

## 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 \_\_\_\_\_

**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**

**CERTIFICATE OF PHYSICIAN ASSISTANT EDUCATION**

I hereby certify that \_\_\_\_\_ was admitted to the  
(Name)  
\_\_\_\_\_  
Physician Assistant Program in  
\_\_\_\_\_  
(City, State) on \_\_\_\_\_  
(Date)  
and completed all requirements for graduation on \_\_\_\_\_  
(Date)

A \_\_\_\_\_ was granted/will be granted on  
(Specify Certificate/Diploma/Degree)  
\_\_\_\_\_  
(Date)

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

Date: \_\_\_\_\_

[ AFFIX SEAL ]

Signed: \_\_\_\_\_  
(Authorized Officer of the School)

**State of Vermont  
Board of Medical Practice  
108 Cherry Street P.O. Box 70  
Burlington, VT 05402  
(802) 657-4220**

**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 \_\_\_\_\_, \_\_\_\_\_

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 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.)

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[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, 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
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

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 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 their medical education?  Yes  No  Don't Know

Were any limitations or special requirements imposed on the applicant because of questions of academic or technical competence?  Yes  No  Don't Know

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 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: \_\_\_\_\_