, Zip Code: _____

Date of Birth: _____

Social Security Number: _____

School of Podiatric Medicine of Graduation and Branch Location:

_____

Date of Graduation: _____

Applicants Signature: _____

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, the applicant

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.

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
Relationship with patients:	_____ 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

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 reason that this person cannot currently practice medicine safely?	____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 applicant's medical education. Please check the appropriate response. If you answer "yes" to either question, please provide a short explanation.

Do you know of any leaves of absence or interruptions in applicant's medical education?	____Yes	____ No
Do you know of any limitations or special requirements imposed on the applicant during medical education because of questions of academic or technical competence?	____Yes	____ No

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 their 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, the applicant was competent to practice as a medical practitioner and was not the subject of any disciplinary action.

I recommend (Applicant)_____ for licensure in Vermont.

Signed: _____ Date: _____

Print or Type Name and Title: _____

MEDICAL MALPRACTICE CLAIM REPORTING FORM

Must Complete Form. Do not say "See Attached"

Name of Applicant: _____

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):

1. Anesthesiologist
2. Primary Care Physician
3. Referring Physician
4. Attending Physician
5. Consultant Specialist
6. Surgeon
7. Fellow
8. PGY 1
9. PGY 2
10. PGY 3
11. PGY 4
12. PGY 5
13. PGY 6
14. PGY 7
15. Workman's Compensation Evaluator
16. Court Psychiatrist
17. On-Call Physician
18. Group Practitioner/Partner
19. Other: Specify _____
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 of 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 appealed filed (month/day/year): _____

Date appealed 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 currently pending
_____ Case dismissed against you _____ Against all defendants

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

Additional information, if any:

_____

_____

_____

_____