VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
P.O. BOX 70
BURLINGTON, VT 05402-0070
(802) 657-4220

LIMITED TEMPORARY LICENSE APPLICATION
STATEMENT OF PROGRAM DIRECTOR/SUPERVISING PHYSICIAN

This section must be completed by the Program Director/physician who will be supervising your work in Vermont. This licensed physician will be responsible and liable for all negligent and wrongful acts or omissions of the limited temporary license holder. Termination of appointment as an intern, resident, fellow or medical officer of such designated hospital or institution shall operate as a revocation of such limited temporary license. This limited temporary license shall be revoked upon the death or legal incompetence of the licensed physician or upon ten days written notice of the licensed physician.

I certify that (name of applicant) _____ is under my direct supervision and control **in a formal ACGME-approved residency program** at:

Hospital or Institution:

_____

Department:

_____

Address:

_____

City, State, Zip Code

_____

For the period _____ to _____.

I state that the above applicant is under my direct supervision and control. I further state that I shall be legally responsible and liable for all negligent or wrongful acts or omissions of this limited temporary license holder.

_____ _____
Signature of Program Director/Supervising Physician | Program Director/Supervising Physician's Vermont License Number

_____ _____
Printed Name of Program Director/Supervising Physician | Date

_____
Address

_____
City, State, Zip Code

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

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LIMITED TEMPORARY LICENSE APPLICATION
STATEMENT OF THE PROGRAM DIRECTOR

(THIS FORM TO BE USED FOR RESIDENTS PARTICIPATING IN AN AWAY ROTATION ONLY)

This section must be completed by the Director of the residency program in which the applicant is currently engaged.

I certify that (name of applicant) _____ is engaged as an intern, resident, fellow or medical officer at:

Hospital or Institution:

_____

Department:

_____

Address:

_____

City, State, Zip Code

_____

For the period _____ to _____.

I further state that (name of applicant) _____ is a resident/fellow in good standing and is scheduled to participate in an ***away rotation*** at:

Hospital or Institution:

_____

Department:

_____

Address:

_____

City, State, Zip Code

_____

For a period of _____ to _____. This is an approved rotation within the framework of the residency program.

_____ _____

Signature of Program Director Date

_____

Printed Name of Program Director

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

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):

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 Workmen'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 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 judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

_____

_____

_____