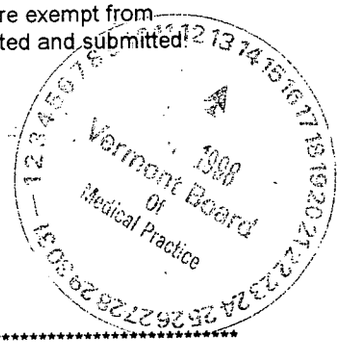
ENTERED NC Pd

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE ONE OF FIVE

I hereby apply for the renewal of my LICENSE AS A PHYSICIAN for the period from 12/01/98 to 11/30/2000. TWO YEAR RENEWAL FEE: $300.
Enclose a check in the amount of $300. made payable to the Vermont Board of Medical Practice.
Physicians 80 years of age or older or on full time active military duty (verification required) are exempt from payment of a renewal fee; however the physician license renewal application must be completed and submitted.
LATE FEE: Late applications are assessed a $25 late fee.



042-0006255

Edd Gilbert Lyon MD
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.
- **Thank you for your cooperation.**

SECTION I

Name: LYON (Last) EDD (First) GILBERT (Middle) _____ (Former)

Vermont License Number: 042-0006255

Other Name(s), if any, under which you were licensed in Vermont and elsewhere since your last renewal: _____

Mailing Address: ~~VAIL RD RR1 BOX 2958~~ 140 HOSPITAL DR (Street)

BENNINGTON (City), VT. (State) 05201 (Zip Code) 802-447-0051 (Phone)

Office Address: 140 HOSPITAL DR (Street)

BENNINGTON (City), VT. (State) 05201 (Zip Code) 802-447-1191 (Phone)

Home Address: VAIL RD RR 1 BOX 2958

City, State, Zip Code: BENNINGTON, VT. 05201
Note: Circle your preferred mailing address. Please note that this address will be public and listed on the Board's website.

Daytime Telephone Number: Area Code: (802) 447-1191

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF FIVE

Are you currently active in clinical practice in Vermont? X Yes ____ No

Do you intend to practice medicine without hospital privileges? ____ Yes X No

SPECIALTY

Specialty: FAMILY PRACTICE

Subspecialty: ____

American Specialty Board Certified? X Yes ____ No

Specialty?: FAMILY PRACTICE Year Certified?: 1978

If applicable, year recertified? ____

Subspecialty Certificate?: ____ Year Certified? ____

If applicable, year recertified? ____

PRACTICE

Do you have hospital privileges? X Yes ____ No

List all hospitals where you have, or previously have had, staff privileges. Include name, address, and dates.

Name	Address	From/To	Specialty/Subspecialty
SOUTHWESTERN VT. MED. CENTER		1978 - PRESENT	F.P.

OTHER LICENSES

Do you hold, or have you ever held, a medical license in any other state? X Yes ____ No If yes, complete the section below.

State	License Number	Date Issued	Status (Active or Inactive)
OKLA.	DON'T KNOW	1975	INACTIVE

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE THREE OF FIVE

SECTION II

SECTION II - "Yes" answers to Questions 1 - 24 require an explanation on the enclosed Form A.
Important note regarding the following questions: "Yes" answers on past 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 1998-2000 period if the answer to any of the questions on the next two pages changes from "No" to "Yes". (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 applied for and been denied a license to practice medicine or any healing art? ___Yes _X_ No

2. Have you withdrawn an application for a license to practice medicine or any healing art? ___ Yes _X_ No

3. Have you voluntarily surrendered or resigned a license to practice medicine or any healing art in lieu of disciplinary action? ___Yes _X_ No

4. 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 _X_ No

5. To your knowledge, are you the subject of an investigation by any **other** licensing board as of the date of this application? [redacted]

6. Have you been denied the privilege of taking an examination before any State Medical Examining Board? ___Yes _X_ No

7. Have you discontinued your education, training, or practice for a period of more than three months? ___Yes _X_ No

8. Have you been dismissed or asked to leave a residency training program(s) before completion? ___ Yes _X_ No

9. 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 _X_ 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 _X_ No

11. 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 _X_ No

12. 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)? [redacted]

13. Have you been turned down for coverage by a malpractice insurance carrier? ___Yes _X_ No

14. 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_X_ No

15. Have you been a defendant in any criminal proceeding other than minor traffic offenses (Note: DWI - Driving While Intoxicated - is NOT a minor offense)? ___Yes_X_ No

16. To your knowledge, are you the subject of an investigation for a criminal act? [redacted]

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE FOUR OF FIVE

SECTION II CONTINUED - "Yes" answers to Questions 17 - 24 require an explanation on the enclosed Form A.
For purposes of Questions 17 - 24, the following phrases or words are defined below:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and

2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently", for purposes of this renewal application, does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

17. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If "yes," please explain. [redacted]

18. Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? If "yes," please explain. [redacted]

19. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If "yes," please explain. [redacted]

20. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If "yes," please explain. [redacted]

21. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism? If "yes," please explain. [redacted]

22. Are you currently engaged in the illegal use of controlled substances? [redacted]

23. If "yes," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not illegally using controlled substances? If "yes," please explain. [redacted]

24. Have you been diagnosed with or have you been treated for bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder? [redacted]

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE - SECTION III
1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION - PAGE FIVE OF FIVE
STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

Applicant's Statement 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:**

X 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" .

Applicant's Statement 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:**

X 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".

Applicant's Statement Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renewal 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:**

X 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 15 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 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.

Social Security # [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.

STATEMENT OF APPLICANT

I certify that the information stated by me in this application is true and accurate to the best of my knowledge. I understand that providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant Edd Tyler Date 10/5/98

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

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE ONE OF SEVEN

Your Name: EDD GILBERT LYON

MEDICAL MALPRACTICE CLAIM (QUESTION 12) 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: PHICO

Claimant Name: Rachel Middlestadt

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: T 4 4 Basis Code: _____

Basis Code: _____ 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.

I did not even see this patient. She received care from our practice physician's Assistant and is suing the practice as a whole.

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	11 Nursing Home	(12) Physician's Office
13 Walk-In Center	14 Other _____	15 Unknown	

Question 12 continued on next page

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED -1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF SEVEN

MEDICAL MALPRACTICE CLAIM (QUESTION 12) 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	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

Firm: Paul, Frank, & Collins, Inc.

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

City, State, Zip: Burlington, VT. 05402

Telephone Number: (802) 658-0042

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: _____ Award: _____

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 Question 12 on the next page

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION
PAGE THREE OF SEVEN
TABLE I - BASIS CODES - QUESTION 12 - 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

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION
PAGE FOUR OF SEVEN

WITHDRAWAL OR DENIAL OF LICENSE (QUESTIONS 1 & 2) ATTACH DOCUMENTS

State: _____ Year: _____

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

_____

_____

VOLUNTARILY SURRENDERED OR RESIGNED A LICENSE TO PRACTICE MEDICINE OR ANY HEALING ART (QUESTION 3) - ATTACH DOCUMENTS

State: _____ Year: _____

Circumstances: _____

_____

_____

DISCIPLINARY CHARGES OR ACTION (QUESTION 4) - 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: _____

_____

_____

INVESTIGATION BY ANY OTHER LICENSING BOARD (QUESTION 5) - ATTACH DOCUMENTS

Name of Licensing Board: _____ Date: _____

Location of Licensing Board: _____

Circumstances: _____

_____

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE FIVE OF SEVEN

DENIAL OF EXAMINATION PRIVILEGES (QUESTION 6) ATTACH DOCUMENTS

State: _____ Year: _____

Circumstances under which examination privileges denied:

_____

_____

RESIDENCY TRAINING PROGRAM(S) NOT COMPLETED - DISCONTINUED EDUCATION, TRAINING, PRACTICE (QUESTIONS 7 & 8) - ATTACH DOCUMENTS

Residency Training Program(s): _____

Location of Program(s): _____ Year: _____

Circumstances: _____

_____

AFFECTING HEALTH CARE INSTITUTION STAFF PRIVILEGES, EMPLOYMENT OR APPOINTMENT (QUESTION 9)- ATTACH DOCUMENTS

Institution Involved: _____
Location: _____ Date: _____

Circumstances: _____

_____

_____

_____

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

Third Party Payer: _____ Year: _____

Circumstances: _____

_____

_____

CONFIRMED QUALITY CONCERN NOTICE BY PEER REVIEW ORGANIZATION (PRO) (QUESTION 11) ATTACH DOCUMENTS

PRO: _____ Year: _____

Location of PRO: _____

Circumstances: _____

_____

TO RESPOND TO QUESTION 12 SEE PAGE ONE OF THIS FORM

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE SIX OF SEVEN

TURNED DOWN FOR COVERAGE BY MALPRACTICE INSURANCE CARRIER (QUESTION 13) ATTACH DOCUMENTS

Malpractice Insurance Carrier: _____ Year: _____

Circumstances: _____

_____

_____

_____

PRIVILEGE TO PRESCRIBE CONTROLLED SUBSTANCES (QUESTION 14) - ATTACH DOCUMENTS

Name of Organization Involved: _____

Type of Restriction: _____ Date: _____

Circumstances of restriction: _____

_____

_____

_____

_____

CRIMINAL INVESTIGATION - PROCEEDING (QUESTIONS 15 AND 16) - ATTACH DOCUMENTS

Court: _____

City and State: _____

Charge: _____

Date: _____

Description: _____

_____

_____

_____

_____

Status: _____

_____

Conviction?: _____ Date: _____

Plea?: _____ Date: _____

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION
PAGE SEVEN OF SEVEN

MEDICAL CONDITION, TREATMENT, USE OF CHEMICAL OR ILLEGAL SUBSTANCES (QUESTIONS 17,18,19, 20, 21, 22, 23, & 24)

Treating Organization: _____

Address: _____

_____

_____

Telephone: (_____) _____

Person Responsible for Treatment: _____

Type of Diagnosis, Condition or Treatment - Field of Practice - Use of Chemical Substances: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Dates of Illness or Dependency: _____ to _____

Dates of Treatment: _____ to _____

Name and Location of Rehabilitation/Professional Assistance or Monitoring Program: _____

Telephone: (_____) _____

_____

Contact Person at Program: _____

Edd Gilbert Lyon MD
140 Hospital Drive
Bennington, VT 05201