

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 _____

Licensure Verification Form (Form #1)

Applicant: Most boards require verification of each professional license ever held. Refer to the licensure verification resource at <http://www.fsmb.org/licensure/uniform-application/> to determine fees and preferred verification method(s) for each state medical and osteopathic verifying board. You may use this form for each board that requires a written request for verification. In Section 1, list the board you are applying to for licensure, using the directory at <http://www.fsmb.org/policy/contacts> to ensure you list the correct name and address. Mail this completed form and any required fee to the verifying board.

Verifying Board: Unless using electronic verification, complete Section 2 below and email or mail this form to the board at the address listed in Section 1. Use an additional sheet of paper if needed for explanation(s).

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type ☐ MD ☐ DO ☐ _____
Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Authorization for Verifying Board: I am applying for a license to practice medicine. The board that I am applying to for licensure requires that this form or an otherwise accepted method of verification be completed by all boards through which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of _____ to provide any and all information pertaining to my license number _____ to the board at the address listed below.

Board name	<u>Vermont Board of Medical Practice</u>
Mailing address	<u>280 State Drive, Waterbury, VT 05671-8320</u>
Email Address	<u>AHS.VDHMedicalBoard@vermont.gov</u>

Applicant signature _____ Date _____

Section 2: Board Verification of Licensure

Name of issuing board or license entity _____

Name of licensee (last, first, middle, suffix) _____

License type _____ License number _____ Issue date _____ Expiration date _____

1. Is this license current? If not current, please explain: ☐ Yes ☐ No
2. Have formal disciplinary proceedings been initiated against this applicant's license by a disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form. ☐ Yes ☐ No
☐ Cannot answer under state law
3. 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? If yes, please explain on a separate sheet of paper and attach it to this form. ☐ Yes ☐ No
☐ Cannot answer under state law

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.

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

Signature _____
Print name _____
Title _____ Date _____
Phone number _____ Fax number _____
Email _____

Please email or mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

Medical or School Verification Form (Form #2)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form and a copy of your medical school diploma to the current dean of your medical or osteopathic school. Copy this form for multiple schools.

Dean or Designated Official: Complete Section 2 of this two-page form and certify the enclosed copy of the diploma by placing your school seal on it. Mail the sealed diploma, an official copy of the physician's transcripts, this completed form, and any other documentation needed to the board at the address listed in Section 1. If transcripts are not in English, an original, certified, and official English translation is required.

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type ☐ MD ☐ DO ☐ _____
 Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____
 Name _____ if _____ different _____ when _____ diploma _____ awarded _____
 Name of school _____

*The social security number is to be used for purposes of identification only and may not be used for any other reason.

Waiver for Release of Information: I am applying for a license to practice medicine. I authorize the medical/osteopathic school listed above to provide any and all information pertaining to my medical/osteopathic education at that institution to the board at the address listed below. I request that the dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached) as described in the instructions above, then mail this completed form, the sealed diploma copy, and a copy of my official transcripts to the board listed below at the given address:

Board name _____ Vermont Board of Medical Practice _____
 Mailing address _____ 280 State Drive, Waterbury, VT 05671-8320 _____
 Email Address _____ AHS.VDHMedicalBoard@vermont.gov _____

Applicant signature _____ Date _____

Section 2: Medical School Verification

School name _____
 Complete address w/country _____
 School name if different when applicant attended _____
 Hours of undergraduate education required for admission _____ Total weeks of education applicant attended _____
 Attendance (mm/yyyy) from _____ to _____ Graduation date _____ Degree awarded _____

Unusual Circumstances

The following questions apply to unusual circumstances that occurred during any part of the individual's medical or osteopathic education. Check the appropriate responses and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation attached to this form.

- Do the official records for this individual reflect interruptions or extensions in his/her medical/osteopathic education? Yes ☐ No ☐
 If **yes**, indicate the reasons for each interruption or extension, the dates of each interruption or extension, and whether each interruption or extension was approved or unapproved.

<input type="checkbox"/> Personal or family	From _____ to _____	<input type="checkbox"/> Approved	<input type="checkbox"/> Unapproved
<input type="checkbox"/> Academic remediation	From _____ to _____	<input type="checkbox"/> Approved	<input type="checkbox"/> Unapproved
<input type="checkbox"/> Health	From _____ to _____	<input type="checkbox"/> Approved	<input type="checkbox"/> Unapproved
<input type="checkbox"/> Financial	From _____ to _____	<input type="checkbox"/> Approved	<input type="checkbox"/> Unapproved
<input type="checkbox"/> Participation in a joint degree program	From _____ to _____	<input type="checkbox"/> Approved	<input type="checkbox"/> Unapproved
<input type="checkbox"/> Participation in a non-research special study (e.g., fellowship, intl. experience)	From _____ to _____	<input type="checkbox"/> Approved	<input type="checkbox"/> Unapproved
<input type="checkbox"/> Other _____	From _____ to _____	<input type="checkbox"/> Approved	<input type="checkbox"/> Unapproved

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical/osteopathic education? Yes ☐ No ☐ **If yes**, indicate below the reasons for each time of probation and the dates of placement on and removal from probation. Also attach documentation or information of each circumstance and outcome.

<input type="checkbox"/> Academic	From _____ to _____	<input type="checkbox"/> Documentation attached
<input type="checkbox"/> Unprofessional conduct	From _____ to _____	<input type="checkbox"/> Documentation attached
<input type="checkbox"/> Behavioral reasons	From _____ to _____	<input type="checkbox"/> Documentation attached
<input type="checkbox"/> Other _____	From _____ to _____	<input type="checkbox"/> Documentation attached

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical/osteopathic school or parent university? **If yes**, explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

4. Do the official records for this individual reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical/osteopathic school or parent university? **If yes**, explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

5. Do the official records for this individual 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? **If yes**, explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

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.

AFFIX INSTITUTIONAL SEAL HERE

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

Signature _____
Print name _____
Title _____ Date _____
Phone number _____ Fax number _____
Email _____

Please email or mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

Institution Name: _____ Institution Address: _____ _____ Affiliated School: _____	<p><u>Please return to Vermont Board of Medical Practice,</u> <u>280 State Drive, Waterbury, VT 05671-8320</u> <u>AHS.VDHMedicalBoard@vermont.gov</u></p> <p><u>Program Director or designated Official:</u> Please complete Section 2, and email or mail this form and any other items to the designated state medical board at the address listed in Section 1. Thank you.</p>						
Section 1: To be completed by the Applicant. <u>Board Information:</u> To be completed by the applicant. <div style="color: red;">Applicant Please Sign Here →</div>	<p>Name: _____ Suffix _____ Practitioner type: M.D. <input type="checkbox"/> D.O. <input type="checkbox"/></p> <p>Date of birth: _____ (mm/dd/yyyy) SSN* _____ <small>*The social security number is to be used for purposes of identification only and may not be used for any other reason.</small></p> <p>Name if different when diploma awarded: _____</p> <p>Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined below. I authorize the postgraduate training program listed above to provide any all information pertaining to my training there to the board listed below:</p> <p>Board Name: Vermont Board of Medical Practice _____</p> <p>Mailing address: 280 State Drive, Waterbury, VT 05671-8320</p> <p>Applicant Signature _____ Date _____</p>						
Section 2 : Program Participation : Important: Report Incomplete Training Levels (years) separate from those that were successfully completed. If the training level (year) is currently in progress report the expected completion date in the "To" field. Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations. Report Internships, Residencies and Fellowships separately. Unusual Circumstances: Check the appropriate responses and explain any "Yes" or omitted response(s) on a separate sheet of paper. Attach pages as needed.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 35%; padding: 5px;"> Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research </td> <td style="width: 65%; padding: 5px;"> Specialty/Subspecialty: _____ From: ____/____/____ To: ____/____/____ Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSA <input type="checkbox"/> APPAP <input type="checkbox"/> None of these </td> </tr> <tr> <td style="padding: 5px;"> Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research </td> <td style="padding: 5px;"> Specialty/Subspecialty: _____ From: ____/____/____ To: ____/____/____ Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSA <input type="checkbox"/> APPAP <input type="checkbox"/> None of these </td> </tr> <tr> <td style="padding: 5px;"> Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research </td> <td style="padding: 5px;"> Specialty/Subspecialty: _____ From: ____/____/____ To: ____/____/____ Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSA <input type="checkbox"/> APPAP <input type="checkbox"/> None of these </td> </tr> </table> <div style="margin-top: 10px;"> <p>1. Did this individual ever take a leave of absence or break from his/her training? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Was this individual ever placed on probation? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Was this individual ever disciplined or placed under investigation? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Were any negative reports for behavioral reasons ever filed by instructors? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </div>	Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Specialty/Subspecialty: _____ From: ____/____/____ To: ____/____/____ Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSA <input type="checkbox"/> APPAP <input type="checkbox"/> None of these	Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Specialty/Subspecialty: _____ From: ____/____/____ To: ____/____/____ Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSA <input type="checkbox"/> APPAP <input type="checkbox"/> None of these	Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Specialty/Subspecialty: _____ From: ____/____/____ To: ____/____/____ Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSA <input type="checkbox"/> APPAP <input type="checkbox"/> None of these
Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Specialty/Subspecialty: _____ From: ____/____/____ To: ____/____/____ Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSA <input type="checkbox"/> APPAP <input type="checkbox"/> None of these						
Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Specialty/Subspecialty: _____ From: ____/____/____ To: ____/____/____ Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSA <input type="checkbox"/> APPAP <input type="checkbox"/> None of these						
Training Level: _____ (e.g., 1, 2, 3, etc.) <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	Specialty/Subspecialty: _____ From: ____/____/____ To: ____/____/____ Successfully Completed?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress Accredited by: <input type="checkbox"/> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSA <input type="checkbox"/> APPAP <input type="checkbox"/> None of these						
Certification: Affix your institutional seal in this space. If no seal is available, you must have this form notarized.	<p>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. This section <u>MUST</u> be signed by the program director (M.D. or D.O. only). (Signature by personnel other than an M.D. or D.O. must attach an authorization letter. Applicable only for Nevada State Board of Medical Examiners.)</p> <p>Signature: _____</p> <p>Print name: _____</p> <p>Title: _____</p> <p>Email address: _____</p> <p>Phone Number: _____ Date: _____</p>						

Fifth Pathway Verification Form (Form #4)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form to your Fifth Pathway program director.

Program Director or Designated Official: Complete Section 2 of this form. Email or mail this completed form and any other documentation (if applicable) to the board at the address listed in Section 1.

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type ☐ MD ☐ DO ☐ _____
 Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____
 Name _____ if _____ different _____ when _____ certificate _____ awarded _____
 Name of medical school _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined above. I authorize the designated official to provide any and all information pertaining to my time there to the board listed below:

Board name Vermont Board of Medical Practice
 Mailing address 280 State Drive, Waterbury, VT 05671-8320
 Email Address AHS.VDHMedicalBoard@vermont.gov

Applicant signature _____ Date _____

Section 2: Fifth Pathway Verification

Institution name _____ Affiliated school _____
 Institution name if different when applicant attended _____
 Institution address w/country _____

Type of Clinical Rotation	From	To	Weeks Credit
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Completed? ☐ Yes. Attendance was from _____ to _____. Completion date was _____.
☐ No. Withdrawal* date was _____. **If the applicant withdrew or was dismissed, please explain below.*
☐ No. Dismissal* date was _____. **If the applicant withdrew or was dismissed, please explain below.*

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.

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

Signature _____
 Print name _____
 Title _____ Date _____
 Phone number _____ Fax number _____
 Email _____

Please email or mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

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

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER

Name of applicant: _____

The Applicant named above has applied to the Vermont Board of Medical Practice for a license to practice medicine. 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 (applicant) _____ was at (Institution) _____

From _____ to _____. During that time, the applicant

Was (list Position at 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 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 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
Patient management:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Case presentations:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Relationship with patients:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Participation in Medical Staff Affairs:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Competence in being able to communicate in reading, writing and speaking the English language:	_____ Poor	_____ Fair	_____ Average	_____ Above Average

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 reason that this person cannot currently practice medicine safely? ☐ 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 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 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 residency training program(s)? ☐ Yes ☐ No

Does the applicant call upon consultants when needed? ☐ Yes ☐ No

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please check the appropriate response. If you answer "yes" to either question, please provide a short explanation.

Do you know of any leaves of absence or interruptions in applicant's medical education? ☐ Yes ☐ No

Do you know of any limitations or special requirements imposed on the applicant during medical education because of questions of academic or technical competence? ☐ Yes ☐ No

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 their 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 applicant, the applicant was competent to practice as a medical practitioner and was not the subject of any disciplinary action.

I recommend (Applicant) _____ for licensure in Vermont.

Signed: _____ Date: _____

Print or Type Name and Title: _____

MEDICAL MALPRACTICE CLAIM REPORTING FORM

Must Complete Form. Do not say "See Attached"

Name of Applicant: _____

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):

- | | | | |
|---------------------------|------------|--------------------------------------|--------------------------------|
| 1. Anesthesiologist | 6. Surgeon | 11. PGY 4 | 16. Court Psychiatrist |
| 2. Primary Care Physician | 7. Fellow | 12. PGY 5 | 17. On-Call Physician |
| 3. Referring Physician | 8. PGY 1 | 13. PGY 6 | 18. Group Practitioner/Partner |
| 4. Attending Physician | 9. PGY 2 | 14. PGY 7 | 19. Other: Specify _____ |
| 5. Consultant Specialist | 10. PGY 3 | 15. Workman's Compensation Evaluator | 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 of 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 appealed filed (month/day/year): _____

Date appealed 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 currently pending

_____ Case dismissed against you _____ Against all defendants

IMPORTANT: In addition to the above information, please attach a copy of the complaint and final judgement, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:
