

Vermont Department of Health - Board of Medical Practice  
108 Cherry Street, PO Box 70  
Burlington, VT 05402-0070  
[medicalboard@vdh.state.vt.us](mailto: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? This does not include prescribing you would do using electronic medical records in your practice.  
 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)

\_\_\_\_\_  
(Reason for Action)  In lieu  In settlement

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

A. **Judgments**



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
		<input type="checkbox"/> yes <input type="checkbox"/> no			
		<input type="checkbox"/> yes <input type="checkbox"/> no			
		<input type="checkbox"/> yes <input type="checkbox"/> no			

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

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

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

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

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

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(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.

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

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(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.

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(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

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(Title) (Publication) (Year)

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(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

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(Activities or Awards)

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

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

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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:

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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         | 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 \_\_\_\_\_

**SPECIALTY CODES LIST**  
(primary care specialties in boldface)

0101 Allergy and Immunology	1503 Clinical Pathology	2301 Thoracic Surgery
0102 Clinical & Laboratory Immunology	1504 Blood Banking/Transfusion Medicine	
	1505 Chemical Pathology	2401 Urology
0201 Anesthesiology	1506 Cytopathology	
0202 Critical Care Medicine	1507 Dermatopathology	4001 Abdominal Surgery
0203 Pain Management	1508 Forensic Pathology	4002 Acupuncture
	1509 Hematology	4003 Addiction Medicine
0301 Colon & Rectal Surgery	1510 Immunopathology	4004 Adult Reconstructive Orthopedics
	1511 Medical Microbiology	4005 Allergy
0401 Dermatology	1512 Neuropathology	
0402 Dermatopathology	1513 Pediatric Pathology	4006 Cardiovascular Surgery
0403 Clinical & Laboratory Dermatology		4007 Clinical Pharmacology
0404 Dermatological Immunology	<b>1601 Pediatrics</b>	4008 Diabetes
	<b>1602 Adolescent Medicine</b>	
0501 Emergency Medicine	1603 Clinical & Laboratory Immunology	4009 Facial Plastic Surgery
0502 Medical Toxicology	1604 Medical Toxicology	
0503 Pediatric Emergency Medicine	1605 Neonatal-Perinatal Medicine	<b>4010 General Practice</b>
0504 Sports Medicine	1606 Pediatric Cardiology	
	1607 Pediatric Critical Care Medicine	<b>4011 Gynecology</b>
<b>0601 Family Practice</b>	1608 Pediatric Emergency Medicine	4012 Head & Neck Surgery
<b>0602 Geriatric Medicine</b>	1609 Pediatric Endocrinology	4013 Hepatology
0603 Sports Medicine	1610 Pediatric Gastroenterology	4014 Homeopathic Medicine
	1611 Pediatric Hematology-Oncology	4015 Immunology
<b>0701 Internal Medicine</b>	1612 Pediatric Infectious Disease	
<b>0702 Adolescent Medicine</b>	1613 Pediatric Nephrology	4016 Legal Medicine
0703 Cardiac Electrophysiology	1614 Pediatric Pulmonology	4017 Musculoskeletal Oncology
0704 Cardiovascular Disease	1615 Pediatric Rheumatology	4018 Neuroradiology
0705 Critical Care Medicine	1616 Pediatric Sports Medicine	4019 Nutrition
0706 Clinical & Lab Immunology	1617 Children with Special Health Needs	<b>4020 Obstetrics</b>
0707 Endocrinology Diabetes & Metabolism		
0708 Gastroenterology	1701 Physical Medicine & Rehabilitation	4021 Oral & Maxillofacial Surgery
<b>0709 Geriatric Medicine</b>		4022 Orthopedic Surgery Of The Spine
0710 Hematology	1801 Plastic Surgery	4023 Orthopedic Trauma
0711 Infectious Disease	1802 Hand Surgery	4024 Pain Medicine
0712 Medical Oncology		4025 Pediatric Allergy
0713 Nephrology	1901 Preventive Medicine	
0714 Pulmonary Disease	1902 Aerospace Medicine	4026 Pediatric Ophthalmology
0715 Rheumatology	1903 Occupational Medicine	4027 Pediatric Orthopedics
0716 Sports Medicine	1904 Public Health & General Preventive	4028 Pediatric Surgery (Neurology)
	1905 Medical Toxicology	4029 Pediatric Urology
0801 Medical Genetics	1906 Underseas Medicine	4030 Psychoanalysis
0802 Clinical Biochemical Genetics		
0803 Clinical Biochemical/Molecular Genetics	<b>Psychiatry &amp; Neurology</b>	4031 Radioisotopic Pathology
0804 Clinical Cytogenetics	(Board Name - Not A Specialty)	4032 Sports Medicine (Orthopedic Surgery)
0805 Clinical Genetics (Md)	2001 Psychiatry	4033 Traumatic Surgery
0806 Clinical Molecular Genetics	2002 Neurology	4034 Sleep Medicine
	2003 Neurology With Special Qualifications	
0901 Neurological Surgery	In Child Neurology	9001 Rotating Internship (Residency)
0902 Critical Care Medicine	2004 Addiction Psychiatry	9999 Other - Please Specify
1001 Nuclear Medicine	2005 Child & Adolescent Psychiatry	
	2006 Forensic Psychiatry	
<b>1101 Obstetrics &amp; Gynecology</b>	2007 Geriatric Psychiatry	
1102 Critical Care Medicine	2008 Clinical Neurophysiology	
1103 Gynecologic Oncology		
1104 Maternal & Fetal Medicine	2101 Radiology	
1105 Reproductive Endocrinology	2102 Diagnostic Radiology	
	2103 Radiation Oncology	
1201 Ophthalmology	2104 Radiological Physics	
	2105 Nuclear Radiology	
1301 Orthopaedic Surgery	2106 Pediatric Radiology	
1302 Hand Surgery	2107 Vascular & Interventional Radiology	
	2201 Surgery	
1401 Otolaryngology	2202 Surgery Of The Hand	
1402 Otolaryngology/Neurology	2203 Pediatric Surgery	
1403 Pediatric Otolaryngology	2204 Surgical Critical Care	
1501 Anatomic & Clinical Pathology	2205 General Vascular Surgery	
1502 Anatomic Pathology		

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  
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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 SUPERVISING PHYSICIAN/ PROGRAM DIRECTOR**

This section must be completed by the Supervising physician/Program Director 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 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.**

**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](http://healthvermont.gov/hc/med_board/bmp.aspx). You may check this site at any time to confirm your status. If you consent, your consent is effective until you revoke your consent. **If you wish to make a change, you may download consent and revocation forms at the web address above. If you do not have web access, you may contact your licensing board for assistance.**

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

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

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

\*\*\*\*\*

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

I consent:

\_\_\_\_\_  
Signature \_\_\_\_\_  
Date

\_\_\_\_\_  
Name (printed or typed)

\_\_\_\_\_  
License type (profession) \_\_\_\_\_  
Vermont License Number

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City, State, Zip

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

**REVOCAION OF CONSENT FORM**

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

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

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Name (printed or typed)

\_\_\_\_\_  
License type (profession) Vermont License Number

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City, State, Zip

Please mail your completed form to:

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

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.