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.

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

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: ___________________________
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 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)

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Signature of authorized representative

Printed Name of authorized representative

[Affix Seal]

Date
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

completed all
(City/State) on __________________________ and
requirements for graduation on __________________________
(Date)
(Date)

A __________________________________ was granted on
(specific Certificate/Diploma/Degree) __________________________
(Date)

Signature of Authorized Officer of the School

Printed Name of Authorized Officer of the School                      [Affix Seal]

Date
VERIFICATION OF POSTGRADUATE PODIATRIC MEDICAL EDUCATION

To be completed by the Training Program Director:

Name of Institution: ____________________________________________

Address: ______________________________________________________

____________________________________________________________________

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

____________________________________________________________________

I hereby certify that ___________________________ was enrolled

in the __________________________________________________________

Program Type (residency, fellowship)

______________________________________________________________

Department (e.g. Radiology, Internal Medicine)

At this institution from mm/dd/yyyy to mm/dd/yyyy

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/yyyy

Date: ____________________________

Signed: ____________________________

(Official of the Sponsoring Institution) (AFFIX SEAL)

Print Name: ____________________________________________

Title: ______________________________________________________

Return directly to the Board
Request Scores

- Please complete the Part I/II Score Request Form. Forms are also available at the school registrar 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) web site 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 their new address and phone number:

Federation of Podiatric Medical Boards
12116 Flag Harbor Drive
Germantown, MD 20874-1979.
Telephone: (202) 810-3762
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
(301) 424-1000

Or

www.fpmb.org

ATTENTION 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: ________________________________
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:

Competence and skill: _______ Poor _______ Fair _______ Average _______ Above Average

Cooperativeness ability to work with others:

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:

Participation in Medical Staff Affairs:

Competence in being able to communicate in reading, writing and speaking the English language:

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: __________________________________________

Reference Form
Page 2 of 2
Return Directly to the Board
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 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
02 Primary Care Physician
03 Referring Physician
04 Attending Physician
05 Consultant Specialist
06 Surgeon
07 Fellow
08 PGY 1
09 PGY 2
10 PGY 3
11 PGY 4
12 PGY 5
13 PGY 6
14 PGY 7
15 Workmen'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 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: