Vermont Department of Health - Board of Medical Practice
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
medicalboard@vdh.state.vt.us
802-657-4220 or 800-745-7371

APPLICATION FOR REINSTATEMENT OF LAPSED LICENSE– MEDICAL DOCTOR APPLICATION CHECKLIST

Application for Reinstatement of Lapsed 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 an employee. False statements on this form are grounds for unprofessional conduct.
- Personal Interview. Once your application is complete, you will receive the name, address, and telephone number of a member of the Board of Medical Practice to contact and schedule your interview.

Please submit the following as part of your application.

- ☐ $600 Payable to the Vermont Department of Health
- ☐ Applicant's statement regarding Child Support, Taxes, and Unemployment Compensation Contributions
- ☐ Statement of Good Standing
- ☐ Form B Authorization for Release of Records and Information
- ☐ **Direct verification-**The "CERTIFICATE OF MEDICAL LICENSURE" must be completed by the Medical Board of each state where a license is or has been held.
- ☐ Three (3) Completed Reference Forms mailed **directly** to the Board
  - ☐ Reference #1
  - ☐ Reference #2
  - ☐ Reference #3
- ☐ American Medical Association Profile Form **Must be sent by the applicant directly to the AMA**
- ☐ National Practitioner Data Bank self query. **Send the original, unaltered response to the Board.**
- ☐ Curriculum vitae (CV/Resume)

Note: ***FCVS Acceptance-*** *The Board accepts certain documents (see * above) verified by theFederation of State Medical Boards' Federation Credentials Verification Service (FCVS). For more information please call 1-888-ASK-FCVS.*

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

APPLICATION FOR REINSTATEMENT OF LAPSED LICENSE PHYSICIAN–MEDICAL DOCTOR

I hereby apply for REINSTATEMENT OF MY LAPSED LICENSURE AS A PHYSICIAN in the state of Vermont.

Part I - Identity Questions

1. Print your full name as you wish it to appear on the license:

_____
Last Name First Name Middle Name Suffix

2. Have you ever legally changed your name? ___**Yes** ___ **No**
   If yes, enclose a certified copy of the legal document stating the change.

   Other name(s), if any under which you were licensed elsewhere:

   _____
   Last Name First Name Middle Name Suffix

3. Your Date of Birth:____/____/____
   Month/Day/Year

4: Your mailing address: (Check one: □ home address □ work address)

Care of: _____

Street: _____

Town/City: _____

State: _____

Zip: _____

5. Your contact information:

Home telephone number with area code: (_____)_____

Work telephone number with area code: (_____)_____

E-mail Address: _____

____ Please check here if the Department of Health may use this e-mail address to send you public health information

6. Were you in active clinical practice in the past 12 Months? ___ **Yes** ___ **No**

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

Month and year you started practicing as a physician (excluding residency/fellowship training)?

_____

8. Have you ever held a Vermont Limited Temporary License: ___**Yes** ___ **No**
   If yes, License Number _____

9. Do you hold, or have you ever held, a medical license in any other state? ___ **Yes** ___**No**

If yes, complete the section below:

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

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

Part II – Education, Training, Practice and Examinations

10. Premedical Education

Please provide the names of premedical schools you attended and the dates of attendance.

Name and location of institution	**Degree**	**From**	**To**

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

11. Medical Professional Schools

Please provide the name of the medical professional school you attended and the date of graduation. (We will have similar information on file with your original application; we are asking you here to provide an update for the statutory web profile.)

_____
(School/Institution) (City) (State) (Year of Graduation)

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

12. Graduate Medical Education
Please provide the names of graduate medical schools you attended and the dates of attendance.

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

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

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

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

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

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

14. Examinations

USMLE____ FLEX____ National Board____ LMCC____

State Exam____ Which State? _____ If yes, make sure that the scores are included on the Certificate of Medical Licensure to be sent to that Board.

15. International Medical Graduates
A. ECFMG Standard Certificate Number: _____Date issued: _____
B. Are you a graduate of a fifth pathway program: ____ Yes _____ No

16. Practice
Do you have hospital privileges? ____ Yes _____ No
List all hospitals where you have, or previously have had, staff privileges. Include name, address, and dates.

Name	Address	From/To	Specialty/Subspecialty

Part III - Licensure and Practice Questions

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

17. Have you ever applied for and been denied a license to practice medicine or any other healing art?
    ___Yes ___No
18. Have you ever withdrawn an application for a license to practice medicine or any other healing art?
    ___Yes ___No
19. Have you ever voluntarily surrendered or resigned a license to practice medicine or any other healing art in lieu of disciplinary action or any other reason?
    ___Yes ___No
20. 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
21. Have you ever been denied the privilege of taking an examination before any state medical examining board?
    ___Yes ___No
22. Have you ever discontinued your education, training, or clinical practice for a period of more than three months?
    ___Yes ___No
23. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?
    ___Yes ___No
24. 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
25. 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
26. Do you currently or have you ever prescribed any prescription medication over the internet?
    ___Yes ___No

Are you presently or have you ever been a defendant in a criminal proceeding?
___Yes ___No

Part IV - Confidential Section

Part III is exempt from public disclosure

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

27. 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
28. To your knowledge, are you presently the subject of criminal investigation under which you have not been charged?
    ___Yes ___No

MEDICAL QUESTIONS

Please answer "**Yes**" or "**No**" to the questions below. Definitions are provided to assist you in answering. Please explain any "**Yes**" answers on Form A.

DEFINITIONS

In answering the questions above, please use these definitions:

"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.

29. 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.

30. 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.

31. 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 V - Statutory Profile Questions

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 as you can. You will receive a copy of your profile prior to its initial release to the public and 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 photostatic copies of court papers, licensing authority decisions, and other documents relevant to the questions below in order to have a true and accurate description of the actions taken.

33. **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.

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

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

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

34. **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.

_____
(Conviction Date) (Court) (City/State) (Charge)

_____
(Conviction Date) (Court) (City/State) (Charge)

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

35. **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. (We will have the documentation on file; we are asking you to provide the description.)

_____
(Date) (Final Disposition – Summary)

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

36. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]

Please provide a description of all formal charges served by licensing authorities of other states, the findings, conclusions, and orders of such licensing authorities, and final disposition of such matters by the courts, if appealed, in those states. Please provide copies of papers fully documenting these matters.

_____

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

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

37. **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.

_____

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

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

B. **Other Restrictions**

Please provide a description of all resignations from, or nonrenewal 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.

_____

(Date) (Hospital) (State)

_____

(Nature of Action) (Action) (Reason for Action)

□ In Lieu □ In Settlement

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

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

A. **Judgments**

Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you, and any pending malpractice cases; complete Form A and provide copies of papers fully documenting these matters.

□ Judgment □ Arbitration

_____

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

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

B. Settlements

Please provide a description of all pending settlements and settlements of medical malpractice claims against you. Please complete Form A and provide copies of papers fully documenting these matters.

_____

(Date) (Court) (State) (Amount Assessed Against You)

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

39. **Appointments/Teaching** [See 26 VSA § 1368(a)(12)] Note: Answering #39 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)

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

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)

_____

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

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

40. **Publications** [See 26 VSA § 1368(a)(13)] Note: Answering #40 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)

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

41. **Activities** [See 26 VSA § 1368(a)(14)] Note: Answering #41 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)

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

- End of Statutory Profile Questions -

42. **Interview**

A. In which part of Vermont would you prefer to be interviewed? (Northern – Burlington area, Southern – Bennington, Springfield, Central – Montpelier area, or using video technology)_____

B. When are you scheduled to begin work in Vermont? _____

C. Where will the primary setting of your practice be located?

_____

D. Brief Description of your anticipated practice.

_____

E. What has been your physical residence (city, state) in the past ten years?

_____

Part VI - Photograph

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

PHOTOGRAPH

Part VII - Signature

Reminder - You must also complete and sign the enclosed Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions, and Form B, authorization for release of information as appropriate.

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

Return completed application to:

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, P0 Box 70
Burlington VT 05402-0070

Vermont Department of Health
Board of Medical Practice
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
medicalboard@vdh.state.vt.us
802-657-4220 or 800-745-7371

FORM B

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

TO WHOM IT MAY CONCERN:

I, _____ HEREBY AUTHORIZE YOU to furnish to
(Name of Applicant)

the Vermont Board of Medical Practice or its designated representative, all materials and information within your possession or control relating to me, of whatever kind and wherever located and including, but not limited to, my professional experience and qualifications, my licensing history, my practice, and any other material or information, including investigative files, which, in the sole discretion of the Vermont Board of Medical Practice, may be useful to said Board in its review of my licensing status.

Only in regard to this specific authorization for disclosure to the Vermont Board of Medical Practice and for no other purpose, I expressly WAIVE confidentiality and any privileges or immunities accorded this information by State or Federal Law, and I hold you harmless from disclosure of same to the Vermont Board of Medical Practice.

YOU ARE ALSO AUTHORIZED to report information, either orally or in writing, directly to the Vermont Board of Medical Practice or its designated representative on a continuing basis until this authorization is revoked, by me, in writing.

A CONFORMED PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL SERVE IN ITS STEAD.

2) I further authorize the Vermont Board of Medical Practice to communicate with future employers and/or locum tenens companies regarding the status of my application.

Signature: _____

Date: _____

Print or Type Name: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: (_____)_____

Subscribed and sworn to before me, this _____day of _____

_____ Notary Public

A CONFORMED COPY, ATTEST _____
Notary Public

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

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_____

State of Vermont

Department of Health

Board of Medical Practice

Statement of Good Standing

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

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

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

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

(1) 60 days or fewer have elapsed since the date a judgment was issued; or

(2) the person is in compliance with a repayment plan approved by the judiciary.

_____ _____

Date Signature

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

(Questions 17 and 18) Withdrawal or denial of License - Attach documents

State_____ Year_____
Circumstances under which license was withdrawn, denied, revoked, not renewed, or otherwise terminated_____

_____

(Question 19) Voluntarily surrendered or resigned a license to practice medicine or any healing art - Attach documents

State_____ Year_____

Circumstances_____

_____

(Question 20) Disciplinary charges or action - Attach documents

Name of organization involved_____ Date_____

Duration_____

Action taken (circle all that apply)

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

Circumstances_____

_____

_____

(Question 21) Denial of examination privileges - Attach documents

State_____ Year_____

Circumstances under which examination privileges denied _____

_____

_____

(Questions 22 and 23) Residency Training Program(s) not completed - discontinued education, training, practice - Attach documents

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances_____

_____

(Question 24) Affecting Health Care Institution Staff Privileges, Employment or Appointment - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances_____

_____

(Question 25) Privilege to prescribe controlled substances - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

_____

_____

_____

_____

(Question 26) Internet prescribing

Please provide a general description of your practice of internet prescribing

_____

_____ _____

(Questions 27 and 29) Criminal Investigation - Proceeding - Attach documents

Court _____

City and State _____

Charge _____

Description _____

_____

_____

Status_____

_____

Conviction? _____ Yes _____ No Date _____

Plea? _____ Yes _____ No Date _____

(Question 28) Investigation by any other licensing board - Attach documents

Name of Licensing Board_____ Date _____

Location of Licensing Board_____

Circumstances_____

(Questions 30 and 31) 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 38) 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:

_____

_____

_____

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

LIST OF THREE REFERENCES

Detach the attached Reference Forms and send to the individuals designated below* ALONG WITH A COPY OF THE SIGNED FORM B RELEASE. Return this sheet to the Board with your application. Individuals completing the reference forms must return the forms directly to the Board.

*NOTE: Program Director should be substituted for Chief of Service for applicants who are applying for a license while still in residency training or have completed a residency within the last year. (SEE ATTACHED SEPARATE FORM FOR PROGRAM DIRECTOR.)

Names, addresses and telephone numbers of three references:

1) Reference #1 - Chief of Service (See Program Director Note * above): _____

Address: _____

_____

City, State, Zip Code: _____

Telephone: (_____) _____

How long and in what capacity has this individual known you? _____

2) Reference #2 - Active physician staff member at the hospital where you have a current or recent appointment:

Name: _____

Address: _____

_____

City, State, Zip Code: _____

Telephone: (_____) _____

How long and in what capacity has this individual known you? _____

3) Reference #3 - Active physician staff member at the hospital where you have a current or recent appointment:

Name: _____

Address: _____

_____

City, State, Zip Code: _____

Telephone: (_____) _____

How long and in what capacity has this individual known you? _____

Note: If you are unable to provide references from these individuals because you have never held hospital privileges, attach such an explanation to this form when you submit your application. Three other references from physicians you have worked with most recently will then be required.

Chief of Service Form
Return Directly to Board

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

REFERENCE FORM TO BE COMPLETED BY CHIEF OF SERVICE, PAGE ONE OF TWO

Name of Applicant: _____

The physician named above has applied to the Vermont Board of Medical Practice for a license to practice medicine in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following reference form. **Thank you for your cooperation.**

Please complete all parts of this form. If more room is needed, please attach additional information.

Dr. _____ was at _____

from _____ to _____. During that time, he/she was

(List status in the Institution): _____.

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

Basic medical knowledge:	____ Poor	____ Fair	____ Average	____ Above Average
Professional judgment:	____ Poor	____ Fair	____ Average	____ Above Average
Sense of responsibility	____ Poor	____ Fair	____ Average	____ Above Average
Moral character/ ethical conduct	____ Poor	____ Fair	____ Average	____ Above Average
Competence and skill:	____ Poor	____ Fair	____ Average	____ Above Average
Cooperativeness, ability to work with others:	____ Poor	____ Fair	____ Average	____ Above Average
History & physical exam taking:	____ Poor	____ Fair	____ Average	____ Above Average
Record keeping	____ Poor	____ Fair	____ Average	____ Above Average
Case presentations:	____ Poor	____ Fair	____ Average	____ Above Average
Patient management:	____ Poor	____ Fair	____ Average	____ Above Average
Physician-Patient relationship:	____ Poor	____ Fair	____ Average	____ Above Average
Competence in being able to communicate in reading, writing and speaking the English language:	____ Poor	____ Fair	____ Average	____ Above Average
Participation in Medical Staff Affairs	____ Poor	____ Fair	____ Average	____ Above Average

Chief of Service Form
Continued

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

REFERENCE FORM TO BE COMPLETED BY CHIEF OF SERVICE, PAGE TWO OF TWO

Name of Applicant: _____

How long have you known the applicant and in what capacity? _____

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner? _____ Yes _____ No

Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine? _____ Yes _____ No

Do you know of any pending professional misconduct proceedings or medical malpractice claims? _____ Yes _____ No

Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is not minor.) _____ Yes _____ No

Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice? _____ Yes _____ No

Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures? _____ Yes _____ No

Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? _____ Yes _____ No

Do you know of a failure of the applicant to complete a residency training program(s)? _____ Yes _____ No

Does the applicant call upon consults when needed? _____ Yes _____ No

In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluating this applicant. Of particular value to us in evaluating any candidate are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

The above report is based on:

_____ Close personal observation
_____ General impression
_____ A composite of faculty/staff evaluations
_____ Other - Specify: _____

I further certify that at the time of completion of the above training, or during my association with the physician, he/she was competent to practice medicine and he/she was not the subject of any disciplinary action.

I recommend _____ for licensure in Vermont.
Name of Physician

Signed: _____ Date: _____

Print or Type Name and Title: _____

Reference Form: #2
Return Directly to Board

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER
AT THE HOSPITAL WHERE YOU HAVE A CURRENT OR RECENT APPOINTMENT, PAGE ONE OF TWO

Name of Applicant: _____

The physician named above has applied to the Vermont Board of Medical Practice for a license to practice medicine in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following reference form. **Thank you for your cooperation.**

Please complete all parts of this form. If more room is needed, please attach additional information.

Dr. _____ was at _____

from _____ to _____. During that time, he/she was

(List status in the Institution): _____.

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

Basic medical knowledge:	____ Poor	____ Fair	____ Average	____ Above Average
Professional judgment:	____ Poor	____ Fair	____ Average	____ Above Average
Sense of responsibility:	____ Poor	____ Fair	____ Average	____ Above Average
Moral character/ ethical conduct:	____ Poor	____ Fair	____ Average	____ Above Average
Competence and skill:	____ Poor	____ Fair	____ Average	____ Above Average
Cooperativeness, ability to work with others:	____ Poor	____ Fair	____ Average	____ Above Average
History & physical exam taking:	____ Poor	____ Fair	____ Average	____ Above Average
Record keeping	____ Poor	____ Fair	____ Average	____ Above Average
Case presentations:	____ Poor	____ Fair	____ Average	____ Above Average
Patient management:	____ Poor	____ Fair	____ Average	____ Above Average
Physician-Patient relationship:	____ Poor	____ Fair	____ Average	____ Above Average
Competence in being able to communicate in reading, writing and speaking the English language:	____ Poor	____ Fair	____ Average	____ Above Average
Participation in Medical Staff Affairs	____ Poor	____ Fair	____ Average	____ Above Average

Reference Form #2
Continued

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER
AT THE HOSPITAL WHERE YOU HAVE A CURRENT OR RECENT APPOINTMENT, PAGE TWO OF TWO

Name of Applicant: _____

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner? _____ Yes _____ No

Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine? _____ Yes _____ No

Do you know of any pending professional misconduct proceedings or medical malpractice claims? _____ Yes _____ No

Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is not minor.) _____ Yes _____ No

Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice? _____ Yes _____ No

Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures? _____ Yes _____ No

Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? _____ Yes _____ No

Do you know of a failure of the applicant to complete a residency training program(s)? _____ Yes _____ No

Does the applicant call upon consults when needed? _____ Yes _____ No

In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluating this applicant. Of particular value to us in evaluating any candidate are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

The above report is based on:

_____ Close personal observation
_____ General impression
_____ A composite of faculty/staff evaluations
_____ Other - Specify: _____

I further certify that at the time of completion of the above training, or during my association with the physician, he/she was competent to practice medicine and he/she was not the subject of any disciplinary action.

I recommend _____ for licensure in Vermont.
Name of Physician

Signed: _____ Date: _____

Print or Type Name and Title: _____

Reference Form #3
Return Directly to Board

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER
AT THE HOSPITAL WHERE YOU HAVE A CURRENT OR RECENT APPOINTMENT, PAGE ONE OF TWO

Name of Applicant: _____

The physician named above has applied to the Vermont Board of Medical Practice for a license to practice medicine in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following reference form. **Thank you for your cooperation.**

Please complete all parts of this form. If more room is needed, please attach additional information.

Dr. _____ was at _____

from _____ to _____. During that time, he/she was

(List status in the Institution): _____.

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

Basic medical knowledge:	____ Poor	____ Fair	____ Average	____ Above Average
Professional judgment:	____ Poor	____ Fair	____ Average	____ Above Average
Sense of responsibility:	____ Poor	____ Fair	____ Average	____ Above Average
Moral character/ ethical conduct:	____ Poor	____ Fair	____ Average	____ Above Average
Competence and skill:	____ Poor	____ Fair	____ Average	____ Above Average
Cooperativeness, ability to work with others:	____ Poor	____ Fair	____ Average	____ Above Average
History & physical exam taking:	____ Poor	____ Fair	____ Average	____ Above Average
Record keeping	____ Poor	____ Fair	____ Average	____ Above Average
Case presentations:	____ Poor	____ Fair	____ Average	____ Above Average
Patient management:	____ Poor	____ Fair	____ Average	____ Above Average
Physician-Patient relationship:	____ Poor	____ Fair	____ Average	____ Above Average
Competence in being able to communicate in reading, writing and speaking the English language:	____ Poor	____ Fair	____ Average	____ Above Average
Participation in Medical Staff Affairs	____ Poor	____ Fair	____ Average	____ Above Average

Reference Form #3
Continued

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER
AT THE HOSPITAL WHERE YOU HAVE A CURRENT OR RECENT APPOINTMENT, PAGE TWO OF TWO

Name of Applicant: _____

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner? _____ Yes _____ No

Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine? _____ Yes _____ No

Do you know of any pending professional misconduct proceedings or medical malpractice claims? _____ Yes _____ No

Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is not minor.) _____ Yes _____ No

Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice? _____ Yes _____ No

Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures? _____ Yes _____ No

Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? _____ Yes _____ No

Do you know of a failure of the applicant to complete a residency training program(s)? _____ Yes _____ No

Does the applicant call upon consults when needed? _____ Yes _____ No

In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluating this applicant. Of particular value to us in evaluating any candidate are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

The above report is based on:

_____ Close personal observation
_____ General impression
_____ A composite of faculty/staff evaluations
_____ Other - Specify: _____

I further certify that at the time of completion of the above training, or during my association with the physician, he/she was competent to practice medicine and he/she was not the subject of any disciplinary action.

I recommend _____ for licensure in Vermont.
Name of Physician

Signed: _____ Date: _____

Print or Type Name and Title: _____

AMA Physician Profile Service Order Form

Please complete this form and attach DR-505 form when requesting AMA Physician Profiles.

___ Check only if new customer

Date: ____/____/_____

ACCOUNT #: _____
CONTACT: _____
ORGANIZATION: _____
DEPARTMENT: _____
ADDRESS: _____
_____
_____
CITY/STATE/ZIP: _____
PHONE: _____
FAX: _____
EMAIL: _____

For same day electronic ordering and delivery, logon to the AMA's Profile Web site at: www.ama-assn.org/go/amaprofiles

If you have any questions, please call 800-665-2882 for ordering assistance.

Delivery Options (check one):

____ **Electronic Online Delivery**
Same day delivery.
Delivered as a .PDF file.

____ **Standard Mail Delivery**
Mailed within 10 business days.
Delivered - US First Class mail.

Product Type (check one):

____ **AMA Physician Profile**
$31 per Profile when 1 or 2 Profiles are ordered.
$28 per Profile when 3 or more Profiles are ordered.
(pricing subject to change)

____ **AMA Physician Reappointment Profile**
$14 per Profile when 1 or 2 Profiles are ordered.
$11 per Profile when 3 to 9 Profiles are ordered.
$7 per Profile when 10 or more Profiles are ordered
(pricing subject to change)

Ordering Methods:

Place your order online at:
www.ama-assn.org/go/amaprofiles

Mail in your order/payment to:
American Medical Association
75 Remittance Drive, Suite #6397
Chicago IL 60675-6397

Fax in your order to:
312 464-5900
All faxed in orders require credit card information.

Number of Profiles Requested: _____

Order Total: $_____
Sales Tax: $_____
Total Due with Sales Tax: $_____
Enclosed Payment Amount: $_____

All Profile Orders are Subject to State Sales Tax*

AZ	CA	CN	CT	DC	GA
IA	IL	MN	NJ	NY	NC
			WI		

**Subject to change*

Note: If your organization is tax exempt, please include a copy of your 'Tax Exempt Certificate' with your order.

Method of Payment (select one):

____VISA ____Master Card ____AMEX

Credit Card Number: _____ Expiration: ___/_____

Authorizing Signature: _____

Card Holder Name (Print): _____

____Check enclosed (Make check payable to AMA Profiles. Include your account number on the check.)

Request Agreement

for Physician Profile Data from the Physician Masterfile

American Medical Association
Physicians dedicated to the health of America

Department of Credentialing Products
Division of Database Products and Licensing

Form DR-505

Requesting Organization _____

Individual or Department _____

Local Address _____

City _____ State _____ Zip _____

To assure proper identification of the physicians, please complete as much of this form as possible and mail with order form. See instructions on order form. Physician Profile Data will be prepared on the requested physicians and forwarded to your organization.

Type of Request (check one) ☐ Standard ☐ Express

Full Name of MD/DO _____ Date of Birth _____

Professional Mailing Address _____

Medical School of Graduation _____ Year _____ ECFMG No. _____

Full Name of MD/DO _____ Date of Birth _____

Professional Mailing Address _____

Medical School of Graduation _____ Year _____ ECFMG No. _____

Full Name of MD/DO _____ Date of Birth _____

Professional Mailing Address _____

Medical School of Graduation _____ Year _____ ECFMG No. _____

To order **additional profiles**, please duplicate this form.

Important: Please provide number of physicians on this request _____ Date of this request _____

Purpose for which profiles are being requested _____

_____

It is mutually agreed between the American Medical Association ("AMA") and the undersigned Requesting Organization that the Physician Profiles are provided to the Requesting Organization on the above named physicians with the understanding that: (1) the information on the Profile will be treated with total confidentiality; (2) that such information is granted solely to the Requesting Organization and is granted as a non-exclusive limited license, consistent with and limited to the specific purposes set forth above; (3) that no Profile information will be released, copied, extracted or otherwise usurped for the use by any other party, entity, organization or government agency; and (4) that upon a breach of any of the foregoing covenants or upon the effective date of any statute, regulation or court decision mandating any disclosure whatsoever of such Profile information by the Requesting Organization, such license to use and possess the Profile shall be automatically and immediately terminated and the Profile and any information or data contained thereon or, in any way, derived therefrom shall be returned to AMA immediately, but, in no event, later than 48 hours after such automatic termination.

AMA endeavors to maintain its physicians' records with information that is complete, current, and timely; however, because of possible reporting and processing delays, no representations or warranties as to the accuracy or completeness can be or is made. In consideration of the receipt of each physician record provided by AMA, the Requesting Organization hereby releases AMA, its agents and servants from any and all liability whatsoever for inaccurate or incomplete information in each such physician record.

Any signed Request Agreement transmitted by FAX machine shall be treated in all manner and respects as the original document and shall have the same legal and binding effect as any document with an original signature. At the request of the AMA any faxed document shall be re-executed by the requesting organization in an original form. The AMA and the undersigned hereby agree that neither shall raise the use of a FAX machine as a defense to this agreement and forever waive such a defense.

Agreement must be signed in order to process your request. Inquiry submitted and terms of data release agreed to by:

Signature _____ Title _____

© 1999 American Medical Association

DATS-99-1546 [illegible]

NATIONAL PRACTITIONER DATA BANK
HEALTHCARE INTEGRITY and PROTECTION DATA BANK
PO Box 10832, Chantilly, Virginia 20153-0832
www.npdb-hipdb.com

On-line Self-Query Process

- Log-on to web site for NPDB as shown above

TO SUBMIT A QUERY:

- Select "Report to and Query the Data Banks"
- Click on "Perform a Self-Query"
- Select the type of self-query you wish to perform
  Individual or organization

- Provide ALL required information

- Provide your credit card information (VISA, MasterCard, or Discover)
  (Checks or cash not accepted)

- Once all information is complete, click CONTINUE. A formatted copy of the self-query is generated immediately with a Data Bank Control Number (DCN) listed at the top of the page. Print this formatted copy, and keep the DCN to monitor the processing status of your self-query. To print a query from the IQRS, you must have Adobe Acrobat Reader version 4.0 or higher installed on your computer.

- To complete the self-query process, you **must sign the formatted self-query application in the presence of a notary public** and mail it to the NPDB-HIPDB. Self-queries received without notarization or with an incomplete notarization are rejected. Notarized forms that are missing credit card information will be rejected.

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

NATIONAL PRACTITIONER DATA BANK SELF QUERY

Effective September 1, 1990, the Federal government opened the National Practitioner Data Bank. This data bank, mandated by Congress, tracks regulatory board disciplinary actions, certain actions resulting from peer review and malpractice payments.

You must self query this data bank on your own record as part of the application process for a Vermont medical license. Simply query the data bank using the attached form and when you receive the response, **SEND THE ORIGINAL, UNALTERED** response to the Board. You may keep a photocopy if you wish.

Before completing the data bank form, please contact the **Data Bank Help Line** for assistance: Help Line Toll Free Number: 1-800-767-6732.

Vermont Department of Health – Board of Medical Practice

PRESCRIBER DATA-SHARING PROGRAM CONSENT FORM

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

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

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

__ I consent _____ _____

Signature Date

_____ _____

Print Name Vermont License or Certification Number

VERMONT

Department of Health

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

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

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

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

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

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

Rev. 10/30/07

VERMONT

Department of Health

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

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

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

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

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

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

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

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

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

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

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