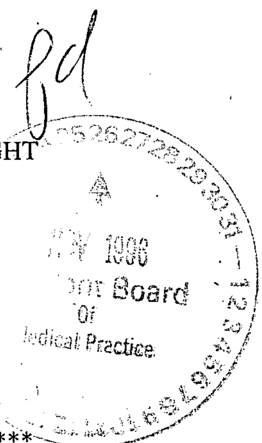
42-6255 LYON, EDD G.



STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE ONE OF EIGHT

I hereby apply for the renewal of my LICENSE AS A PHYSICIAN for the period from 12/01/96 to 11/30/98. **TWO YEAR RENEWAL FEE: *$300.00.***
Enclose a check in the amount of ***$300.00*** made payable to the Vermont Board of Medical Practice.

EDD G. LYON
140 HOSPITAL DRIVE
BENNINGTON, VT 05201

****

Important:
- Please print legibly or type your answers.
- Answer all questions completely - it is not adequate to state that the Board already has the information. Use the enclosed Form A to provide explanations to "yes" answers in Section II.
- Make a copy of this form and all attachments for your own records.
- Do not delegate this important task to an employee, as false statements on this form are grounds for unprofessional conduct.
- Do not remove any pages from this document.

-Thank you for your cooperation.

SECTION I

(Section I contains general information of interest to both the Board of Medical Practice and the Department of Health.)

1. Name: EDD GILBERT LYON
2. Vermont License Number: 42-6255
3. Other Name(s), if any, under which you were licensed in Vermont and elsewhere since your last renewal:
4. Home Address: VAIL RD RR1 BOX 2958

   City, State, Zip Code: BENNINGTON, VT 05201
5. Office Address: 140 HOSPITAL DRIVE

   City, State, Zip Code: BENNINGTON, VT 05201

Note: Circle either "Home Address" or "Office Address" as your preferred mailing address.

6. Daytime Telephone Number: (802)447-1191
7. Date of Birth: 12/20/46
8. Sex (M/F): M
9. Are you currently active in clinical practice in Vermont? X Yes ___No

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF EIGHT

SECTION I CONTINUED

10. Licensing Examination Taken - Check: ✓ National Boards ___FLEX ___State Examination-Identify State:
___USMLE ___Other Examination Specify:

11. Undergraduate Degree: (B.A., B.S., etc.): BA Year of Graduation: 1969

Major Course of Study: BIOLOGY

Degree Granting Institution: HAMILTON COLLEGE

Location: CLINTON, NY USA

First Institution (If transfer): ______

Location: ______

12. Medical Degree: (M.D. or Other, please specify): MD Year of Graduation: 1975

Degree Granting Medical School: ALBANY MEDICAL COLLEGE

Location: ALBANY, NY USA

First Medical School (If transfer): UNIVERSIDAD AUTONOMA DE GUADALAJARA

Location: GUADALAJARA, MEXICO

13. Do you have hospital privileges **in Vermont?** ✓ Yes ___No
Name(s) and Location(s) of Hospital(s):

(a) SOUTHWESTERN VT. MEDICAL CENTER

(b) ______

(c) ______

(d) ______

(e) ______

14. Other states where you hold an active license to practice: ______

15. States where you were previously licensed to practice: OKLAHOMA

42-6255 LYON, EDD G.

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE THREE OF EIGHT

SECTION I CONTINUED

16. Please list your specialty(ies) and indicate if you are American Board of Medical Specialties certified in those specialties:

	Specialty Code	Specialty Name	Board Certified ([Y]es/[N]o)	Year Certified/Recertified
(a)	0 6 0 1	FAMILY PRACTICE	Y	1978 / 1996
(b)				/
(c)				/

17. Please list the institutions where you have had residency or fellowship training:

	Residency Institution #1	Residency Institution #2	Residency Institution #3
Institution Name	UNIVERSITY OF OKLAHOMA		
City	TULSA		
State	OK		
Country	USA		
Specialty Code (See list)	0 6 0 1		
Specialty Name	FAMILY PRACTICE		
Year Residency Completed	1978		

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, FOUR OF EIGHT

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STATE OF VERMONT - BOARD OF MEDICAL PRACTICE

1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE FIVE OF EIGHT

SECTION II: PLEASE CHECK YES OR NO.

A "YES" ANSWER REQUIRES AN EXPLANATION ON THE ENCLOSED FORM A.

(Section II is for the reporting of information, which is retained solely by the Board of Medical Practice and is **not** part of the data base maintained by the Department of Health.)

During the past two years:

1. Have you had any organic illness, emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine, resident or fellow?

2. Have you been a defendant in any criminal proceeding other than minor traffic offenses? ____YES ✓ NO

3. Are you currently under investigation for a criminal act?

4 Have you been dependent upon alcohol or drugs?

5. Are any formal disciplinary charges pending or has any disciplinary action 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

6. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim/complaint/demand for damages)?

7. Have you had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, resigned from a medical staff in lieu of disciplinary action or resigned from a medical staff after a complaint or peer review action has been initiated against you? ____YES ✓ NO

8. Have you voluntarily surrendered or resigned a license to practice medicine or any healing art in lieu of disciplinary action? ____YES ✓ NO

9. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered by any jurisdiction or federal agency at any time? ____YES ✓ NO

10. Have you been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill? ____YES ✓ NO

11. Have you withdrawn an application for a medical license or been denied a medical license for any reason? ____YES ✓ NO

12. Have you been turned down for coverage by a malpractice insurance carrier? ____YES ✓ NO

13. Have you been notified as a responsible party of a confirmed quality concern (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? ____YES ✓ NO

14. Have you been the subject of an investigation by any **other licensing board**?

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE SIX OF EIGHT

SECTION II CONTINUED

15. Have you been dismissed or asked to leave a residency training program(s) before completion? ____YES ✓ NO

IMPORTANT NOTE REGARDING THE QUESTIONS ABOVE AND ON THE PREVIOUS PAGE:

Except for questions 1 and 4, "Yes" answers on past license renewals must be updated on Form A. For example, if a previously reported malpractice action has been dismissed, please indicate that on Form A. You have a continuing obligation to update the Board during the 1996-1998 period if the answer to any of the questions above changes from "No" to "Yes".

SECTION III

Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions

IMPORTANT: WITHOUT EXCEPTION, ALL LICENSEES MUST COMPLETE (1), (2), (3), (4) AND (5) BELOW OR THE LICENSE WILL NOT BE RENEWED. THANK YOU FOR YOUR COOPERATION.

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 due 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, 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:**

__✓__ 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 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".

(continued on page 8)

YOU MUST COMPLETE OTHER SIDE

SECTION III CONTINUED

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 two 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 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 unemployment contributions or payments in lieu of unemployment contributions due to the 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".

4. **SOCIAL SECURITY NUMBER:** [redacted]* DATE OF BIRTH: 12 / 20 / 46

* The disclosure of your social security number is mandatory, 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 tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

5. **STATEMENT OF APPLICANT**

I further certify that all information contained in this renewal application (including all pages and attachments) is true and accurate to the best of my knowledge. *Failure to provide truthful and accurate information may constitute grounds for denial of license renewal or disciplinary action.*

Date: 11/16/96 Signature: [signature]

Return the completed form and fee to:
(Return envelope enclosed)

Vermont Board of Medical Practice
109 State Street
Montpelier, Vermont 05609-1106

QUESTIONS?: (802) 828-2673

IMPORTANT: Please be sure to write your license number on your check. Check for the correct spelling of your name and proper address on the page one label. Print any changes in the adjoining space. Sign and date the application. Enclose the correct fee of $300.00* in check or money order payable to the Vermont Board of Medical Practice.

***Note:** Physicians 80 years of age or older are exempt from payment of a renewal fee; however the physician license renewal application must be completed and submitted.

SECTION IV

42-6255 LYON, EDD G.

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV

(Section IV is especially for the needs of health care access planning/physician recruitment and retention efforts in Vermont)

1. (a) Check **all** of the activities that describe your current status as a physician:
   - ✓ Active in clinical practice in Vermont
   - __ Active in clinical practice outside Vermont
   - __ Administration
   - ✓ Teaching
   - __ Research
   - __ Retired
   - __ Other

   (b) How many hours per week do you spend on administration, teaching and research? 1/2 hours

2. Postgraduate training in Vermont:
   (a) Are you currently in a postgraduate training program in Vermont as a resident or clinical fellow?
   __Yes ✓No **Note: If you answered YES, please answer questions (b) and (c)**
   (b) Are you a ___Resident ___Clinical Fellow ___Research Fellow?
   (c) What is the medical school that you are affiliated with for this training?
   ___University of Vermont ___Dartmouth ___Other (Please specify)________________

***** Note: If you are providing patient care in Vermont, CONTINUE.**
Otherwise, STOP and return this survey with your relicensing application.

3. What is the date you started practicing medicine (excluding residency or fellowship training)?
   (Month/Year) 08/1978

4. What is the date you started practicing medicine in Vermont (excluding residency or fellowship training)?
   (Month/Year) 08/1978

5. Do you plan to retire or reduce your patient care hours in the next 12 months? ___Yes ✓No

SECTION IV CONTINUED

Instructions for completing this portion:

* Estimate if exact figures are not available.
* Please complete a WORK SITE section for each location where you provide patient care.
* Do not include, as a separate site, hospitals and nursing homes where you provide care to patients normally seen in an outpatient/office setting.
* Be as detailed as possible.
* Use the enclosed yellow sheet to make selections for the Specialty Code and Specialty Name columns.
* Do not remove any pages from this document.

6(a). WORK SITE: NUMBER ONE

Town: BENNINGTON County: BENNINGTON

(*Note: Enter the town and county in which the site is located, not a mailing address or Post Office box.)

Check the **ONE** practice setting from the selections below that most accurately reflects your practice at this site:

PRACTICE SETTINGS

___ Solo Practice
_✓_ Group Practice
___ Community Health Center or Clinic (Non-Hospital)
___ Hospital Outpatient Clinic
___ School or College Health Center
___ Business or Work Site
___ Hospital Emergency Room
___ Hospital Inpatient
___ Extended Care Facility / Nursing Home
___ Other: Specify

Average hours per week that you spend at this site providing DIRECT PATIENT CARE. **Include** both AMBULATORY CARE and HOSPITAL CARE of patients who originate from this site. Please **exclude** on-call hours.

Please complete one full line for each SPECIALTY that YOU practice at this site:

	Specialty Code	Specialty Name	Hours Per Week
Primary Specialty at this Site	0 6 0 1	FAMILY PRACTICE	48
Secondary Specialty at this Site			
Other Specialty at this Site			

Do you plan to continue practice at this site for the next 12 months? _✓_Yes ___No

Will you accept new patients at this site? _✓_Yes ___No

Will you accept new Medicaid patients at this site? _✓_Yes ___No

Will you accept new Medicare patients at this site? _✓_Yes ___No

Are you working with physician's assistants and/or nurse practitioners at this site? _✓_Yes ___No

If yes, enter the number of: Physician's Assistants _____ Nurse Practitioners _1_

For FAMILY and GENERAL PRACTITIONERS, PEDIATRICIANS and INTERNISTS (primary care): Do you provide primary care services to adolescents (ages 10-20) at this site? _✓_Yes ___No

For FAMILY and GENERAL PRACTITIONERS: Which of the following obstetrical services do you provide to patients from this site? _____Prenatal care and delivery _____Prenatal care only __✓__No obstetrical services provided

SECTION IV CONTINUED

Instructions for completing this portion:

* Estimate if exact figures are not available.
* Please complete a WORK SITE section for each location where you provide patient care.
* Do not include, as a separate site, hospitals and nursing homes where you provide care to patients normally seen in an outpatient/office setting.
* Be as detailed as possible.
* Use the enclosed yellow sheet to make selections for the Specialty Code and Specialty Name columns.
* Do not remove any pages from this document.

6(b). WORK SITE: NUMBER TWO

Town: BENNINGTON County: BENNINGTON

(*Note: Enter the town and county in which the site is located, not a mailing address or Post Office box.)

Check the **ONE** practice setting from the selections below that most accurately reflects your practice at this site:

PRACTICE SETTINGS

___ Solo Practice
___ Group Practice
___ Community Health Center or Clinic (Non-Hospital)
___ Hospital Outpatient Clinic
___ School or College Health Center
___ Business or Work Site
___ Hospital Emergency Room
✓ Hospital Inpatient
___ Extended Care Facility / Nursing Home
___ Other: Specify

Average hours per week that you spend at this site providing DIRECT PATIENT CARE. **Include** both AMBULATORY CARE and HOSPITAL CARE of patients who originate from this site. Please **exclude** on-call hours.

Please complete one full line for each SPECIALTY that YOU practice at this site:

	Specialty Code	Specialty Name	Hours Per Week
Primary Specialty at this Site	0 6 0 1	FAMILY PRACTICE	3
Secondary Specialty at this Site			
Other Specialty at this Site			

Do you plan to continue practice at this site for the next 12 months? ✓ Yes ___No

Will you accept new patients at this site? ✓ Yes ___No

Will you accept new Medicaid patients at this site? ✓ Yes ___No

Will you accept new Medicare patients at this site? ✓ Yes ___No

Are you working with physician's assistants and/or nurse practitioners at this site? ✓ Yes ___No
If yes, enter the number of: Physician's Assistants _____ Nurse Practitioners 1

For FAMILY and GENERAL PRACTITIONERS, PEDIATRICIANS and INTERNISTS (primary care): Do you provide primary care services to adolescents (ages 10-20) at this site? ✓ Yes ___No

For FAMILY and GENERAL PRACTITIONERS: Which of the following obstetrical services do you provide to patients from this site? _____Prenatal care and delivery _____Prenatal care only ✓ No obstetrical services provided

SECTION IV CONTINUED

Instructions for completing this portion:
* Estimate if exact figures are not available.
* Please complete a WORK SITE section for each location where you provide patient care.
* Do not include, as a separate site, hospitals and nursing homes where you provide care to patients normally seen in an outpatient/office setting.
* Be as detailed as possible.
* Use the enclosed yellow sheet to make selections for the Specialty Code and Specialty Name columns.
* Do not remove any pages from this document.

6(c). WORK SITE: NUMBER THREE

Town: RUTLAND CITY County: RUTLAND
(*Note: Enter the town and county in which the site is located, not a mailing address or Post Office box.)

Check the **ONE** practice setting from the selections below that most accurately reflects your practice at this site:

PRACTICE SETTINGS

___ Solo Practice
___ Group Practice
_✓_ Community Health Center or Clinic (Non-Hospital)
___ Hospital Outpatient Clinic
___ School or College Health Center
___ Business or Work Site
___ Hospital Emergency Room
___ Hospital Inpatient
___ Extended Care Facility / Nursing Home
___ Other: Specify

Average hours per week that you spend at this site providing DIRECT PATIENT CARE. **Include** both AMBULATORY CARE and HOSPITAL CARE of patients who originate from this site. Please **exclude** on-call hours.

Please complete one full line for each SPECIALTY that YOU practice at this site:

	Specialty Code	Specialty Name	Hours Per Week
Primary Specialty at this Site	0 6 0 1	FAMILY PRACTICE	3
Secondary Specialty at this Site			
Other Specialty at this Site			

Do you plan to continue practice at this site for the next 12 months? _✓_Yes ___No

Will you accept new patients at this site? _✓_Yes ___No

Will you accept new Medicaid patients at this site? _✓_Yes ___No

Will you accept new Medicare patients at this site? _✓_Yes ___No

Are you working with physician's assistants and/or nurse practitioners at this site? _✓_Yes ___No
If yes, enter the number of: Physician's Assistants _____ Nurse Practitioners _2_

For FAMILY and GENERAL PRACTITIONERS, PEDIATRICIANS and INTERNISTS (primary care): Do you provide primary care services to adolescents (ages 10-20) at this site? _✓_Yes ___No

For FAMILY and GENERAL PRACTITIONERS: Which of the following obstetrical services do you provide to patients from this site? _____Prenatal care and delivery _____Prenatal care only _✓_No obstetrical services provided

SECTION IV CONTINUED

Instructions for completing this portion:

* Estimate if exact figures are not available.
* Please complete a WORK SITE section for each location where you provide patient care.
* Do not include, as a separate site, hospitals and nursing homes where you provide care to patients normally seen in an outpatient/office setting.
* Be as detailed as possible.
* Use the enclosed yellow sheet to make selections for the Specialty Code and Specialty Name columns.
* Do not remove any pages from this document.

6(c). WORK SITE: NUMBER FOUR

Town: ______________________ County: ______________________

(*Note: Enter the town and county in which the site is located, not a mailing address or Post Office box.)

Check the **ONE** practice setting from the selections below that most accurately reflects your practice at this site:

PRACTICE SETTINGS

___ Solo Practice
___ Group Practice
___ Community Health Center or Clinic (Non-Hospital)
___ Hospital Outpatient Clinic
___ School or College Health Center
___ Business or Work Site
___ Hospital Emergency Room
___ Hospital Inpatient
___ Extended Care Facility / Nursing Home
___ Other: Specify

Average hours per week that you spend at this site providing DIRECT PATIENT CARE. **Include** both AMBULATORY CARE and HOSPITAL CARE of patients who originate from this site. Please **exclude** on-call hours.

Please complete one full line for each SPECIALTY that YOU practice at this site:

	Specialty Code	Specialty Name	Hours Per Week
Primary Specialty at this Site			
Secondary Specialty at this Site			
Other Specialty at this Site			

Do you plan to continue practice at this site for the next 12 months? ___Yes ___No

Will you accept new patients at this site? ___Yes ___No

Will you accept new Medicaid patients at this site? ___Yes ___No

Will you accept new Medicare patients at this site? ___Yes ___No

Are you working with physician's assistants and/or nurse practitioners at this site? ___Yes ___No
If yes, enter the number of: Physician's Assistants _____ Nurse Practitioners _____

For FAMILY and GENERAL PRACTITIONERS, PEDIATRICIANS and INTERNISTS (primary care): Do you provide primary care services to adolescents (ages 10-20) at this site? ___Yes ___No

For FAMILY and GENERAL PRACTITIONERS: Which of the following obstetrical services do you provide to patients from this site? _____Prenatal care and delivery _____Prenatal care only _____No obstetrical services provided

FORM A - PLEASE PROVIDE EXPLANATIONS TO SECTION II "YES" ANSWERS ON THIS FORM

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1996-1998 PHYSICIAN LICENSE RENEWAL APPLICATION - PAGE ONE OF SIX

Your Name: EDD LYON Vermont License Number: 42-6255

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 6) You will need TABLE I on Page 3 to complete this section. Please supply the following information regarding each instance of alleged malpractice: This form should be photocopied and filled out separately for each claim. Additional sheets may be attached if necessary. Please type or print clearly.

Insurer: Planned Protection Insurance Company, Ltd.

Claimant Name: CHUN HUA LEE and DAU MIN LEE

Description of Alleged Basis(es) of Claim (Allegations Only: This does not constitute an admission of fault or liability.) See Codes on TABLE I, Page 3.

Basis Code: I 5 D Basis Code: ____ ____ ____

Basis Code: I D 2 Basis Code: ____ ____ ____

Additional Descriptive Information - 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; and
4) Your degree of responsibility for the course of treatment in leading to the claim.

1) Pregnant at approximately 6-7 wk gestation and otherwise healthy
2) Uterus perforated and patient found to have ectopic pregnancy both of which were surgically repaired without complication
3-4) I performed therapeutic abortion which led to perforation. Informed consent was obtained by clinic personnel but claimant claims not to have understood.

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

Incident Location (circle one):

01 Emergency Room	02 Labor/Delivery	03 Laboratory/X-Ray/Testing	04 Operating Room
05 Outpatient	06 Patient Room	07 Hospital-Other	08 Hospital-Unknown
09 HMO	(10 Clinic) [circled]	11 Nursing Home	12 Physician's Office
13 Walk-In Center	14 Other ________	15 Unknown	

Section A continued on next page

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1996-1998 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF SIX

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 6) CONTINUED

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 (circled)	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

Legal Representative (include name, address and telephone number):

Name: S. Crocker Bennett, II

Firm: Paul, Frank & Collins, Inc.

Address: One Church St. P.O. Box 1307

City, State, Zip: Burlington, Vt. 05402

Telephone Number: (802) 658-2311

Indicate Decision, Appeal, Settlement, Dismissal:

If a Court or Arbitration Panel heard your case, indicate the following:

Decision determined by (Check one): ✓ Judge _____ Jury _____ Arbitration Panel

Decision: Allegation T50 dismissed Award: ____________
T82 still pending

If your case was appealed, indicate the following: Date Appeal Filed (Month, Day, Year) ___/___/___

Date Appeal Decided: ___/___/___

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:

____

____

____

Table I for Section A on the next page

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1996-1998 PHYSICIAN LICENSE RENEWAL APPLICATION - PAGE THREE OF SIX
TABLE I - BASIS CODES - ALLEGATIONS ONLY

DIAGNOSIS RELATED
D01 Delay in Diagnosis
Failure to Diagnose:
D02 Abdominal Problems (other than appendicitis or ulcer)
D03 AIDS/AIDS Related Complex
D04 Allergy
D05 Appendicitis
D06 Arthritis
D07 Bladder Problem
D08 Bowel Problem
D09 Breast Cancer
D10 Cancer (other than breast)
D11 Cardiac Disorder/Illness/Problem (not myocardial infarction)
D12 Circulatory Problem
D13 Diabetes
D14 Fracture/Dislocation
D15 Gall Bladder Disorder
D16 Genetic Disorder
D17 Hemorrhage
D18 Hernia
D19 Implanted Foreign Body
D20 Infection
D21 Kidney Disorder
D22 Liver Disorder
D23 Meningitis
D24 Myocardial Infarction
D25 Neurological Disorder
D26 Orthopaedic Problem (other than fracture/dislocation)
D27 Pneumonia/Pneumothorax
D28 Poisoning
D29 Respiratory Problem
D30 Tendon Injury
D31 Thrombosis
D32 Tumor
D33 Ulcer or Complication(s) of Ulcer
D34 Other Specify: ______________________________

D35 Failure to Obtain Consent for Diagnostic Procedures/Exceeding consent obtained
D36 Misdiagnosis
D37 Ordering/Performing Unnecessary Diagnostic Tests/Procedures
D38 Failure to Perform Diagnostic Test(s)
D39 Other Diagnosis Related Injury

EQUIPMENT
E01 Equipment: Misuse
E02 Equipment: Malfunction
E03 Equipment: Other Specify: ________________________

IMPROPER TREATMENT
T01 Delay in Treatment
T02 Failure to Obtain Informed Consent/Exceeding Consent Obtained
T03 Improper Choice of Treatment
T04 Infection
T05 Fracture/Dislocation
T06 Chronic Vegetative State Resulting from Medical Intervention

Improper Treatment: Anesthesia Related
T07 Failure to obtain informed consent/exceeding consent obtained
T08 Failure to take adequate patient history
T09 Failure to monitor
T10 Failure to test equipment/improper use of equipment
T11 Improper intubation
T12 Improper positioning
T13 Wrong amount/type of anesthesia prescribed
T14 Allergic/adverse reaction
T15 Teeth damage
T16 Other Specify: _______________________

TRANSFUSION
TR17 Mismatch
TR18 Caused AIDS
TR19 Caused Hepatitis
TR20 Other Specify: _______________________

Improper Treatment: Medication Related
T21 Failure to obtain informed consent/exceeding consent obtained
T22 Failure to take adequate patient history
T23 Failure to diagnose drug related problem(s) (other than addiction)
T24 Failure to diagnose drug addiction
T25 Prescribing to a known addict
T26 Wrong medication ordered
T27 Wrong dose of medication ordered
T28 Improper route of administration
T29 Drug side effect
T30 Failure to prescribe
T31 Drug toxicity/overdose
T32 Other Specify: ____________________

Improper Treatment: Mental Illness Related
T33 Failure to obtain informed consent/exceeding consent obtained
T34 Failure to diagnose mental disorder/illness/problem
T35 Improper medication prescribed
T36 Improper commitment
T37 Improper discharge
T38 Improper monitoring
T39 Improper use of seclusion/restraints
T40 Suicide/Suicide attempt by inpatient
T41 Suicide/Suicide attempt by outpatient
T42 Other Specify: _____________________

Improper Treatment: Obstetrics-Gynecology Related
T43 Failure to obtain informed consent/exceeding consent obtained
T44 Failure to diagnose pregnancy, normal
T45 Failure to diagnose pregnancy related problem
T46 Failure to diagnose ectopic pregnancy
T47 Failure to diagnose endometriosis
T48 Failure to diagnose fetal distress
T49 Failure to identify mother-fetus blood problem
T50 Improper performance of abortion
T51 Improper management of pregnancy
T52 Improper management of delivery
T53 Improperly performed vaginal delivery
T54 Improperly performed C-section
T55 Delay in performing C-section
T56 Delay in treating fetal distress
T57 Failed sterilization
T58 Wrongful life/birth
T59 Fetal death/stillborn
T60 Maternal death related to delivery
T61 Other Specify: _____________________

Improper Treatment: Surgery Related
T62 Failure to obtain informed consent/exceeding consent obtained
T63 Improper performance
T64 Failure to diagnose post-operative complications
T65 Improper treatment of post-operative complications
T66 Retained foreign bodies (e.g. needle, sponge, instrument, etc.)
T67 Delay in surgery
T68 Unnecessary surgery
T69 Wrong body part
T70 Laceration or penetration not within scope of surgery
T71 Death in the course of/resulting from surgery
T72 Other Specify: __________________________

Improper Treatment: Specified Procedures
T73 Angiography
T74 Arteriography
T75 CAT scan
T76 Catheterization
T77 Colonoscopy
T78 Cryosurgery
T79 Discogram
T80 Electroconvulsive Therapy
T81 Endoscopy
T82 Esophageal Dilatations
T83 Injection/Immunization
T84 Laparoscopy
T85 Lasers, used in treatment
T86 Myelography

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SECTION B: CRIMINAL INVESTIGATION - PROCEEDING (QUESTIONS 2 AND 3) - ATTACH DOCUMENTS

Court:______________________ Charge:______________________ Date:__________

Description:____

____

____

____

Status: ____
Conviction?: ______________________ Date: ______________
Plea?: ______________________ Date: ______________

SECTION C: DISCIPLINARY CHARGES OR ACTION (QUESTION 5) - 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 or right 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: ____

____

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SECTION D: PRIVILEGE TO PRESCRIBE CONTROLLED SUBSTANCES (QUESTION 9) - ATTACH DOCUMENTS

Name of Organization Involved: ____

Type of Restriction: ______________________ Date:______________

Circumstances of restriction: ____

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SECTION E: WITHDRAWAL OR DENIAL OF LICENSE (QUESTION 11) - ATTACH DOCUMENTS

State: ______________________ Year: __________

Circumstances under which license was withdrawn or denied (revoked, not renewed, or otherwise terminated):

____

____

SECTION F: INVESTIGATION BY ANY OTHER LICENSING BOARD (QUESTION 14) - ATTACH DOCUMENTS

Name of Licensing Board: ______________________ Date: ______________

Location of Licensing Board: ______________________________

Circumstances: ______________________________________

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SECTION G: RESIDENCY TRAINING PROGRAM(S) NOT COMPLETED (QUESTION 15) - ATTACH DOCUMENTS

Residency Training Program(s): ______________________________

Location of Program(s): ______________________ Year: ______________

Circumstances: ______________________________________

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SECTION H: TREATMENT FOR EMOTIONAL DISTURBANCE OR MENTAL ILLNESS, ORGANIC ILLNESS, ALCOHOL OR DRUG DEPENDENCY (QUESTIONS 1 AND 4)

Treating Organization: ______________________________________

Address: ____

____

Telephone: (__________) ______________________________

Person Responsible for Treatment: ______________________________

Type of Condition and Treatment: ______________________________

____

____

Dates of Illness/Dependency: ______________________ to ______________________

Dates of Treatment: ______________________ to ______________________

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SECTION I: AFFECTING HEALTH CARE INSTITUTION STAFF PRIVILEGES, EMPLOYMENT OR APPOINTMENT (QUESTION 7) - ATTACH DOCUMENTS

Institution Involved: ______________________________

Date: ______________________________

Circumstances: ______________________________

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SECTION J: VOLUNTARILY SURRENDERED OR RESIGNED A LICENSE TO PRACTICE MEDICINE OR ANY HEALING ART (QUESTION 8) - ATTACH DOCUMENTS

State: ______________ Year: ______________

Circumstances: ______________________________

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SECTION K: DENIAL OF RIGHT TO PARTICIPATE OR ENROLL - THIRD PARTY PAYER (QUESTION 10) ATTACH DOCUMENTS

Third Party Payer: ______________ Year: ______________

Circumstances: ______________________________

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SECTION L: TURNED DOWN FOR COVERAGE BY MALPRACTICE INSURANCE CARRIER (QUESTION 12) ATTACH DOCUMENTS

Malpractice Insurance Carrier: ______________ Year: ______________

Circumstances: ______________________________

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SECTION M: CONFIRMED QUALITY CONCERN NOTICE BY PEER REVIEW ORGANIZATION (PRO) (QUESTION 13) ATTACH DOCUMENTS

PRO: ______________ Year: ______________

Location of PRO: ______________________________

Circumstances: ______________________________

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