



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. **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 initial certification, \$50 for each additional certification, payable to the Vermont Department of Health
 - 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.

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)
-------------------	---------	--------------	---------

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)

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)

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

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)

(Reason for Action) In lieu In settlement

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

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:

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
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_____	_____	_____
_____	_____	_____

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 (ACCME) 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 Department of Health — Board of Medical Practice

108 Cherry Street, P.O. Box 70

Burlington, VT 05402-0070

http://healthvermont.gov/hc/med_board/bmp.aspx

802-657-4220

Consent to Disclosure of Prescriber-Identifiable Information for, Marketing or Promoting Prescription Drugs

Under Vermont law, 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-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, and a copy of the law appears on the reverse side of this consent form.

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 below and sign next to it. Your consent is effective for this licensing or certification period.

If you do not wish to consent, you do not need to complete this consent form.

If you do 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 a Revocation of Consent form and sending it to the Board of Medical Practice. The Revocation form may be obtained directly from the Board or on the Board's website.

I consent _____
Signature Date

Print Name Vermont License or Certification Number

Print Mailing Address _____

Telephone _____

§ 4631. Confidentiality of prescription information

(a) It is the intent of the general assembly to advance the state's interest in protecting the public health of Vermonters, protecting the privacy of prescribers and prescribing information, and to ensure costs are contained in the private health care sector, as well as for state purchasers of prescription drugs, through the promotion of less costly drugs and ensuring prescribers receive unbiased information.

(b) As used in this section:

(1) "Electronic transmission intermediary" means an entity that provides the infrastructure that connects the computer systems or other electronic devices used by health care professionals, prescribers, pharmacies, health care facilities and pharmacy benefit managers, health insurers, third-party administrators, and agents and contractors of those persons in order to facilitate the secure transmission of an individual's prescription drug order, refill, authorization request, claim, payment, or other prescription drug information.

(2) "Health care facility" shall have the same meaning as in section 9402 of this title.

(3) "Health care professional" shall have the same meaning as in section 9402 of this title.

(4) "Health insurer" shall have the same meaning as in section 9410 of this title.

(5) "Marketing" shall include advertising, promotion, or any activity that is intended to be used or is used to influence sales or the market share of a prescription drug, influence or evaluate the prescribing behavior of an individual health care professional to promote a prescription drug, market prescription drugs to patients, or evaluate the effectiveness of a professional pharmaceutical detailing sales force.

(6) "Pharmacy" means any individual or entity licensed or registered under chapter 36 of Title 26.

(7) "Prescriber" means an individual allowed by law to prescribe and administer prescription drugs in the course of professional practice.

(8) "Promotion" or "promote" means any activity or product the intention of which is to advertise or publicize a prescription drug, including a brochure, media advertisement or announcement, poster, free sample, detailing visit, or personal appearance.

(9) "Regulated records" means information or documentation from a prescription dispensed in Vermont and written by a prescriber doing business in Vermont.

(c)(1) The department of health and the office of professional regulation, in consultation with the appropriate licensing boards, shall establish a prescriber data-sharing program to allow a prescriber to give consent for his or her identifying information to be used for the purposes described under subsection (d) of this section. The department and office shall solicit the prescriber's consent on licensing applications or renewal forms and shall provide a prescriber a method for revoking his or her consent. The department and office may establish rules for this program.

(2) The department or office shall make available the list of prescribers who have consented to sharing their information. Entities who wish to use the information as provided for in this section shall review the list at minimum every six months.

(d) A health insurer, a self-insured employer, an electronic transmission intermediary, a pharmacy, or other similar entity shall not sell, license, or exchange for value regulated records containing prescriber-identifiable information, nor permit the use of regulated records containing prescriber-identifiable information for marketing or promoting a prescription drug, unless the prescriber consents as provided in subsection (c) of this section. Pharmaceutical manufacturers and pharmaceutical marketers shall not use prescriber-identifiable information for marketing or promoting a prescription drug unless the prescriber consents as provided in subsection (c) of this section.

(e) The prohibitions set forth in subsection (d) of this section shall not apply to the following:

- (1) the sale, license, exchange for value, or use, of regulated records for the limited purposes of pharmacy reimbursement; prescription drug formulary compliance; patient care management; utilization review by a health care professional, the patient's health insurer, or the agent of either; or health care research;
 - (2) the dispensing of prescription medications to a patient or to the patient's authorized representative;
 - (3) the transmission of prescription information between an authorized prescriber and a licensed pharmacy, between licensed pharmacies, or that may occur in the event a pharmacy's ownership is changed or transferred;
 - (4) care management educational communications provided to a patient about the patient's health condition, adherence to a prescribed course of therapy and other information relating to the drug being dispensed, treatment options, recall or patient safety notices, or clinical trials;
 - (5) the collection, use, or disclosure of prescription information or other regulatory activity as authorized by chapter 84, chapter 84A, or section 9410 of this title, or as otherwise provided by law;
 - (6) the collection and transmission of prescription information to a Vermont or federal law enforcement officer engaged in his or her official duties as otherwise provided by law; and
 - (7) the sale, license, exchange for value, or use of patient and prescriber data for marketing or promoting if the data do not identify a prescriber, and there is no reasonable basis to believe that the data provided could be used to identify a prescriber.
- (f) In addition to any other remedy provided by law, the attorney general may file an action in superior court for a violation of this section or of any rules adopted under this section by the attorney general. The attorney general shall have the same authority to investigate and to obtain remedies as if the action were brought under the Vermont consumer fraud act, chapter 63 of Title 9. Each violation of this section or of any rules adopted under this section by the attorney general constitutes a separate civil violation for which the attorney general may obtain relief. (Added 2007, No. 80, § 17; amended 2007, No. 89 (Adj. Sess.), § 3, eff. March 5, 2008.)

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

You must answer questions 1, 2, and 3.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

- 1. You must check one of the two statements below regarding child support regardless whether or not you have children:
I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.
or
I hereby certify that I am NOT in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business shall not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due and payable and all returns have been filed, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

- 2. You must check one of the two statements below regarding taxes:
I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a \$10,000.00 fine or both).
or
I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

- 3. You must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment contributions:
I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a \$10,000.00 fine or both.)
or
I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.
or
I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #* ___/___/___ Date of Birth ___/___/___

* The disclosure of your social security number is mandatory, it is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by the Department of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

STATEMENT OF APPLICANT

I certify that the information stated by me in this application is true and accurate to the best of my knowledge and that I understand providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant _____ Date _____