

**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: \_\_\_\_\_

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

APPLICATION FOR LIMITED TEMPORARY LICENSE

CERTIFICATE OF MEDICAL EDUCATION

To be completed by an *officer of your school of medicine*

I hereby certify that \_\_\_\_\_ was admitted to the  
(Name)

\_\_\_\_\_ School of Medicine in

\_\_\_\_\_ on \_\_\_\_\_  
and \_\_\_\_\_  
(City/State)

completed all requirements for graduation on \_\_\_\_\_  
(Date)

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

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

Signed: \_\_\_\_\_

[ - Affix Seal - ]

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

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APPLICATION FOR LIMITED TEMPORARY LICENSE

CERTIFICATE OF 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, including a limited temporary and/or training license.

I, \_\_\_\_\_, Secretary of the \_\_\_\_\_ State board of medical examiners, certify that \_\_\_\_\_ was granted Certificate Number \_\_\_\_\_ to practice medicine 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 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.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Signed: \_\_\_\_\_ [ Affix Seal ]

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

BOARD OF MEDICAL PRACTICE  
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LIMITED TEMPORARY LICENSE APPLICATION  
STATEMENT OF SUPERVISING PHYSICIAN/ PROGRAM DIRECTOR

This section must be completed by the Supervising physician/Program Director 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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BOARD OF MEDICAL PRACTICE  
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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 \_\_\_\_\_

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