

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

**Affidavit
And
Authorization For Release of Information**

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Applicant's Signature (must be signed in the presence of a notary) _____

Applicant's Printed Last Name _____

Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.) _____

Date of Signature _____

Applicant Photograph

Securely tape or glue in this square a current front-view 2" x 2" passport-type color photograph of yourself.

NOTARY

Dated _____ Signed _____

State of _____ County of _____

SUBSCRIBED AND SWORN TO before me this _____ day of, _____ 20_____

My commission expires: _____ (NOTARY PUBLIC SIGNATURE & SEAL)

Applicant Name: _____ Date: _____

Licensure Verification Form
(Copy this form for multiple licenses)

Form #1

I am applying for a license to practice medicine. The Board requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the following Board: _____

TO BE COMPLETED BY APPLICANT

Applicant Name: _____			
Last	First	Middle	Suffix
Date of Birth: _____		Social Security Number: _____	
		License Number: _____	
<small>(From State/Province you are sending this form to)</small>			
<i>The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.</i>			
I hereby authorize the licensing agency of the State/Province of _____ to furnish the information to the Board indicated below.			
Signature of Applicant _____		Date _____	
Board Name: _____			
Address: _____			
Street	City	State/Province	ZIP Code

TO BE COMPLETED BY STATE LICENSING BOARD OR CANADIAN PROVINCE

Name of Licensee: _____
Last First Middle Suffix

License Type: _____ License #: _____ Issue Date: _____ Expiration Date: _____

Is this license current? Yes No If No, please explain: _____

1) Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?
 Yes No Cannot answer under state law
If Yes, please explain: _____

2) Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand or in any other manner disciplined; or has the applicant's license ever been revoked, suspended or, in any other manner, limited by a licensing or disciplinary authority in your state?
 Yes No Cannot answer under state law
If Yes, please explain: _____

Affix Board Seal Here

Board Authorized Signature: _____
Title: _____
Date: _____

Please return this form to the Board listed at the top of this form.

Applicant Name: _____ Date: _____

Medical School Verification – Page 1 of 4

(Copy this form for multiple schools)

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to your medical school along with a copy of your diploma. Request the Dean or designated official to complete Section 3 of this form and return this form, the sealed copy of your diploma (to be sealed by your medical school) and a copy of your official transcripts directly to this Board.

Section 1: Applicant Information

Last Name: _____

First Name: _____

Middle Name: _____

Suffix: _____

Name if different when diploma awarded: _____

Social Security Number: _____

Date of Birth: _____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the medical school below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

Applicant's Signature _____

Date _____

Section 2: Instructions to the Dean or designated official of medical school

Please complete Section 3 of this form, certify the enclosed copy of the above named applicant's diploma by placing your school seal on it, enclose an official copy of the transcripts of the above named physician and forward all of this information directly to this Board to the following address:

Board Name: _____

Address _____

City _____

State/Province _____

ZIP Code _____

Medical School Verification – Page 2 of 4
(Copy this form for multiple schools)

Section 3: Medical School Verification

Medical School Name: _____

School name if different when the above applicant attended: _____

Medical School Address: _____

Street

City

State/Province

ZIP Code

Hours of undergraduate education required for admission into your school: _____

Applicant's Attendance Dates: From _____ To _____ Graduation Date: _____ Degree: _____

(Indicate N/A if not applicable)

(Indicate N/A if not applicable)

Total weeks of education applicant attended your school: _____

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature: _____

Print name: _____

Title: _____

Date: _____

Phone number: _____ Fax: _____

E-mail: _____

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized)

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

Medical School Verification – Page 3 of 4
(Copy this form for multiple schools)

1. Does this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?

Response YES NO

If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			<input type="checkbox"/>	<input type="checkbox"/>
Academic remediation			<input type="checkbox"/>	<input type="checkbox"/>
Health			<input type="checkbox"/>	<input type="checkbox"/>
Financial			<input type="checkbox"/>	<input type="checkbox"/>
Participation in joint degree program (e.g., MD/PhD)			<input type="checkbox"/>	<input type="checkbox"/>
Participation in non-research special study (e.g., fellowship, international experience)			<input type="checkbox"/>	<input type="checkbox"/>
Participation in non-degree research			<input type="checkbox"/>	<input type="checkbox"/>
Other			<input type="checkbox"/>	<input type="checkbox"/>
Please Specify: _____				

2. Does this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response YES NO

If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
<input type="checkbox"/> Academic Probation		
<input type="checkbox"/> Probation for unprofessional conduct/behavioral reasons		
<input type="checkbox"/> Probation for other reason		
Please specify reason: _____		

3. Does this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response YES NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s): _____

Medical School Verification – Page 4 of 4
(Copy this form for multiple schools)

4. Does this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? Response YES NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Does this individual's official records reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? Response YES NO

If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

Postgraduate Training Verification - Page 1 of 3
(Copy this form for multiple programs)

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to your training program. Request the Program Director or designated official to complete Section 3 of this form and return this form and the Program Director's recommendation letter directly to this Board.

Section 1: Applicant Information

Last Name: _____

First Name: _____

Middle Name: _____

Suffix: _____

Name if different when diploma awarded: _____

Social Security Number: _____

Date of Birth: _____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

Applicant's Signature

Date

Section 2: Instructions to the PROGRAM DIRECTOR or designated official of POSTGRADUATE TRAINING PROGRAM.

Please complete Section 3 of this form and attach a recommendation letter from the Program Director and forward this information directly to this Board at the following address:

Board Name: _____

Address _____

City _____

State/Province _____

ZIP Code _____

Postgraduate Training Verification - Page 2 of 3
(Copy this form for multiple programs)

Section 3: Postgraduate Training Verification

Institution Name: _____

Institution Address: _____

Street _____

City _____

State/Province _____

ZIP Code _____

Affiliated Medical School Name: _____

Program Type/Specialty: _____

Postgraduate Year: _____

- Internship
 Residency
 Fellowship
 Research
 Chief Resident

Other: _____

From Date: ____/____/____ To Date: ____/____/____

Successfully Completed?: Yes No In Progress
 (The definition of Successfully Completed is: In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?)

Accredited by: ACGME AOA LCGME RSC CFPC RCPSC APPAP None of these

Unusual Circumstances:

Did this individual ever take a leave of absence or break from his/her training? Yes No

Was this individual ever placed on probation? Yes No

Was this individual ever disciplined or placed under investigation? Yes No

Were any negative reports for behavioral reasons ever filed by instructors? Yes No

Were any limitations or special requirements placed upon this individual because Yes No

of questions of academic incompetence, disciplinary problems or any other reason?

Please explain any "Yes" response from above (attach additional pages if necessary): _____

Postgraduate Training Verification - Page 3 of 3
(Copy this form for multiple programs)

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature: _____

Print name: _____

Title: _____

Date: _____

Phone number: _____

Fax: _____

E-mail: _____

AFFIX INSTITUTIONAL SEAL HERE (If no seal is available, this form must be notarized)

If you completed Section 5 of the application, you must complete this form
Fifth Pathway Verification

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to the director of your 5th Pathway Program. Request the Program Director or designated official to complete Section 3 of this form and return this form and the Program Director's recommendation letter directly to this Board.

Section 1: Applicant information

Last Name: _____ Suffix: _____

First Name: _____ Middle Name: _____

Name if different when diploma awarded: _____

Social Security Number: _____

Date of Birth: _____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

Applicant's Signature _____ Date _____

Section 2: Instructions to the PROGRAM DIRECTOR or designated official

Please complete Section 3 of this form and attach a recommendation letter from the Program Director and forward this information directly to this Board at the following address:

Board Name: _____

Address _____

City _____

State/Province _____ ZIP Code _____

Section 3: Medical School Verification

Medical School Name: _____

School name if different when the above applicant attended: _____

Applicant's Attendance Dates: From _____ To _____ Program Completion Date: _____
(Indicate N/A if not applicable)

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature: _____

Print name: _____

AFFIX INSTITUTIONAL SEAL HERE.

Title: _____

(if no seal is available, this form

Date: _____

must be notarized)

Phone number: _____

Fax: _____

E-mail: _____

Uniform Application for Physician State Licensure

Addendum 4A

Reference Form

Substitute forms are not acceptable. This form may be duplicated as needed.

This form is to be completed by the individual providing the reference.
Please return the completed form directly to the Board at:

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

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

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 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 evaluation 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: _____

27. Medical Malpractice Court Judgments/Settlement [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 the below information 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 the below information 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:

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 Workman'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: _____
