

State of Vermont
Department of Health
(division or program name here)
108 Cherry Street-PO Box 70
Burlington, VT 05402-0070
HealthVermont.gov

[phone] 802-657-4223
[fax] 802-657-4227
Toll 800-745-7371

Agency of Human Services

Memorandum

TO: Anesthesiologist Assistant
FROM: Medical Practice Board
DATE: October 31, 2009
RE: 2010 Anesthesiologist Assistant Certification Renewal Instructions

Enclosed is your 2010 Anesthesiologist Assistant Certification Renewal Application. Please follow the instructions below and return the completed application with documentation and payment to this office no later than January 15, 2010. If you have any questions or need additional information do not hesitate to contact us at 802 657-4220, 800 745-7371 or medicalboard@vdh.state.vt.us. **Your certification will lapse if we have not received your completed application and fee by January 31, 2010.**

INSTRUCTIONS

- enter, correct or update all information
- print legibly or type your answers
- answer all questions completely, even if you believe the information is already on file with the Board
- use the enclosed Form A to provide explanations to "yes" answers in Parts II -IV
- write your name and certificate number on each attachment
- make a copy of the completed forms and all attachments for your own records
- do not delegate this important task to any other person. False statements on this form may be grounds for charges of unprofessional conduct

Be sure to enclose:

- completed application and appropriate attachments, e.g. Form A, Primary and Secondary Supervising Physician Applications, CME Form, NCCAA Certificate, Scope of Practice, etc.
- completed *Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions, whether or not you have children*
- Statement of Good Standing
- completed **clinical practice questions** and any other attachments
- a check for \$115 for initial certification, \$50 for each additional certification, payable to the Vermont Department of Health
 - o **LATE FEE:** Applications post-marked or received after 1/31/10 will be assessed a \$25 late fee.

Please return the completed application, attachments and fee no later than January 15, 2010 to facilitate timely processing and avoid an interruption in your ability to practice because of a lapsed certification.

Please Note:

Certificatees have a continuing obligation during each two-year renewal period to promptly notify the Board of any change or new information including, but not limited to, disciplinary or other action limiting or conditioning their certificate or ability to practice in any jurisdiction. Failure to do so may subject the certificatee to disciplinary action by the Board.

Thank you.



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

2010 ANESTHESIOLOGIST ASSISTANT CERTIFICATION RENEWAL APPLICATION

PART I

Certificate # AAA- _____

1. Name: _____

2. Other Name(s), if any, under which you were certified or licensed in Vermont and elsewhere:

3. Work Address:

City, State, Zip Code:

4. Home Address:

City, State, Zip Code:

Please check your preferred mailing address: Home Work
(This address will be public and listed on the Board's website)

5. Email Address

6. Daytime Telephone Number:

7. Date of Birth: Month: _____ Day _____ Year _____

8. Place of Birth: _____

9. Do you have hospital privileges in Vermont? Yes No

Hospital Name(s) and Location(s):

10. In what year did you start working as an anesthesiologist assistant in Vermont? _____

11. Were you in active clinical practice in Vermont during the past 12 months? Yes No

12. Other states where you now hold an active certification or license to practice:

13. States where you previously were certified or licensed to practice:

14. Specialty: _____ DEA Number: _____

15. Name and office address of current EMPLOYER:

Name _____ Address _____

16. Please list (use additional sheet if necessary) name(s) and address(es) of physicians who currently serve as your PRIMARY and SECONDARY SUPERVISING PHYSICIAN(S).

Primary Supervising Physician(s):

Name _____ Address _____

Secondary Supervising Physician(s):

Name _____ Address _____

17. Scope of Practice: The Board of Medical Practice requires that you and your primary supervising physician(s) review the most current scope of practice for your practice setting, paying attention to any additions or deletions in duties and procedures. Please review, date and sign your scope of practice and have your PRIMARY SUPERVISING PHYSICIAN sign it as well. Attach a copy of your signed scope of practice to this application.

a. Has there been a change in your scope of practice which has not been reviewed by the Board?
 Yes No

18. Please provide a letter from your Supervising Physician attesting to the fact that you have practiced as an Anesthesiologist Assistant within the past twelve months.

19. Continuing Medical Education (CME) requirements:

NCCAA certified Anesthesiologist Assistant: Attach proof of current NCCPA certification; this will serve as adequate proof of CME completion.

20. Primary Supervising Physician and Second Supervisory Physician forms are provided. They must be completed and returned with this application.

PART II

"Yes" answers to Questions 21 - 44 require an explanation on Form A.

21. Have you ever applied for and been denied a certificate to practice medicine or any other healing art?
 yes no

22. Have you ever withdrawn an application for a certificate to practice medicine or any other healing art?

yes no

23. Have you ever voluntarily suspended, surrendered or resigned a certificate to practice medicine or any other healing art in lieu of disciplinary action or any other reason?

yes no

24. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?

yes no

25. Have you ever been denied the privilege of taking an examination before any state medical examining board?

yes no

26. Have you ever discontinued your education, training, or practice for a period of more than three months?

yes no

27. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?

yes no

28. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?

yes no

29. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?

yes no

30. Are you presently or have you ever been a defendant in a criminal proceeding?

yes no

31. Do you currently or have you ever prescribed any prescription medication over the internet? This does not include prescribing you would do using electronic medical records in your practice.

yes no

PART III

(Unless otherwise ordered by a court, your responses to the questions in Part III are considered exempt from public disclosure.)

Any "yes" response to the questions below must be fully explained on the enclosed Form A.

32. To your knowledge, are you the subject of an investigation by any other licensing board under which you have not been charged as of the date of this application? yes no

33. To your knowledge, are you presently the subject of a criminal investigation under which you have not been charged? yes no

The following definitions are provided to assist you in answering questions 34 through 36.

"Ability to practice medicine" - This term includes:

The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and

The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" - Includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as a licensee.

"Chemical substances" - This term is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

34. Do you have a medical condition that potentially or in any way impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?

yes no

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

35. Are you currently engaged in the use of alcohol or other chemical substances that potentially or in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety?

yes no

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

36. Are you currently engaged in the illegal use of controlled substances?

yes no

In explaining a "Yes" answer on Form A, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine.

IMPORTANT

Since 1999, Board fees have been used to create and maintain the Vermont Practitioners Health Program, a confidential program for the identification, treatment and rehabilitation of practitioners, including anesthesiologist assistants, affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-0400 (a confidential line).

Part IV - Statutory Profile Questions

The following questions are required by Vermont law, 26 VSA § 1368, to update and maintain a data repository within the Department of Health and to make individual profiles on all health care professionals

licensed, certified, or registered by the Department available to the public. Your practitioner profile is located at the following website http://healthvermont.gov/hc/med_board/profile_search.aspx.

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 37 through 42 have changed since your last application. We cannot process your application without them.

37. Criminal Convictions [See 26 VSA § 1368(a)(1)] Check here if none

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past 10 years **Please provide complete copies of documentation for each matter.**

(Conviction Date)	(Court)	(City/State)	(Crime)
-------------------	---------	--------------	---------

38. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)] Check here if none

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction. **Please provide complete copies of documentation for each matter.**

(Conviction Date)	(Court)	(City/State)	(Charge)
-------------------	---------	--------------	----------

(Conviction Date)	(Court)	(City/State)	(Charge)
-------------------	---------	--------------	----------

(Conviction Date)	(Court)	(City/State)	(Charge)
-------------------	---------	--------------	----------

39. Vermont Board of Medical Practice Matters [See 26 VSA § 1368(a)(3)] Check here if none

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed.

(Date)	(Final Disposition - Summary)
--------	-------------------------------

(Date)	(Final Disposition - Summary)
--------	-------------------------------

(Date)	(Final Disposition - Summary)
--------	-------------------------------

40. Licensing or Certification Authority Matters in Other States [See 26 VSA § 1368(a)(4)]

Check here if none

Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states. **Please provide complete copies of documentation for each matter.**

(Date of Final Disposition)	(Licensing or Certification Authority)	(Court)	(City/State)	(Nature of Charge)
-----------------------------	--	---------	--------------	--------------------

(Date of Final Disposition) (Licensing or Certification Authority) (Court) (City/State) (Nature of Charge)

41. Restriction of Hospital Privileges [See 26 VSA § 1368(a)(5)] Check here if none

Revocation/Involuntary Restrictions

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you. **Please provide complete copies of documentation for each matter.**

(Date) (Hospital) (State) (Nature of Restriction) (Reason for Restriction)

(Date) (Hospital) (State) (Nature of Restriction) (Reason for Restriction)

B. Other Restrictions Check here if none

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital. **Please provide complete copies of documentation for each matter.**

(Date) (Hospital) (State)

(Nature of Action) (Action)

(Reason for Action) In lieu In settlement

42. Medical Malpractice Court Judgments/Settlements [See 26 VSA § 1368(a)(6A)]

A. Judgments Check here if none

Please complete the attached Form A and provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you within the past 10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. **Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.**

Judgment Arbitration

(Date) (Court) (State) (Nature of Case) (Amount Assessed Against You)

Judgment Arbitration

(Date) (Court) (State) (Nature of Case) (Amount Assessed Against You)

46. Activities [See 26 VSA § 1368(a)(14)]

Note: Answering #46 is optional. By answering, you are granting permission to have this information posted on the web. Please provide information regarding your professional or community service activities and awards.

(Activities or Awards)

47. Practice Setting [See 26 VSA § 1368(a)(15)]

What is the location of your primary practice setting?

Town/City, State

48. Translating Services [See 26 VSA § 1368(a)(16)]

Please identify any translating services available at your primary practice location.
Are any translating services available at your primary practice location? Yes No

If yes, please describe the translating services available:

49. Medicaid/New Patients [See 26 VSA § 1368(a)(17)]

A. Medicaid participation
Do you participate in the Medicaid program? Yes No

B. New Medicaid Patients
Are you currently accepting new Medicaid patients? Yes No

Part V

I hereby affirm that the information provided above is true and accurate, and that I have answered the questions to the best of my knowledge and ability.

Date: _____

Applicant's Signature

Reminder - You must also complete the enclosed Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions regardless of whether or not you have children

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

(Questions 21 and 22) Withdrawal or denial of License - Attach documents

State _____ Year _____
Circumstances under which license was withdrawn, denied, revoked, not renewed, or otherwise terminated _____

(Question 23) Voluntarily surrendered or resigned a license to practice medicine or any healing art - Attach documents

State _____ Year _____
Circumstances _____

(Question 24) Disciplinary charges or action - Attach documents

Name of organization involved _____ Date _____

Duration _____

Action taken (circle all that apply)

- | | |
|---|---|
| 01 Revocation of right or privilege | 12 Leave of absence |
| 02 Suspension of right or privilege | 13 Withdrawal of an application |
| 03 Censure | 14 Termination or non-renewal of contract |
| 04 Written reprimand or admonition | 15 Medical Records Suspension |
| 05 Restriction of right or privilege | 16 Probation |
| 06 Non-renewal of right or privilege | 17 Assurance of Discontinuance |
| 07 Fine | 18 Consent Agreement |
| 08 Required performance of public service | 19 Letter of Agreement |
| 09 Education/Training/Counseling/Monitoring | 20 Expulsion from Membership |
| 10 Denial of rights or privilege | 21 Reprimand |
| 11 Resignation | 22 Other Specify) _____ |

Circumstances _____

(Question 25) Denial of examination privileges - Attach documents

State _____ Year _____

Circumstances under which examination privileges denied _____

(Questions 26 and 27) Residency Training Program(s) not completed - discontinued education, training, practice - Attach documents

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances _____

(Question 28) Affecting Health Care Institution Staff Privileges, Employment or Appointment - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances _____

(Question 29) Privilege to prescribe controlled substances - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction _____

(Questions 30 and 33) Criminal Investigation - Proceeding - Attach documents

Court _____

City and State _____

Charge _____

Description _____

Status _____

Conviction? ____ Yes ____ No Date _____

Plea? ____ Yes ____ No Date _____

(Question 31) Internet prescribing

Please provide a general description of your practice of internet prescribing

(Question 32) Investigation by any other licensing board - Attach documents

Name of Licensing Board _____ Date _____

Location of Licensing Board _____

Circumstances _____

(Questions 34-36) Medical condition, treatment, use of chemical or illegal substances

Treating organization _____

Address _____ Telephone _____

Type of diagnosis, condition or treatment - field of practice - use of chemical substances

Dates of illness or dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____ Telephone _____

Contact person at Program _____

(Question 42) Medical Malpractice Claim

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 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:

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

APPLICATION BY PROPOSED PRIMARY SUPERVISING ANESTHESIOLOGIST

Please print. Attach additional sheets as needed.

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

Mailing Address _____
(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 anesthesiologist assistants you currently supervise:

CERTIFICATE OF PROPOSED PRIMARY SUPERVISING ANESTHESIOLOGIST

I hereby certify that, in accordance with 26 VSA, Chapter 29, I shall be legally responsible for all professional activities of _____, A.A. while under my supervision. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice. I further certify that notice will be posted that an anesthesiologist assistant is used, in accordance with 26 VSA, Chapter 29, Section 1657. I also affirm that I have read and will abide by all provisions of 26 VSA, Chapter 29, 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 anesthesiologist assistants.

(Date) (Signature of Proposed Primary Supervising Anesthesiologist)

Co-signature of A. A. Applicant: _____

Note: An AA who prescribes controlled drugs must obtain an ID number from DEA. DEA Number _____

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

APPLICATION BY PROPOSED SECONDARY SUPERVISING ANESTHESIOLOGIST

Please print. Incomplete applications will be returned. Attach additional sheets as needed.

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

Mailing Address _____
(Office Name)

(Street)

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

Vermont License #: _____

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all the names and addresses of anesthesiologist assistants you currently supervise:

CERTIFICATE OF PROPOSED SECONDARY SUPERVISING ANESTHESIOLOGIST

I hereby certify that, in accordance with 26 VSA, Chapter 29, I shall be legally responsible for all professional activities of _____, A.A. while I am supervising him/her. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 29, Section 1657. I also affirm that I have read and will abide by all provisions of 26 VSA, Chapter 29, 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 anesthesiologist assistants.

(Date)

(Signature of Proposed Secondary Supervising Anesthesiologist)

State of Vermont
Department of Health
Board of Medical Practice

Statement of Good Standing

**Regarding Any Unpaid Judgment Issued by the Judicial Bureau or District Court
for Fines or Penalties for a Violation or Criminal Offense**

I hereby state that I am in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense.

I understand that a license may not be issued or renewed without such a statement.

I further understand that, for the purposes of this section, a person is in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense if:

- (1) 60 days or fewer have elapsed since the date a judgment was issued; or
- (2) the person is in compliance with a repayment plan approved by the judiciary.

Signature: _____

Date: _____

VERMONT'S PRESCRIPTION CONFIDENTIALITY LAW
Prescriber Data-Sharing Program

CONSENT FORM

Under Vermont's Act 80, a law passed in 2007, pharmaceutical companies may not use information that identifies prescribers in prescription drug records for marketing or promoting prescription drugs unless the prescriber consents. The text of the law, which took effect July 1, 2009, is found at 18 V.S.A. § 4631. The Vermont Attorney General has links to the statute and further information about the implementation of this law on the website. Go to <http://www.atg.state.vt.us/> and follow the link for Prescribed Products and then look for information on Prescription Confidentiality.

If you wish, you may permit your identifying information in drug prescription records to be used for marketing and promoting of prescription drugs. The only way to grant permission is by giving your consent in the manner described below. If you do not consent, your identifying information from prescription drug records cannot be used for marketing or promoting prescription drugs.

The list of everyone who has a current consent on file with their licensing board, as well as consent and revocation forms are available online at: http://healthvermont.gov/hc/med_board/bmp.aspx. You may check this site at any time to confirm your status. If you consent, your consent is effective until you revoke your consent. **If you wish to make a change, you may download consent and revocation forms at the web address above. If you do not have web access, you may contact your licensing board for assistance.**

How to consent: If you want to consent to the use of your information for marketing and promoting prescription drugs, sign your name, complete the form, and return it as part of your license application or license renewal. If you consent, your name will be included on the list of Vermont prescribers who have consented, and your information may be used for marketing and promoting prescription drugs. You may also complete this form at any time and mail it to your licensing board.

If you do not consent: If you do not wish your identifying information in prescription drug records to be used for marketing or promoting prescription drugs, you need do nothing.

If you choose not to consent, please leave this form blank.

To consent, sign, date, and fill out the form below. Return the completed form with your license application or license renewal or mail the form to **Board of Medical Practice, PO Box 70, Burlington, VT 05402-0070.**

I consent:

Signature

Date

Name (printed or typed)

License type (profession)

Vermont License Number

Mailing Address

City, State, Zip

**VERMONT'S PRESCRIPTION CONFIDENTIALITY LAW
Prescriber Data-Sharing Program**

REVOCAION OF CONSENT FORM

If at any time a prescriber wishes to revoke his or her consent to use of prescriber identifiable drug information, the revocation must occur using this form.

I _____ (**print name**) hereby **revoke** my consent to the use of regulated records which include prescription information containing my prescriber-identifiable data for the purpose of marketing or promoting a prescription drug.

Signature

Date

Name (printed or typed)

License type (profession)

Vermont License Number

Mailing Address

City, State, Zip

Please mail your completed form to:

Board of Medical Practice
Vermont Department of Health
PO Box 70
Burlington, VT 05402-0070

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

You must answer questions 1, 2, and 3.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

- 1. You must check one of the two statements below regarding child support regardless whether or not you have children:
- I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.
or
- I hereby certify that I am NOT in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business shall not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due and payable and all returns have been filed, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

- 2. You must check one of the two statements below regarding taxes:
- I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a \$10,000.00 fine or both).
or
- I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

- 3. You must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment contributions:
- I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a \$10,000.00 fine or both).
or
- I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.
or
- I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #* ____/____/____ Date of Birth ____/____/____

* The disclosure of your social security number is mandatory, it is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by the Department of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

STATEMENT OF APPLICANT

I certify that the information stated by me in this application is true and accurate to the best of my knowledge and that I understand providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant _____ Date _____