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 MEDICINE IN VERMONT
LIMITED TEMPORARY PHYSICIAN
APPLICATION CHECKLIST

Application for License to Practice 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 medical school diploma
- ☐ **Direct verification**-The "CERTIFICATE OF MEDICAL EDUCATION" form must be completed by the school of 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 PHYSICIAN LICENSE APPLICATION

I hereby make application for a Limited Temporary License to practice 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 _____, MD 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 medicine or any other healing art?
□ yes □ no

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 Have you ever withdrawn an application for a license to practice medicine or any other healing art?

□ yes □ no

13. Have you ever voluntarily suspended, surrendered or resigned a license to practice 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)
(Conviction Date)	(Court)	(City/State)	(Charge)

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)

_____ □ In lieu □ In settlement
(Reason for Action)

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

Please provide the names of medical professional schools you attended and the dates of graduation. (We will have similar information on file with your original application; we are asking you here to provide an update for the statutory web profile.) 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 medical education that you have received or will receive. (We will have similar information on file with your original application; we are asking you here to provide an update for the statutory web profile.)

(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. **Specialty Board Certification** [See 26 VSA § 1368(a)(9)]

Enter up to three specialty codes from the enclosed ***Specialty Codes List***. List your primary specialty first. If you cannot locate a specialty, please write the specialty name in the space provided.

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
		☐ yes ☐ no			
		☐ yes ☐ no			
		☐ yes ☐ no			

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

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

_____

37. **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)

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

Note: Answering #38 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)

39. **Publications** [See 26 VSA § 1368(a)(13)] ☐ 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 publications in peer-reviewed medical literature within the past 10 years. ☐ Not applicable

(Title) (Publication) (Year)

(Title) (Publication) (Year)

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

Note: Answering #40 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)

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

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

Town or City State

42. **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:

43. **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 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
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_____

_____

_____

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, PO Box 70
Burlington, VT 05402-0070
medicalboard@vdh.state.vt.us
802-657-4220 or 800-745-7371

FORM B

1. **AUTHORIZATION FOR RELEASE OF RECORDS AND INFORMATION AND**
2. **AUTHORIZATION TO COMMUNICATE WITH FUTURE EMPLOYERS REGARDING THE STATUS OF 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, 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 licensing 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.

Signature: _____

Date: _____

Print or Type Name: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: (_____) _____

Subscribed and sworn to before me, this _____ day of _____

_____ Notary Public

A CONFORMED COPY, ATTEST _____
Notary Public

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

SPECIALTY CODES LIST

(primary care specialties in boldface)

0101 Allergy and Immunology
0102 Clinical & Laboratory Immunology

0201 Anesthesiology
0202 Critical Care Medicine
0203 Pain Management

0301 Colon & Rectal Surgery

0401 Dermatology
0402 Dermatopathology
0403 Clinical & Laboratory Dermatology
0404 Dermatological Immunology

0501 Emergency Medicine
0502 Medical Toxicology
0503 Pediatric Emergency Medicine
0504 Sports Medicine

0601 Family Practice
0602 Geriatric Medicine
0603 Sports Medicine

0701 Internal Medicine
0702 Adolescent Medicine
0703 Cardiac Electrophysiology
0704 Cardiovascular Disease
0705 Critical Care Medicine
0706 Clinical & Lab Immunology
0707 Endocrinology Diabetes & Metabolism
0708 Gastroenterology
0709 Geriatric Medicine
0710 Hematology
0711 Infectious Disease
0712 Medical Oncology
0713 Nephrology
0714 Pulmonary Disease
0715 Rheumatology
0716 Sports Medicine

0801 Medical Genetics
0802 Clinical Biochemical Genetics
0803 Clinical Biochemical/Molecular Genetics
0804 Clinical Cytogenetics
0805 Clinical Genetics (Md)
0806 Clinical Molecular Genetics

0901 Neurological Surgery
0902 Critical Care Medicine
1001 Nuclear Medicine

1101 Obstetrics & Gynecology
1102 Critical Care Medicine
1103 Gynecologic Oncology
1104 Maternal & Fetal Medicine
1105 Reproductive Endocrinology

1201 Ophthalmology

1301 Orthopaedic Surgery
1302 Hand Surgery

1401 Otolaryngology
1402 Otology/Neurotology
1403 Pediatric Otolaryngology
1501 Anatomic & Clinical Pathology
1502 Anatomic Pathology
1503 Clinical Pathology
1504 Blood Banking/Transfusion Medicine
1505 Chemical Pathology
1506 Cytopathology
1507 Dermatopathology
1508 Forensic Pathology
1509 Hematology
1510 Immunopathology
1511 Medical Microbiology
1512 Neuropathology
1513 Pediatric Pathology

1601 Pediatrics
1602 Adolescent Medicine
1603 Clinical & Laboratory Immunology
1604 Medical Toxicology
1605 Neonatal-Perinatal Medicine
1606 Pediatric Cardiology
1607 Pediatric Critical Care Medicine
1608 Pediatric Emergency Medicine
1609 Pediatric Endocrinology
1610 Pediatric Gastroenterology
1611 Pediatric Hematology-Oncology
1612 Pediatric Infectious Disease
1613 Pediatric Nephrology
1614 Pediatric Pulmonology
1615 Pediatric Rheumatology
1616 Pediatric Sports Medicine
1617 Children with Special Health Needs

1701 Physical Medicine & Rehabilitation

1801 Plastic Surgery
1802 Hand Surgery

1901 Preventive Medicine
1902 Aerospace Medicine
1903 Occupational Medicine
1904 Public Health & General Preventive
1905 Medical Toxicology
1906 Underseas Medicine

Psychiatry & Neurology
(Board Name - Not A Specialty)
2001 Psychiatry
2002 Neurology
2003 Neurology With Special Qualifications In Child Neurology
2004 Addiction Psychiatry
2005 Child & Adolescent Psychiatry
2006 Forensic Psychiatry
2007 Geriatric Psychiatry
2008 Clinical Neurophysiology

2101 Radiology
2102 Diagnostic Radiology
2103 Radiation Oncology
2104 Radiological Physics
2105 Nuclear Radiology
2106 Pediatric Radiology
2107 Vascular & Interventional Radiology
2201 Surgery
2202 Surgery Of The Hand
2203 Pediatric Surgery
2204 Surgical Critical Care
2205 General Vascular Surgery
2301 Thoracic Surgery

2401 Urology

4001 Abdominal Surgery
4002 Acupuncture
4003 Addiction Medicine
4004 Adult Reconstructive Orthopedics
4005 Allergy

4006 Cardiovascular Surgery
4007 Clinical Pharmacology
4008 Diabetes

4009 Facial Plastic Surgery

4010 General Practice

4011 Gynecology
4012 Head & Neck Surgery
4013 Hepatology
4014 Homeopathic Medicine
4015 Immunology

4016 Legal Medicine
4017 Musculoskeletal Oncology
4018 Neuroradiology
4019 Nutrition
4020 Obstetrics

4021 Oral & Maxillofacial Surgery
4022 Orthopedic Surgery Of The Spine
4023 Orthopedic Trauma
4024 Pain Medicine
4025 Pediatric Allergy

4026 Pediatric Ophthalmology
4027 Pediatric Orthopedics
4028 Pediatric Surgery (Neurology)
4029 Pediatric Urology
4030 Psychoanalysis

4031 Radioisotopic Pathology
4032 Sports Medicine (Orthopedic Surgery)
4033 Traumatic Surgery
4034 Sleep Medicine

9001 Rotating Internship (Residency)
9999 Other - Please Specify

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 LICENSE

CERTIFICATE OF MEDICAL EDUCATION

To be completed by an ***officer of your school of medicine***

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

_____ School of 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
BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
P.O. BOX 70
BURLINGTON, VT 05402-0070
(802) 657-4220

APPLICATION FOR LIMITED TEMPORARY 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

BOARD OF MEDICAL PRACTICE

P.O. BOX 70
BURLINGTON, VT 05402-0070
(802) 657-4220

LIMITED TEMPORARY LICENSE APPLICATION
STATEMENT OF PROGRAM DIRECTOR/SUPERVISING PHYSICIAN

This section must be completed by the Program Director/physician who will be supervising your work in Vermont. This licensed physician 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 formal ACGME-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 Physician

_____
Program Director/Supervising Physician's Vermont License Number

_____
Printed Name of Program Director/Supervising Physician

_____
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

LIMITED TEMPORARY LICENSE APPLICATION
STATEMENT OF THE PROGRAM DIRECTOR

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.

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.

Vermont Department of Health – Board of Medical Practice

PRESCRIBER DATA-SHARING PROGRAM CONSENT FORM

Under Vermont's Act 80, a law passed in 2007, a prescriber may give consent so that his or her identifiable data in prescription drug records may be used for marketing or promoting prescription drugs. If a prescriber chooses not to consent, the use of prescriber's identifiable data in prescription drug records is restricted as provided for in the law. The text of the law is found at 18 V.S.A. § 4631. The Board of Medical Practice has provided a fact sheet with additional information about this law and its implementation.

If you choose to consent to the use of your identifiable data in prescription drug records for marketing or promoting prescription drugs, please check the "I consent" box and sign next to it. Your consent is effective for this licensing or certification period. If you choose not to consent, please leave this section blank. If you complete this form, please return it to the Board of Medical Practice with your completed license or certification application or renewal form.

You may revoke your consent at any time by signing the Revocation of Consent form and sending it to the Board of Medical Practice.

__ I consent _____ _____

Signature Date

_____ _____

Print Name Vermont License or Certification Number

VERMONT

Department of Health

THE VERMONT PRESCRIBER DATA-SHARING PROGRAM: FACT SHEET FOR PRESCRIBERS

Beginning January 1, 2008, Vermont licensed or certified health professionals with authority to prescribe and administer prescription drugs in the course of their professional practice ("prescribers") may consent to the use of their identifiable data for marketing or promoting prescription drugs as permitted by a new Vermont law known as Act 80. Prescribers may indicate their consent by signing the appropriate part of their professional license or certification application or renewal application form. The applicable professional licensing board will transmit the prescriber's consent to the Prescriber Data-Sharing Program administered by the Vermont Department of Health.

The text of the law is found at 18 V.S.A. § 4631. It also may be found online at: http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2008/acts/ACT080.HTM (See Section 17, Prescription Drug Data Confidentiality).

PLEASE NOTE: The Office of the Attorney General has determined that the law will not be enforced until at least September 1, 2008. The Prescriber Data-Sharing Program will accept and process consent forms submitted with new or renewal license or certification applications beginning January 1, 2008. However, the Attorney General's decision to defer enforcement means that a prescriber's identifiable data in prescription drug records may continue to be used for marketing or promoting prescription drugs until September 1, 2008, even though the prescriber has not consented to that use.

The delay in enforcement is necessary because license renewal schedules will not permit full implementation for some time. In the meantime, any prescriber who signs the consent as part of an initial or renewal license or certification application will be registered by the Prescriber Data-Sharing Program and that information will be available on the date the Office of the Attorney General determines the law should be enforced.

Further information and updates on the implementation of the Prescriber Data-Sharing Program are available online at: http://www.atg.state.vt.us/display.php?smod=151 under the heading "Prescription Drug Data Confidentiality Law."

VERMONT

Department of Health

THE VERMONT PRESCRIBER DATA-SHARING PROGRAM: FAQ (Frequently Asked Questions)

Q: Why is the consent form included with my 2008 application or renewal form if the law is not being enforced?
A: At this time, the Attorney General has determined to delay enforcement of the law at least until September 1, 2008. Therefore, the Prescriber Data-Sharing Program will begin accepting and registering consent forms as part of the prescriber's initial or renewal applications filed after January 1, 2008 so that the program will be ready for implementation when the law is enforced. You may obtain a copy of the letter explaining the Attorney General's position at: http://www.atg.state.vt.us/display.php?smod=151 under the heading "Prescription Drug Data Confidentiality Law."

Q: When the law is enforced, what will change?
A: The new law allows Vermont health care professionals to prevent, with some exceptions, the use of their prescriber identifiable data for the marketing and promotion of prescription drugs.

Q: What is my "prescriber identifiable data" and where does it come from?
A: Prescriber identifiable data refers to information, such as your name, in prescription drug records that identifies you as the prescriber for a particular prescription. A person with access to your prescriber identifiable data would know, for example, that you wrote a prescription for a particular drug and dose on a specified date, although the person would not know the name of the patient.

Q: What will happen if I sign the consent form?
A: Your consent will be registered with the Prescriber Data-Sharing Program. Ultimately, when the Attorney General begins to enforce the law, entities that want to use your prescriber identifiable data for prescription drug marketing and promotion purposes will be able to do so.

Q: What will happen if I don't sign the form?
A: If you don't sign the form, then you will not be registered in the Prescriber Data-Sharing Program and when the law is enforced those entities that want to use your prescriber identifiable data for prescription drug marketing and promotion purposes will not be able to do so.

Q: I want to file a consent form now. Where do I obtain the form?
A: Consent forms are routinely provided new applicants or as part of a renewal application for those health care professionals with prescribing authority. If you wish to file a consent form at any time separate from your application, please contact your licensing board and ask for a form. The consent forms will be available online by January 1, 2008 on the Board of Medical Practice and Office of Professional Regulation websites.

Q: I do not want to consent. How do I register my choice now?
A: The Prescriber Data-Sharing Program will maintain a registry of those prescribers who do consent and there will *not* be a registry of those who do not consent. If you choose not to consent, do not sign the form when you complete your new or renewal application when you return it to your professional licensing board.

Q: Will I have to renew my consent?
A: Yes. Consent forms will be registered for the license or certification period and you will receive another consent form with your next renewal application.

Q: What if I change my mind and want to revoke my consent?
A: After you have submitted a consent form, you may revoke your consent at any time. You may obtain a revocation form from your professional licensing board. The revocation forms will be available online by January 1, 2008 on the Board of Medical Practice and Office of Professional Regulation websites.

Q: Where can I obtain additional information about the law?
A: Further information and updates on the implementation of the Prescriber Data-Sharing Program are available online under the heading "Prescription Drug Data Confidentiality Law" at: http://www.atg.state.vt.us/display.php?smod=151