

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

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

Agency of Human Services

### Memorandum

TO: Physician Assistant

FROM: Medical Practice Board

DATE: October 31, 2009

RE: 2010 Physician Assistant Certification Renewal Instructions

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

#### INSTRUCTIONS

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

#### Be sure to enclose:

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

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

#### **Please Note:**

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

Thank you.



DEPARTMENT OF HEALTH  
BOARD OF MEDICAL PRACTICE  
108 Cherry Street, PO Box 70  
Burlington VT 05402-0070  
802 657-4220 or 800-745-7371

**2010 PHYSICIAN ASSISTANT CERTIFICATION RENEWAL APPLICATION**

**PART I**

Certificate #055-\_\_\_\_\_

1. Name: \_\_\_\_\_

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

\_\_\_\_\_

3. Work Address:

\_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

4. Home Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

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

5. Email Address \_\_\_\_\_

6. Daytime Telephone Number: Area Code:

\_\_\_\_\_

7. Date of Birth:

\_\_\_\_\_

8. Place of Birth: \_\_\_\_\_

9. Certification Examination Taken – (Check box and enter date of examination):

- ( \_\_\_/\_\_\_/\_\_\_ ) NCCPA
- ( \_\_\_/\_\_\_/\_\_\_ ) State Examination-Identify state: \_\_\_\_\_
- ( \_\_\_/\_\_\_/\_\_\_ ) Other Examination specify: \_\_\_\_\_

10. Basis for Vermont Certification – (Check box):

- Apprenticeship Trained
- University Trained

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

Hospital Name(s) and Location(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. In what year did you start working as a physician assistant in Vermont? \_\_\_\_\_

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

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

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

16. Specialty: \_\_\_\_\_ DEA Number: \_\_\_\_\_

17. Name and office address of current EMPLOYER:

Name	Address
_____	_____

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

Primary Supervising Physician(s):

Name	Address
_____	_____
_____	_____

Secondary Supervising Physician(s):

Name	Address
_____	_____
_____	_____

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

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

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

21. Continuing Medical Education (CME) requirements:

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

b. For all others, an explanation of requirements and a CME Record form must be completed.

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

## PART II

"Yes" answers to Questions 23 - 47 require an explanation on Form A.

23. Have you ever applied for and been denied a certificate to practice medicine or any other healing art?  
 yes  no
24. Have you ever withdrawn an application for a certificate to practice medicine or any other healing art?  
 yes  no
25. Have you ever voluntarily suspended, surrendered or resigned a certificate to practice medicine or any other healing art in lieu of disciplinary action or any other reason?  
 yes  no
26. 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
27. Have you ever been denied the privilege of taking an examination before any state medical examining board?  
 yes  no
28. Have you ever discontinued your education, training, or practice for a period of more than three months?  
 yes  no
29. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?  
 yes  no
30. 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
31. 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
32. Do you currently or have you ever prescribed any prescription medication over the internet? This does not include prescribing you would do using electronic medical records in your practice.  
 yes  no
33. Are you presently or have you ever been a defendant in a criminal proceeding?  
 yes  no

### PART III

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

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

34. 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
35. To your knowledge, are you presently the subject of a criminal investigation under which you have not been charged?  
 yes  no

The following definitions are provided to assist you in answering questions 36 through 38.

"Ability to practice medicine" - This term includes:

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

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

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

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

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

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

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

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

36. 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.

37. 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.

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

yes  no

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

#### IMPORTANT

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

#### Part IV - Statutory Profile Questions

The following questions are required by Vermont law, 26 VSA § 1368, to update and maintain a data repository within the Department of Health and to make individual profiles on all health care professionals licensed, certified, or registered by the Department available to the public. Your practitioner profile is located at the following website [http://healthvermont.gov/hc/med\\_board/profile\\_search.aspx](http://healthvermont.gov/hc/med_board/profile_search.aspx).

**Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if**

**your answers to questions 38 through 43 have changed since your last application. We cannot process your application without them.**

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

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

(Conviction Date)	(Court)	(City/State)	(Crime)
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40. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)]  Check here if none

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

(Conviction Date)	(Court)	(City/State)	(Charge)
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(Conviction Date)	(Court)	(City/State)	(Charge)
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(Conviction Date)	(Court)	(City/State)	(Charge)
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41. Vermont Board of Medical Practice Matters [See 26 VSA § 1368(a)(3)]  Check here if none

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

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

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

(Date)	(Final Disposition - Summary)
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42. Licensing or Certification Authority Matters in Other States [See 26 VSA § 1368(a)(4)]

Check here if none

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

(Date of Final Disposition)	(Licensing or Certification Authority)	(Court)	(City/State)	(Nature of Charge)
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(Date of Final Disposition)	(Licensing or Certification Authority)	(Court)	(City/State)	(Nature of Charge)
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43. Restriction of Hospital Privileges [See 26 VSA § 1368(a)(5)]  Check here if none

Revocation/Involuntary Restrictions

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

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

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

B. Other Restrictions  Check here if none

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

\_\_\_\_\_  
 (Date) (Hospital) (State)  
 (Nature of Action) (Action)  In lieu  
 In settlement  
 (Reason for Action)

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

A. Judgments  Check here if none

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

Judgment  Arbitration

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

Judgment  Arbitration

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

B. Settlements  Check here if none

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

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

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

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

What month and year did you start practicing as a Physician Assistant? \_\_\_\_\_

46. Appointments/Teaching [See 26 VSA § 1368(a)(12)] Note: Answering #46 is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. Appointments

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

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

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

B. Teaching

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

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

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

Note: Answering #47 is optional. By answering, you are granting permission to have this information posted on the web. Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years.

\_\_\_\_\_  
(Title) (Publication) (Year)

\_\_\_\_\_  
(Title) (Publication) (Year)

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

Note: Answering #48 is optional. By answering, you are granting permission to have this information posted on the web. Please provide information regarding your professional or community service activities and awards.

\_\_\_\_\_  
(Activities or Awards)

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

What is the location of your primary practice setting?

\_\_\_\_\_  
Town/City, State

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

Please identify any translating services available at your primary practice location.

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

If yes, please describe the translating services available:

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

A. Medicaid participation

Do you participate in the Medicaid program?  Yes  No

B. New Medicaid Patients

Are you currently accepting new Medicaid patients?  Yes  No

**Part V**

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

Date: \_\_\_\_\_

\_\_\_\_\_  
Applicant's Signature

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

Vermont Department of Health - Board of Medical Practice  
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

**(Questions 23 and 24) Withdrawal or denial of License - Attach documents**

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

**(Question 25) Voluntarily surrendered or resigned a license to practice medicine or any healing art - Attach documents**

State \_\_\_\_\_ Year \_\_\_\_\_  
Circumstances \_\_\_\_\_  
\_\_\_\_\_

**(Question 26) Disciplinary charges or action - Attach documents**

Name of organization involved \_\_\_\_\_ Date \_\_\_\_\_  
Duration \_\_\_\_\_

Action taken (circle all that apply)

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

Circumstances \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(Question 27) Denial of examination privileges - Attach documents**

State \_\_\_\_\_ Year \_\_\_\_\_  
Circumstances under which examination privileges denied \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(Questions 28 and 29) Residency Training Program(s) not completed - discontinued education, training, practice**

**- Attach documents**

Residency Training Program(s) \_\_\_\_\_

Location of Programs \_\_\_\_\_ Year \_\_\_\_\_

Circumstances \_\_\_\_\_

**(Question 30) Affecting Health Care Institution Staff Privileges, Employment or Appointment - Attach documents**

Institution involved \_\_\_\_\_

Location \_\_\_\_\_ Year \_\_\_\_\_

Circumstances \_\_\_\_\_

**(Question 31) Privilege to prescribe controlled substances - Attach documents**

Name of organization involved \_\_\_\_\_

Type of restriction \_\_\_\_\_ Date \_\_\_\_\_

Circumstances of restriction

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(Question 32) Internet prescribing**

**Please provide a general description of your practice of internet prescribing**

\_\_\_\_\_  
\_\_\_\_\_

**(Questions 33 and 35) Criminal Investigation - Proceeding - Attach documents**

Court \_\_\_\_\_

City and State \_\_\_\_\_

Charge \_\_\_\_\_

Description \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Status \_\_\_\_\_

Conviction? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_

Plea? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_

**(Question 34) Investigation by any other licensing board - Attach documents**

Name of Licensing Board \_\_\_\_\_ Date \_\_\_\_\_

Location of Licensing Board \_\_\_\_\_

Circumstances \_\_\_\_\_

**(Questions 36-38) Medical condition, treatment, use of chemical or illegal substances**

Treating organization \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

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

Dates of illness or dependency \_\_\_\_\_ to \_\_\_\_\_

Dates of treatment \_\_\_\_\_ to \_\_\_\_\_

Name of Rehabilitation/Professional Assistance or Monitoring Program \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Contact person at Program \_\_\_\_\_

**(Question 44) Medical Malpractice Claim**

Please provide the following information regarding each instance of alleged malpractice. This section should be photo copied and filled out separately for each claim. Additional sheets may be obtained/used if necessary.

Insurer \_\_\_\_\_

Claimant name \_\_\_\_\_

Description of alleged claim (allegations only): This does not constitute an admission of fault or liability.

Please indicate:

1. Patient's condition at point of your involvement;
2. Patient's condition at end of treatment;
3. The nature and extent of your involvement with the patient;
4. Your degree of responsibility for the course of treatment in leading to the claim; and
5. Narrative of event.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

\_\_\_\_\_

Your role (circle one):

- |                           |                                     |
|---------------------------|-------------------------------------|
| 01 Anesthesiologist       | 11 PGY 4                            |
| 02 Primary Care Physician | 12 PGY 5                            |
| 03 Referring Physician    | 13 PGY 6                            |
| 04 Attending Physician    | 14 PGY 7                            |
| 05 Consultant Specialist  | 15 Workmen's Compensation Evaluator |
| 06 Surgeon                | 16 Court Psychiatrist               |
| 07 Fellow                 | 17 On-Call Physician                |
| 08 PGY 1                  | 18 Group Practitioner/Partner       |
| 09 PGY 2                  | 19 Other: Specify _____             |
| 10 PGY 3                  | 20 Unknown                          |

Your Legal Representative in this matter (include name, address and telephone number)

Name \_\_\_\_\_

Firm \_\_\_\_\_

Address \_\_\_\_\_

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

Phone \_\_\_\_\_

**Indicate Decision, Appeal, Settlement, Dismissal:**

If a Court or Arbitration Panel heard your case, indicate the following:

Court \_\_\_\_\_

Court's location \_\_\_\_\_

Docket number \_\_\_\_\_

Date the action was filed \_\_\_\_\_

Decision determined by (check one): \_\_\_\_\_ Judge \_\_\_\_\_ Jury \_\_\_\_\_ Arbitration Panel

Decision: \_\_\_\_\_ Award: \_\_\_\_\_

If your case was appealed, indicate the following: Date appeal filed (month, day, year) \_\_\_\_/\_\_\_\_/\_\_\_\_

Date appeal decided: (month, day, year) \_\_\_\_/\_\_\_\_/\_\_\_\_

If your case was settled, indicate the following:

Settlement amount paid on your behalf: \_\_\_\_\_

Total settlement amount: \_\_\_\_\_

Date of settlement: (month, day, year) \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Case dismissed against you \_\_\_\_\_ Against all defendants

**Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.**

**Additional information, if any:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

**PRIMARY SUPERVISING PHYSICIAN APPLICATION**

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

Name in full \_\_\_\_\_  
(Last) (First) (Middle)

Mailing Address \_\_\_\_\_  
(Office Name)

\_\_\_\_\_  
(Street)

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

Vermont License #: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What arrangements have you made for supervision when you are not available or out of town:

\_\_\_\_\_  
\_\_\_\_\_

**CERTIFICATE OF SUPERVISING PHYSICIAN**

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of \_\_\_\_\_, P.A. while under my supervision. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice. I further certify that notice will be posted that a physician assistant is used, in accordance with 26 VSA, Chapter 31, Section 1741.

I further certify that I have read the statutes and Board rules governing physician assistants.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Supervising Physician)

Co-signature of PA: \_\_\_\_\_

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number \_\_\_\_\_

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

**SECONDARY SUPERVISING PHYSICIAN APPLICATION**

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

Name in full \_\_\_\_\_  
(Last) (First) (Middle)

Mailing Address \_\_\_\_\_  
(Office Name)

\_\_\_\_\_  
(Street)

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

Vermont License #: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all physician's assistants names and addresses you currently supervise:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN**

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of \_\_\_\_\_, P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted.

I further certify that I have read the statutes and Board rules governing physician assistants.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Secondary Supervising Physician)

**VERMONT DEPARTMENT OF HEALTH  
BOARD OF MEDICAL PRACTICE  
108 Cherry Street, PO Box 70  
Burlington VT 05402-0070  
802 657-4220 or 800 745-7371**

**2010-2012 PHYSICIANS ASSISTANT CERTIFICATION RENEWAL APPLICATION  
CONTINUING MEDICAL EDUCATION (CME) RECORD**

**\*\*\*ONLY FILL OUT IF NOT NCCPA CERTIFIED\*\*\***

You are required to record a minimum of 100 hours every two-year cycle, at least 40 of which must be in Category I. Complete this CME Record form using the definitions provided on the reverse side of the form, keep a copy for your personal records and return the original with your 2010-2012 Physician Assistant Certification Renewal Application.

**CATEGORY I**

Program Title	Date	CME Hours	Sponsor	Location

**CATEGORY II**

Program Title	Date	CME Hours	Sponsor	Location

Total Category I Hours: \_\_\_\_\_ + Total Category II Hours: \_\_\_\_\_ = Total Hours: \_\_\_\_\_

Your Signature: \_\_\_\_\_

**2010-2012 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION  
CONTINUING MEDICAL EDUCATION (CME) RECORD (Continued)**

## Definitions

### **CATEGORY I:**

Programs that have been accredited by the American Academy of Physicians Assistants (AAPA) or the American Academy of Family Physicians (AAFP) or organizations accredited by the Accreditation Council on Continuing Medical Education (ACCM) to grant Category I toward the Physicians Recognition Award. The program should specify the accrediting organization and number of Category I hours.

The other 60 hours may be recorded in Category I or in elective Category II credits.

### **CATEGORY II:**

1. CME programs not recognized by the Vermont Board of Medical Practice, American Medical Association, American Academy of Family Physicians, and American College of Surgeons; the Nation Commission on Certification of Physicians Assistants; etc.
2. Medical teaching of personnel in the health professions.
3. Publication and presentations made at medical meetings and at CME programs. Credit will be given for each paper, publication, or each chapter of a book authored (first publication only).
4. Non-supervised individual continuing medical education activities:
  - a. self-directed learning through use of AV tapes, reading of medical publications, participation in a journal club, or individual participation in radio, TV or telephone networks;
  - b. case review with a consultant includes an organized presentation of current medical knowledge, lasting one hour or more. Descriptive information should include the name of the consultant, topic and date; and
  - c. patient care review through peer review, medical audits, chart audits, etc.
5. College courses on related topics.
6. Other activities that would contribute to medical education, to be approved on a case-by-case basis.

Hours for CME are calculated as one hour of CME for each hour clocked unless specified otherwise by the Board.

**State of Vermont**  
**Department of Health**  
**Board of Medical Practice**

**Statement of Good Standing**

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

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

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

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

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

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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

**CONSENT FORM**

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

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

The list of everyone who has a current consent on file with their licensing board, as well as consent and revocation forms are available online at: [http://healthvermont.gov/hc/med\\_board/bmp.aspx](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**

**REVOCACTION 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

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 \_\_\_\_\_