UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Affidavit and Authorization for Release of Information

Applicant: In the presence of a notary public, sign this form with attached photo. If you are using FCVS for credentials verification, consider having that form notarized at the same time. Send the separate notarized FCVS form to FCVS. **Do not send this form to FCVS** as doing so will delay your licensure.

Please return to the Vermont Board of Medical Practice, 280 State Drive, Waterbury, VT 05671-8320
AHS.VDHMedicalBoard@vermont.gov

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 Uniform Application for Physician State 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 Photograph

Securely tape or glue a recent (per the board's instructions) front-view 2" x 2" passport-type color photo of yourself in this square.

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

_____
Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)

_____
Date of signature (must correspond to date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left.]

NOTARY

State of _____, County of _____,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this _____ day of _____, 20____.

Notary Public Signature _____ My Notary Commission Expires _____

Vermont Department of Health
Board of Medical Practice
280 State Drive, Waterbury, VT 05671-8320
AHS.VDHMedicalBoard@vermont.gov
802-657-4220

APPLICATION FOR LIMITED TEMPORARY PODIATRIST LICENSE

CERTIFICATE OF PODIATRIC MEDICAL EDUCATION

To be completed by an officer of your School of Podiatric Medicine

I hereby certify that _____ was admitted to the
(Name)

_____ School of Podiatric Medicine in

_____ on _____
(City, State) (Date)

and completed all requirements for graduation on _____.
(Date)

A _____ was granted/will be granted on
(Specify Certificate/Diploma/Degree)

_____.
(Date)

Date: _____

Signed: _____

[AFFIX SEAL]

Print Name: _____

Title: _____

State of Vermont
Board of Medical Practice
280 State Drive, Waterbury, VT 05671-8320
AHS.VDHMedicalBoard@vermont.gov
(802) 657-4220

APPLICATION FOR LIMITED TEMPORARY PODIATRIST LICENSE

CERTIFICATE OF MEDICAL LICENSURE

This section must be completed by the regulatory authority in the states in which **you now hold or have ever held** a license to practice medicine, including a limited temporary and/or training license.

I, _____ Secretary of the _____

State Board of medical examiners, certify that _____ was granted

Certificate Number _____ to practice medicine in the State of

_____ on the _____ day of _____,

_____ 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 aforesaid _____ in their 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.)

_____

_____

_____

Date: _____

Signed: _____

[AFFIX SEAL]

Printed Name: _____

Title: _____

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE
280 State Drive, Waterbury, VT 05671-8320
AHS.VDHMedicalBoard@vermont.gov

APPLICATION FOR LIMITED TEMPORARY PODIATRIST LICENSE

STATEMENT OF SUPERVISING PODIATRIST / PROGRAM DIRECTOR

This section must be completed by the Supervising podiatrist/Program Director who will be supervising your work in Vermont. This licensed podiatrist will be responsible and liable for all negligent and wrongful acts or omissions of the limited temporary license holder. Termination of appointment as an intern, resident, fellow, or medical officer of such designated hospital or institution shall operate as a revocation of such limited temporary license. This limited temporary license shall be revoked upon the death or legal incompetence of the licensed physician or upon ten days written notice of the licensed physician.

I certify that (name of applicant) _____ is under my direct supervision and control **in an approved residency program** at:

Hospital or Institution: _____

Department: _____

Address: _____

City, State, Zip Code: _____

For the period _____ to _____

I state that the above applicant is under my direct supervision and control. I further state that I shall be legally responsible and liable for all negligent or wrongful acts or omissions of this limited temporary license holder.

_____ _____
Signature of Program Director/Supervising Podiatrist | Program Director/Supervising Podiatrist's Vermont License Number

_____ _____
Printed Name of Program Director/Supervising Podiatrist | Date

_____
Address

_____
City, State, Zip Code

PLEASE EMAIL OR MAIL COMPLETED FORM TO THE BOARD'S ADDRESS LISTED ABOVE. THANK YOU.

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE
280 State Drive, Waterbury, VT 05671-8320
AHS.VDHMedicalBoard@vermont.gov

APPLICATION FOR LIMITED TEMPORARY PODIATRIST LICENSE

STATEMENT OF THE PROGRAM DIRECTOR

(THIS FORM IS TO BE USED FOR RESIDENTS PARTICIPATING IN AN AWAY ROTATION ONLY)

This section must be completed by the Director of the residency program in which the applicant is currently engaged.

I certify that (name of applicant) _____ is engaged as an intern, resident, fellow, or medical officer at:

Hospital or Institution: _____

Department: _____

Address: _____

City, State, Zip Code: _____

For the period _____ to _____

I further state that (name of applicant) _____ is a resident/fellow in good standing and is scheduled to participate in an **away rotation** at:

Hospital or Institution: _____

Department: _____

Address: _____

City, State, Zip Code:
_____

For the period _____ to _____. This is an approved rotation within the framework of the residency program.

_____ _____
Signature of Program Director Date

_____
Printed Name of Program Director

PLEASE EMAIL OR MAIL COMPLETED FORM TO THE BOARD'S ADDRESS LISTED ABOVE. THANK YOU.