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: _____

EMPLOYMENT CONTRACT FORM

I, _____ , an applicant for
(Applicant's Name)

Certification as a Radiologist Assistant, am employed by

_____
(Employer's Name Including Department)

for the period beginning _____
(Month/Day/Year)

Termination of my contract will cause my Certification to become null and void.

_____ _____
Signature of Radiologist Assistant (Date)

_____ _____
Signature of Supervising Radiologist (Date)

Print Name of Supervising Radiologist _____

NOTE: A contract from each separate employer is required.

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VT 05401
(802) 657-4223

APPLICATION BY PROPOSED PRIMARY SUPERVISING RADIOLOGIST

Name in full _____
(Last) (First) (Middle)

Address where RA will be supervised:

_____
(Office Name)

_____
(Street)

_____
(City/State) (Zip Code) (Telephone Number)

Vermont Physician License #: _____

Hospital(s) where you have privileges:

Hospital(s) Location

_____

_____

_____

What arrangements have you made for supervision when you are not available:

_____

_____

List the names and addresses of all Radiologist Assistants you currently supervise:

_____

_____

CERTIFICATE OF PROPOSED PRIMARY SUPERVISING RADIOLOGIST

I hereby certify that, in accordance with 26 VSA, Chapter 52, I shall be legally responsible for all professional activities of _____, RA. while under my supervision. I further certify that the protocol attached to this application, and does not exceed the normal limits of my practice. I further certify that notice will be posted that a Radiologist Assistant is used, in accordance with 26 VSA, Chapter 52, Section 2863. I also affirm that I have read and will abide by all provisions of 26 VSA, Chapter 52, and Section 5 of the Rules of the Vermont Board of Medical Practice.

I further certify that I have read the statutes and Board rules governing Radiologist Assistants.

_____ _____
(Date) (Signature of Proposed Primary Supervising Radiologist)

_____ _____
(Date) (Signature of Radiologist Assistant)

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VT 05401
(802) 657-4223

APPLICATION BY PROPOSED SECONDARY SUPERVISING RADIOLOGIST

Name in full _____
(Last) (First) (Middle)

Address where RA will be supervised:

_____
(Office Name)

_____
(Street)

_____
(City/State) (Zip Code) (Telephone Number)

Vermont Physician License #: _____

Hospital(s) where you have privileges:

Hospital(s) Location

_____

_____

_____

What arrangements have you made for supervision when you are not available:

_____

_____

List the names and addresses of all Radiologist Assistants you currently supervise:

_____

_____

CERTIFICATE OF PROPOSED SECONDARY SUPERVISING RADIOLOGIST

I hereby certify that, in accordance with 26 VSA, Chapter 52, I shall be legally responsible for all professional activities of _____, R.A. while I am supervising him/her. I further certify that the protocol attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 52, Section 2863. I also affirm that I have read and will abide by all provisions of 26 VSA, Chapter 52, and Section 5 of the Rules of the Vermont Board of Medical Practice.

I further certify that I have read the statutes and Board rules governing Radiologist Assistants.

_____ _____
(Date) (Signature of Proposed Secondary Supervising Radiologist)

VERMONT BOARD OF MEDICAL PRACTICE
RADIOLOGIST ASSISTANT PROTOCOL

A protocol means a written document detailing those areas of medical practice including duties and medical acts, delegated to the Radiologist Assistant by the supervising physician for whom the physician is qualified by education, training and experience. At no time shall the protocol of the Radiologist Assistant exceed the normal scope of either the primary or secondary supervising physician(s) practice.

Radiologist Assistants practice medicine with physician supervision. Radiologist Assistants may perform those duties and responsibilities, including the prescribing and dispensing of medical devices that are delegated by their supervising physician(s).

Radiologist Assistants shall be considered the agents of their supervising physicians in the performance of all practice-related activities, including but not limited to the ordering of diagnostic, therapeutic and other medical services.

It is the obligation of each team of physician(s) and the Radiologist Assistant(s) to insure that the written scope of practice submitted to the Board for approval clearly delineates the role of the Radiologist Assistant in the medical practice of the supervising physician. This should cover at least the following categories:

a) Narrative: A brief description of the practice setting, the types of patients and patient encounters common to this practice and a general overview of the role of the Radiologist Assistant in that practice.

b) Supervision: A detailed explanation of the mechanisms for on-site physician supervision and communication, back-up and secondary supervising physician utilization. Included here should be a description of the method of transport and back-up procedures for immediate care and transport of patients who are in need of emergency care when the supervising physician is not on premises. This explanation should include issues such as, ongoing review of the Radiologist Assistant's activities, retrospective chart review, co-signing of patient charts, and utilization of the services of non-supervising physicians and consultants.

c) Sites of Practice: A description of any and all practice sites (i.e. office, clinic, outpatient, hospital inpatient, industrial sites, schools, etc.). For each site, include a description of the RA's activities.

d) Tasks/Duties: A list of the RA's tasks and duties in the supervising physician's scope of practice.

This list should express a sense of involvement in the level of medical care in that practice. The supervising physician may only delegate those tasks for which the Radiologist Assistant is qualified by education, training and experience to perform. Notwithstanding the above, the Radiologist Assistant should initiate emergency care when required while accessing back-up assistance. At no time should a particular task assigned to the RA fall outside of the scope of practice of the supervising physician.

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401
(802) 657- 4220

RADIOLOGIST ASSISTANT

VERIFICATION OF 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 medical practitioner.

I _____, on behalf of the _____

State Board of _____, certify that _____
(or other authority)

was granted Certificate/License Number _____

to practice as a _____ in the State of _____

on the _____ day of _____

and that said certificate or license has never been revoked, suspended or conditioned in any way, or the certificate holder or licensee has never been disciplined by this authority in any way.

(AFFIX SEAL) _____ _____
(Authorized Representative) (Date)

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401
(802) 657- 4220

CERTIFICATE OF RADIOLOGIST ASSISTANT EDUCATION

I hereby certify that, _____ was admitted to the
(Name)

_____ Radiologist Assistant

Program in _____ on _____
(City and State) (Date)

and has completed all requirements for graduation on _____.
(Date)

A _____ was granted on _____
(Specify certificate/diploma/degree) (Date)

Is this program recognized by the ARRT under its "recognition Criteria for RA educational programs?"

_____ Yes _____ No

(AFFIX SEAL)

Date: _____

Signed: _____
(Authorized Officer of the School)

TO PROGRAM: Return to above address

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, 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:	_____ 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

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: _____

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 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:

_____

_____

_____