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

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:
Licensure Verification Form
(Copy this form for multiple licenses)

I am applying for a license to practice medicine. The Board requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the following Board:

TO BE COMPLETED BY APPLICANT

Applicant Name: Last First Middle Suffix
Date of Birth: Social Security Number: License Number: (From State/Province you are sending this form to)

The applicant’s social security number is to be used for purposes of identification and may not be used for any other reason.

I hereby authorize the licensing agency of the State/Province of to furnish the information to the Board indicated below.

Signature of Applicant ___________________________ Date

Board Name: ___________________________
Address: __________________________________________________________

TO BE COMPLETED BY STATE LICENSING BOARD OR CANADIAN PROVINCE

Name of Licensee: Last First Middle Suffix
License Type: License #: Issue Date: Expiration Date:

Is this license current? Yes No If No, please explain:

1) Have formal disciplinary proceedings been initiated against applicant’s license by a disciplinary authority in your state?
   Yes No Cannot answer under state law
   If Yes, please explain:

2) Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand or in any other manner disciplined; or has the applicant’s license ever been revoked, suspended or, in any other manner, limited by a licensing or disciplinary authority in your state?
   Yes No Cannot answer under state law
   If Yes, please explain:

Affix Board Seal Here
Board Authorized Signature: ____________________________________________
Title: ______________________________________________________________
Date: ________________

Please return this form to the Board listed at the top of this form.

Applicant Name: ___________________________ Date: __________________
If you completed Section 5 of the application, you must complete this form

Fifth Pathway Verification

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to the director of your 5th Pathway Program. Request the Program Director or designated official to complete Section 3 of this form and return this form and the Program Director's recommendation letter directly to this Board.

Section 1: Applicant Information

Last Name: ___________________________ Suffix: ___________________________
First Name: ___________________________ Middle Name: _______________________
Name if different when diploma awarded: ___________________________
Social Security Number: ___________________________
Date of Birth: ___________________________

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

Applicant’s Signature ___________________________ Date ___________________________

Section 2: Instructions to the PROGRAM DIRECTOR or designated official

Please complete Section 3 of this form and attach a recommendation letter from the Program Director and forward this information directly to this Board at the following address:

Board Name: ___________________________
Address: ___________________________
City: ___________________________
State/Province: ___________________________ ZIP Code: ___________________________

Section 3: Medical School Verification

Medical School Name: ___________________________
School name if different when the above applicant attended: ___________________________
Applicant's Attendance Dates: From ___________ To ___________ Program Completion Date: ___________ (Indicate N/A if not applicable)

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature: ___________________________
Print name: ___________________________

AFFIX INSTITUTIONAL SEAL HERE

Title: ___________________________
Date: ___________________________
Phone number: ___________________________
Fax: ___________________________
E-mail: ___________________________

Uniform Application for Physician State Licensure
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.

<table>
<thead>
<tr>
<th>The basic medical knowledge:</th>
<th>Poor</th>
<th>Fair</th>
<th>Average</th>
<th>Above Average</th>
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<tbody>
<tr>
<td>Professional judgement:</td>
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<td>Sense of responsibility:</td>
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<td>Moral character/ethical</td>
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<td>conduct:</td>
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<td>Competence and skill:</td>
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<td>Cooperativeness ability to</td>
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<td>work with others:</td>
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<td>History &amp; physical exam</td>
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<td>taking:</td>
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<td>Patient management:</td>
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<td>Physician-Patient relationship:</td>
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<td>Participation in Medical Staff Affairs:</td>
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<tr>
<td>Competence in being able to communicate in reading, writing and speaking the English language:</td>
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</tbody>
</table>
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: ______________________________
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 photocopied 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
  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 _____________________________________________________________

Form A
Page 1 of 5
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:

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________