

**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: \_\_\_\_\_

**EMPLOYMENT CONTRACT**

I, \_\_\_\_\_, an applicant for  
(Applicant's Name)

Certification as a Physician Assistant, am employed by

\_\_\_\_\_  
(Employer's Name)

for the period beginning \_\_\_\_\_  
(Month/Day/Year)

Termination of my contract will cause my Certification to become null and void.

\_\_\_\_\_  
Signature of Physician Assistant (Date)

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

Print Name of Physician \_\_\_\_\_

NOTE: A contract from each separate employer is required.

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE  
108 CHERRY STREET  
BURLINGTON, VERMONT 05401-0070  
(802) 657- 4220

VERIFICATION OF PHYSICIAN ASSISTANT LICENSURE OR CERTIFICATION

This section must be completed by the regulatory authority in the states in which **you now hold or have ever held** a license or certification to practice as a physician's assistant.

I, \_\_\_\_\_ Secretary of the \_\_\_\_\_

State Board of \_\_\_\_\_, certify that

\_\_\_\_\_ was granted Certificate Number \_\_\_\_\_

to practice as a physician's assistant in the State of \_\_\_\_\_

on the \_\_\_\_\_ day of \_\_\_\_\_ 19 \_\_\_\_\_

and that said certificate has never been revoked, suspended or conditioned in any way, or the licensee has never been disciplined by the Board in any way.

NOTE: If licensed by written examination the secretary should further certify:

I further certify that the aforesaid \_\_\_\_\_ in his/her written

Examination before this Board, obtained a general average of \_\_\_\_\_ percent in the

Following branches:

(The subjects of the examination and rating of each must be stated in full.)

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

(AFFIX SEAL) \_\_\_\_\_  
(Secretary/Director)

\_\_\_\_\_  
(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 \_\_\_\_\_

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**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)

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE  
108 CHERRY STREET  
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(802) 657- 4220

CERTIFICATE OF PHYSICIAN ASSISTANT EDUCATION

I hereby certify that, \_\_\_\_\_ was admitted to the  
(Name)  
\_\_\_\_\_  
Physician Assistant

Program in \_\_\_\_\_ on \_\_\_\_\_  
(City and State) (Date)

and completed all requirements for graduation on \_\_\_\_\_  
(Date)

A \_\_\_\_\_ was granted on \_\_\_\_\_  
(Specify certificate/diploma/degree) (Date)

Is this program CAHEA or successor agency approved? \_\_\_\_\_ Yes \_\_\_\_\_ No

(AFFIX SEAL)

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

Signed: \_\_\_\_\_  
(Authorized Officer of the School)

TO PROGRAM: Return to above address

**STATE OF VERMONT – BOARD OF MEDICAL PRACTICE**  
**108 CHERRY STREET**  
**BURLINGTON, VERMONT 05401-0070**  
**(802) 657- 4220**

Name of applicant: \_\_\_\_\_

The physician assistant named above has applied to the Vermont Board of Medical Practice for a certification to practice as a physician assistant 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.

Name \_\_\_\_\_ 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.

The basic medical knowledge to be expected in a PA:	_____	Poor	_____	Fair	_____	Average	_____	Above Average
Professional judgement:	_____	Poor	_____	Fair	_____	Average	_____	Above Average
Sense of responsibility:	_____	Poor	_____	Fair	_____	Average	_____	Above Average
Moral character/ethical conduct:	_____	Poor	_____	Fair	_____	Average	_____	Above Average
Competence and skills in the tasks delegated:	_____	Poor	_____	Fair	_____	Average	_____	Above Average
Cooperativeness ability to work with others:	_____	Poor	_____	Fair	_____	Average	_____	Above Average
Willingness to accept directions and limitations in role:	_____	Poor	_____	Fair	_____	Average	_____	Above Average
History & physical exam:	_____	Poor	_____	Fair	_____	Average	_____	Above Average
Record keeping:	_____	Poor	_____	Fair	_____	Average	_____	Above Average
P.A.-Patient relationship:	_____	Poor	_____	Fair	_____	Average	_____	Above Average
Track record in adhering to scope of practice:	_____	Poor	_____	Fair	_____	Average	_____	Above Average
Ability to communicate in reading, writing and speaking the English language:	_____	Poor	_____	Fair	_____	Average	_____	Above Average

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REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH MOST RECENTLY  
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 as a physician's assistant?  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?  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 concern (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 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 applicant 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 previous evaluations
- Other – Specify: \_\_\_\_\_

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

I recommend \_\_\_\_\_ for licensure in Vermont.

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

Print or Type Name and Title: \_\_\_\_\_

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

Name \_\_\_\_\_ 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.

The basic medical knowledge to be expected in a PA:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Professional judgement:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Sense of responsibility:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Moral character/ethical conduct:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Competence and skills in the tasks delegated:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Cooperativeness ability to work with others:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Willingness to accept directions and limitations in role:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
History & physical exam:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Record keeping:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
P.A.-Patient relationship:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Track record in adhering to scope of practice:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Ability to communicate in reading, writing and speaking the English language:	_____ Poor	_____ Fair	_____ Average	_____ Above Average

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REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH MOST RECENTLY  
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 as a physician's assistant?  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?  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 concern (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 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 applicant 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 previous evaluations
- Other – Specify: \_\_\_\_\_

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

I recommend \_\_\_\_\_ for licensure in Vermont.

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

Print or Type Name and Title: \_\_\_\_\_

## VERMONT BOARD OF MEDICAL PRACTICE PHYSICIAN ASSISTANT SCOPE OF PRACTICE

"Scope of practice" means a written document detailing those areas of medical practice including duties and medical acts, delegated to the physician assistant by the supervising physician for which the licensee is qualified by education, training and experience. At no time shall the scope of practice of the physician assistant exceed the normal scope of either the primary or secondary supervising physician(s) practice.

Physician assistants practice medicine with physician supervision. Physician assistants may perform those duties and responsibilities, including the prescribing and dispensing of drugs and medical devices, that are delegated by their supervising physician(s).

Physician assistants shall be considered the agents of their supervising physicians in the performance of all practice-related activities, including but not limited to, the ordering of diagnostic, therapeutic and other medical services.

It is the obligation of each team of physician(s) and the physician assistant(s) to insure that the written scope of practice submitted to the Board for approval clearly delineates the role of the physician assistant in the medical practice of the supervising physician. This should cover at least the following categories:

a) Narrative: A brief description of the practice setting, the types of patients and patient encounters common to this practice and a general overview of the role of the physician assistant in that practice.

b) Supervision: A detailed explanation of the mechanisms for on-site and off-site physician supervision and communication, back-up and secondary supervising physician utilization. Included here should be a description of the method of transport and back-up procedures for immediate care and transport of patients who are in need of emergency care when the supervising physician is not on premises. This explanation should include issues such as, ongoing review of the physician assistant's activities, retrospective chart review, co-signing of patient charts, and utilization of the services of non-supervising physicians and consultants.

c) Sites of Practice: A description of any and all practice sites (i.e. office, clinic, hospital outpatient, hospital inpatient, industrial sites, schools, etc.). For each site, a description of the PA's activities.

d) Tasks/Duties: A list of the PA's tasks and duties in the supervising physician's scope of practice.

This list should express a sense of involvement in the level of medical care in that practice. The supervising physician may only delegate those tasks for which the physician assistant is qualified by education, training and experience to perform. Notwithstanding the above, the physician assistant should initiate emergency care when required while accessing back-up assistance. At no time should a particular task assigned to the-PA fall outside of the scope of practice of the supervising physician.

e) An authorization to prescribe medications which includes the following statements:

1) The physician assistant named in this document will be authorized to prescribe medications in accordance with the scope of practice submitted to and approved by the Vermont Board of Medical Practice.

2) The physician assistant named in this document will be authorized to prescribe controlled drugs in accordance with the scope of practice submitted to and approved by the Vermont Board of Medical Practice. A physician assistant who prescribes controlled drugs must obtain an identification number from the federal Drug Enforcement Agency (DEA). The physician assistant DEA number is (insert DEA number).

### 3.1.11 AUTHORITY TO PRESCRIBE DRUGS

The certified physician's assistant may prescribe only those drugs utilized by the primary supervising physician and permitted by the scope of practice submitted to and approved by the Board.

The drug order shall be signed, "(physician assistant's name) for (physician's name)".

Upon a pharmacist's request, the Board shall furnish a copy of the Board approved scope of practice and a signature sample of the physician's assistant.

### 3.1.12 PRIMARY SUPERVISING PHYSICIAN

The supervising physician shall:

1. be qualified to practice medicine in the field(s) of medicine in which he or she actively practices;
2. supervise physician assistants only in the field(s) of medicine in which he or she actively practices;
3. submit his or her usual scope of practice as defined in 3.1.1, 10 a).
4. outline in detail how he or she will be available for consultation and review of work performed by the physician's assistant;
5. supervise no more physician assistants concurrently than have been approved by the Board after review of the system of care delivery;
6. furnish copies of the physician assistant's scope of practice to any medical facilities with which the physician's assistant is affiliated or employed;
7. conduct and document regular chart reviews, such as chart audits, and retrospective patient care audits, or review and countersign PA notes;
8. immediately notify the Board in writing of dissolution of the physician assistant's employment contract and the reason(s) for dissolution. Similar notification is required if the scope of practice changes, the employer(s) change, or there is a change in the primary or secondary supervising physician(s). Board approval must be received, otherwise the PA's certificate becomes void. Documents already on file with the Board need not be resubmitted.
9. sign a statement certifying that the primary supervising physician has read the statutes and Board rules governing physician assistants.

### 3.1.13 SECONDARY SUPERVISING PHYSICIAN

The secondary supervising physician shall:

1. be qualified to practice in the field(s) of medicine in which the physician assistant is practicing;
2. supervise physician assistants only in the field(s) of medicine in which he or she actively practices;
3. be responsible for the physician assistant's medical acts only when consulted by the physician assistant.
4. be available for consultation as secondary supervising physician;
5. have read and signed the scope of practice submitted to and approved by the Board;
6. supervise no more physician assistants concurrently than have been approved by the Board after review of the system of care delivery;
7. immediately notify the Board of dissolution of secondary supervision and reasons for dissolution of the physician assistant employment contract. The notification shall include the reasons for ending the employment relationship if any of the grounds of unprofessional conduct as described in 26 V.S.A. Section 1736 has occurred;
8. sign a statement certifying that the secondary supervising physician has read the statutes and Board rules governing physician assistants.