VERMONT

State of Vermont
Department of Health
Medical Practice Board
108 Cherry Street – PO Box 70
Burlington, VT 05402-0070
www.HealthyVermonters.info

[phone] 802-657-4220
[toll-free] 800-745-7371
[fax] 802-657-4227

Agency of Human Services

Memorandum

TO: Physician Assistant

FROM: Medical Practice Board

DATE: October 31, 2005

RE: 2006 Physician Assistant Certification Renewal Instructions

Enclosed is your 2006 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 13, 2006. 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, 2006***.

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
- ☐ completed ***clinical practice questions*** and any other attachments
- ☐ a check for $100 for primary certification, $50 for each secondary certification, payable to the Vermont Department of Health
  - ***LATE FEE***: Applications post-marked or received after 1/31/06 will be assessed a $25 late fee plus $5 for every additional month or fraction of a month.

Please return the completed application, attachments and fee no later than January 13, 2006 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.

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

2006 PHYSICIAN ASSISTANT CERTIFICATION RENEWAL APPLICATION

PART I

Certificate # 055-00

1. Name: _____

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

_____

3. Home Address:

_____

City, State, Zip Code:_____

4. Work 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: Month: _____ Day _____ Year _____

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. Did you 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 - 46 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?

    □ 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 for reasons other than a family need?

    □ 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. 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.

33. To your knowledge, are you the subject of an investigation by any other licensing board as of the date of this application? □ yes □ no

34. To your knowledge, are you presently the subject of a criminal investigation? □ yes □ no

The following definitions are provided to assist you in answering questions 35 through 37.

"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.

35. Do you have a medical condition that 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.

36. Are you currently engaged in the use of alcohol or other chemical substances that 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.

37. 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://healthyvermonters.com/bmp/mbsearchform.shtml.

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.

38. 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)

39. 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)
(Conviction Date)	(Court)	(City/State)	(Charge)
(Conviction Date)	(Court)	(City/State)	(Charge)

40. 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)

41. 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)

42. 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

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

A. Judgments ☐ Check here if none

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

☐ Judgment ☐ Arbitration

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

☐ Judgment ☐ Arbitration

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

B. Settlements ☐ Check here if none

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

_____
(Date) (Court) (State) (Amount of Settlement Against You)

_____
(Date) (Court) (State) (Amount of Settlement Against You)

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

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

45. Appointments/Teaching [See 26 VSA § 1368(a)(12)] Note: Answering #45 is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. Appointments

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

_____

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

_____

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

B. Teaching

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

_____

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

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

Note: Answering #46 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)

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

Note: Answering #47 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)

_____

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

What is the location of your primary practice setting?

_____

Town/City, State

49. 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:

_____

_____

_____

50. 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

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

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full _____
(Last) (First) (Middle)

Mailing Address _____
(Office Name)

_____
(Street)

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

Vermont License #: _____

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

_____

_____

_____

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

_____

_____

CERTIFICATE OF SUPERVISING PHYSICIAN

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

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

_____ _____
(Date) (Signature of Supervising Physician)

Co-signature of PA: _____

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

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

SECONDARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full _____
(Last) (First) (Middle)

Mailing Address _____
(Office Name)

_____
(Street)

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

Vermont License #: _____

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

_____
_____
_____

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

_____
_____
_____

CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

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

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

_____ _____
(Date) (Signature of Secondary Supervising Physician)

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

2006-2008 PHYSICIANS ASSISTANT CERTIFICATION RENEWAL APPLICATION CONTINUING MEDICAL EDUCATION (CME) RECORD

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 2006-2008 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:

_____

2006-2008 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.

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
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 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

_____

_____

_____

_____

(Questions 32 and 34) Criminal Investigation - Proceeding - Attach documents

Court _____

City and State _____

Charge _____

Description _____

_____

_____

Status_____

_____

Conviction? _____ Yes _____ No Date _____

Plea? _____ Yes _____ No Date _____

(Question 33) Investigation by any other licensing board - Attach documents

Name of Licensing Board_____ Date _____

Location of Licensing Board_____

Circumstances_____

(Questions 35-37) 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 43) 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:

_____

_____

_____