

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

APPLICATION FOR LICENSE TO PRACTICE PODIATRIC MEDICINE IN VERMONT
LIMITED TEMPORARY PODIATRIST
APPLICATION 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 any other person. False statements on this form may be grounds for unprofessional conduct.

Please submit the following as part of your application.

- A check in the amount of \$70 payable to the Vermont Department of Health
- Applicant's statement regarding Child Support, Taxes, and Unemployment Compensation Contributions whether or not you have children
- Statement of Good Standing
- Copy of podiatric medical school diploma
- Direct verification**-The "CERTIFICATE OF PODIATRIC MEDICAL EDUCATION" form must be completed by the school of podiatric medicine and returned directly to the board.
- Direct verification**-The "CERTIFICATE OF MEDICAL LICENSURE" form must be completed by the Medical Board of each state where a license is or has been held (temporary or full).
- Copy of ECFMG certificate
- National Practitioner Data Bank Self Query (NPDB)
- CV/Resume
- Form A to provide explanations to yes answers

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

LIMITED TEMPORARY PODIATRIST LICENSE APPLICATION

I hereby make application for a Limited Temporary License to practice podiatric medicine and surgery as an intern, resident, fellow or medical officer in the State of Vermont at the _____ Hospital or Institution, Department of _____, under the supervision of _____, DPM and submit the following information.

Part I

1. Name: _____
(Last) (First) (Middle) (Extension)
a. Have you ever legally changed your name? ___Yes___ No
If yes, enter your former name, or other name under which you were licensed in Vermont or elsewhere in the past two years; _____
b. Your name, as it should appear on your license: _____

2. Date of Birth: _____
(Month) (Day) (Year)

3. Home Address: _____
(Street)

(City) (State) (Zip)

4. Work Address: _____
(Street)

(City) (State) (Zip)

5. Please check your preferred mailing address: ___Home___ ___Work___
NOTE: The mailing address will be listed on the Board's web site.

6. Home Telephone Number: (_____) _____

7. Work Telephone Number: (_____) _____

8. E-mail address: _____

Part II

9. Are you currently participating in residency or fellowship training? yes no

10. Do you hold, or have you ever held, a medical license (including temporary) in any other state? yes no
If yes, complete the section below:

State	License Number	Type of License	Date Issued	Status (Active or Inactive)

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

11. Have you ever applied for and been denied a license to practice podiatric medicine or any other healing art?
 yes no
12. Have you ever withdrawn an application for a license to practice podiatric medicine or any other healing art?
 yes no
13. Have you ever voluntarily suspended, 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
14. 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
15. Have you ever been denied the privilege of taking an examination before any state medical examining board?
 yes no
16. Have you ever discontinued your education, training, or practice for a period of more than three months?
 yes no
17. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?
 yes no
18. 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
19. 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
20. Are you presently or have you ever been a defendant in a criminal proceeding?
 yes no
21. Do you currently or have you ever prescribed any prescription medication over the internet?
 yes no

Part III

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.

22. 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

23. To your knowledge, are you presently the subject of criminal investigation under which you have not been charged?

yes no

The following definitions are provided to assist you in answering the following questions. Please explain any "Yes" answers on Form A.

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make appropriate clinical diagnoses 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 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.

24. 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.

25. 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.

26. 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 physicians 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

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 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.

27. **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.**

Not applicable

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

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

28. **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.**

Not applicable

(Conviction Date)	(Court)	(City/State)	(Charge)
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(Conviction Date)	(Court)	(City/State)	(Charge)
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29. **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.
 Not applicable

(Date) (Final Disposition - Summary)

30. **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.**
 Not applicable

(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)

31. **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.**

Not applicable

(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.**

Not applicable

(Date) (Hospital) (State)

(Nature of Action) (Action)

(Reason for Action) In lieu In settlement

32. **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.**

Not applicable

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.**

Not applicable

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

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

33. Podiatric Medical Professional Schools [See 26 VSA § 1368(a)(7)]

Please provide the names of podiatric professional schools you attended and the dates of graduation. Please attach a copy of diploma.

(School/Institution) (Specialty) (City) (State) (Year of Graduation/Anticipated Year of Graduation)

(School/Institution) (Specialty) (City) (State) (Year of Graduation/Anticipated Year of Graduation)

If necessary, please use an additional sheet and check this box:

34. Graduate Medical Education [See 26 VSA § 1368(a)(8)]

Please provide information about any graduate podiatric medical education that you have received or will receive.

(School/Institution) (Specialty) (City) (State) (Year of Graduation) (Anticipated Training)

(School/Institution) (Specialty) (City) (State) (Year of Graduation) (Anticipated Training)

If necessary, please use an additional sheet and check this box:

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

What month and year did you start practicing as a podiatrist (including residency)?

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

List all hospitals where you currently have hospital staff privileges. Not applicable

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

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

37. **Appointments/Teaching** [See 26 VSA § 1368(a)(12)] Not applicable

Note: Answering #37 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)

38. **Publications** [See 26 VSA § 1368(a)(13)] Not applicable

Note: Answering #38 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. Not applicable

(Title) (Publication) (Year)

(Title) (Publication) (Year)

39. **Activities** [See 26 VSA § 1368(a)(14)] Not applicable

Note: Answering #39 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)

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

What is the location of your primary practice setting? Not applicable

Town or City

State

41. **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? Not applicable

If yes, please describe here the translating services available:

42. **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

Photograph

PLEASE PROVIDE A PHOTOGRAPH:
Attach a recent photograph (head and shoulders). Proofs are not acceptable. Please sign the front of the photograph. Do not use staples.



PHOTOGRAPH

Part VI

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

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

**Vermont Department of Health
Board of Medical Practice
P.O. Box 70, Burlington, VT 05402**

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

Withdrawal or denial of License (Questions 11 and 12) - Attach documents

State _____ Year _____

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

Voluntarily surrendered or resigned a license to practice podiatric medicine or any healing art (Question 13) - Attach documents

State _____ Year _____

Circumstances _____

Disciplinary charges or action (Question 14) - 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 _____

Denial of examination privileges (Question 15) - Attach documents

State _____ Year _____

Circumstances under which examination privileges denied _____

Residency Training Program(s) not completed - discontinued education, training, practice (Questions 16 and 17) - Attach documents

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances _____

Affecting Health Care Institution Staff Privileges, Employment or Appointment (Question 18) - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances _____

Privilege to prescribe controlled substances (Question 19) - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

Criminal Investigation - Proceeding (Questions 20 and 23) - Attach documents

Court _____

City and State _____

Charge _____

Description _____

Status _____

Conviction? Yes No Date _____

Plea? _____ Yes _____ No _____ Date _____

Investigation by any other licensing board (Question 21) - Attach documents

Name of Licensing Board _____ Date _____

Location of Licensing Board _____

Circumstances _____

(Question 21) Internet prescribing

Please provide a general description of your practice of internet prescribing

Medical condition, treatment, use of chemical or illegal substances (Questions 24-26)

Treating organization _____

Address _____ Telephone _____

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

Dates of illness of dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____ Telephone _____

Contact person at Program _____

(Question 32) 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:

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

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
P.O. BOX 70
BURLINGTON, VT 05402-0070
(802) 657-4220

APPLICATION FOR LIMITED TEMPORARY PODIATRIST LICENSE

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)

completed all requirements for graduation on _____
(Date)

A _____ was granted/will be granted on
(Specify Certificate/Diploma/Degree).

(Date)

Date: _____

Signed: _____

[Affix Seal]

Printed Name: _____

Title: _____

VERMONT DEPARTMENT OF HEALTH
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108 CHERRY STREET
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APPLICATION FOR LIMITED TEMPORARY PODIATRIST LICENSE

CERTIFICATE OF 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, including a limited temporary and/or training license.

I, _____, Secretary of the _____ State board of medical examiners, certify that _____ was granted Certificate Number _____ to practice medicine in the State of _____ on the _____ day of _____, _____, and that said certificate has never been revoked, suspended or conditioned in any way, or the licensee has never been disciplined by the board in any way.

NOTE: If licensed by written examination, the secretary 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.)

Date: _____

Signed: _____

[Affix Seal]

Printed Name: _____

Title: _____

VERMONT DEPARTMENT OF HEALTH
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APPLICATION FOR LIMITED TEMPORARY PODIATRIST LICENSE

STATEMENT OF SUPERVISING PODIATRIST/ PROGRAM DIRECTOR

This section must be completed by the Supervising podiatrist/Program Director who will be supervising your work in Vermont. This licensed podiatrist will be responsible and liable for all negligent and wrongful acts or omissions of the limited temporary license holder. Termination of appointment as an intern, resident, fellow or medical officer of such designated hospital or institution shall operate as a revocation of such limited temporary license. This limited temporary license shall be revoked upon the death or legal incompetence of the licensed physician or upon ten days written notice of the licensed physician.

I certify that (name of applicant) _____ is under my direct supervision and control in a approved residency program at:

Hospital or Institution:

Department:

Address:

City, State, Zip Code

For the period _____ to _____

I state that the above applicant is under my direct supervision and control. I further state that I shall be legally responsible and liable for all negligent or wrongful acts or omissions of this limited temporary license holder.

Signature of Program Director/Supervising Podiatrist

Program Director/Supervising Podiatrist's Vermont License Number

Printed Name of Program Director/Supervising Podiatrist

Date

Address

City, State, Zip Code

PLEASE MAIL COMPLETED FORM TO THE BOARD'S ADDRESS LISTED ABOVE. THANK YOU.

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
P.O. BOX 70
BURLINGTON, VT 05402-0070
(802) 657-4220

APPLICATION FOR LIMITED TEMPORARY PODIATRIST LICENSE
STATEMENT OF THE PROGRAM DIRECTOR

(THIS FORM TO BE USED FOR RESIDENTS PARTICIPATING IN AN AWAY ROTATION ONLY)

This section must be completed by the Director of the residency program in which the applicant is currently engaged.

I certify that (name of applicant) _____ is engaged as an intern, resident, fellow or medical officer at:

Hospital or Institution:

Department:

Address:

City, State, Zip Code

For the period _____ to _____

I further state that (name of applicant) _____ is a resident/fellow in good standing and is scheduled to participate in an *away rotation* at:

Hospital or Institution:

Department:

Address:

City, State, Zip Code

For a period of _____ to _____. This is an approved rotation within the framework of the residency program.

Signature of Program Director

Date

Printed Name of Program Director

PLEASE MAIL COMPLETED FORM TO THE BOARD'S ADDRESS LISTED ABOVE. THANK YOU.

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'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

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.