VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
P.O. Box 70, Burlington, VT 05402

PODIATRIST INITIAL LICENSURE APPLICATION INSTRUCTIONS AND CHECKLIST

Application for License to Practice Podiatric Medicine in Vermont

- Please print legibly or type.
- Answer all questions completely.
- Make a copy of the completed form and all attachments for your records.
- Please be sure to write your name on each attachment.
- Do not delegate this important task to an employee. False statements on this form are grounds for unprofessional conduct.
- Personal Interview. Once your application is complete, you will receive the name, address, and telephone number of a member of the Board of Medical Practice to contact and schedule your interview.
-

Please submit the following as part of your application.

- ☐ $625 Payable to the Vermont Department of Health.
- ☐ Completed Podiatrist Initial Licensure Application
- ☐ Certified Copy of Birth Certificate
- ☐ Copy of Podiatric Medical School Diploma
- ☐ "CERTIFICATE OF PODIATRIC MEDICAL EDUCATION" must be completed by an authorized representative of your school of podiatric medicine and returned **directly** to this office
- ☐ "CERTIFICATE OF PODIATRIC MEDICAL LICENSURE" must be completed by an authorized representative of each state where you hold or have held a license and returned **directly** to this office. **Copies of licenses are not accepted**.
- ☐ **Certified** copy of National Board scores (National Board of Podiatric Medical Examiners) parts I and II – to be sent **directly** to this office from the Examining Agency (see attached form)
- ☐ **Certified** copy of PMLexis (Podiatric Medical Licensure Examination for States) Scores – to be sent directly to this office from the Examining Agency (see attached form)
- ☐ **Direct** "VERIFICATION OF POSTGRADUATE PODIATRIC MEDICAL EDUCATION"
- ☐ Three (3) completed Reference Forms mailed **directly** to the Board by the Chief of Service and two other active physician staff members at the hospital where you have a current or recent appointment

  _____#1 Chief of Service or Program Director
  _____#2 Active Physician Staff Member
  _____#3 Active Physician Staff Member

- ☐ Complete Form A if you answered yes to any questions
- ☐ Child Support/Tax/Unemployment Form
- ☐ Statement of Good Standing
- ☐ National Practitioner Data Bank self query. **Send the original, unaltered response to the Board.**
- ☐ Federation of Podiatric Medical Boards Disciplinary Inquiry. Can be requested online at FPMB.org. **Must be sent by the applicant directly to the Federation.**
- ☐ Curriculum vitae (CV/Resume)

VERMONT DEPARTMENT OF HEALTH
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P.O. Box 70, Burlington, VT 05402

APPLICATION FOR LICENSE TO PRACTICE PODIATRY IN VERMONT

I hearby apply for LICENSURE AS A PODIATRIST in the state of Vermont.

Part I

1. Name: _____
(Last) (First) (Middle)

2. Home Address: _____
(Street)

_____
(City) (State) (Zip)

3. Work Address: _____
(Street)

_____
(City) (State) (Zip)

4. Please check your preferred mailing address: ____ Home ____ Work

Please Note: The address you provide as your mailing address will be the address posted on our website and be made available to the public.

5. Have you ever legally changed your name? ___Yes ___ No If yes, enclose a certified copy of the document by which the name was changed.

6. Your name, as it should appear on your certificate: _____

7. Have you ever been licensed or certified elsewhere under another name? ___ yes ___ no If yes, please complete the following:

_____
(Name) (Place) (License or Certificate)

8. Home Telephone Number: (_____) _____

9. Work Telephone Number: (_____) _____

10. E-mail address: _____

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

12. Place of Birth:_____
Attach a certified copy of your birth certificate.

13. Were you in active clinical practice in the past 12 months? _____Yes _____No

14. Basis for Licensure: _____ National Boards – Parts I and II
_____ PMLexis
_____ State Examination: State:_____
_____ Other: Specify:_____

PREMEDICAL EDUCATION

15. List post-secondary schools attended

(Name and location of Institution)	(From/To)	(Degree)
(Name and location of Institution)	(From/To)	(Degree)

PODIATRIC MEDICAL EDUCATION
SEE ALSO: CERTIFICATE OF PODIATRIC MEDICAL EDUATION

16. List podiatric schools attended:

(Name and location of institution)	(From/To)	(Degree)
(Name and location of institution)	(From/To)	(Degree)

Specialty Board Certification

17. List your specialty, primary specialty first.

(Specialty)	(Board Certified ☐ yes ☐ no)	(Name of Board)	(Year Certified)	(Year Recertified)
(Specialty)	(Board Certified ☐ yes ☐ no)	(Name of Board)	(Year Certified)	(Year Recertified)

TRAINING

18. List residency or other post-graduate training chronologically. Give names, addresses of hospitals, exact dates (month/day/year) and type of training.

Name	Address	From/To	Training

PRACTICE

19. Do you have hospital privileges? _____Yes _____No

List all hospitals where you have, or previously have had, staff privileges. Include name, address, and dates.

Name	Address	From/To	Training

OTHER LICENSES

20. Do you hold, or have you ever held, a podiatric license in any other state? _____ Yes _____ No

If yes, complete the section below and send a Certificate of Podiatric Medical Licensure form to the licensing authority in each State for completion. Completed forms must be sent directly to this office from the licensing authority.

State	License Number	Date Issued	Status

EXAMINATIONS

21. Check as appropriate:

NATIONAL BOARDS: Have you ever taken the National Boards? _____ Yes _____ No

PMLEXIS: Have you ever taken the PMLexis examination? _____ Yes _____ No
If yes, have a **certified copy** of your results forwarded to this office by the National Board of Podiatric Medical Examiners (see attached form).

STATE EXAMINATION: Have you ever taken a state Podiatric Board Examination? ___ Yes ___No
If yes, make sure that the scores are included on the Certificate of Podiatric Medical Licensure to be sent to that Board (see attached Certificate of Podiatric Medical Licensure).

Part II

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

22. Have you ever applied for and been denied a license to practice podiatric medicine or any other healing art?
_____Yes _____No

23. Have you ever withdrawn an application for a license to practice podiatric medicine or any other healing art?
_____Yes _____No

24. Have you ever voluntarily surrendered or resigned a license to practice podiatric medicine or any other healing art in lieu of disciplinary action or any other reason?

_____Yes _____No

25. 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

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

_____Yes _____No

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

_____Yes _____No

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

_____Yes _____No

29. 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

30. 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

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

_____Yes _____No

32. 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

Confidential Section (The following section is exempt from public disclosure)

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

33. 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

34. To your knowledge, are you presently the subject of criminal investigation under which you have charged?

_____Yes _____No

MEDICAL QUESTIONS

Please answer "**Yes**" or "**No**" to the questions below. Definitions are provided to assist you in answering. Please explain any "**Yes**" answers on Form A.

DEFINITIONS

In answering the following questions, please use these definitions:

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
2. 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
3. The physical capability to perform medical tasks and 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 podiatrist.

"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.

35. 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.

36. 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.

37. 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, part of each license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a **confidential** program for the identification, treatment and rehabilitation of practitioners 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 III - Statutory Profile Questions

Vermont law, 26 VSA § 1368, creates a data repository within the Department of Health. Under this law, the Department must collect certain information to create individual profiles on all health care professionals licensed, certified, or registered by the Department pursuant to Title 26 of the VSA. Please try to answer the following questions as best you can. You will receive a copy of your profile prior to its initial release to the public and each time the profile is modified or amended. You will be given a reasonable time to correct factual inaccuracies that appear in such profile. As noted below, certain questions do not need to be answered.

It is very important for us to receive copies of court papers, licensing and certification authority decisions, and other documents relevant to the questions below in order to have a true and accurate description of the actions taken.

38. **Criminal Convictions** [See 26 VSA § 1368(a)(1)]

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. For purposes of this question, "convicted" means that you pleaded guilty or that you were found or adjudged guilty by a court of competent jurisdiction. **Please provide copies of papers fully documenting the convictions.**

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

39. **Nolo Contendere/Matters Continued** [See 26 VSA § 1368(a)(2)]

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 copies of papers fully documenting these matters.**

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

40. **Vermont Board of Medical Practice Matters** [See 26 VSA § 1368(a)(3)]

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)

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

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 copies of papers fully documenting these matters.**

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

42. **Restriction of Hospital Privileges** [See 26 VSA § 1368(a)(5)]

A. 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 copies of papers fully documenting these matters.**

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

B. Other Restrictions

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 copies of papers fully documenting these matters.**

(Date) (Hospital) (State)

(Nature of Action) (Action)

(Reason for Action) ☐ In lieu ☐ In settlement

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

A. Judgments

Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you in which a payment was awarded to a complaining party. **Please provide copies of papers fully documenting these matters.**

☐ Judgement ☐ Arbitration

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

☐ Judgement ☐ Arbitration

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

B. Settlements

Please provide a description of all settlements of medical malpractice claims against you in which a payment was awarded to a complaining party. **Please provide copies of papers fully documenting these matters.**

(Date) (Court) (State) (Amount of Settlement Against You)

(Date) (Court) (State) (Amount of Settlement Against You)

44. **Years of Practice** [See 26 VSA § 1368(a)(10)]

What month and year did you start practicing as a podiatrist?

45. **Hospital Privileges** [See 26 VSA § 1368(a)(11)]

List all hospitals where you currently have hospital staff privileges:

(Name) (City) (State) (Year Started)

(Name) (City) (State) (Year Started)

(Name) (City) (State) (Year Started)

46. **Appointments/Teaching** [See 26 VSA § 1368(a)(12)]

Note: Answering #46 is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. Appointments

Please provide information about your appointments to medical school or professional school faculties.

(School) (City) (State) (Nature of Appointment) From (year) To (year)

(School) (City) (State) (Nature of Appointment) From (year) To (year)

B. Teaching

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years.

(School/Institution) (City) (State) (Nature of Teaching) From (year) To (year)

47. **Publications** [See 26 VSA § 1368(a)(13)]

Note: Answering #47 is optional. By answering, you are granting permission to have this information posted on the web.

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years.

(Title) (Publication) (Year)

(Title) (Publication) (Year)

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

Note: Answering #48 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)

Part IV – Interview, Photograph and Signature

A. In which part of Vermont would you prefer to be interviewed? (Northern – Burlington area, Southern – Springfield, Central – Montpelier, video technology or webcam.)

_____

B. When are you scheduled to begin work in Vermont? _____

C. Where will the primary setting of your practice be located?

_____

D. Brief Description of your anticipated practice.

_____

E. What has been your physical residence (city, state) in the past ten years?

_____

_____

PROVIDE A PHOTOGRAPH: Attach a photograph below, taken within the last 60 days (head and shoulders). Proofs are not acceptable. Sign the front of the photograph. **Please do not use staples.**

Reminder - You must also complete the enclosed Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions.

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:_____ _____

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

REVOCATION 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_____

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.

_____ _____

Date Signature

FORM B

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

FORM B: 1) AUTHORIZATION FOR RELEASE OF RECORDS AND INFORMATION AND 2) AUTHORIZATION TO COMMUNICATE WITH FUTURE EMPLOYERS REGARDING THE STATUS IF YOUR APPLICATION

TO WHOM IT MAY CONCERN:

I, _____ HEREBY AUTHORIZE YOU to furnish to
(Name of Applicant)

the Vermont Board of Medical Practice or its designated representative, all materials and information within your possession or control relating to me, of whatever kind and wherever located and including, but not limited to, my professional experience and qualifications, my licensing history, my practice as a podiatrist, and any other material or information, including investigative files, which, in the sole discretion of the Vermont Board of Medical Practice, may be useful to said Board in its review of my certification status.

Only in regard to this specific authorization for disclosure to the Vermont Board of Medical Practice and for no other purpose, I expressly WAIVE confidentiality and any privileges or immunities accorded this information by State or Federal Law, and I hold you harmless from disclosure of same to the Vermont Board of Medical Practice.

YOU ARE ALSO AUTHORIZED to report information, either orally or in writing, directly to the Vermont Board of Medical Practice or its designated representative on a continuing basis until this authorization is revoked, by me, in writing.

A CONFORMED PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL SERVE IN ITS STEAD.

2) I further authorize the Vermont Board of Medical Practice to communicate with future employers and/or locum tenens companies regarding the status of my application for licensure.

Signature: _____

Date: _____

Print or Type Name: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: (_____)_____

Subscribed and sworn to before me, this_____day of _____

_____

Notary Public

RETURN ORIGINAL TO THE BOARD WITH YOUR APPLICATION
SEND COPIES WITH THE REFERENCE FORMS

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

(Questions 22 and 23) Withdrawal or denial of License - Attach documents

State_____ Year_____
Circumstances under which license was withdrawn, denied, revoked, not renewed, or otherwise terminated_____

_____

(Question 24) Voluntarily surrendered or resigned a license to practice medicine or any healing art - Attach documents

State_____ Year_____

Circumstances_____

_____

(Question 25) Disciplinary charges or action - Attach documents

Name of organization involved_____ Date_____

Duration_____

Action taken (circle all that apply)

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

Circumstances_____

_____

_____

(Question 26) Denial of examination privileges - Attach documents

State_____ Year_____

Circumstances under which examination privileges denied _____

_____

_____

(Questions 27 and 28) Residency Training Program(s) not completed - discontinued education, training, practice - Attach documents

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances _____

_____

(Question 29) Affecting Health Care Institution Staff Privileges, Employment or Appointment - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances _____

_____

(Question 30) Privilege to prescribe controlled substances - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

_____

_____

_____

_____

(Questions 31 and 34) Criminal Investigation - Proceeding - Attach documents

Court _____

City and State _____

Charge _____

Description _____

_____

_____

Status _____

_____

Conviction? _____ Yes _____ No Date _____

Plea? _____ Yes _____ No Date _____

(Question 32) Internet prescribing

Please provide a general description of your practice of internet prescribing

_____

_____

(Question 33) Investigation by any other licensing board - Attach documents

Name of Licensing Board_____ Date _____

Location of Licensing Board_____

Circumstances_____

(Questions 35-37) 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 43) 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:

_____

_____

_____

Reference Form #1 Return Directly to the Board

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

REFERENCE FORM TO BE COMPLETED BY CHIEF OF SERVICE OR PROGRAM DIRECTOR

Name of applicant: _____
The person named above has applied to the Vermont Board of Medical Practice for a license to practice as a podiatrist in Vermont. 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 _____ was at _____

from _____ to _____. During that time, he/she

was (list status in 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 to be expected in a podiatrist:	_____ 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 skills in the tasks delegated:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Cooperativeness ability to work with others:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Willingness to accept directions and limitations in role:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
History & physical exam:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Record keeping:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Podiatrist-Patient relationship:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Track record in adhering to scope of practice:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Ability to communicate in reading, writing and speaking the English language:	_____ Poor	_____ Fair	_____ Average	_____ Above Average

Return Directly to the Board

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

REFERENCE FORM TO BE COMPLETED BY CHIEF OF SERVICE OR PROGRAM DIRECTOR

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 as a podiatrist?	____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?	____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 training program(s)?	____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 podiatrist, he/she was competent to practice as a podiatrist and he/she was not the subject of any disciplinary action.

I recommend _____ for licensure in Vermont.

Signed: _____ Date: _____

Print or Type Name and Title: _____

Reference Form #2

Return Directly to the Board

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

Name of applicant: _____
The person named above has applied to the Vermont Board of Medical Practice for a license to practice as a podiatrist in Vermont. 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 _____ was at _____

from _____ to _____. During that time, he/she

was (list status in 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 to be expected in a podiatrist:	_____ 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 skills in the tasks delegated:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Cooperativeness ability to work with others:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Willingness to accept directions and limitations in role:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
History & physical exam:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Record keeping:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Podiatrist-Patient relationship:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Track record in adhering to scope of practice:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Ability to communicate in reading, writing and speaking the English language:	_____ Poor	_____ Fair	_____ Average	_____ Above Average

Return Directly to the Board

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

REFERENCE FORM TO BE COMPLETED BY PHYSICIAN/PODIATRIST WORKED WITH MOST RECENTLY PAGE TWO OF TWO

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 as a podiatrist?	____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?	____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 training program(s)?	____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 podiatrist, he/she was competent to practice as a podiatrist and he/she was not the subject of any disciplinary action.

I recommend _____ for licensure in Vermont.

Signed: _____ Date: _____

Print or Type Name and Title: _____

Reference Form #3

Return Directly to the Board

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

Name of applicant: _____
The person named above has applied to the Vermont Board of Medical Practice for a certification to practice as a podiatrist in Vermont. 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 _____ was at _____

from _____ to _____. During that time, he/she

was (list status in 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 to be expected in a podiatrist:	_____ 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 skills in the tasks delegated:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Cooperativeness ability to work with others:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Willingness to accept directions and limitations in role:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
History & physical exam:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Record keeping:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Podiatrist-Patient relationship:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Track record in adhering to scope of practice:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Ability to communicate in reading, writing and speaking the English language:	_____ Poor	_____ Fair	_____ Average	_____ Above Average

Return Directly to the Board

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

REFERENCE FORM TO BE COMPLETED BY PHYSICIAN/PODIATRIST WORKED WITH MOST RECENTLY PAGE TWO OF TWO

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 as a podiatrist?	____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?	____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 training program(s)?	____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 podiatrist, he/she was competent to practice as a podiatrist and he/she was not the subject of any disciplinary action.

I recommend _____ for licensure in Vermont.

Signed: _____ Date: _____

Print or Type Name and Title: _____

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
P.O. Box 70, Burlington, VT 05402

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

_____ on _____ and
(City/State) (Date)

completed all requirements for graduation on _____.
(Date)

A _____ was granted on
_____.
(specify Certificate/Diploma/Degree) (Date)

_____
Signature of Authorized Officer of the School

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

_____
Date

Vermont Department of Health
Board of Medical Practice
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
medicalboard@vdh.state.vt.us
802-657-4220 or 800-745-7371

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
(Name)

in the _____
Program Type (residency, fellowship)

_____
Department (e.g. Radiology, Internal Medicine)

At this institution from _____ to _____
mm/dd/yy mm/dd/yy

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/yy

Date: _____

Signed: _____ (AFFIX SEAL)
(Official of the Sponsoring Institution)

Print Name: _____

Title: _____

Return directly to the Board

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
P.O. Box 70, Burlington, VT 05402

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

_____ [Affix Seal]
Printed Name of authorized representative

_____
Date

REQUEST FOR NBPME SCORES
Please print firmly and complete all items. Send this form to:
THOMSON PROMETRIC-NBPME
2000 LENOX Drive, 3rd Floor, Lawrenceville, NJ 08648
Phone: 877-302-8952

Date _____ Year of Graduation _____ Social Security # = OPTIONAL

Check scores to be sent: Part I _____ Part II _____ Phone

NAME ADDRESS CITY/STATE/ZIP

← This is a mailing label
Please print your full name and address.

FEE: $35.00

The fee covers the transmittal of Part I and Part II scores and must accompany each request.

Make check payable to NBPME.

Your signature

A copy is forwarded to the address listed below with your NBPME scores.

A copy remains in our office file.

Please retain a copy for your file.

This is a mailing label

Please print below the exact name, office, and address to which scores are to be sent.

NAME ADDRESS CITY/STATE/ZIP

Date scores sent _____
Board Use Only

Federation of Podiatric Medical Boards

PMLexis/Part III Score & Disciplinary Reports

Please fill out the form below to request your PMLexis/Part III Score Reports or Disciplinary Reports to be sent to State Boards only. Personal reports cannot be sent to individuals. On the next screen you will have the option to pay online by credit card or to print out a form to mail in with a check.

MANAGED CARE GROUPS: Managed Care Groups must send reports by mail (click here for address). This form is reserved strictly for individuals ordering reports to be sent to State Boards.

First Name:

Middle Name: (optional)

Last Name:

Maiden Name: (optional)

Date Of Birth: (use 4-digit year) *(Sample: 1/1/1900)*

Social Security Number: *(Sample: 123-45-6789)*

Phone Number: *(Sample: 561-555-1212)*

E-Mail Address:

ADDRESS

(If you plan on paying by credit card, this address must match the address on file with your credit card. If you plan on paying by check and mailing your request, use your mailing address.)

Address:

Address (line 2): (optional)

City:

State: [Select a State]

Zip Code: *(Sample: 00000)*

MAILING ADDRESS ☐ **Click this box if your Mailing address is different than above.**

You must make at least one selection below. It is permissible to select both.

☐ **Click this box to request PMLexis/Part III Score Reports.**

☐ **Click this box to request Disciplinary Reports.**

TOTAL CHARGES: $0.00* Cancel / Home NEXT

***Disciplinary reports are offered at a reduced rate when sent to State Boards who are paid up members of the Federation of Podiatric Medical Boards.**

Customer Service: 561-752-3735 / Privacy Policy & Security Statement

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NATIONAL PRACTITIONER DATA BANK
HEALTHCARE INTEGRITY and PROTECTION DATA BANK
PO Box 10832, Chantilly, Virginia 20153-0832
www.npdb-hipdb.com

On-line Self-Query Process

- Log-on to web site for NPDB as shown above

TO SUBMIT A QUERY:

- Select "Report to and Query the Data Banks"
- Click on "Perform a Self-Query"
- Select the type of self-query you wish to perform
  Individual or organization

- Provide ALL required information

- Provide your credit card information (VISA, MasterCard, or Discover)
  (Checks or cash not accepted)

- Once all information is complete, click CONTINUE. A formatted copy of the self-query is generated immediately with a Data Bank Control Number (DCN) listed at the top of the page. Print this formatted copy, and keep the DCN to monitor the processing status of your self-query. To print a query from the IQRS, you must have Adobe Acrobat Reader version 4.0 or higher installed on your computer.

- To complete the self-query process, you **must sign the formatted self-query application in the presence of a notary public** and mail it to the NPDB-HIPDB. Self-queries received without notarization or with an incomplete notarization are rejected. Notarized forms that are missing credit card information will be rejected.

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

NATIONAL PRACTITIONER DATA BANK SELF QUERY

Effective September 1, 1990, the Federal government opened the National Practitioner Data Bank. This data bank, mandated by Congress, tracks regulatory board disciplinary actions, certain actions resulting from peer review and malpractice payments.

You must self query this data bank on your own record as part of the application process for a Vermont medical license. Simply query the data bank using the attached form and when you receive the response, **SEND THE ORIGINAL, UNALTERED** response to the Board. You may keep a photocopy if you wish.

Before completing the data bank form, please contact the **Data Bank Help Line** for assistance: Help Line Toll Free Number: 1-800-767-6732.