STATE OF VERMONT
RENEWAL APPLICATION

I hereby apply for the renewal of my **LIMITED TEMPORARY LICENSE** as a **Physician** for the period from **07/01/91** to **06/30/92** under the provisions of 26 V.S.A. § 1391(e).
Renewal fee **$40.00**

60-0001563 A

ALLEGRA LUCILLE SHUMWAY
MCHV/FAMILY PRACTICE
COLCHESTER AVENUE
BURLINGTON VT 05401

Permanent
42-5297

Home Address: _____

City, State, Zip Code: _____

INFORMATION NEEDED

PLEASE CIRCLE YES OR NO. A "YES" ANSWER REQUIRES AN EXPLANATION.

Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine? YES/NO

Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine? YES/NO

Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses? YES/NO

Are you now, or have you been in the past, dependent upon alcohol or drugs? YES/NO

Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? YES/NO

Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? YES/NO

Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action? YES/NO

Have you ever voluntarily surrendered a license to practice medicine or any healing art? YES/NO

Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time? YES/NO

Have you ever 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

Have you withdrawn an application for a medical license or been denied a medical license for any reason? YES/NO

Have you ever been turned down for coverage by a malpractice insurance carrier? YES/NO

Other states where you are now licensed to practice: _____

YOU MUST SIGN THE REVERSE SIDE OR YOUR LICENSE WILL NOT BE RENEWED

A professional license may not be renewed unless the licensee 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 child support would impose an unreasonable hardship (15 V.S.A. § 795).

A professional license may not be renewed unless the licensee 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). The maximum penalty for perjury is fifteen years in prison, a $10,000 fine, or both.

STATEMENT OF APPLICANT

I hereby certify that; I am not subject to any support order or I am subject to a support order and am in good standing with respect to or in full compliance with a plan to pay any and all child support due the State of Vermont as of the date of this application.

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.

I further certify that all information contained in this renewal application is true and accurate to the best of my knowledge.

Date _____ Signature_____

Print Name: _____

IMPORTANT: Please be sure to write your license number on your check. Check for correct spelling of name and proper address. Print any changes in the adjoining space. Sign and date the application. Enclose the correct fee in check or money order payable to the Secretary of State.

****

FOR OFFICE USE ONLY: VERMONT BOARD OF MEDICAL PRACTICE

****

Renewal: Complete: _____ Sent to Board for Review: _____

Posted: _____ Returned from Board for posting: _____/_____
Date Initial

License Printed: _____

VERMONT BOARD OF MEDICAL PRACTICE

LIMITED TEMPORARY LICENSE RENEWAL

STATEMENT OF SUPERVISING PHYSICIAN

I certify that _____ is engaged as an intern, resident, fellow or medical officer at:

Hospital: _____

Department: _____

Address: _____

City, State, Zip Code: _____

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

_____ _____

Supervising Physician's Name **Printed** Date

_____

Address

_____

City, State, Zip Code

_____ _____

Signature of Supervising Physician Supervising Physician's License Number

NOTE: "Affidavit of Supervising Physician" must be completed by and signed by the individual who will be supervising your work at the location indicated on this Renewal Application.

Return the completed form and fee to:

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

Recd $10.00

RENEWAL APPLICATION

I hereby apply for the renewal of my **LIMITED TEMPORARY LICENSE** as a **Physician** for the period from 07/01/1990 to 06/30/91 under the provisions of Title 26, Chapter 23 VSA. **Renewal Fee $10.00**

SO-0001543
SHOAWAY ALLEGRA LUCILLE
MCHV/FAMILY PRACTICE
COLCHESTER AVENUE
BURLINGTON VT 05401

SECRETARY OF STATE
PROCESSED
JUN 12 1990

SPECIAL INSTRUCTIONS

DURING THE PREVIOUS YEAR, HAVE YOU: A YES REQUIRES AN EXPLANATION
please circle either yes or no

Had any treatment for mental illness? [redacted]
Had any convictions other than for minor traffic violations? [redacted]
Had an addiction to or been treated for drug or alcohol abuse? [redacted]
Had any jurisdiction deny or take action against your license? [redacted]
Had any final liability judgments or settlements? [redacted]
Had any hospital privileges denied, conditioned or revoked? [redacted]

A new law provides that a professional license may not be renewed unless the licensee 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 the 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).

The maximum penalty for perjury is fifteen years in prison, a $10,000 fine, or both.

I hereby certify that the information contained on this renewal application is true and accurate to the best of my knowledge.

I further 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 the State of Vermont as of the date of this application.

Date 5/29/90 Signature Allegra Shumway

IMPORTANT: Check for correct spelling of name and proper address. Print any changes in the adjoining space. Sign and date the application. Enclose the correct fee in a check or money order payable to the Secretary of State.

STATEMENT OF SUPERVISING PHYSICIAN

I certify that the physician named in the Renewal Application above is engaged as an intern, (resident,) fellow or medical office at:

Hospital: Medical Center Hospital of Vermont

Dept: Family Practice

City, State: Burlington, Vermont

I further state that I recognize that I shall be legally responsible and liable for all negligent or wrongful acts or omissions of the limited temporary licensee.

Allan M. Ramsay, M.D.
Supervising Physician's Name **Printed**

May 22, 1990
Date

Allan Ramsay M.D.
Signature of Supervising Physician

42-0006573 (Vermont)
Supervising Physician's License #

NOTE: "Affidavit of Supervising Physician" must be completed by and signed by the individual who will be supervising your work at the location indicated on this Renewal Application.

Return the completed form and fee to: *Board of Medical Practice*
Licensing & Registration Div.
Pavilion Office Building
Montpelier, VT 05602

Recd $10.00
6/19/89

RENEWAL APPLICATION

I hereby apply for the renewal of my **LIMITED TEMPORARY LICENSE** as a **Physician** for the period from **07/01/1989** to **06/30/90**, under the provisions of Title 26, Chapter 23 VSA. **Renewal Fee $10.00**

SPECIAL INSTRUCTIONS

DURING THE PREVIOUS YEAR, HAVE YOU: A YES REQUIRES AN EXPLANATION
please circle either yes or no

Had any treatment for mental illness? [redacted]
Had any convictions other than for minor traffic violations? [redacted]
Had an addiction to or been treated for drug or alcohol abuse? [redacted]
Had any jurisdiction deny or take action against your license? [redacted]
Had any final liability judgments or settlements? [redacted]
Had any hospital privileges denied, conditioned or revoked? [redacted]

A new law provides that a professional license may not be renewed unless the licensee 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 the 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).

The maximum penalty for perjury is fifteen years in prison, a $10,000 fine, or both.

I hereby certify that the information contained on this renewal application is true and accurate to the best of my knowledge.

I further 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 the State of Vermont as of the date of this application.

Date 4/26/89 Signature [signature]

IMPORTANT: Check for correct spelling of name and proper address. Print any changes in the adjoining space. Sign and date the application. Enclose the correct fee in a check or money order payable to the Secretary of State.

STATEMENT OF SUPERVISING PHYSICIAN

I certify that the physician named in the Renewal Application above is engaged as an intern, resident, fellow or medical office at:

Hospital: Medical Center Hospital of Vermont

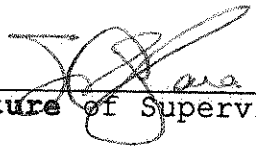
Dept: Family Practice

City, State: Burlington, VT 05401

I further state that I recognize that I shall be legally responsible and liable for all negligent or wrongful acts or omissions of the limited temporary licensee.

John J. Saia, M.D.
Supervising Physician's Name **Printed**

May 1, 1989
Date



Signature of Supervising Physician

42-000-4287
Supervising Physician's License #

NOTE: "Affidavit of Supervising Physician" must be completed by and signed by the individual who will be supervising your work at the location indicated on this Renewal Application.

Return the completed form and fee to: *Board of Medical Practice*
Licensing & Registration Div.
Pavilion Office Building
Montpelier, VT 05602

STATUS SHEET

LIMITED TEMPORARY PERMITS

#1563

NAME: Allegra L. Shumway

HOSPITAL: MCHV

DEPARTMENT: Family Practice

X APPLICATION - RECEIVED: 6-9-88 FEE: 15.00

X AUTHORIZATION OF SUPERVISORY PHYSICIAN - John Daua

X MEDICAL SCHOOL CERTIFICATE

____ COPY OF MEDICAL SCHOOL DIPLOMA - UVM

#1563

VERMONT STATE BOARD OF MEDICAL PRACTICE

APPLICATION FOR LIMITED TEMPORARY LICENSE TO PRACTICE MEDICINE

To the Vermont State Board of Medical Practice:

I hereby make application for a limited temporary license to practice medicine and surgery as an interne, resident, fellow or medical officer in the State of Vermont at the Medical Center Hospital of Vermont Department of Family Practice, under the supervision of John J. Saia, M.D., and submit the following information as required by law.

1. Name in full Allegra Lucille Shumway
2. Vermont Address [redacted]
3. Present Address (If Different) Same as above
4. Place of Birth [redacted] 5. Date of Birth [redacted]
6. Have you ever been convicted of a crime other than a minor traffic violation? No If yes, explain.
7. Have you ever discontinued your education, training or practice for a period of more than three months? yes If yes, explain on back.
8. Education: List chronologically each college or university at which you have been enrolled.

Name	Location	Dates	Degree
Kirkland College	Clinton, NY	9/74 - 5/78	BA
Tompkins-Cortland Community College	Dryden, NY	9/82 - 5/83	—
Vermont College of Medicine	Burlington, VT	9/84 - 5/88	MD

9. Training: List chronologically all post-graduate training positions held.

Name of Institution	Location	Dates
No previous post-graduate training		

I discontinued my education for 6 yrs between college (graduated May '78) and Medical school. During that time I was occupied as a Farm worker, U.S. Peace Corps volunteer, (1979-81) Lab worker, Waitress, and home maker,

10. Have you ever been denied a certificate by, or the privilege of taking an examination before any State Medical Examining Board? No If yes, explain. _____

11. Do you have a Standard ECFMG Certificate? NO If so, attach copy.

12. Have you ever taken the FLEX Examination? NO If so, where? _____

When _____ Passed or Failed _____

13. Attach a photocopy of your Medical School Diploma. If possible.

DATE: May 6, 1988 SIGNED: Allegra Shumway M.D.

AFFIDAVIT TO APPLICANT

I, Allegra Shumway BEING FIRST DULY SWORN, DEPOSE AND SAY THAT I AM THE PERSON REFERRED TO IN THE FOREGOING APPLICATION AND SUPPORTING DOCUMENTS AND THAT THE ATTACHED PHOTOGRAPH IS A TRUE LIKENESS OF MYSELF. I HAVE READ THE QUESTIONS IN THIS APPLICATION AND ANSWERED THEM TO THE BEST OF MY ABILITY AND KNOWLEDGE. FURTHER, SHOULD I FURNISH ANY FALSE INFORMATION ON THIS APPLICATION I HEREBY AGREE THAT SUCH ACT SHALL CONSTITUTE CAUSE FOR DENIAL OF MY APPLICATION OR IMMEDIATE REVOCATION OF MY LIMITED TEMPORARY LICENSE.

Allegra Shumway
SIGNED

SUBSCRIBE AND SWORN TO BEFORE ME THIS 5th DAY OF May, 1988

COUNTY Chittenden STATE Vermont

NOTARY PUBLIC David H. Beck
SIGNED

Mail completed form to:

Board of Medical Practice
Licensing & Registration
Pavilion Building
Montpelier, VT 05602

Telephone: (802) 828-2673

SUPERVISORY AUTHORIZATION

This section must be completed by the physician who will be supervising your work while in Vermont. This licensed physician will be responsible and liable for all negligent or wrongful acts or omissions of the limited temporary licensee. Termination of appointment as interne, resident, fellow or medical officer of such designated hospital or institution shall operate as a revocation of such limited temporary license. Such limited temporary license shall be revoked upon the death or legal incompetency of the licensed physician or upon ten-days written notice of the licensed physician.

I certify that the said Dr. Allegra Shumway is engaged as an interne, resident, fellow or medical officer for the Medical Center Hospital for the period June 23, 1988 to June 30, 1989.

I further state that I shall be legally responsible and liable for all negligent or wrongful acts or omissions of this limited temporary licensee.

_____ M.D.
Supervising Physician John J. Saia, M.D.

Vermont License # 4287

Seal of Hospital

(NOTE: If hospital has no seal the signature must be acknowledged before a Notary Public)

State of _____

County of _____

In _____ on the _____ day of _____ 19___, before me personally appeared _____ M.D. to me known and known by me to be the party executing the foregoing instrument, and he acknowledged said instrument, by him executed, to be his free act and deed.

(SEAL)

_____
Notary Public

My commission expires on _____.

CERTIFICATE OF GRADUATION

Must be Completed For All Applicants

To whom it may concern:

This is to certify that Allegra L. Shumway

attended University of Vermont College of Medicine

from Sept. 1994 until May 1998

The degree Doctor of Medicine was conferred on May 21, 1998

(SEAL)

(President, Secretary or Dean)

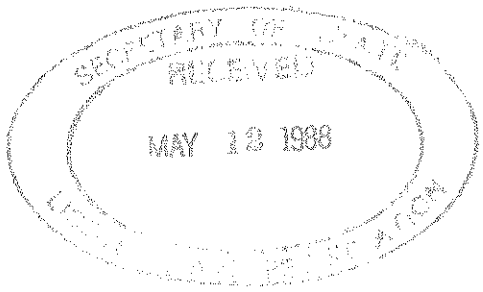
(Title)

9 Jun 98
Date

Please forward completed form to:

Board of Medical Practice
Licensing & Registration
Pavilion Building
Montpelier, VT 05602

Telephone: (802) 828-2673


SECRETARY OF STATE
RECEIVED
MAY 13 1988

Recd $125.00

APPLICATION FOR LICENSE TO PRACTICE MEDICINE IN VERMONT

Please submit in typewritten form only. Incomplete applications will be returned. When space provided is insufficient, attach additional sheets. All documents must be received within six (6) months or the application becomes invalid.

Must Be Completed By All Applicants

Name in full Shumway (Last) Allegra (First) Lucille (Middle) _____ (Former)

Mailing Address [redacted]

[redacted]

Office Address _____ (Street) _____ (City)

_____ (State) _____ (Zip Code) _____ (Phone)

Name as you want it to appear on your license certificate: Allegra Shumway

Have you ever legally changed your name? NO If so, enclose a certified copy of the legal document stating the change.

Date of Birth [redacted] Place of Birth [redacted]

PREMEDICAL EDUCATION

(Name and location of institute)	(From / To)	(Degree)
Kirkland College, Clinton, NY	9/74 - 5/78	B.A.

MEDICAL EDUCATION - See also Certificate of Medical Education

(Name and location of institute)	(From / To)	(Degree)
University of Vermont college of medicine, Burlington, VT	9/84 - 5/88	M D

The College of Medicine
of

The University of Vermont

To all to whom these presents may come, sendeth greetings
Whereas the Faculty of the College and the University Senate
have recommended

Allegra Lucille Shumway, B.A.

as having completed the Studies assigned and passed the Examinations required, We, the Trustees of the University by virtue of the authority vested in us do hereby confer upon her the Degree of

Doctor of Medicine

and admit her to all the rights, privileges and honors appertaining thereto
In Witness Whereof, the seal of the University and the signature
of the President the Dean and the Secretary are hereunto affixed.

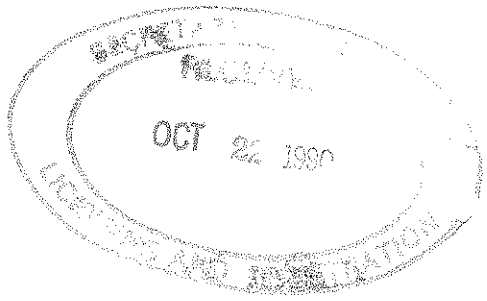
Given at Burlington, Vermont on the twenty-first day of May in the year of our Lord One Thousand Nine Hundred and Eighty-Eight and of the University the One Hundred and Ninety-Seventh.

William H. Luginbuhl
Dean

Ray W. Allen
Secretary of the Board of Trustees

President of the University

CERTIFICATE OF MEDICAL EDUCATION



To be completed by an officer of your School of Medicine

I hereby certify that Allegra Shumway, M.D. (Name) was admitted to the University of Vermont School of Medicine in Burlington, Vermont (City and State) on August 27 1984 (Date) and completed all requirements for graduation on April 30 1988 (Date).

A Doctor of Medicine (Specify ~~certificate/diploma~~/degree) was granted on May 21, 1988 (Date).

(SEAL)

Date October 18 1990 Signed _____
(Authorized Officer of the School)
David M. Tormey M.D., Associate Dean for Student Affairs and Alumni Relations

VERMONT SECRETARY OF STATE'S OFFICE, BOARD OF MEDICAL PRACTICE, PAVILION OFFICE BUILDING, MONTPELIER, VERMONT 05602 - (802) 828-2363

REV. 6/89

NATIONAL BOARD OF MEDICAL EXAMINERS® • 3930 CHESTNUT STREET, PHILADELPHIA, PA 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Allegra L. Shumway, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

DEC 31 1990

Attest L. THOMPSON BOWLES, M.D., PH.D.
Chairman of the Board

SEAL ROBERT L. VOLLE, PH.D.
President of the Board

Philadelphia, Pa.
07/01/89

Certificate # 363332

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from U VERMONT COL OF MEDICINE in MAY 1988 and whose birth date is 01/25/1956. This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/86		
Anatomy	480	79
Physiology	555	84
Biochemistry	460	78
Pathology	535	83
Microbiology	485	80
Pharmacology	505	81
Behavioral Sciences	570	85
TOTAL TEST (Minimum Passing Score 380/75)	515	81
PART II passed 09/87		
Medicine	475	81
Surgery	505	82
Obstetrics and Gynecology	580	86
Public Health and Preventive Medicine	645	89
Pediatrics	495	82
Psychiatry	600	87
TOTAL TEST (Minimum Passing Score 290/75)	560	84
PART III passed 03/89		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)	595	85
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		83

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

Melanie Valente
Secretary for Certification

SEAL

10/19/90
Date

MCHV
Medical Center Hospital of Vermont

September 13, 1990

Vermont Board of Medical Practice
Pavilion Office Building
Montpelier, Vermont 05602

To Whom It May Concern:

This letter is written on behalf of the Medical Center Hospital of Vermont and the University of Vermont College of Medicine in regards to:

Allegra Shumway, M. D.,

who has satisfactorily completed one year of a Residency in Family Practice at this institution from June 22, 1988 to June 30, 1989. Dr. Shumway has remained in this program since July 1, 1989 and continues to perform satisfactorily. This program is accredited by the Acceditation Council for Graduate Medical Education (ACGME).

If you need further information, please contact Dr. Louis I. Hochheiser, Chairman, Department of Family Practice, Medical Center Hospital of Vermont, Burlington, VT 05401.

Sincerely,

John W. O'Donnell
Executive Vice President

JWO/jon

(802) 656-2345
Burlington, Vermont 05401
A Vermont Health Foundation Company

VHA
Voluntary Hospitals of America, Inc.

The University of Vermont

DEPARTMENT OF FAMILY PRACTICE
COLLEGE OF MEDICINE, A111 GIVEN BUILDING
BURLINGTON, VERMONT 05405-0063 (802) 656-4330

October 11, 1990

Vermont Board of Medical Practice
26 Terrace Street
Montpelier, VT 05602

Re: Allegra Shumway, M.D.

Dear Sirs:

It is with great pleasure that I write a letter of recommendation for Allegra Shumway, M.D. for a permanent Vermont medical license. As the Associate Chairman for the Department of Family Practice at the University of Vermont College of medicine, I have worked with Dr. Shumway since she joined our residency program as an intern in June, 1988. Having worked closely with her during her residency, I feel qualified to speak of her capabilities as a family physician.

Dr. Shumway has proven herself to be a knowledgeable and skillful physician in training, and I have no reason to suspect that she will not continue to progress during the remaining time in our residency. She is hardworking, intellectually honest, and very diligent in her pursuit of quality patient care. I recommend her to you without reservation for licensure in the State of Vermont.

Sincerely,

William C. Wadland

William C. Wadland, M.D.
Associate Chairman

The University of Vermont
DEPARTMENT OF FAMILY PRACTICE
COLLEGE OF MEDICINE, A111 GIVEN BUILDING
BURLINGTON, VERMONT 05405-0063 (802) 656-4330

October 11, 1990

Vermont Board of Medical Practice
26 Terrace Street
Montpelier, VT 05602

Re: Allegra Shumway, M.D.

Dear Sirs:

I am pleased to support the application of Allegra Shumway, M.D. for licensure in the state of Vermont. As Residency Director for the Department of Family Practice at the University of Vermont College of medicine, I have worked closely with Dr. Shumway since she began her residency training in our Department in June, 1988. I feel qualified to speak knowledgeably reference her capabilities as a family physician.

She has a strong medical knowledge base, a compassionate personality, and high standards of personal conduct. I recommend her to you without reservation.

Sincerely,

Allan Ramsay

Allan M. Ramsay, M.D.
Residency Director

The University of Vermont
DEPARTMENT OF FAMILY PRACTICE
COLLEGE OF MEDICINE, A111 GIVEN BUILDING
BURLINGTON, VERMONT 05405-0063 (802) 656-4330

September 21, 1990

Vermont State Board of Medical Practice
109 State Street
Montpelier, VT 05602

Re: Allegra Shumway, M.D.

Dear Sirs:

I am writing in support of Dr. Allegra Shumway's application for medical licensure in the State of Vermont. Dr. Shumway is currently a third year resident in our program here at the University of Vermont College of Medicine. My contact with Dr. Shumway reveals her to be a thoughtful, competent, caring physician who performs in an excellent manner.

Dr. Allegra Shumway maintains the highest moral standards and I recommend her for medical licensure without reservation.

Sincerely,

Louis I. Hochheiser, M.D.
Professor and Chairman

APPLICANT: Please fill out 1) through 8) below and forward to the Federation of State Medical Boards at the designated address.

DISCIPLINARY INQUIRIES

Federation of State Medical Boards
2630 West Freeway, Suite 138
Fort Worth, Texas 76102-7999

The VERMONT BOARD OF MEDICAL PRACTICE requests a disciplinary search concerning the following individual:

1) Allegra Shannwa
Name

2) [redacted]

3) [redacted]

4) [redacted]

5) [redacted]

6) University of Vermont 5/88
Medical School of Graduation and Branch Location

7) 5/88
8) Date of Graduation

NA
ECFMG No. (if applicable)

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN
OCT 23 1990
James R. Winn, M.D.
JAMES R. WINN, M.D.
EXECUTIVE VICE-PRESIDENT

Requesting organization:

Vermont Board of Medical Practice
Secretary of State
26 Terrace Street
Pavilion Office Building
Montpelier, Vermont 05602

Allegra Shannwa
Physician's Signature

State of Vermont

Office of the Secretary of State

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT

Title 15 § 795 requires that this form must be completed by anyone applying for a license, certification or registration to practice a profession in the State of Vermont.

A professional license may not be issued or renewed unless the licensee 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).

STATEMENT OF APPLICANT

I, Allegra Shumway (Print Full Name) am applying for a license as a/an physician (Profession).

I hereby certify that I am not subject to any support order or I am subject to a support order and am in good standing with respect to or in full compliance with a plan to pay any and all child support due the State of Vermont as of the date of this application.

Date 2/11/91 Signature Allegra Shumway

Secretary of State's Office, Office of Professional Regulation
Pavilion Office Bldg-Montpelier, VT 05602-2710
(802) 828-2363

Office of the Vermont Secretary of State
Redstone Building, 26 Terrace Street

Mail: Pavilion Office Building
Montpelier, VT 05602-2710

James H. Douglas
Secretary of State

Paul S. Gillies
Deputy Secretary of State

BOARD OF MEDICAL PRACTICE

October 30, 1990

Allegra L. Shumway, M.D.
[redacted]

Dear Doctor Shumway:

Your application for medical licensure appears to be complete. It now becomes your responsibility to contact the Board member listed below to arrange for your personal interview.

H. Gordon Page, M.D.
One South Prospect Street
Burlington, Vermont 05401
Telephone: (802) 656-3457

The full Board will act upon your request for licensure at their first, regularly scheduled meeting following your interview. The Board of Medical Practice usually meets on the first Wednesday of each month.

Should you have questions or concerns, please feel free to contact us.

Sincerely,

Debbie Morehouse
Staff Assistant
VT Board of Medical Practice

/dm

Office of the Vermont Secretary of State
Redstone Building, 26 Terrace Street

Mail: Pavilion Office Building
Montpelier, VT 05602-2710

James H. Douglas
Secretary of State

Paul S. Gillies
Deputy Secretary of State

VERMONT BOARD OF MEDICAL PRACTICE

October 30, 1990

H. Gordon Page, M.D.
One South Prospect Street
Burlington, Vermont 05401

RE: Applicant for Personal Interview

Dear Doctor Page:

The completed application for medical licensure for **Allegra L. Shumway, M.D.** appears complete and is enclosed for your review and presentation at the first, regularly scheduled Board meeting following the personal interview.

Should you have questions or concerns, please let us know.

Sincerely,

Debbie Morehouse
Staff Assistant
VT Board of Medical Practice

/dm

Enclosures

Office of the Vermont Secretary of State
Redstone Building, 26 Terrace Street

Mail: Pavilion Office Building
Montpelier, VT 05609-1101

James H. Douglas
Secretary of State

Paul S. Gillies
Deputy Secretary of State

PROFESSIONAL CERTIFICATE

I hereby certify that the following named persons are fully qualified to practice Medicine and Surgery in the State of Vermont.

NAME Allegra L. Shumway, M.D.

LICENSE # 42-0008297

ORIGINAL ISSUE DATE February 15, 1991

EXPIRATION DATE November 30, 1992

License is in good standing. We have no derogatory information in our files.

February 15, 1991
Date

(SEAL)

Staff Assistant

REV. 6/89

To Maureen Hoffler FAMILY PRACTICE UVM

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE ONE OF SIX

NOV 1992
VERMONT BOARD of Medical Practice

I hereby apply for the renewal of my **LICENSE AS A PHYSICIAN** for the period from **12/01/92** to **11/30/94**. **TWO YEAR RENEWAL FEE: $205.**
Enclose a check in the amount of $205. made payable to the Vermont Board of Medical Practice.

42-0008297 A

Allegra Lucille Shumway MD

[redacted]

****

Important:
- Please print legibly or type your answers.
- Answer all questions **(front and back of each page)** 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

1. Name: Allegra Lucille Shumway 2. Vermont License Number: 42- 0008297

3. Other Name(s), if any, under which you were licensed in Vermont and elsewhere: ____

4. Home Address: [redacted]

City, State, Zip Code [redacted]

5. Office Address: 1 High ST, Hardwick VT 05843

City, State, Zip Code: ____

6. Daytime Telephone Number: Area Code [redacted]

7. Date of Birth: Month: [redacted]

8. Place of Birth: [redacted] 9. Sex: ____ Male X Female

10. Licensing Examination Taken - Check: ✓ National Boards ____ FLEX
____ State Examination-Identify State: ____ ____ Other Examination Specify: ____

11. Undergraduate Degree - Circle: (B.A.) B.S. A.B. Other: ____ Year of Graduation: 1978

Degree Granting Institution: Kirkland College Location: Clinton, NY
First Institution (If transfer): ____ Location: ____

12. Medical Degree - Circle: (M.D.) Other: ____ Year of Graduation: 1988

Degree Granting Medical School: University of Vermont Location: Burlington, VT

First Medical School (If transfer): ____ Location: ____

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF SIX

13. Do you have hospital privileges **in Vermont**? X Yes _____ No

Name(s) and Location(s) of Hospital(s): _____

Copley Hospital Morrisville, VT

14. Did you practice in Vermont during the past 12 months? X Yes ____No

15. Other states where you now hold an active license to practice: none

16. States where you previously were licensed to practice: none

17. Please list your specialty(ies) and indicate if you are American specialty board certified in those specialties:

Specialty(ies) & Subspecialty(ies)	American Specialty Board Certified (Yes or No)	
(a) Family Practice	X Yes	No Year Certified/Recertified: 1991 / ____
(b) _____	____ Yes	No Year Certified/Recertified: ____ / ____
(c) _____	____ Yes	No Year Certified/Recertified: ____ / ____

18. Please list the postgraduate educational degrees that you have earned related to your practice:

Institution	City	State	Degree	Year
(a) _____	_____	_____	_____	_____
(b) _____	_____	_____	_____	_____

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

Institution	City	State	Specialty	Year Completed
(a) Medical Center Hospital of VT	Burlington	VT	Family Practice	1991
(b) _____	_____	____	_____	____
(c) _____	_____	____	_____	____

SECTION II: PLEASE CHECK YES OR NO.
A "YES" ANSWER REQUIRES AN EXPLANATION ON THE ENCLOSED FORM A.

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

2. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine, resident or fellow? [redacted]

3. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses? ____ YES X NO

4. Are you currently under investigation for a criminal act? [redacted]

5. Are you now, or have you been in the past, dependent upon alcohol or drugs? [redacted]

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE THREE OF SIX

SECTION II CONTINUED

6. Are any formal disciplinary charges pending or has any disciplinary action ever 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

7. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim/complaint/demand for damages)? [redacted]

8. Have you ever 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

9. Have you ever voluntarily surrendered or resigned a license to practice medicine or any healing art? ____ YES __X__ NO

10. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered by any jurisdiction or federal agency at any time? ____ YES __X__ NO

11. Have you ever 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

12. Have you ever withdrawn an application for a medical license or been denied a medical license for any reason? ____ YES __X__ NO

13. Have you ever been turned down for coverage by a malpractice insurance carrier? ____ YES __X__ NO

14. Have you ever been notified as a responsible party of a Severity Level III quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? ____ YES __X__ NO

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

16. Have you ever been dismissed or asked to leave from a residency training program(s) before completion? ____ YES __X__ NO

SECTION III - TO BE COMPLETED ONLY BY PHYSICIANS PRACTICING IN VERMONT

1. Current Status (please check one): __X__ Active ____ Retired* ____ Other (please explain) _____
***Note: If you are retired or are not practicing in Vermont, you need not complete SECTION III; however you must complete SECTION IV.**

2. Postgraduate training in Vermont:
Are you currently in a postgraduate training program in Vermont as a resident or clinical fellow? ___ Yes __X__ No
If you are in a Vermont program, are you a ____ Resident ____Clinical Fellow ____ Research Fellow?
How many hours per typical week do you spend in this Vermont postgraduate training program? _____hrs./wk. in Vermont.

3. What is the date you started practicing medicine (excluding residency or fellowship training)?
(Month/Year) 7 / 91

4. What is the date you started practicing medicine **in Vermont** (excluding residency or fellowship training)?
(Month/Year) 7 / 91

5. Are you a **staff physician** involved **exclusively** in inpatient care or an emergency room setting? __ Yes __X__ No

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE FOUR OF SIX

SECTION III CONTINUED

Instructions for completing the next portion: Please complete one "site" section for each location where you practice. Be as detailed as possible. Estimate if exact figures are not available.

The codes to be used for the Employment Setting column are as follows (If applicable, list multiple codes at one practice site):

1 Solo Practice
2 Group Practice
3 Community Health Center
4 Hospital Outpatient Clinic
5 Hospital Inpatient
6 HMO (Health Maintenance Organization)
7 Extended Care Facility
8 School/College Health
9 Occupational Health
10 Emergency Room
11 Teaching
12 Other Specify: _____

6. Practice Site Number One

Street Address: 1 High ST.
Town: Hardwick, VT Zip: 05843

Please complete **one full line for each specialty** (example: pediatrics) that you practice at this site.

Specialty	Hours per week engaged in direct patient care	Employment Setting (See codes on Page 4.)	Will the practice of this specialty be discontinued within the next 12 months? (Yes or No)	Will you accept new patients in this specialty? (Yes or No)	What percent of the patients in this specialty are funded by Medicaid? (Estimate if necessary.)	Will you accept new Medicaid patients in this specialty?	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept new Medicare patients in this specialty?
Family Practice	45	3	No	Yes	30%	Yes	25%	Yes

Check the financial organization which best describes this site: ____ For-profit X Nonprofit
If applicable, check the type of services that you perform at this site, even if the service is not practiced as a specialty:
X Adult Medicine X Pediatric Medicine X Prenatal Care X Gynecologic Care
____ Obstetrics If you practice obstetrics, approximately how many deliveries do you perform per year at all practice sites? _____
(For example, a physician specializing in family practice who performs deliveries would check "Obstetrics".)

7. Practice Site Number Two

Street Address: _____ Town: _____ Zip: _____

Please complete **one full line for each specialty** that you practice at this site.

Specialty	Hours per week engaged in direct patient care	Employment Setting (See codes on Page 4.)	Will the practice of this specialty be discontinued within the next 12 months? (Yes or No)	Will you accept new patients in this specialty? (Yes or No)	What percent of the patients in this specialty are funded by Medicaid? (Estimate if necessary.)	Will you accept new Medicaid patients in this specialty?	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept new Medicare patients in this specialty?

Check the financial organization which best describes this site: ____ For-profit ____ Nonprofit
If applicable, check the type of services that you perform at this site, even if the service is not practiced as a specialty: ____ Adult Medicine ____ Pediatric Medicine ____ Prenatal Care ____ Gynecologic Care
____ Obstetrics If you practice obstetrics, approximately how many deliveries do you perform per year at all practice sites? _____

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE FIVE OF SIX

SECTION III CONTINUED

8. Practice Site Number Three
Street Address: _____
Town: _____ Zip: _____
Please complete **one full line for each specialty** that you practice at this site.

Specialty	Hours per week engaged in direct patient care	Employment Setting (See codes on Page 4.)	Will the practice of this specialty be discontinued within the next 12 months? (Yes or No)	Will you accept new patients in this specialty? (Yes or No)	What percent of the patients in this specialty are funded by Medicaid? (Estimate if necessary.)	Will you accept new Medicaid patients in this specialty?	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept new Medicare patients in this specialty?

Check the financial organization which best describes this site: ____ For-profit ____ Nonprofit

Check the type of services that you perform at this site, even if the service is not practiced as a specialty:
____ Adult Medicine ____ Pediatric Medicine ____ Prenatal Care ____ Gynecologic Care
____ Obstetrics If you practice obstetrics, approximately how many deliveries do you perform per year at all practice sites? _____

9. Practice Site Number Four
Street Address: _____
Town: _____ Zip: _____
Please complete **one full line for each specialty** that you practice at this site.

Specialty	Hours per week engaged in direct patient care	Employment Setting (See codes on Page 4.)	Will the practice of this specialty be discontinued within the next 12 months? (Yes or No)	Will you accept new patients in this specialty? (Yes or No)	What percent of the patients in this specialty are funded by Medicaid? (Estimate if necessary.)	Will you accept new Medicaid patients in this specialty?	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept new Medicare patients in this specialty?

Check the financial organization which best describes this site: ____ For-profit ____ Nonprofit

Check the type of services that you perform at this site, even if the service is not practiced as a specialty:
____ Adult Medicine ____ Pediatric Medicine ____ Prenatal Care ____ Gynecologic Care
____ Obstetrics If you practice obstetrics, approximately how many deliveries do you perform per year at all practice sites? _____

SECTION IV: STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE SIX OF SIX

A professional license or other authority to conduct a trade or business may not be renewed unless the licensee 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).

A professional license or other authority to conduct a trade or business may not be renewed unless the licensee 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). The maximum penalty for perjury is fifteen years in prison, a $10,000 fine, or both.

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT

X I hereby certify that I am not subject to any support order or I am subject to a support order and am in good standing with respect to or in full compliance with a plan to pay any and all child support due as of the date of this application.

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" to the address below.

APPLICANT'S STATEMENT REGARDING TAXES

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 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" to the address below.

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.*

Social Security Number: [redacted]

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 in the administration of Vermont tax laws, to identify individuals affected by such laws.

Date: Nov 20, 1992 **Signature:** Allegra Shumway

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 - Toll Free (Within Vermont) 1-800-439-8683 (Ask for the Medical Board)

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 $205.* in check or money order payable to the Vermont Board of Medical Practice.
(Medical Board Renewal Fee: $200. + Office of Professional Regulation (OPR) Fee: $5.00 = $205. OPR's $5.00 of the renewal fee represents an assessment for the Fee Limiting Subfund.)

***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.**

MATTHEW THORNTON HEALTH PLAN

VERIFICATION OF STATE LICENSURE

Provider Name: ALLEGRA LUCILLE SHUMWAY, M.D.

License Number: 42-0008297

Effective: ~~12/01/92~~ 2/15/91

Date of Expiration: 11/30/94

State of Issue: VERMONT

Is the license current and in good standing? Yes

If no, please describe: _____

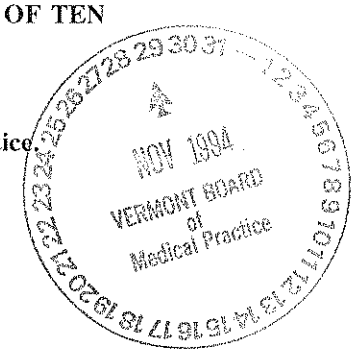
Janice E Lyfield Staff Assistant

Administrator

9/15/94

Date

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE ONE OF TEN



I hereby apply for the renewal of my **LICENSE AS A PHYSICIAN** for the period from **12/01/94** to **11/30/96**. **TWO YEAR RENEWAL FEE: $205.00**.
Enclose a check in the amount of $205.00 made payable to the Vermont Board of Medical Practice

Allegra Lucille Shumway
[redacted]

****

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

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

1. Name: Shumway , Allegra Lucille
2. Vermont License Number: 42-8297
3. Other Name(s), if any, under which you were licensed in Vermont and elsewhere since your last renewal:

4. Home Address: [redacted]

   City, State, Zip Code [redacted]
5. Office Address: Hardwick Area Health Center
   1 High ST
   City, State, Zip Code: Hardwick VT 05843

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

6. Daytime Telephone Number: [redacted]
7. Date of Birth: [redacted]
8. Place of Birth: [redacted]
9. Sex (M/F): F

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF TEN

SECTION I CONTINUED

10. Licensing Examination Taken - Check: X National Boards ____FLEX ____State Examination-Identify State:____
____USMLE ____Other Examination Specify:____

11. Undergraduate Degree: (B.A., B.S., etc.): BA Year of Graduation: 1978

Major Course of Study: Biology + Philosophy

Degree Granting Institution: KIRKLAND COLLEGE

Location: CLINTON , NY USA

First Institution (If transfer):____

Location:____

12. Medical Degree: (M.D. or Other, please specify): MD Year of Graduation: 1988

Degree Granting Medical School: UNIV OF VERMONT

Location: BURLINGTON , VT USA

First Medical School (If transfer):____

Location:____

13. Do you have hospital privileges **in Vermont**? X Yes ____No
Name(s) and Location(s) of Hospital(s):
Copley Hospital Morrisville VT

14. Did you practice in Vermont during the past 12 months? X Yes ____No

15. Other states where you hold an active license to practice: none

16. States where you previously were licensed to practice: none

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

	Specialty Code(s) (See the list of specialty codes.)	**American Board of Medical Specialties Certified (Yes or No)**	**Year Certified/Recertified**
(a)	0601	yes	1991
(b)			/
(c)			/

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE THREE OF TEN

SECTION I CONTINUED

18. Please list the postgraduate educational degrees (MBA, MS, Ph.D., JD, etc.) that you have earned related to your practice:

(a) Postgraduate Degree: (Ph.D., etc.): _____ Year of Graduation:_____

Major Course of Study:_____

Degree Granting Institution:_____

Location:_____

(b) Postgraduate Degree: (Ph.D., etc.): _____ Year of Graduation:_____

Major Course of Study:_____

Degree Granting Institution:_____

Location:_____

(c) Postgraduate Degree: (Ph.D., etc.): _____ Year of Graduation:_____

Major Course of Study:_____

Degree Granting Institution:_____

Location:_____

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE FOUR OF TEN

SECTION I CONTINUED

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

	Institution	City	State	Country	Specialty Code (See attached list of specialty codes)	Year Completed
(a)	Medical center Hosp of VT	Burlington	VT	U.S.A.	0601	1991
(b)						
(a)						

20. Are you a primary and/or secondary supervising physician for a physician's assistant (P.A.)? ✓ Yes ____ No
If yes, please list:

Name of P.A.	Check if: Primary	and/or Secondary
Charles Butterick		✓

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE FIVE OF TEN

SECTION I CONTINUED

21. Are you now in a collaborative relationship with a nurse practitioner? ✓ Yes _____ No
If yes, please list the name(s) of the nurse practitioner(s):

Maria Calderwood

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE SIX OF TEN

SECTION I CONTINUED

This page was intentionally left blank.

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE SEVEN OF TEN

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? [redacted]

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? [redacted]

4. Have you been dependent upon alcohol or drugs? [redacted]

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)? [redacted]

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? [redacted]

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE EIGHT OF TEN

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 1994-1996 period if the answer to any of the questions above changes from "No" to "Yes".

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE NINE OF TEN

SECTION III

(Section III contains the assurances required by the Board of Medical Practice and is **not** part of the data base maintained by the Department of Health.)

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

(1) APPLICANT'S STATEMENT REGARDING CHILD SUPPORT (See Explanation Below)

X I hereby certify that I am not subject to any support order or I am subject to a support order and am in good standing with respect to or in full compliance with a plan to pay any and all child support due as of the date of this application.

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" to the address below.

(2) APPLICANT'S STATEMENT REGARDING TAXES (See Explanation 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 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" to the address below.

(3) SOCIAL SECURITY NUMBER: [redacted]

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 in the administration of Vermont tax laws, to identify individuals affected by such laws.

(4) 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: 11/28/94 **Signature:** Allegra Shumway

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

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

A professional license or other authority to conduct a trade or business may not be renewed unless the licensee 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).

A professional license or other authority to conduct a trade or business may not be renewed unless the licensee 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). The maximum penalty for perjury is fifteen years in prison, a $10,000 fine, or both.

QUESTIONS?: (802) 828-2673 - Toll Free (Within Vermont) 1-800-439-8683 (Ask for the Medical Board)

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 $205.00* in check or money order payable to the Vermont Board of Medical Practice. (Medical Board Renewal Fee: $200.00 + Office of Professional Regulation (OPR) Fee: $5.00 = $205.00 OPR's $5.00 of the renewal fee represents an assessment for the Fee Limiting Subfund.)

***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.**

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TEN OF TEN

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VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV

To be completed only by physicians practicing in Vermont.

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.)
***Note:** If you are retired or are not practicing in Vermont, do not complete Section IV.

1. Current Status (please check one): X Active ___Retired* ___Other (please explain) _____

2. Postgraduate training in Vermont:
   (a) Are you currently in a postgraduate training program in Vermont as a resident or clinical fellow? ___Yes X No
   (b) Are you a ___Resident ___Clinical Fellow ___Research Fellow?
   (c) How many hours per typical week do you spend in this Vermont postgraduate training program?
   _____hrs./wk. in Vermont.
   (d) What is the medical school that you are affiliated with for this training?
   _____University of Vermont _____Dartmouth _____Other (Please specify)_____

3. What is the date you started practicing medicine (excluding residency or fellowship training)?
   (Month/Year) June/ 1991

4. What is the date you started practicing medicine **in Vermont** (excluding residency or fellowship training)?
   (Month/Year) June/ 1991

5. Are you a **staff physician** involved **exclusively** in inpatient care or an emergency room setting? ___Yes X No

6. What is your Unique Physician Identification Number (UPIN)? E16129

Instructions for completing this portion: Please complete a WORK SITE section for each practice and location where you provide patient care. **For example**, if your patient care is distributed in the following manner, you would complete four WORK SITE sections, one for each combination of practice and site:

Practice	Site	WORK SITE Section in this form
Mountain Pediatrics	126 Cherry St., Burlington	NUMBER ONE
City Hospital	Pine St., Burlington	NUMBER TWO
Mountain Pediatrics	Route 116, Hinesburg	NUMBER THREE
Lakeview Pediatrics	Route 7, Vergennes	NUMBER FOUR

Be as detailed as possible. Estimate if exact figures are not available.

Be sure to include the patient care that you provide in an inpatient setting.

The codes to be used for the SPECIALTY column are enclosed on separate sheets.

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

7(a). **WORK SITE: NUMBER ONE**

Name of Practice(s): Hardwick Area Health Center
Street Address: 1 High ST
Town: Hardwick VT Zip Code: 05843

Is your practice at this site affiliated with an **IPA HMO**? ___Yes X No
Is your practice at this site affiliated with a **Group/Staff HMO**? ___Yes ___No
Do you engage in **teaching** at this site? X Yes ___No
Do you engage in **research** at this site? ___Yes X No

Is your **personal** income from this practice site based on (check as many as apply):
X Salary ___Fee for service ___Capitation ___Cost based ___ Other (please specify)_____

The codes to be used for the PRACTICE SETTING column are as follows:

1 Solo Practice	**7** Hospital Owned/Operated Office Practice
2 Group Practice: Single Specialty	**8** Hospital Emergency Room
3 Group Practice: Multi-Specialty	**9** Hospital Outpatient Clinic
4 FQHC/RHC Community Health Center	**10** Hospital Inpatient
5 School or College Health Center	**11** Extended Care Facility
6 Business or Worksite	**12** Other: Specify _____

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

SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	Average hours per week engaged in DIRECT PATIENT CARE	Practice Setting (use codes provided above on this page)	Do you plan to continue the practice of this specialty for the next 12 months? YES or NO	Will you accept new patients in this specialty? YES or NO	Will you accept new **Medicaid** patients in this specialty? YES or NO	Will you accept new **Medicare** patients in this specialty? YES or NO
0601	35	4	Yes	Yes	Yes	Yes

Check the types of **primary care** services that you perform at this site, and the average hours per week of patient care, even if the service is not practiced as a specialty:

	Service	**Hours**
✓	General pediatric medical care	6
✓	General adolescent medical Care	3
✓	General adult medical care	10
✓	General geriatric medical care	8
✓	General gynecological medical care	8
	General obstetric medical care	

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

7(b). **WORK SITE: NUMBER TWO**

Name of Practice(s): Copley Hospital
Street Address: _____
Town: Morrisville VT Zip Code: 05661

Is your practice at this site affiliated with an **IPA HMO**? ___Yes X No
Is your practice at this site affiliated with a **Group/Staff HMO**? ___Yes X No
Do you engage in **teaching** at this site? ___Yes X No
Do you engage in **research** at this site? ___Yes X No

Is your **personal** income from this practice site based on (check as many as apply):
X Salary ___Fee for service ___Capitation ___Cost based ___ Other (please specify)_____

The codes to be used for the PRACTICE SETTING column are as follows:

1 Solo Practice	**7** Hospital Owned/Operated Office Practice
2 Group Practice: Single Specialty	**8** Hospital Emergency Room
3 Group Practice: Multi-Specialty	**9** Hospital Outpatient Clinic
4 FQHC/RHC Community Health Center	**10** Hospital Inpatient
5 School or College Health Center	**11** Extended Care Facility
6 Business or Worksite	**12** Other: Specify _____

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

SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	Average hours per week engaged in DIRECT PATIENT CARE	Practice Setting (use codes provided above on this page)	Do you plan to continue the practice of this specialty for the next 12 months? YES or NO	Will you accept new patients in this specialty? YES or NO	Will you accept new **Medicaid** patients in this specialty? YES or NO	Will you accept new **Medicare** patients in this specialty? YES or NO
0601	8	10	Yes	Yes	Yes	Yes

Check the types of **primary care** services that you perform at this site, and the average hours per week of patient care, even if the service is not practiced as a specialty:

	Service	**Hours**
	General pediatric medical care	
	General adolescent medical Care	
X	General adult medical care	3
X	General geriatric medical care	5
	General gynecological medical care	
	General obstetric medical care	

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

7(c). **WORK SITE: NUMBER THREE**

Name of Practice(s): _____
Street Address: _____
Town: _____ Zip Code: _____

Is your practice at this site affiliated with an **IPA HMO**? ___Yes ___No
Is your practice at this site affiliated with a **Group/Staff HMO**? ___Yes ___No
Do you engage in **teaching** at this site? ___Yes ___No
Do you engage in **research** at this site? ___Yes ___No

Is your **personal** income from this practice site based on (check as many as apply):
___Salary ___Fee for service ___Capitation ___Cost based ___ Other (please specify)_____

The codes to be used for the PRACTICE SETTING column are as follows:

1 Solo Practice	**7** Hospital Owned/Operated Office Practice
2 Group Practice: Single Specialty	**8** Hospital Emergency Room
3 Group Practice: Multi-Specialty	**9** Hospital Outpatient Clinic
4 FQHC/RHC Community Health Center	**10** Hospital Inpatient
5 School or College Health Center	**11** Extended Care Facility
6 Business or Worksite	**12** Other: Specify _____

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

SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	Average hours per week engaged in DIRECT PATIENT CARE	Practice Setting (use codes provided above on this page)	Do you plan to continue the practice of this specialty for the next 12 months? YES or NO	Will you accept new patients in this specialty? YES or NO	Will you accept new **Medicaid** patients in this specialty? YES or NO	Will you accept new **Medicare** patients in this specialty? YES or NO

Check the types of **primary care** services that you perform at this site, and the average hours per week of patient care, even if the service is not practiced as a specialty:

	Service	**Hours**
	General pediatric medical care	
	General adolescent medical Care	
	General adult medical care	
	General geriatric medical care	
	General gynecological medical care	
	General obstetric medical care	

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

7(d). **WORK SITE: NUMBER FOUR**

Name of Practice(s): _____
Street Address: _____
Town: _____ Zip Code: _____

Is your practice at this site affiliated with an **IPA HMO**? ___Yes ___No
Is your practice at this site affiliated with a **Group/Staff HMO**? ___Yes ___No
Do you engage in **teaching** at this site? ___Yes ___No
Do you engage in **research** at this site? ___Yes ___No

Is your **personal** income from this practice site based on (check as many as apply):
___Salary ___Fee for service ___Capitation ___Cost based ___ Other (please specify)_____

The codes to be used for the PRACTICE SETTING column are as follows:

1 Solo Practice	**7** Hospital Owned/Operated Office Practice
2 Group Practice: Single Specialty	**8** Hospital Emergency Room
3 Group Practice: Multi-Specialty	**9** Hospital Outpatient Clinic
4 FQHC/RHC Community Health Center	**10** Hospital Inpatient
5 School or College Health Center	**11** Extended Care Facility
6 Business or Worksite	**12** Other: Specify _____

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

SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	Average hours per week engaged in DIRECT PATIENT CARE	Practice Setting (use codes provided above on this page)	Do you plan to continue the practice of this specialty for the next 12 months? YES or NO	Will you accept new patients in this specialty? YES or NO	Will you accept new **Medicaid** patients in this specialty? YES or NO	Will you accept new **Medicare** patients in this specialty? YES or NO

Check the types of **primary care** services that you perform at this site, and the average hours per week of patient care, even if the service is not practiced as a specialty:

	Service	**Hours**
	General pediatric medical care	
	General adolescent medical Care	
	General adult medical care	
	General geriatric medical care	
	General gynecological medical care	
	General obstetric medical care	

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

THIS IS TO CERTIFY

that Allegra Shumway, M.D. of Colchester, Vermont

a graduate of University of Vermont

in the year 1988 having successfully qualified as a practitioner in medicine before this Board has been registered as provided by the Laws of the State.

Susan M Spaulding
Chairman

Jane S. Kinsman
Secretary

Certificate No. 8297

Montpelier February 15, 1991
Date

STATE OF VERMONT
Office of Secretary of State

Received September 6, 1991
and duly recorded.

Signed Secretary of State

Office of the Vermont Secretary of State
Redstone Building, 26 Terrace Street

Mail: Pavilion Office Building
Montpelier, VT 05609-1101

James H. Douglas
Secretary of State

Paul S. Gillies
Deputy Secretary of State

BOARD OF MEDICAL PRACTICE

March 7, 1991

Allegra L. Shumway, M.D.
[redacted]

RE: Vermont Medical License
#42-0008297

Dear Doctor Shumway:

Congratulations! On March 6, 1991, by unanimous vote of the Vermont Board of Medical Practice, you were granted a Vermont medical license. Please note your license number indicated above.

Your registration card is enclosed and a wall certificate has been ordered and will be sent to you under separate cover. All medical licenses must be renewed biennially. You will receive a notification two months prior to renewal.

Please let us know if you have any questions or concerns.

Sincerely,

Debra Morehouse
Staff Assistant
VT Board of Medical Practice

PLEASE NOTIFY THIS OFFICE IMMEDIATELY OF ANY ADDRESS CHANGE

/dm

Enclosure

PHYSICIAN STATUS SHEET

NAME Allegra L. Shumway

ADDRESS [redacted]

PHONE

APPLICATION RECEIVED 10/30/90 FEE RECEIVED CP 125.00

X COMPLETED SECTION I

X CERTIFIED COPY OF BIRTH CERTIFICATE

X NOTARIZED COPY OF MEDICAL SCHOOL DIPLOMA, FROM: Univ. of Vermont - 1988

X SECTION II, "CERTIFICATE OF MEDICAL EDUCATION"

SECTION III, "CERTIFICATE OF MEDICAL LICENSURE"

N/A N/A

X FLEX OR NATIONAL BOARD SCORES (FLEX N/A NB 83

N/A NOTARIZED COPY OF SPECIALTY BOARD CERTIFICATE, FROM:

X PHOTO COPY OF POST GRADUATE CERTIFICATE, FROM: Medical Center Hosp. of VT

THREE LETTERS OF RECOMMENDATION:

X William C. Wadland, M.D.

X Allan M. Ramsay, M.D. Dir.

X Louis D. Hackeberg, M.D. Chair

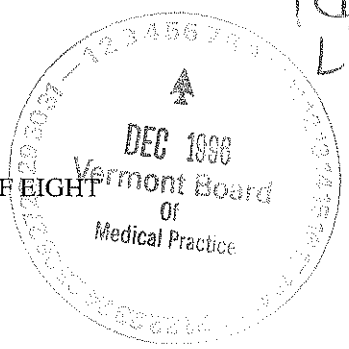
FORMS FROM THE FOLLOWING AGENCIES:

X AMA X FEDERATION N/A ECFMG

X CHILD SUPPORT FORM

Pd
LF

42-8297 SHUMWAY, ALLEGRA L.



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.

ALLEGRA L. SHUMWAY
[redacted]

****

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: ALLEGRA LUCILLE SHUMWAY

2. Vermont License Number: 42-8297

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

4. Home Address: [redacted]

City, State, Zip Code: [redacted]

5. Office Address: HARDWICK AREA HEALTH CENTER

1 HIGH ST

City, State, Zip Code: HARDWICK, VT 05843

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

6. Daytime Telephone Number: [redacted]

7. Date of Birth: [redacted]

8. Sex (M/F): F

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: X National Boards ___FLEX ___State Examination-Identify State:
___USMLE ___Other Examination Specify:

11. Undergraduate Degree: (B.A., B.S., etc.): BA Year of Graduation: 1978

Major Course of Study: BIOLOGY

Degree Granting Institution: KIRKLAND COLLEGE

Location: CLINTON, NY USA

First Institution (If transfer): _____

Location: _____

12. Medical Degree: (M.D. or Other, please specify): MD Year of Graduation: 1988

Degree Granting Medical School: University of Vermont College of Medicine

Location: BURLINGTON, VT USA

First Medical School (If transfer): _____

Location: _____

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

(a) COPLEY HOSPITAL

(b) _____

(c) _____

(d) _____

(e) _____

14. Other states where you hold an active license to practice: NONE

15. States where you were previously licensed to practice: NONE

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	/
(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	MCHV		
City	BURLINGTON		
State	VT		
Country	USA		
Specialty Code (See list)	0 6 0 1		
Specialty Name	FAMILY PRACTICE		
Year Residency Completed	1991		

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? [redacted]

2. Have you been a defendant in any criminal proceeding other than minor traffic offenses? ___YES _X_NO

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

4 Have you been dependent upon alcohol or drugs? [redacted]

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 _X_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)? [redacted]

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 _X_NO

8. Have you voluntarily surrendered or resigned a license to practice medicine or any healing art in lieu of disciplinary action?
___YES _X_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 _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 withdrawn an application for a medical license or been denied a medical license for any reason?
___YES _X_NO

12. Have you been turned down for coverage by a malpractice insurance carrier? ___YES _X_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? _X_YES ___NO

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

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 __X__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".

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

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:

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".

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".

(continued on page 8)

YOU MUST COMPLETE OTHER SIDE

42-8297 SHUMWAY, ALLEGRA L.

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

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:**

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 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: [redacted]

* 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: 12/5/96 Signature: Allegra Shumway

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.

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV

42-8297 SHUMWAY, ALLEGRA L.

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:
   - [X] 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? 0 hours

2. Postgraduate training in Vermont:
   (a) Are you currently in a postgraduate training program in Vermont as a resident or clinical fellow?
   ___Yes [X] 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) 06/1991

4. What is the date you started practicing medicine in Vermont (excluding residency or fellowship training)?
   (Month/Year) 06/1991

5. Do you plan to retire or reduce your patient care hours in the next 12 months? ___Yes [X] 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: MORRISTOWN County: LAMOILLE

(*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
X Community Health Center or Clinic (Non-Hospital)
___ Hospital Outpatient Clinic
___ School or College Health Center
___ Business or Work Site
___ Hospital Emergency Room
X Hospital Inpatient
X 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	0601	FAMILY PRACTICE	8
Secondary Specialty at this Site			
Other Specialty at this Site			

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

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

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

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

Are you working with physician's assistants and/or nurse practitioners at this site? X Yes ___No
If yes, enter the number of: Physician's Assistants 1 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? X 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 X 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: HARDWICK County: CALEDONIA

(*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
X 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	0601	FAMILY PRACTICE	35
Secondary Specialty at this Site			
Other Specialty at this Site			

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

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

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

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

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

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: Allegra Shumway **Vermont License Number:** 42-8297

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: _____

Claimant Name: _____

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: _____ _____ _____ 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.

_____

_____

_____

_____

_____

_____

_____

_____

_____

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	

Section A continued on next page

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

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

Institution Involved: _____

Date: _____

Circumstances: _____

_____

_____

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

State: _____ Year: _____

Circumstances: _____

_____

_____

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

Third Party Payer: _____ Year: _____

Circumstances: _____

_____

_____

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

Malpractice Insurance Carrier: _____ Year: _____

Circumstances: _____

_____

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

PRO: [redacted] Year [redacted]

Location of PRO: _____

Circumstances: [redacted]

109 State Street
Montpelier, VT 05609-1106
Tel.: (802) 828-2673
Fax: (802) 828-2853

State of Vermont
Board of Medical Practice

December 6, 1996
(Date)

[redacted]

License # 42-8297

Your 1996 physician license renewal has been received by this office. Your renewal **CANNOT** be processed until we receive

✓ $300.00 renewal fee + $25.00 late fee = $325.00

_____ Page one, Section I, Item_____

_____ Page two, Section I, Item_____

_____ Page three, Section I, Item_____

_____ Page five, Section II, Item_____

_____ Page six, Section II, Item_____

_____Page seven, Section III, Item_____

_____ Page eight, Section III, Item_____

A copy of the page that needs to be completed is attached. Please complete the necessary item, initial, date and return as soon as possible.

Sincerely,
Cheryl Blake
Cheryl Blake
Staff Assistant

State of Vermont
Board of Medical Practice
109 State Street
Montpelier, VT 05609-1106
(802) 828-2363

VERIFICATION OF LICENSURE

This is to cerify that according to the records of the Board of Medical Practice on 08 August 1997 regarding:

Allegra Lucille Shumway MD

[redacted]

The Board of Medical Practice granted this License as a Physician numbered 042-0008297 on 15 February 1991. Current Specialty registered in: Family Practice

Current Status: ACTIVE
Date of Expiration: 30 November 1998

Our records also indicate the following information:

Date of Birth: [redacted]
School/College Education: University of Vermont
Date of Graduation: 05/21/1988
Degree earned: MD

Basis of Licensure: Unknown code

Examination Information:

	Subject	
National Boards	83	07/01/1989 1st

This licensee met all requirements at the time of licensure in accordance with the appropriate regulations of this state.

Board Action information:

No charges have been preferred against this licensee.

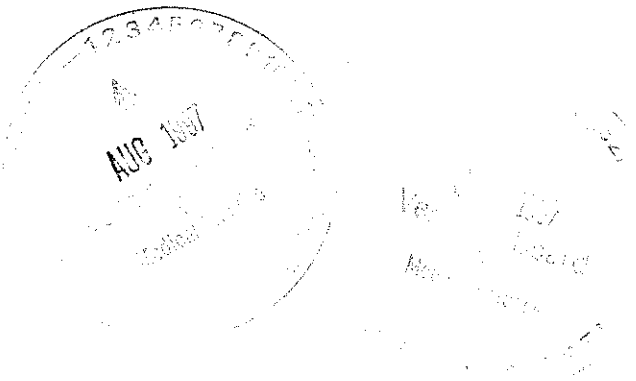
I hereby certify, as a staff assistant to the Board of Medical Practice, to the best of my knowledge, the information above is true and accurate.

Cheryl A. Blake 8-8-97
Signature of Staff Assistant Date

Professional Credentials Verification Service

Massachusetts Medical Society 1440 Main Street, Waltham, MA 02154-1600 (617) 893-4610 / Fax (617) 893-7891

July 18, 1997



Vermont Medical Practice Board
109 State Street
Pavillion P.O.
Montpelier, VT 05609-1101

RE: **Allegra L. Shumway, M.D.** 000000008052
Date of Birth: [redacted]
Lic No: 0420008297

The above referenced practitioner has applied for affiliation with a participating hospital/managed care plan of the Professional Credentials Verification Service (PCVS) and states that he/she is currently licensed to practice in your state. We would appreciate your verification of this information by completing the statement below and returning it in the enclosed envelope.

Attached is an authorization for release of information signed by the applicant allowing us to make this inquiry.

Thank you for your prompt response.

Sincerely,

Amy McIntire

Professional Credentials Verification Service

Enc: Authorization for Release; Return Envelope

****

License Number 042-0008297 Date Issued 2-15-91

Date of Expiration 11-30-98

Has this license ever been voluntarily/involuntarily relinquished? ____Yes* ✓No

Has this Board ever suspended, revoked, reduced, limited, or refused to renew this license? ____Yes* ✓No

Has this Board ever initiated any disciplinary action against the applicant, or is any such action pending? ____Yes* ____No See attached

*If yes, please provide appropriate details on a separate page.

Verified by: Cheryl A. Blake Staff Assistant
Name/Title

Date: 8-8-97

ooslic.lt3

109 State Street
Montpelier, VT 05609-1106
Tel.: (802) 828-2673
Fax: (802) 828-2853

State of Vermont
Board of Medical Practice

This Board has never taken disciplinary action against this individual.

Under Vermont Statute 3 VSA §131 this Board can neither confirm nor deny whether there are closed or pending investigation files.

Cheryl A. Blake

Cheryl A. Blake
Staff Assistant

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.

042-0008297

Allegra Lucille Shumway MD
[redacted]

Received
Vermont Board of Medical Practice

****

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: Shumway (Last) Allegra (First) Lucille (Middle) _____ (Former)

Vermont License Number: 042-0008297

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

Mailing Address [redacted]

Office Address: None (Street)

_____ (City) _____ (State) _____ (Zip Code) _____ (Phone)

Home Address: Same as mailing address

City, State, Zip Code: _____
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 [redacted]

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? ____ Yes _____ No

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

SPECIALTY

Specialty: Family Practice

Subspecialty:_____

American Specialty Board Certified? X Yes _____No

Specialty?:_____ Year Certified?:_____

If applicable, year recertified? _____

Subspecialty Certificate?:_____ Year Certified?_____

If applicable, year recertified? _____

PRACTICE

Do you have hospital privileges? _____ 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

OTHER LICENSES

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

State	License Number	Date Issued	Status (Active or 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 [redacted]

* 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 [signature] Date 10/13/98

Redstone Building
26 Terrace Street
Drawer 09
Montpelier, VT 05609-1101

Tel: (802) 828-2363
http://www.sec.state.vt.us

Deborah L. Markowitz
Secretary of State

William A. Dalton
Deputy Secretary

Jessica G. Porter
Director, Professional Regulation

State of Vermont
Office of the Secretary of State

VT SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
26 TERRACE STREET, REDSTONE BUILDING
DRAWER 09
MONTPELIER, VT 05609-1106
(802) 828-2390

MEMO

To: Allegra Shumway, M.D.
From: Diane W. Lafaille, Board Administrator DWL
Subject: Ionizing Privileges
Date: 23 May 2003

Dear. Dr. Shumway:

I have forwarded a copy of your application for certification of your having read the Syllabi on *Radiography Radiation Protection* and *Fluoroscopy Radiation Protection*, and viewed the VCR tape to the VT Board of Medical Practice.

That Board will add ionizing privileges to your medical license and issue you a new license with that endorsement on it. This letter will serve as compliance with § 2804 until that license is received.

Feel free to contact me at (802) 828-2390 if you have questions. My E-mail address is: "dlafaill@sec.state.vt.us"

Thank you.

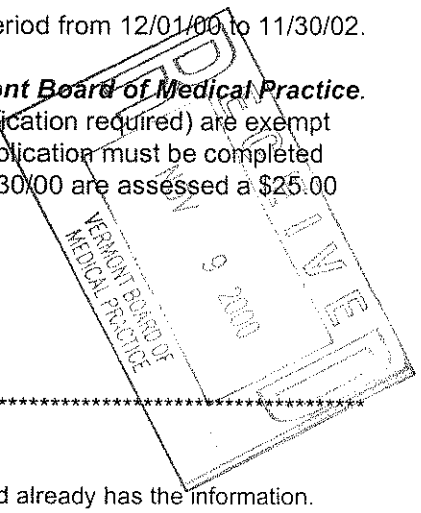
STATE OF VERMONT -- BOARD OF MEDICAL PRACTICE
2000-2002 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE ONE OF FIVE

I hereby apply for the renewal of my LICENSE AS A PHYSICIAN for the period from 12/01/00 to 11/30/02.
TWO YEAR RENEWAL FEE: $350.00
Enclose a check in the amount of $350.00 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: Applications post-marked or received after 11/30/00 are assessed a $25.00 late fee.

042-0008297

Allegra Lucille Shumway MD

[redacted]



****

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 the completed 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.

SECTION I

Name: Shumway Allegra Lucille
(Last) (First) (Middle) (Former)

Vermont license number: 042-0008297 Other name(s), if any, under which you were licensed in Vermont and elsewhere since your last renewal _____

"MAILING ADDRESS" will be public and listed on the Board's website. All addresses must be included.

MAILING ADDRESS: [redacted]

OFFICE ADDRESS: Planned Parenthood 30 Coventry
(Street)

Newport VT 05855 802-334-5822
(City) (State) (Zip Code) (Telephone)

HOME ADDRESS: _____
(Street)

Same as Mailing adress
(City) (State) (Zip Code) (Telephone)

STATE OF VERMONT -- BOARD OF MEDICAL PRACTICE
2000 - 2002 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF FIVE

Are you currently active in clinical practice in Vermont? X Yes ___ No
Did you practice in Vermont during the past 12 months? ___ Yes ___ No
Do you intend to practice medicine without hospital privileges? ___ Yes ___ No

SPECIALTY

Specialty: Family Practice

Subspecialty: _____

American Specialty Board Certified: X Yes _____ No

Specialty: Family Practice Year Certified: ~~1988 1994~~ 1991

If applicable, year recertified: 1998

PRACTICE

Do you have hospital privileges? _____ Yes X No

List all hospitals where you have, or previously have had, staff privileges. Include full information.

Name	Address	Dates/From-To	Specialty/Subspecialty

LICENSE IN OTHER JURISDICTIONS

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

State	License Number	Date Issued	Status (Active, Inactive, Other)

STATE OF VERMONT -- BOARD OF MEDICAL PRACTICE
2000-2002 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE THREE OF FIVE

SECTION III: "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, indicate that on Form A. **YOU HAVE A CONTINUING OBLIGATION TO UPDATE THE BOARD DURING THE 2000-2002 PERIOD IF THE ANSWER TO ANY OF THE QUESTIONS ON THE NEXT TWO PAGES CHANGE FROM "NO" TO "YES".**

(Section III 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 ever applied for and been denied a license to practice medicine or any healing art? ___ Yes X No
2. Have you ever withdrawn an application for a license to practice medicine or any healing art? ___ Yes X No
3. Have you ever 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 ever 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 ever been denied the privilege of taking an examination before any State Medical Examining Board? ___ Yes X No
7. Have you ever discontinued your education, training, or practice for a period of more than three months? ___ Yes X No
8. Have you ever been dismissed, suspended, or asked to leave a residency training program(s) before completion? ___ Yes X No
9. Have you ever 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 ever 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 ever been notified as a responsible party of a confirmed quality concern (quality of hospital care provided to Medicare patient) 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 ever been turned down for coverage by a malpractice insurance carrier? ___ Yes X No
14. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted by or surrendered to any jurisdiction or federal agency at any time? ___ Yes X No
15. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses? (Note: 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
2000-2002 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE FOUR OF FIVE

SECTION III CONTINUED: "Yes" answers to Questions 17 through 24 requires an explanation on the enclosed Form A. For purposes of Questions 17 through 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 addition, 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, 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, explain on Form A. [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, explain on Form A. [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, explain on Form A. [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, explain on Form A. [redacted]

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

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

23. If yes to 22, 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, explain on Form A. [redacted]

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

SECTION IV
APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS
PAGE FIVE OF FIVE

You must answer questions 1, 2, and 3.

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 dues 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 regarding taxes:

X I hereby certify, under the pains and penalties or 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".

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 three statements below regarding unemployment contributions or payments in lieu of unemployment contributions:

____ I hereby certify, under the pains and penalties or 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.

or

X I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #* [redacted] Date of Birth [redacted]

*** The disclosure of your social security number is mandatory, it 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 Vermont 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 and that providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant [signature] Date 10/23/00

2569

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE

2002 PHYSICIAN'S LICENSE RENEWAL APPLICATION

I hereby apply for the renewal of my LICENSE AS A PHYSICIAN for the period from 12/01/02 to 11/30/04.

Instructions

- *Please enclose a check in the amount of $350 payable to the Vermont Department of Health.*
  Note: 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: Applications post-marked or received after 11/30/02 are assessed a $25 late fee.
- *Please print legibly or type your answers. Please type or print in block letters, one letter (or digit) in each box.*
- *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 Parts II and III.*
- *Please be sure to write your name and license number on each attachment.*
- *Please be sure to complete the Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions.*
- *Make a copy of the completed form and all attachments for your own records.*
- *Do not delegate this important task to an employee. False statements on this form are grounds for unprofessional conduct.*
- *Please return the document in its entirety at your earliest convenience. Your current license expires on November 30, 2002.*

Part I - Identity Questions

Vermont Physician's License Number: 042-0008297

RECEIVED
NOV 13 2002
VERMONT BOARD OF MEDICAL PRACTICE

1. Print your full name as you wish it to appear on the license:

First name: Allegra

Middle name: Lucille

Last name: Shumway

Extension:

2. Have you ever legally changed your name? ☐ Yes ☒ No

Former name, or any other name under which you were licensed in Vermont or elsewhere in the past two years: _____

3. Your date of birth: M M D D Y Y Y Y [redacted]

4: Your mailing address: (Check one: ☒ Home address ☐ Work address)

Care of:

Street: [redacted]

Town/City: [redacted]

State:

Zip Code:

5. Your electronic addresses:

Home telephone (optional): [redacted] example: 802-555-1212

Work telephone: 802 - 334 - 5822 x

E-mail (optional):

6. Were you in active practice in Vermont in the past 12 Months? ☒ **Yes** ☐ **No**

7. Are you currently participating in residency or fellowship training ☐ **Yes** ☒ **No**

8. Do you hold, or have you ever held, a medical license in any other state? ☐ **Yes** ☒ **No**

If yes, complete the section below:

State	License Number	Date Issued M M D D Y Y Y Y	Status (Active, inactive, other)

If necessary, please use an additional sheet and check this box: .....☐

Part II - Licensure and Practice Questions

Any "yes" response to the questions below must be fully explained on the enclosed Form A.

9. Have you ever applied for and been denied a license to practice medicine or any other healing art?
☐ **Yes** ☒ **No**

10. Have you ever withdrawn an application for a license to practice medicine or any other healing art?
☐ **Yes** ☒ **No**

11. Have you ever voluntarily surrendered or resigned a license to practice medicine or any other healing art in lieu of disciplinary action?
☐ **Yes** ☒ **No**

12. Are any formal disciplinary charges pending or has any disciplinary action ever 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**

13. Have you ever been denied the privilege of taking an examination before any state medical examining board?
☐ **Yes** ☒ **No**

14. Have you ever discontinued your education, training, or practice for a period of more than three months, for reasons other than a family situation?
☐ Yes ☒ No

15. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?
☐ Yes ☒ No

16. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?
☐ Yes ☒ No

17. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?
☐ Yes ☒ No

18. Are you presently a defendant in a criminal proceeding?
☐ Yes ☒ No

Part III - Confidential Section

Part III is exempt from public disclosure

Any "yes" response to the questions below must be fully explained on the enclosed Form A.

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

20. To your knowledge, are you presently the subject of criminal investigation?
[redacted]

MEDICAL QUESTIONS

Please answer "**Yes**" or "**No**" to the questions below. Definitions are provided after the questions to assist you in answering. Please explain any "**Yes**" answers on Form A.

21. Do you have a medical condition that in any way impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?
[redacted]

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

22. Are you currently engaged in the use of alcohol or other chemical substances that in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety?
[redacted]

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

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

In explaining a "Yes" answer on Form A, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine.

IMPORTANT

Since 1999, part of each license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a **confidential** program for the identification, treatment and rehabilitation of physicians affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-4393 (a confidential line).

DEFINITIONS

In answering the questions above, please use these definitions:

"Ability to practice medicine" - This term includes:

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, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as a licensee.

"Chemical substances" - This term 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.

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the
Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

Part IV - Statutory Profile Questions

Vermont law, 26 VSA § 1368, creates a data repository within the Department of Health. Under this law, the Department must collect certain information to create individual profiles on all health care professionals licensed, certified, or registered by the Department pursuant to Title 26 of the VSA. Please try to answer the following questions as best as you can. You will receive a copy of your profile prior to its initial release to the public and each time the profile is modified or amended. You will be given a reasonable time to correct factual inaccuracies that appear in such profile. As noted below, certain questions do not need to be answered.

It is very important for us to receive photostatic copies of court papers, licensing authority decisions, and other documents relevant to the questions below in order to have a true and accurate description of the actions taken.

24. **Criminal Convictions** [See 26 VSA § 1368(a)(1)]

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past 10 years. For purposes of this question, "convicted" means that you pleaded guilty or that you were found or adjudged guilty by a court of competent jurisdiction. **Please provide copies of papers fully documenting the convictions.**

Conviction Date M M	D D	Y Y Y Y	Court	City	State	Crime

If necessary, please use an additional sheet and check this box: .....☐

25. **Nolo Contendere/Matters Continued** [See 26 VSA § 1368(a)(2)]

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction. **Please provide copies of papers fully documenting these matters.**

Date M M	D D	Y Y Y Y	Court	City	State	Charge	Nature of Action
							☐ Nolo Contendere ☐ Matter Continued
							☐ Nolo Contendere ☐ Matter Continued
							☐ Nolo Contendere ☐ Matter Continued

If necessary, please use an additional sheet and check this box: .....☐

26. **Vermont Board of Medical Practice Matters** [See 26 VSA § 1368(a)(3)]

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed, within the past 10 years. (We will have the documentation on file; we are asking you to provide the description.)

Date M M	D D	Y Y Y Y	Final Disposition (Summary)

If necessary, please use an additional sheet and check this box: .....☐

27. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]

Please provide a description of all formal charges served by licensing authorities of other states, the findings, conclusions, and orders of such licensing authorities, and final disposition of such matters by the courts, if appealed, in those states within the past 10 years. **Please provide copies of papers fully documenting these matters.**

Date of Final Disposition M M	D D	Y Y Y Y	Licensing Authority	Court	City	State	Nature of Charges

If necessary, please use an additional sheet and check this box: .....☐

28. **Restriction of Hospital Privileges** [See 26 VSA § 1368(a)(5)]

A. Revocation/Involuntary Restrictions

Please provide a description of any revocation or involuntary restriction of your hospital privileges within the past 10 years that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you. **Please provide copies of papers fully documenting these matters.**

Date M M	D D	Y Y Y Y	Hospital	State	Nature of Restriction	Reason for Restriction

If necessary, please use an additional sheet and check this box: .....☐

B. Other Restrictions

Please provide a description of all resignations from, or nonrenewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital within the past 10 years. **Please provide copies of papers fully documenting these matters.**

Date M M D D Y Y Y Y	Hospital	State	Nature of Action	Action	Reason for Action
				☐ In Lieu of ☐ In Settlement	
				☐ In Lieu of ☐ In Settlement	
				☐ In Lieu of ☐ In Settlement	

If necessary, please use an additional sheet and check this box: .....☐

29. **Medical Malpractice Court Judgments/Settlements** [See 26 VSA § 1368(a)(6A)]

A. Judgments

Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you within the past 10 years in which a payment was awarded to a complaining party. **Please provide copies of papers fully documenting these matters.**

Date M M D D Y Y Y Y	Court	State	Nature of Case	Amount Assessed Against You
			☐ Judgment ☐ Arbitration	
			☐ Judgment ☐ Arbitration	
			☐ Judgment ☐ Arbitration	

If necessary, please use an additional sheet and check this box: .....☐

B. Settlements

Please provide a description of all settlements of medical malpractice claims against you within the past 10 years in which a payment was awarded to a complaining party. **Please provide copies of papers fully documenting these matters.**

Date M M	D D	Y Y Y Y	Court	State	Amount of Settlement Against You

If necessary, please use an additional sheet and check this box: .....☐

30. **Medical Professional Schools** [See 26 VSA § 1368(a)(7)]

Please provide the names of medical professional schools you attended and the dates of graduation. (We will have similar information on file with your original application; we are asking you here to provide an update for the statutory web profile.)

School	City	State	Year of Graduation
UVM College of Medicine	Burlington	VT	1988

If necessary, please use an additional sheet and check this box: .....☐

31. **Graduate Medical Education** [See 26 VSA § 1368(a)(8)]

Please provide information about any graduate medical education that you have received. (We will have similar information on file with your original application; we are asking you here to provide an update for the statutory web profile.)

School/Institution	Specialty	City	State	Year of Graduation
UVM / MCHV	Family Practice	Burlington	VT	1991

If necessary, please use an additional sheet and check this box: .....☐

32. **Specialty Board Certification** [See 26 VSA § 1368(a)(9)]

Enter up to three specialty codes from the enclosed ***Specialty Codes List***. List your primary specialty first. If you cannot locate a specialty, please write the specialty name in the space provided.

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
0601	Family Practice	☒ yes ☐ no	American Board of Family Practice	1991	1998
		☐ yes ☐ no			
		☐ yes ☐ no			

33. **Years of Practice** [See 26 VSA § 1368(a)(10)]

What month and year did you start the practice of medicine (excluding residency/fellowship training)?

M	M	Y	Y	Y	Y
0	7	1	9	9	1

34. **Hospital Privileges** [See 26 VSA § 1368(a)(11)]

List all hospitals where you currently have hospital staff privileges: None

Name	City	State	Year Started

If necessary, please use an additional sheet and check this box: .....☐

35. **Appointments/Teaching** [See 26 VSA § 1368(a)(12)] Note: Answering #35 is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. Appointments

Please provide information about your appointments to medical school or professional school faculties.

School	City	State	Nature of Appointment	From (year)	To (year)

If necessary, please use an additional sheet and check this box: .....☐

B. Teaching

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years.

School/Institution	City	State	Nature of Teaching	From (year)	To (year)

If necessary, please use an additional sheet and check this box: .....☐

36. **Publications** [See 26 VSA § 1368(a)(13)] Note: Answering #36 is optional. By answering, you are granting permission to have this information posted on the web.

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years.

Title	Publication	Year

If necessary, please use an additional sheet and check this box: .....☐

37. **Activities** [See 26 VSA § 1368(a)(14)] Note: Answering #37 is optional. By answering, you are granting permission to have this information posted on the web.

Please provide information regarding your professional or community service activities and awards.

Activities or Awards

If necessary, please use an additional sheet and check this box: .....☐

38. **Practice Setting** [See 26 VSA § 1368(a)(15)]

What is the location of your primary practice setting?

Town or City: Newport

State: VT

39. **Translating Services** [See 26 VSA § 1368(a)(16)]

Please identify any translating services available at your primary practice location.
Are any translating services available at your primary practice location?

☐ **Yes** ☐ **No**

If yes, please describe here the translating services available:

If necessary, please use an additional sheet and check this box: .....☐

40. **Medicaid/New Patients** [See 26 VSA § 1368(a)(17)]

A. **Medicaid participation**

Do you participate in the Medicaid program? ☒ **Yes** ☐ **No**

B. **New Medicaid Patients**

Are you currently accepting new Medicaid patients? ☒ **Yes** ☐ **No**

Part V - Clinical Practice Questions

Please fill in all of the boxes below that describe your practice as a physician (check all that apply):

☒ Active in clinical practice (in direct patient care) in Vermont

☐ Active in clinical practice (in direct patient care) outside Vermont

☐ Administration

☐ Teaching

☐ Research

☐ Not currently in active practice

Are you currently participating in residency or fellowship training? ☐ **Yes** ☒ **No**

BEFORE YOU CONTINUE:

- **Are you active in clinical practice (in direct patient care) in Vermont? If the answer is No, please skip the rest of this section and go to Part VI.**
- **Are you currently participating in residency or fellowship training? If the answer is Yes, please skip the rest of this section and go to Part VI.**

41. What month and year did you start practice of medicine **in Vermont** (excluding residency/fellowship training)?

M	M	Y	Y	Y	Y
0	7	1	9	9	1

42. For each location in Vermont where you provide patient care, please answer all of the questions:

- If necessary, please describe sites beyond the first 4 on an additional sheet and check this box: ... ☐

A. Town or city (actual location, not mail address):

Site 1: Newport

Site 2:

Site 3:

Site 4:

Question	Site 1	Site 2	Site 3	Site 4
B. Number of weeks per year that you spend providing direct patient care at this site: (Full-time is considered to be 48 weeks / year)	48			

Question	Site 1	Site 2	Site 3	Site 4
C. Chose the one description that best fits the practice setting (of each site). (If you provide hospital care to patients who originate from your office or clinic, chose only the setting from which they originate.)				
Community-based practice including associated hospital care (e.g., solo or group office sites, community health center)	☐	☐	☐	☐
Hospital-based practice (e.g., emergency rooms, in-patient services, out-patient services, laboratory, etc.)	☐	☐	☐	☐
School or college health center	☐	☐	☐	☐
Business or work site	☐	☐	☐	☐
Extended care/nursing home	☐	☐	☐	☐
Other: Community Health Center without associated Hospital Practice	☒	☐	☐	☐

D. Specialties at each site:
Please note the specialty, using the code from the enclosed **Specialty Codes List.** For each specialty, enter the average number of hours during which you provide direct patient care, including diagnosis, treatment and clinical reporting, in a working week. Include both the ambulatory care hours and hospital care hours of patients originating from this office or clinic. Exclude on-call hours.

	Site 1	Site 2	Site 3	Site 4
Specialty Code	0601			
(Specialty name, if code unknown)				
Hours per week	23			
Secondary Specialty, if any				
Hours per week in secondary specialty				
Tertiary Specialty, if any				
Hours per week in tertiary specialty				

E. Please answer each question:	Site 1	Site 2	Site 3	Site 4
I will accept new patients here	☑	☐	☐	☐
I participate in Medicaid here	☒	☐	☐	☐
I will accept new Medicaid patients here	☒	☐	☐	☐
I participate in Medicare here	☒	☐	☐	☐
I will accept new Medicare patients here	☐	☐	☐	☐
I work as a *locum tenens* here	☐	☐	☐	☐

Part VI - Signature

Reminder - You must also complete the enclosed Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions

I hereby aver that the information provided above is true and accurate, and that I have answered the questions to the best of my knowledge and ability.

Date: 11/12/02 _____ _____
Applicant's Signature

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

You must answer questions 1, 2, and 3.

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 dues 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 regarding taxes:

✓ I hereby certify, under the pains and penalties or 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".

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 three 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 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.

or

✓ I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #* [redacted] Date of Birth [redacted]

* The disclosure of your social security number is mandatory, it 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 Vermont 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 and that I understand providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant _____ Date

Residency Training Program(s) not completed - discontinued education, training, practice (Questions 14 and 15) - Attach documents

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances _____

_____

Affecting Health Care Institution Staff Privileges, Employment or Appointment (Question 16) - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances _____

_____

Privilege to prescribe controlled substances (Question 17) - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

_____

_____

_____

_____

Criminal Investigation - Proceeding (Questions 18 and 20) - Attach documents

Court _____

City and State _____

Charge _____

Description _____

_____

_____

Status _____

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

Withdrawal or denial of License (Questions 9 and 10) - Attach documents

State_____ Year_____
Circumstances under which license was withdrawn, denied, revoked, not renewed, or otherwise terminated_____

_____

Voluntarily surrendered or resigned a license to practice medicine or any healing art (Question 11) - Attach documents

State_____ Year_____

Circumstances_____

_____

Disciplinary charges or action (Question 12) - 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 of rights 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_____

_____

_____

Denial of examination privileges (Question 13) - Attach documents

State_____ Year_____

Circumstances under which examination privileges denied _____

_____

_____

Conviction? _____ Yes _____ No Date _____

Plea? _____ Yes _____ No Date _____

Medical condition, treatment, use of chemical or illegal substances (Questions 21-27)

Treating organization _____

Address _____Telephone _____

Type of diagnosis, condition or treatment - field of practice - use of chemical substances

_____

_____

Dates of illness of dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____Telephone _____

Contact person at Program _____

Investigation by any other licensing board (Question 19) - Attach documents

Name of Licensing Board_____ Date _____

Location of Licensing Board_____

Circumstances_____

Vermont Department of Health - Board of Medical Practice

SPECIALTY CODES LIST

(primary care specialties in boldface)

0101	Allergy and Immunology
0102	Clinical & Laboratory Immunology
0201	Anesthesiology
0202	Critical Care Medicine
0203	Pain Management
0301	Colon & Rectal Surgery
0401	Dermatology
0402	Dermatopathology
0403	Clinical & Laboratory Dermatology
0404	Dermatological Immunology
0501	Emergency Medicine
0502	Medical Toxicology
0503	Pediatric Emergency Medicine
0504	Sports Medicine
0601	**Family Practice**
0602	**Geriatric Medicine**
0603	Sports Medicine
0701	**Internal Medicine**
0702	**Adolescent Medicine**
0703	Cardiac Electrophysiology
0704	Cardiovascular Disease
0705	Critical Care Medicine
0706	Clinical & Lab Immunology
0707	Endocrinology Diabetes & Metabolism
0708	Gastroenterology
0709	**Geriatric Medicine**
0710	Hematology
0711	Infectious Disease
0712	Medical Oncology
0713	Nephrology
0714	Pulmonary Disease
0715	Rheumatology
0716	Sports Medicine
0801	Medical Genetics
0802	Clinical Biochemical Genetics
0803	Clinical Biochemical/Molecular Genetics
0804	Clinical Cytogenetics
0805	Clinical Genetics (Md)
0806	Clinical Molecular Genetics
0901	Neurological Surgery
0902	Critical Care Medicine
1001	Nuclear Medicine
1101	**Obstetrics & Gynecology**
1102	Critical Care Medicine
1103	Gynecologic Oncology
1104	Maternal & Fetal Medicine
1105	Reproductive Endocrinology
1201	Ophthalmology
1301	Orthopaedic Surgery
1302	Hand Surgery
1401	Otolaryngology
1402	Otology/Neurotology
1403	Pediatric Otolaryngology
1501	Anatomic & Clinical Pathology
1502	Anatomic Pathology
1503	Clinical Pathology
1504	Blood Banking/Transfusion Medicine
1505	Chemical Pathology
1506	Cytopathology
1507	Dermatopathology
1508	Forensic Pathology
1509	Hematology
1510	Immunopathology
1511	Medical Microbiology
1512	Neuropathology
1513	Pediatric Pathology
1601	**Pediatrics**
1602	**Adolescent Medicine**
1603	Clinical & Laboratory Immunology
1604	Medical Toxicology
1605	Neonatal-Perinatal Medicine
1606	Pediatric Cardiology
1607	Pediatric Critical Care Medicine
1608	Pediatric Emergency Medicine
1609	Pediatric Endocrinology
1610	Pediatric Gastroenterology
1611	Pediatric Hematology-Oncology
1612	Pediatric Infectious Disease
1613	Pediatric Nephrology
1614	Pediatric Pulmonology
1615	Pediatric Rheumatology
1616	Pediatric Sports Medicine
1617	Children with Special Health Needs
1701	Physical Medicine & Rehabilitation
1801	Plastic Surgery
1802	Hand Surgery
1901	Preventive Medicine
1902	Aerospace Medicine
1903	Occupational Medicine
1904	Public Health & General Preventive
1905	Medical Toxicology
1906	Underseas Medicine
	Psychiatry & Neurology (Board Name - Not A Specialty)
2001	Psychiatry
2002	Neurology
2003	Neurology With Special Qualifications In Child Neurology
2004	Addiction Psychiatry
2005	Child & Adolescent Psychiatry
2006	Forensic Psychiatry
2007	Geriatric Psychiatry
2008	Clinical Neurophysiology
2101	Radiology
2102	Diagnostic Radiology
2103	Radiation Oncology
2104	Radiological Physics
2105	Nuclear Radiology
2106	Pediatric Radiology
2107	Vascular & Interventional Radiology
2201	Surgery
2202	Surgery Of The Hand
2203	Pediatric Surgery
2204	Surgical Critical Care
2205	General Vascular Surgery
2301	Thoracic Surgery
2401	Urology
4001	Abdominal Surgery
4002	Acupuncture
4003	Addiction Medicine
4004	Adult Reconstructive Orthopedics
4005	Allergy
4006	Cardiovascular Surgery
4007	Clinical Pharmacology
4008	Diabetes
4009	Facial Plastic Surgery
4010	**General Practice**
4011	**Gynecology**
4012	Head & Neck Surgery
4013	Hepatology
4014	Homeopathic Medicine
4015	Immunology
4016	Legal Medicine
4017	Musculoskeletal Oncology
4018	Neuroradiology
4019	Nutrition
4020	**Obstetrics**
4021	Oral & Maxillofacial Surgery
4022	Orthopedic Surgery Of The Spine
4023	Orthopedic Trauma
4024	Pain Medicine
4025	Pediatric Allergy
4026	Pediatric Ophthalmology
4027	Pediatric Orthopedics
4028	Pediatric Surgery (Neurology)
4029	Pediatric Urology
4030	Psychoanalysis
4031	Radioisotopic Pathology
4032	Sports Medicine (Orthopedic Surgery)
4033	Traumatic Surgery
4034	Sleep Medicine
9001	Rotating Internship (Residency)
9999	Other - Please Specify

Pd $400 6

8297

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, PO Box 70
Burlington VT 05402-0070
802 657-4220 or 800-745-7371

2004 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

1. **Your legal name:** SHUMWAY, ALLEGRA LUCILLE

Last Name | First Name | Middle Name | Suffix

a. Have you ever legally changed your name? ___Yes _X_ No

If yes, enter your former name and any other name(s) under which you were licensed in Vermont or elsewhere in the past two years;

Last Name | First Name | Middle Name: | Suffix

b. Indicate your name, as it should appear on your license:

Last Name | First Name | Middle Name: | Suffix

RECEIVED NOV 3

2. **Your Date of Birth:** [redacted]

3. **Home Address:** [redacted]

4. **Work Address:** [redacted]

79 Coventry ST Suite 3
(Street)

Newport VT 05855
(City) (State) (Zip)

5. **Please check your preferred mailing address:** ____ **Home** _X_ **Work**
NOTE: ***The mailing address will be publicly listed on the Board's web site.***

6. **Home Telephone Number with Area Code:** [redacted]

7. Work Telephone Number with Area Code: (802) 334-5822

8. E-mail address: [redacted]

Please [illegible] may use this e-mail address to send you public health information.
☒ yes ☐ no

PART II

9. **Were you in active practice in Vermont in the past 12 Months?** ☒ yes ☐ no

10. **Do you hold, or have you ever held, a medical license in any other state?** ☐ yes ☒ no
If yes, complete the section below and attach additional pages if necessary.

None reported

State	License Number	Type of License	Date Issued	Status (Active or Inactive)

ANY "YES" RESPONSE TO THE QUESTIONS BELOW MUST BE FULLY EXPLAINED ON THE ENCLOSED FORM A.

11. **Have you ever applied for and been denied a license to practice medicine or any other healing art?**
☐ yes ☒ no

12. **Have you ever withdrawn an application for a license to practice medicine or any other healing art?**
☐ yes ☒ no

13. **Have you ever voluntarily suspended, surrendered or resigned a license to practice medicine or any other healing art in lieu of disciplinary action?**
☐ yes ☒ no

14. **Are any formal disciplinary charges pending or has any disciplinary action ever 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

15. **Have you ever been denied the privilege of taking an examination before any state medical examining board?**
☐ yes ☒ no

16. **Have you ever discontinued your education, training, or practice for a period of more than three months for reasons other than a family need?**
☐ yes ☒ no

17. **Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?**
☐ yes ☒ no

18. **Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?**
☐ yes ☒ no

19. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?

□ yes ☒ no

20. Are you presently or have you ever been a defendant in a criminal proceeding?

□ yes ☒ no

PART III

(Unless otherwise ordered by a court, your responses to the questions in Part III are considered exempt from public disclosure.)

Any "yes" response to the questions below must be fully explained on the enclosed Form A.

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

22. To your knowledge, are you presently the subject of a criminal investigation? [redacted]

The following definitions are provided to assist you in answering questions 23 through 25.

"Ability to practice medicine" - This term includes:

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, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as a licensee.

"Chemical substances" - This term 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.

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

23. Do you have a medical condition that in any way impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety? [redacted]

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have

participated or do participate in a monitoring program.

24. Are you currently engaged in the use of alcohol or other chemical substances that in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety?

[redacted]

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

25. Are you currently engaged in the illegal use of controlled substances?

[redacted]

In explaining a "Yes" answer on Form A, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine.

CONFIDENTIAL ASSISTANCE IS AVAILABLE

Since 1999, part of each license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a service of the Vermont Medical Society. This is a **confidential** program for the identification, treatment and rehabilitation of physicians affected by the disease of substance abuse. For further information about this program, call 802-223-0400 (a confidential line).

PART IV

The following questions are required by Vermont law, 26 VSA § 1368, to update and maintain a data repository within the Department of Health and to make individual profiles on all health care professionals licensed, certified, or registered by the Department available to the public. Your physician profile is located at the following website http://healthyvermonters.com/bmp/mbsearchform.shtml.

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 26 through 31 have changed since your last application. We cannot process your application without them.

26. **Criminal Convictions** [26 VSA § 1368(a)(1)] ☒ Check here if none

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past ten years not listed below. **Please provide complete copies of documentation for each matter.**

None reported

(Conviction Date)	(Court)	(City/State)	(Crime

27. **Nolo Contendere/Matters Continued** [26 VSA § 1368(a)(2)] ☒ Check here if none

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction not listed below. **Please provide complete copies of documentation for each matter.**

None reported

(Conviction Date) (Court) (City/State) (Charge)

28. **Vermont Board of Medical Practice Matters** [26 VSA § 1368(a)(3)] ☒ Check here if none

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed.
None reported

(Date) (Final Disposition - Summary)

29. **Licensing or Certification Authority Matters in Other States** [26 VSA § 1368(a)(4)]
☒ Check here if none

Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states, if not listed below. **Please provide complete copies of documentation for each matter.**
None reported

(Date of Final Disposition) (Licensing or Certification Authority) (Court) (City/State) (Nature of Charge)

30. **Restriction of Hospital Privileges** [26 VSA § 1368(a)(5)]

A. **Revocation/Involuntary Restrictions** ☒ Check here if none

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you if not listed below. **Please provide complete copies of documentation for each matter.**
None reported

(Date) (Hospital) (State) (Nature of Restriction) (Reason for Restriction)

B. **Other Restrictions** ☒ Check here if none

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital if not listed below. **Please provide complete copies of documentation for each matter.**
None reported

(Date) (Hospital) (State)

(Nature of Action) (Action)

In lieu In settlement

(Reason for Action)

31. **Medical Malpractice Court Judgments/Settlements** [26 VSA § 1368(a)(6A)]

A. **Judgments** ☒ Check here if none

Please complete the attached Form A and provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you within the past 10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. **Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.**

Judgement Arbitration
None reported

(Date) (Court) (State) (Nature of Case) (Amount Assessed Against You)

B. **Settlements** ☒ Check here if none

Please provide a description of all settlements of medical malpractice claims against you within the past 10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. **Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.**

(Date) (Court) (State) (Amount of Settlement Against You)

32. **Medical Professional Schools** [26 VSA § 1368(a)(7)]

Please provide the names of medical professional schools you attended and the dates of graduation if not listed below.

UNIVERSITY OF VERMONT, VT

1988

(School/Institution) (City) (State) (Year of Graduation)

If necessary, please use an additional sheet and check this box: .....☐

33. **Graduate Medical Education/Residency** [26 VSA § 1368(a)(8)]

Please provide information about any graduate medical education/residency attended or completed that is not listed below.

Fletcher Allen Health Care ,VT

Family Practice

1991

(School/Institution) (Specialty) (City) (State) (Year of Graduation)

If necessary, please use an additional sheet and check this box: .....☐

34. **Specialty Board Certification** [26 VSA § 1368(a)(9)]

Please verify the following information regarding your specialty board certification and update as necessary using the attached Specialty Codes List.

Family Practice
American Board of Family Practice
1991, 1998

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
		☐ yes ☐ no			
		☐ yes ☐ no			

35. **Years of Practice** [26 VSA § 1368(a)(10)]

Month and year you started practicing as a physician? 7//1991

36. **Hospital Privileges** [26 VSA § 1368(a)(11)] ☐ Check here if none

List all information for all hospitals where you currently have hospital staff privileges if not listed below:

None reported

(Name) (City) (State) (Year Started)

37. **Appointments/Teaching** [26 VSA § 1368(a)(12)]

Note: Answering #37 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

A. Appointments ☐ Check here if none

Please provide information about your appointments to medical school or professional school faculties if not listed.

None reported

(School) (City) (State) (Nature of Appointment) From (year) To (year)

B. Teaching ☐ Check here if none

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years if not listed.

None reported

(School/Institution) (City) (State) (Nature of Teaching) From (year) To (year)

38. **Publications:** [26 VSA § 1368(a)(13)] □ Check here if none

Note: Answering #36 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years if not listed.

None reported

(Title) (Publication) (Year)

39. **Activities** [26 VSA § 1368(a)(14)] □ Check here if none

Note: Answering #39 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your professional or community service activities and awards if not listed.

None reported

(Activities or Awards)

40. **Practice Setting** [26 VSA § 1368(a)(15)] □ Check here if none

What is the location of your primary practice setting? NEWPORT, VT

Town or City State

41. **Translating Services** [26 VSA § 1368(a)(16)] □ Check here if none

Please identify any translating services available at your primary practice location.
Are any translating services available at your primary practice location? □ Not applicable

If yes, please describe here the translating services available:

None

If necessary, please use an additional sheet and check this box: .....□

42. **Medicaid/New Patients** [26 VSA § 1368(a)(17)]

A. **Medicaid participation**

Do you participate in the Medicaid program? ☒ yes □ no □ not applicable

B. **New Medicaid Patients**

Are you currently accepting new Medicaid patients? ☒ yes □ no □ not applicable

Part V

I hereby affirm that the information provided above is true and accurate, and that I have answered the questions to the best of my knowledge and ability.

Date: Nov 1, 2004

Applicant's Signature

Reminder - You must also complete the enclosed Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions regardless of whether or not you have children

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

(Questions 11 and 12) Withdrawal or denial of License - Attach documents

State_____ Year_____
Circumstances under which license was withdrawn, denied, revoked, not renewed, or otherwise terminated_____

_____

(Question 13) Voluntarily surrendered or resigned a license to practice medicine or any healing art - Attach documents

State_____ Year_____

Circumstances_____

_____

(Question 14) Disciplinary charges or action - 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 of rights 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_____

_____

_____

(Question 15) Denial of examination privileges - Attach documents

State_____ Year_____

Circumstances under which examination privileges denied _____

_____

_____

(Questions 16 and 17) Residency Training Program(s) not completed - discontinued education, training, practice - Attach documents

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances _____

_____

(Question 18) Affecting Health Care Institution Staff Privileges, Employment or Appointment - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances _____

_____

(Question 19) Privilege to prescribe controlled substances - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

_____

_____

_____

_____

(Questions 20 and 22) Criminal Investigation - Proceeding - Attach documents

Court _____

City and State _____

Charge _____

Description _____

_____

_____

Status _____

_____

Conviction? _____ Yes _____ No Date _____

Plea? _____ Yes _____ No Date _____

(Question 21) Investigation by any other licensing board - Attach documents

Name of Licensing Board_____ Date _____

Location of Licensing Board_____

Circumstances_____

(Questions 23-25) Medical condition, treatment, use of chemical or illegal substances

Treating organization _____

Address _____Telephone _____

Type of diagnosis, condition or treatment - field of practice - use of chemical substances

_____

_____

Dates of illness or dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____Telephone _____

Contact person at Program _____

(Question 31) Medical Malpractice Claim

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):

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

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 or 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 appeal filed (month, day, year) _____/_____/_____
Date appeal 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 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:

Vermont Department of Health - Board of Medical Practice
APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

You must answer questions 1, 2, and 3.

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 dues 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 regarding taxes:

☒ I hereby certify, under the pains and penalties or 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".

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 three 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 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.

or

☒ I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #* [redacted] Date of Birth [redacted]

* The disclosure of your social security number is mandatory, it 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 Vermont 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 and that I understand providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant _____ Date Nov 1, 2004

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, PO Box 70
Burlington VT 05402-0070
802 657-4220 or 800-745-7371

2006 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

License Number: 042-0008297

1. **Your legal name:**

   Allegra Lucille Shumway

   a. Have you ever legally changed your name? ___Yes _X_ No

   If yes, enter your former name and any other name(s) under which you were licensed in Vermont or elsewhere in the past two years;

   Last Name | First Name | Middle Name: | Suffix

   b. Indicate your name, as it should appear on your license:

   Shumway, Allegra Lucille
   Last Name | First Name | Middle Name: | Suffix

RECEIVED
NOV 17 2006
Vermont Board of Medical Practice

2. **Your Date of Birth:** [redacted]

3. **Home Address and email address:** [redacted]

4. **Work Address:**

   PO Box 932
   79 Coventry Street Suite 3
   NEWPORT VT 05855
   [redacted]

5. **Please check your preferred mailing address:** ____ **Home** _X_ **Work**
   NOTE: ***The mailing address will be publicly listed on the Board's web site.***

6. **Home Telephone Number with Area Code:** [redacted]

7. **Work Telephone Number with Area Code:** (802) 334-5822

8. **E-mail address (if not appearing in #3):** [redacted]

Please check here if the Department of Health may use this e-mail address to send you public health information.
☒ yes ☐ no

PART II

9. Were you in active practice in Vermont in the past 12 Months? ☒ yes ☐ no

10. Do you hold, or have you ever held, a medical license (including temporary) in any other state?
☐ yes ☒ no

If yes, complete the section below and attach additional pages if necessary.

State	License Number	Type of License	Date Issued	Status (Active, Inactive, or other, e.g. conditioned, restricted, limited)
None reported				

ANY "YES" RESPONSE TO THE QUESTIONS BELOW MUST BE FULLY EXPLAINED ON THE ENCLOSED FORM A.

11. Have you ever applied for and been denied a license to practice medicine or any other healing art?
☐ yes ☒ no

12. Have you ever withdrawn an application for a license to practice medicine or any other healing art?
☐ yes ☒ no

13. Have you ever voluntarily suspended, surrendered or resigned a license to practice medicine or any other healing art in lieu of disciplinary action?
☐ yes ☒ no

14. Are any formal disciplinary charges pending or has any disciplinary action ever 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

15. Have you ever been denied the privilege of taking an examination before any state medical examining board?
☐ yes ☒ no

16. Have you ever discontinued your education, training, or practice for a period of more than three months for reasons other than a family need?
☐ yes ☒ no

17. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?
☐ yes ☒ no

18. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?
☐ yes ☒ no

19. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?
☐ yes ☒ no

20. Are you presently or have you ever been a defendant in a criminal proceeding?

□ yes ☒ no

PART III

(Unless otherwise ordered by a court, your responses to the questions in Part III are considered exempt from public disclosure.)

Any "yes" response to the questions below must be fully explained on the enclosed Form A.

21. To your knowledge, are you the subject of an investigation by any other licensing board as of the date of this application?

[redacted]

22. To your knowledge, are you presently the subject of a criminal investigation?

[redacted]

The following definitions are provided to assist you in answering questions 23 through 25.

"Ability to practice medicine" - This term includes:

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, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as a licensee.

"Chemical substances" - This term 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.

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

23. Do you have a medical condition that in any way impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?

[redacted]

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

24. Are you currently engaged in the use of alcohol or other chemical substances that in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety?

[redacted]

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

25. Are you currently engaged in the illegal use of controlled substances?

[redacted]

CONFIDENTIAL ASSISTANCE IS AVAILABLE

Since 1999, part of each license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a service of the Vermont Medical Society. This is a **confidential** program for the identification, treatment and rehabilitation of physicians affected by the disease of substance abuse. For further information about this program, call 802-223-0400 (a confidential line).

PART IV

The following questions are required by Vermont law, 26 VSA § 1368, to update and maintain a data repository within the Department of Health and to make individual profiles on all health care professionals licensed, certified, or registered by the Department available to the public. Your physician profile is located at the following website http://healthvermont.gov.

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 26 through 31 have changed since your last application. We cannot process your application without them.

26. **Criminal Convictions** [26 VSA § 1368(a)(1)] ☒ Check here if none

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past ten years not listed below. **Please provide complete copies of documentation for each matter.**

None reported

(Conviction Date)	(Court)	(City/State)	(Crime)

27. **Nolo Contendere/Matters Continued** [26 VSA § 1368(a)(2)] ☒ Check here if none

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction not listed below. **Please provide complete copies of documentation for each matter.**

None reported

(Conviction Date)	(Court)	(City/State)	(Charge)

28. **Vermont Board of Medical Practice Matters** [26 VSA § 1368(a)(3)] ☒ Check here if none

Allegra Summary

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed.

None reported

(Date) (Final Disposition - Summary)

29. **Licensing or Certification Authority Matters in Other States** [26 VSA § 1368(a)(4)]

☑ Check here if none

Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states, if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

(Date of Final Disposition)(Licensing or Certification Authority) (Court) (City/State) (Nature of Charge)

30. **Restriction of Hospital Privileges** [26 VSA § 1368(a)(5)]

A. **Revocation/Involuntary Restrictions**

☑ Check here if none

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

(Date) (Hospital) (State) (Nature of Restriction) (Reason for Restriction)

B. **Other Restrictions**

☑ Check here if none

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

(Date) (Hospital) (State)

(Nature of Action) (Action)

(Reason for Action)

☐ In lieu ☐ In settlement

31. **Medical Malpractice Court Judgments/Settlements** [26 VSA § 1368(a)(6A)]

A. **Judgments**

☑ Check here if none

Please complete the attached Form A and provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you within the past

Allegra Shumway

10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. **Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.**

None reported

☐ Judgement ☐ Arbitration

(Date)	(Court)	(State)	(Nature of Case)	(Amount Assessed Against You)

B. **Settlements** ☒ Check here if none AS 11/21/06

Please provide a description of all settlements of medical malpractice claims against you within the past 10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. **Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.**

None reported

(Date)	(Court)	(State)	(Amount of Settlement Against You)

32. **Medical Professional Schools** [26 VSA § 1368(a)(7)]

Please provide the names of medical professional schools you attended and the dates of graduation if not listed below.

UNIVERSITY OF VERMONT, Burlington, VT

1988

33. **Graduate Medical Education/Residency** [26 VSA § 1368(a)(8)]

Please provide information about any graduate medical education/residency attended or completed that is not listed below.

Fletcher Allen Health Care ,VT

Family Practice

1991

(School/Institution)	(Specialty)	(City)	(State)	(Year of Graduation)
(School/Institution)	(Specialty)	(City)	(State)	(Year of Graduation)

If necessary, please use an additional sheet and check this box: .....☐

34. **Specialty Board Certification** [26 VSA § 1368(a)(9)]

Please verify the following information regarding your specialty board certification and update as necessary using the attached Specialty Codes List.

Family Practice
American Board of Family Practice
1991, 1998, 2005

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
0601		☒ yes ☐ no	American Board of Family Practice	1991	1998, 2005
		☐ yes ☐ no			

35. **Years of Practice** [26 VSA § 1368(a)(10)]

Month and year you started practicing as a physician? **7//1991**

36. **Hospital Privileges** [26 VSA § 1368(a)(11)] ☒ Check here if none

List all information for all hospitals where you currently have hospital staff privileges if not listed below:

None reported

(Name) (City) (State) (Year Started)

37. **Appointments/Teaching** [26 VSA § 1368(a)(12)]

Note: Answering #37 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

A. Appointments ☒ Check here if none

Please provide information about your appointments to medical school or professional school faculties if not listed.

None reported

(School) (City) (State) (Nature of Appointment) From (year) To (year)

B. Teaching ☐ Check here if none

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years if not listed.

None reported

(School/Institution) (City) (State) (Nature of Teaching) From (year) To (year)

38. **Publications:** [26 VSA § 1368(a)(13)] ☒ Check here if none

Note: Answering #38 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years if not listed.

(Title) (Publication) (Year)

(Title) (Publication) (Year)

(Title) (Publication) (Year)

39. **Activities** [26 VSA § 1368(a)(14)] ☐ Check here if none

Note: Answering #39 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your professional or community service activities and awards if not listed.

None reported

(Activities or Awards)

(Activities or Awards)

(Activities or Awards)

40. **Practice Setting** [26 VSA § 1368(a)(15)] ☐ Check here if none

What is the location of your primary practice setting? **NEWPORT, VT**

41. **Translating Services** [26 VSA § 1368(a)(16)] ☐ Check here if none

Please identify any translating services available at your primary practice location.
Are any translating services available at your primary practice location? ☐ Not applicable

If yes, please describe here the translating services available:

Competent language interpreters, including American Sign Language ~~None~~ available at no cost to patient. We have a contract with a telephone interpreter service to translate and interpret if no local interpreter is available

If necessary, please use an additional sheet and check this box: .....☐

42. **Medicaid/New Patients** [26 VSA § 1368(a)(17)]

A. **Medicaid participation**

Do you participate in the Medicaid program? ☒ yes ☐ no ☐ not applicable

B. **New Medicaid Patients**

Are you currently accepting new Medicaid patients? ☒ yes ☐ no ☐ not applicable

Part V

I hereby affirm that the information provided above is true and accurate, and that I have answered the questions to the best of my knowledge and ability.

Date: 11/16/06

Applicant's Signature

Vermont Department of Health - Board of Medical Practice
APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

You must answer questions 1, 2, and 3.

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 dues 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 regarding taxes:

☒ I hereby certify, under the pains and penalties or 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".

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 three 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 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.

or

☒ I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #* [redacted] Date of Birth [redacted]

* The disclosure of your social security number is mandatory, it 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 Vermont 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 and that I understand providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant _____ Date 11/16/06

VERMONT

042-0008297
Allegra Lucille Shumway, MD
PO Box 932
79 Coventry Street Suite 3
Newport, VT 05855

Department of Health
Board of Medical Practice
108 Cherry Street - P. O. Box 70
Burlington, VT 05402-0070
healthvermont.org

[phone] 802-657-4220
[toll free] 800-745-7371
[fax] 802-657-4227

Agency of Human Services

RECEIVED
NOV 22 2006
Vermont Board of Medical Practice

Date: November 17, 2006

Dear Physician:

Your 2006 Physician's License Renewal application has been received by this office and cannot be processed until the following information is received.

- ☐ $450 renewal fee

Application

Part I
- ☐ Item 1
- ☐ Item 2
- ☐ Item 3
- ☐ Item 4
- ☐ Item 5
- ☐ Item 6
- ☐ Item 7
- ☐ Item 8

Part II
- ☐ Item 9
- ☐ Item 10
- ☐ Item 11
- ☐ Item 12
- ☐ Item 13
- ☐ Item 14
- ☐ Item 15
- ☐ Item 16
- ☐ Item 17
- ☐ Item 18
- ☐ Item 19
- ☐ Item 20

Part III
- ☐ Item 21
- ☐ Item 22
- ☐ Item 23
- ☐ Item 24
- ☐ Item 25

Part IV
- ☐ Item 26
- ☐ Item 27
- ☐ Item 28
- ☐ Item 29
- ☐ Item 30A
- ☐ Item 30B
- ☐ Item 31A
- ☑ Item 31B
- ☐ Item 32
- ☐ Item 33
- ☐ Item 34
- ☐ Item 35
- ☐ Item 36
- ☐ Item 37A
- ☐ Item 37B
- ☐ Item 38
- ☐ Item 39
- ☐ Item 40
- ☐ Item 41
- ☐ Item 42A
- ☐ Item 42B

Part V
- ☐ Date
- ☐ Signature

Child Support, Taxes, Unemployment Compensation Statement
- ☐ Number 1 – check one of the two statements
- ☐ Number 2 – check one of the two statements
- ☐ Number 3 – check one of the three statements

Completed Form A
- ☐ Completed form

The page(s) that needs completion (if applicable) is attached. Please complete the necessary item, initial, date and return as soon as possible so that processing may be finalized.

Thank you.

Sincerely,

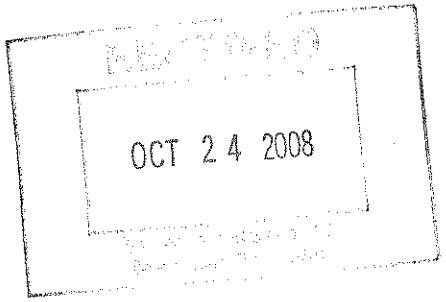
Medical Practice Board
(802) 657-4220 or (800) 745-7371

Enclosures

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, PO Box 70
Burlington VT 05402-0070
802 657-4220 or 800-745-7371

2008 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I



License Number: 042-0008297

1. **Your legal name:**

   Allegra Lucille Shumway

   a. Have you ever legally changed your name? ___Yes _X_ No

   If yes, enter your former name and any other name(s) under which you were licensed in Vermont or elsewhere in the past two years;

Last Name	First Name	Middle Name:	Suffix

   b. Indicate your name, as it should appear on your license:

Last Name	First Name	Middle Name:	Suffix
Shumway	Allegra	Lucille	

2. **Your Date of Birth:** [redacted]

3. **Home Address and email address:** [redacted]

4. **Work Address:** 357 Western Ave Suite 101 St Johnsbury VT 05819 [redacted]

5. **Please check your preferred mailing address:** ____ **Home** _X_ **Work**
   NOTE: ***The mailing address will be publicly listed on the Board's web site.***

6. **Home Telephone Number with Area Code:** [redacted]

7. **Work Telephone Number with Area Code:** (802) 748-8194

8. **E-mail address (if not appearing in #3):**

Please check here if the Department of Health may use this e-mail address to send you public health information.

☒ yes ☐ no

PART II

9. Were you in active clinical practice in Vermont in the past 12 Months? ☒ yes ☐ no

10. Do you hold, or have you ever held, a medical license (including temporary) in any other state?
☒ yes ☐ no

If yes, complete the section below and attach additional pages if necessary.

State	License Number	Type of License	Date Issued	Status (Active, Inactive, or other, conditioned, restricted, limited)
NH	None reported	locum tenens	2008	expired

If necessary, please use an additional sheet and check this box: .....☐

11. Medical Professional Schools [26 VSA § 1368(a)(7)]

Please provide the names of medical professional schools you attended and the dates of graduation if not listed below.

UNIVERSITY OF VERMONT, Burlington, VT
1988

12. Graduate Medical Education/Residency [26 VSA § 1368(a)(8)]

Please provide information about any graduate medical education/residency attended or completed that is not listed below.

Fletcher Allen Health Care ,VT
Family Practice
1991

If necessary, please use an additional sheet and check this box: .....☐

13. Specialty Board Certification [26 VSA § 1368(a)(9)]

Please verify the following information regarding your specialty board certification and update as necessary using the attached Specialty Codes List.

Family Practice
American Board of Family Practice
1991, 1998

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
		☐ yes ☐ no			
		☐ yes ☐ no			

14. Years of Practice [26 VSA § 1368(a)(10)]

Month and year you started practicing as a physician? 7//1991

15. Hospital Privileges [26 VSA § 1368(a)(11)] ☒ Check here if none

List all information for all hospitals where you currently have hospital staff privileges if not listed below:

None reported

ANY "YES" RESPONSE TO THE QUESTIONS BELOW MUST BE FULLY EXPLAINED ON THE ENCLOSED FORM A.

16. Have you ever applied for and been denied a license to practice medicine or any other healing art?

□ yes ☒ no

17. Have you ever withdrawn an application for a license to practice medicine or any other healing art?

□ yes ☒ no

18. Have you ever voluntarily suspended, surrendered or resigned a license to practice medicine or any other healing art in lieu of disciplinary action or any other reason?

□ yes ☒ no

19. Are any formal disciplinary charges pending or has any disciplinary action ever 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

20. Have you ever been denied the privilege of taking an examination before any state medical examining board?

□ yes ☒ no

21. Have you ever discontinued your education, training, or clinical practice for a period of more than three months?

□ yes ☒ no

22. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?

□ yes ☒ no

23. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?

□ yes ☒ no

24. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?

□ yes ☒ no

25. Do you currently or have you ever prescribed any prescription medication over the internet?

□ yes ☒ no

26. Are you presently or have you ever been a defendant in a criminal proceeding?

□ yes ☒ no

PART III

(Unless otherwise ordered by a court, your responses to the questions in Part III are considered exempt from public disclosure.)

Any "yes" response to the questions below must be fully explained on the enclosed Form A.

27. To your knowledge, are you the subject of an investigation by any other licensing board under which you have not been charged as of the date of this application?

[redacted]

28. To your knowledge, are you presently the subject of a criminal investigation under which you have not been charged?

[redacted]

The following definitions are provided to assist you in answering questions 29 through 31.

"Ability to practice medicine" - This term includes:

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, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as a licensee.

"Chemical substances" - This term 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.

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

29. Do you have a medical condition that potentially or in any way impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?

[redacted]

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

30. Are you currently engaged in the use of alcohol or other chemical substances that potentially or in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety?

[redacted]

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

31. Are you currently engaged in the illegal use of controlled substances?

[redacted]

CONFIDENTIAL ASSISTANCE IS AVAILABLE

Since 1999, part of each license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a service of the Vermont Medical Society. This is a **confidential** program for the identification, treatment and rehabilitation of physicians affected by the disease of substance abuse. For further information about this program, call 802-223-0400 (a confidential line).

PART IV

The following questions are required by Vermont law, 26 VSA § 1368, to update and maintain a data repository within the Department of Health and to make individual profiles on all health care professionals licensed, certified, or registered by the Department available to the public. Your physician profile is located at the following website http://healthvermont.gov.

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 32 through 37 have changed since your last application. We cannot process your application without them.

32. **Criminal Convictions** [26 VSA § 1368(a)(1)] ☒ Check here if none

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past ten years not listed below. **Please provide complete copies of documentation for each matter.**

None reported

33. **Nolo Contendere/Matters Continued** [26 VSA § 1368(a)(2)] ☒ Check here if none

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction not listed below. **Please provide complete copies of documentation for each matter.**

None reported

34. **Vermont Board of Medical Practice Matters** [26 VSA § 1368(a)(3)] ☒ Check here if none

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed.

None reported

35. **Licensing or Certification Authority Matters in Other States** [26 VSA § 1368(a)(4)]
☒ Check here if none

Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states, if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

36. **Restriction of Hospital Privileges** [26 VSA § 1368(a)(5)]

A. **Revocation/Involuntary Restrictions** ☒ Check here if none

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

B. **Other Restrictions** ☒ Check here if none

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

37. **Medical Malpractice Court Judgments/Settlements** [26 VSA § 1368(a)(6A)]

A. **Judgments** ☒ Check here if none

Please complete the attached Form A and provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you within the past 10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. **Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.**

None reported

B. **Settlements** ☒ Check here if none

Please provide a description of all settlements of medical malpractice claims against you within the past 10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. **Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.**

None reported

38. **Appointments/Teaching** [26 VSA § 1368(a)(12)]

Note: Answering #38 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

A. Appointments ☒ Check here if none

Please provide information about your appointments to medical school or professional school faculties if not listed.

None reported

B. Teaching ☒ Check here if none

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years if not listed.

None reported

39. **Publications:** [26 VSA § 1368(a)(13)] □ Check here if none

Note: Answering #39 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years if not listed.

40. **Activities** [26 VSA § 1368(a)(14)] □ Check here if none

Note: Answering #40 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your professional or community service activities and awards if not listed.

None reported

41. **Practice Setting** [26 VSA § 1368(a)(15)] □ Check here if none

What is the location of your primary practice setting?

~~NEWPORT, VT~~ St. Johnsbury, VT

42. **Translating Services** [26 VSA § 1368(a)(16)] □ Check here if none

Please identify any translating services available at your primary practice location.
Are any translating services available at your primary practice location?

If yes, please describe here the translating services available:

~~None~~ Translating services available upon request

43. **Medicaid/New Patients** [26 VSA § 1368(a)(17)]

A. **Medicaid participation**

Do you participate in the Medicaid program? ☒ yes □ no

B. **New Medicaid Patients**

Are you currently accepting new Medicaid patients? ☒ yes □ no

Part V

Reminder - You must also complete the enclosed Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions regardless of whether or not you have children

I hereby affirm that the information provided above is true and accurate, and that I have answered the questions to the best of my knowledge and ability.

Date: 9/29/08 _____
Applicant's Signature

Physician Profile Update

26 VSA § 1368 requires the Department to provide you with a copy of your profile prior to the initial release to the public and each time your profile is modified or amended. We intend to use the information in your renewal application for your physician profile.

Please let us know whether you wish to have your profile omit the following information by checking the "OMIT" box below. If the box is not checked, we will include the information in your profile:

OMIT FROM PROFILE

- ☐ Appointments to medical school or professional school faculties, and an indication as to whether you have had a responsibility for teaching graduate medical education within the last 10 years.
- ☐ Information regarding publications in peer-reviewed medical literature within the last 10 years.
- ☐ Information regarding professional or community service activities and awards.

Again, thank you for your cooperation.

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

(Questions 16 and 17) Withdrawal or denial of License - Attach documents

State_____ Year_____
Circumstances under which license was withdrawn, denied, revoked, not renewed, or otherwise terminated_____

_____

(Question 18) Voluntarily surrendered or resigned a license to practice medicine or any healing art - Attach documents

State_____ Year_____

Circumstances_____

_____

(Question 19) Disciplinary charges or action - 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 of rights 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_____

_____

_____

(Question 20) Denial of examination privileges - Attach documents

State_____ Year_____

Circumstances under which examination privileges denied _____

_____

_____

(Questions 21 and 22) Residency Training Program(s) not completed - discontinued education, training, practice - Attach documents

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances _____

_____

(Question 23) Affecting Health Care Institution Staff Privileges, Employment or Appointment - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances _____

_____

(Question 24) Privilege to prescribe controlled substances - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

_____

_____

_____

(Question 25) Internet prescribing

Please provide a general description of your practice of internet prescribing

_____

_____

(Questions 26 and 28) Criminal Investigation - Proceeding - Attach documents

Court _____

City and State _____

Charge _____

Description _____

_____

_____

Status _____

_____

Conviction? _____ Yes _____ No Date _____

Plea? _____ Yes _____ No Date _____

(Question 27) Investigation by any other licensing board - Attach documents

Name of Licensing Board _____ Date _____

Location of Licensing Board _____

Circumstances _____

(Questions 29-30) Medical condition, treatment, use of chemical or illegal substances

Treating organization _____

Address _____ Telephone _____

Type of diagnosis, condition or treatment - field of practice - use of chemical substances

_____

_____

Dates of illness or dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____ Telephone _____

Contact person at Program _____

(Question 37) Medical Malpractice Claim

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):

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

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 or 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 appeal filed (month, day, year) _____/_____/_____
Date appeal 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 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:

_____

_____

_____

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

You must answer questions 1, 2, and 3.

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 dues 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 shall 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 and payable and all returns have been filed, 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 regarding taxes:

☒ I hereby certify, under the pains and penalties or 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".

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 three 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 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.

or

☒ I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #* [redacted] Date of Birth [redacted]

* The disclosure of your social security number is mandatory, it 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 Vermont 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 and that I understand providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant _____ Date 9/29/08

State of Vermont

Department of Health

Board of Medical Practice

Statement of Good Standing

Regarding Any Unpaid Judgment Issued by the Judicial Bureau or District Court for Fines or Penalties for a Violation or Criminal Offense

I hereby state that I am in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense.

I understand that a license may not be issued or renewed without such a statement.

I further understand that, for the purposes of this section, a person is in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense if:

(1) 60 days or fewer have elapsed since the date a judgment was issued; or

(2) the person is in compliance with a repayment plan approved by the judiciary.

Date: 9/29/08

PLEASE NOTE:

In accordance with 4 V.S.A. § 1110 (b), you must sign, date, and return this **Statement of Good Standing** in order for us to renew your license. Thank you.

Renewal - 042.0008297

Name	Allegra Lucille Shumway
Credential	042.0008297

Fee Details

Renewal	$500.00
	$500.00

Renewal Introduction

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
(802)657-4220 or 800-745-7371

PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

Please follow the instructions below and submit the completed application with documentation and payment to this office. If you have any questions or need additional information do not hesitate to contact us at 802-657-4220, 800-745-7371 or medicalboard@state.vt.us.

IMORTANT: Your license will lapse if we have not received your completed application and fee by your expiration date. In addition, you will be subject to late renewal penalty fees and potentially liability if you practice medicine without a license.

INSTRUCTIONS

- enter, correct or update all information
- answer all questions completely, even if you believe the information is already on file with the Board
- use Form A to provide explanations to Malpractice
- do not delegate this important task to any other person. False statements on this application may be grounds for charges of unprofessional conduct.

Be sure to submit:

- completed application
- completed Form A, if applicable
- payment in the amount of $500 to the **Vermont Department of Health**
- ***LATE FEE:*** Applications received after the license expiration date will be assessed a $25 late fee.

Please Note:

- Your Physician License Renewal Application has been pre-populated with information provided by and previously approved by you prior to the initial release of the Department's physician profiles. Please take this opportunity to correct any factual inaccuracies and/or update any information as appropriate.
- Licensees have a continuing obligation during each two-year renewal period to promptly notify the Board of any change or new information including, but not limited to, disciplinary or other action limiting or conditioning their license or ability to practice in any jurisdiction. Failure to do so may subject the licensee to disciplinary action by the Board.

Thank you.

Renewal Part I

Name:
Indicate your full legal name (use no initials). If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Last Name:
   Shumway

2. First Name:
Allegra

3. Middle Name:
Lucille

4. Have you ever legally changed your name?
No

5. If yes, enter your former name and other name(s):

Previous Name	From Month	From Year	To Month	To Year	Reason for Change

6. Date of Birth:
[redacted]

7. Enter your MAILING ADDRESS information:

Attention
Street [redacted]
City [redacted] **State** [redacted] **Zip** [redacted] **Country** United States
E-mail Address [redacted]
Telephone **Alternate Phone (e.g. Pager)**

8. Enter your PUBLIC ACCESS address information:

Attention
Street 90 Washington St.
City Barre **State** VT **Zip** 05641
Country United States
Telephone
E-mail Address
Alternate Phone (e.g. Pager)

Renewal Part II

9. Were you in active clinical practice in the past 12 months?
Yes

10. Do you hold, or have you ever held, a license or certification as a medical practitioner in any other state?
Yes

11. If yes, complete the section below.

State	Profession	License Number	Issue Date	Expiration Date	Status
New Hampshire	MD	14395	01/04/2009	06/30/2013	Active

12. Medical Professional Schools [26 VSA § 1368(a)(7)]
Please provide the names of medical professional schools you attended and the dates of graduation.

School	Graduation Date
School Name: University of Vermont **State**: Vermont **Country**: United States **School Type**: Medical School **Degree**: MD	01/01/1988

13. Graduate Medical Education/Residency [26 VSA § 1368(a)(8)]
Please provide information about any graduate medical education/residency attended or completed that is not listed below.

Site Name	End Date	Specialty
Fletcher Allen Health Care	07/01/1991	Family Practice

14. Specialty Board Certification [26 VSA § 1368(a)(9)]
Please verify the following information regarding your specialty board certification and update as necessary.

Specialty	Certification Board	Certification Date	Specialty Expiration Date
Family Practice	American Board of Family Practice	01/01/1998	12/31/2015
Family Practice	American Board of Family Practice	01/01/1991	01/01/1998

15. **Years of Practice**
What year did you start practicing as a medical professional?
1991

16. **Hospital Privileges** [See 26 VSA § 1368(a)(11)]
List all hospitals where you currently have hospital staff privileges:

Facility Name	State	Start Date
None reported		

ANY "YES" RESPONSE TO THE QUESTIONS BELOW MUST BE FULLY EXPLAINED.

17. Have you ever applied for and been denied a certificate to practice medicine or any other healing art?
No

18. State:

19. Year:

20. Circumstances under which you applied and were denied a certificate to practice medicine or any other healing art:

21. Denied certificate to practice medicine or any other healing art - Upload documents

22. Have you ever withdrawn an application for a certificate to practice medicine or any other healing art?
No

23. State:

24. Year:

25. Circumstances under which license or certificate was withdrawn, denied, revoked, not renewed, or otherwise terminated:

26. Please upload any documents you have that are relevant to this matter.

27. Have you ever voluntarily surrendered or resigned a license or certificate to practice medicine or any other healing art in lieu of disciplinary action or any other reason?
No

28. State:

29. Year:

30. Circumstances:

31. Please upload any documents you have that are relevant to this matter.

32. Are any formal disciplinary charges pending or has any disciplinary action ever 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)?
No

33. Name of organization involved:

34. Date:

35. Duration:

36. Action Taken (add all that apply):

37. Circumstances:

38. Please upload any documents you have that are relevant to this matter.

39. Have you ever been denied the privilege of taking an examination before any state medical examining board?
No

40. State:

41. Year:

42. Circumstances under which examination privileges denied:

43. Please upload any documents you have that are relevant to this matter.

44. Have you ever discontinued your education, training, or clinical practice for a period of more than three (3) months NOT including premedical education?
No

45. If yes, please explain and include the dates over which your education, training, or clinical practice was discontinued:

46. Discontinued Education, Training, or Clinical Practice - Upload documents:

47. Have you ever been dismissed or suspended from, or asked to leave a training program before completion?
No

48. Training program(s):

49. Location of program(s):

50. Year:

51. Circumstances:

52. Please upload any documents you have that are relevant to this matter.

53. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?
No

54. Institution involved:

55. Location:

56. Year:

57. Circumstances:

58. Please upload any documents you have that are relevant to this matter.

59. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?
No

60. Name of organization involved:

61. Type of restriction:

62. Date:

63. Circumstances of restriction

64. Please upload any documents you have that are relevant to this matter.

65. Do you currently, or have you ever, prescribed any prescription medication over the internet? This does not include any prescribing you would do using electronic medical records in your practice.
No

66. Please provide a general description of your practice of internet prescribing:

67. Are you presently, or have you ever been, a defendant in a criminal proceeding?
No

68. Court:

69. City and state:

70. Charge:

71. Description:

72. Status:

73. Date:

Renewal Part III

PART III

(Unless otherwise ordered by a court, your responses to the questions in Part III are considered exempt from public disclosure.)

Any "yes" response to the questions below must be fully explained.

74. To your knowledge, are you the subject of an investigation by any other licensing or certification board under which you have not been charged as of the date of this application?

75. Licensing or certification board:

76. Date:

77. Location of Licensing Board:

78. Circumstances:

79. Please upload any documents you have that are relevant to this matter.

MEDICAL DEFINITIONS

The following definitions are provided to assist you in answering the medical related questions:

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make and exercise reasoned medical judgements, 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 and 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, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as a Physician Assistant licensee.

"Chemical substances" - This term 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.

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

80. Do you have a medical condition that in any way impairs or potentially impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?

[redacted]

81. In explaining "Yes" answer to the previous question, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

82. Please upload any documents you have that are relevant to this matter.

83. Are you currently engaged in the use of alcohol or other chemical substances that potentially or in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety?

[redacted]

84. In explaining a "Yes" answer to the previous question, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

85. Please upload any documents you have that are relevant to this matter.

86. Are you currently engaged in the illegal use of controlled substances?

[redacted]

87. In explaining a "Yes" answer to the previous question, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine.

88. Please upload any documents you have that are relevant to this matter.

Medical condition, treatment, use of chemical or illegal substances:

89. Treating organization:

90. Address:

91. Telephone:

92. Type of diagnosis, condition or treatment - field of practice - use of chemical substances:

93. Dates of illness or dependency (from, to):

94. Dates of treatment (from, to):

95. Name of rehabilitation/professional assistance or monitoring program:

96. Address:

97. Telephone:

98. Contact person at Program:

CONFIDENTIAL ASSISTANCE IS AVAILABLE

Since 1999, part of each license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a service of the Vermont Medical Society. This is a **confidential** program for the identification, treatment and rehabilitation of physicians affected by the disease of substance abuse. For further information about this program, call 802-223-0400 (a confidential line).

Renewal Part IV

Statutory Profile Questions

Vermont law, 26 VSA § 1368, creates a data repository within the Department of Health. Under this law, the Department must collect certain information to create individual profiles on all health care professionals licensed, certified, or registered by the Department pursuant to Title 26 of the VSA. Please try to answer the following questions as best as you can.

99. **Criminal Convictions** [See 26 VSA § 1368(a)(1)] Have you been convicted of any crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets)? For purposes of this question, “convicted” means that you pleaded guilty or that you were found adjudged guilty by a court of competent jurisdiction.

No

100. **Criminal Convictions** [See 26 VSA § 1368(a)(1)] Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted. For purposes of this question, “convicted” means that you pleaded guilty or that you were found adjudged guilty by a court of competent jurisdiction. **Please provide copies of papers fully documenting the convictions.**

Date of Conviction	Court of Conviction	City	State	Description

101. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)]
Have there been any charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without finding by a court of competent jurisdiction?

No

102. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)]
Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continue without finding by a court of competent jurisdiction.

Date of Charges	Court	City	State	Description of Charges

103. Vermont Board of Medical Practice Matters [See 26 VSA § 1368(a)(3)]
Have there been any formal charges served, findings, conclusions, and/or orders of the Board of Medical Practice (including stipluations), and/or final disposition of such matters by the courts, if appealed?

No

104. Vermont Board of Medical Practice Matters [See 26 VSA § 1368(a)(3)]
Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipluations), and final disposition of such matters by the courts, if appealed.

Date	Final Disposition Summary

105. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]
Have there been any formal charges served against you by licensing or certification authorities of other states?

No

106. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]
Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states. **Please provide copies of papers fully documenting these matters.**

Date of Disposition	Licensing Authority	City	State	Description of Disposition

Restriction of Hospital Privileges [See 26 VSA § 1368(a)(5)]

107. Have your hospital privileges ever been revoked or involuntary restricted in relation to competence or character?

No

108.
A. Revocation/Involuntary Restrictions

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you. Please upload copies of papers fully documenting these matters.

Date of Restriction	Hospital Name	State	Nature of Restriction	Reason for Restriction

109. Have your hospital privileges ever been restricted, or have you ever resigned or not renewed your medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital?
No

110.
B. Other Restrictions
Please provide a description of all resignations from, or nonrenewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital. Please upload copies of papers fully documenting these matters.

Date	Hospital Name	State	Action	Nature of Action	In Lieu or In Settlement

111. **Medical Malpractice Court Judgments/Settlements [See 26 VSA § 1368(a)(6A)]** Have you ever been involved in a Malpractice Liability Claim? Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you, and any pending malpractice cases.
No

112.
A. Judgments
Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you, and any pending malpractice cases.

Date of Judgment

113.
B. Settlements Please provide a description of all settlements of all pending settlements and settlements of medical malpractice claims against you. Please complete the below information and provide copies of papers fully documenting these matters.

Date Of Settlement

Medical Malpractice Claim
For each response provided in the previous Medical Malpractice Judgements and/or Settlements questions you must complete the form located **here**. Please download the form, complete it for each response, and then upload to each respective response. **This information is required for each and every response provided for Judgements and/or Settlements.**

Appointments/Teaching [See 26 VSA § 1368(a)(12)]
Note: Providing the following Appointments and Teaching information is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

114. **A. Appointments** Please provide information about your appointments to medical school or professional school faculties.

School	City	State	Nature of Appointment	Year Started	Year Ended

115. **B. Teaching** Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years.

School/Institution	City	State	Nature of Teaching	Year Started	Year Ended

116. Publications [See 26 VSA § 1368(a)(13)]
Note: Answering this question is optional. By answering, you are granting permission to have this information posted on the web.
Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years.

Title	Publication	Publication Date

117. Activities [See 26 VSA § 1368(a)(14)]
Note: Answering this question is optional. By answering, you are granting permission to have this information posted on the web.
Please provide information regarding your professional or community service activities and awards.

Activity or Award

118. Provide the following information for each practice location. Be sure to indicate which is to be your primary practice location.

Practice Name	City	State	Primary Practice	Languages	Accepts Medicaid?	Accepts New Medicaid Patients?
Planned Parenthood of Northern New England	Barre	Vermont	Yes		Yes	Yes
Granite City Medical Associates	Barre	Vermont	Yes		Yes	No

Statement of Good Standing

119.

State of Vermont
Department of Health
Board of Medical Practice

Statement of Good Standing

Regarding Any Unpaid Judgment Issued by the Judicial Bureau or District Court for Fines or Penalties for a Violation or Criminal Offense

I hereby state that either:

A. This does not apply to me because I don't have any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense, or

B. I am in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense.

I understand that a license may not be issued or renewed without such a statement.

I further understand that, for the purposes of this section, a person is in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense if:

1. 60 days or fewer have elapsed since the date a judgment was issued; or
2. the person is in compliance with a repayment plan approved by the judiciary.

Yes

120. Date:
11/15/2012

Child Support, Taxes

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT AND TAXES

You must answer these questions.

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)

121. You must select 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.

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business shall 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 and payable and all returns have been filed, 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)

122. You must select one of the two statements below regarding taxes:

I hereby certify, under the pains and penalties or 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.)

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

123. Social Security Number:

[redacted]

124. Date of Birth:

[redacted]

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

Yes

126. Date:

11/15/2012

Renewal Payment

127. You must choose one of the following payment options to complete your application. Note: Your application will NOT be processed by the Medical Board until payment is received. If you are a commissioned officer on active duty in the armed forces, you must submit a copy of your current active duty orders.

Self / Credit Card

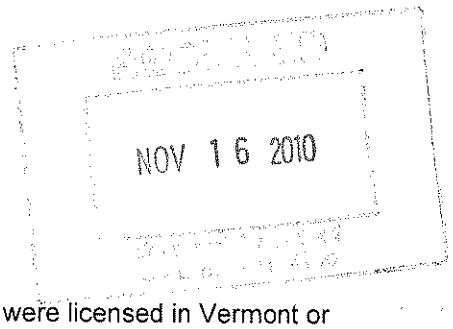
Review

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, PO Box 70
Burlington VT 05402-0070
802 657-4220 or 800-745-7371

2010 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

License Number: 042-0008297



1. **Your legal name:**

   Allegra Lucille Shumway

   a. Have you ever legally changed your name? ___Yes _X_ No

   If yes, enter your former name and any other name(s) under which you were licensed in Vermont or elsewhere in the past two years;

   Last Name | First Name | Middle Name: | Suffix

   b. Indicate your name, as it should appear on your license:

   Shumway | Allegra | Lucille |
   Last Name | First Name | Middle Name: | Suffix

2. **Your Date of Birth:** [redacted]

3. **Mailing Address and email address:**

   [redacted]

4. **Work Address:**

   [redacted]

   79 Coventry ST Suite 3
   Newport VT 05855

5. **Please check your preferred mailing address:** ~~Home~~ **Work** Please use work address
   NOTE: ***The mailing address will be publicly listed on the Board's web site.***

6. **Home Telephone Number with Area Code:** [redacted]

7. **Work Telephone Number with Area Code:** (802) 334-5822

8. **E-mail address (if not appearing in #3):** [redacted]

Please check here if the Department of Health may use this e-mail address to send you public health information.

□ yes □ no

PART II

9. Were you in active clinical practice in Vermont in the past 12 Months? ☒ yes □ no

10. Do you hold, or have you ever held, a medical license (including temporary) in any other state?
☒ yes □ no

If yes, complete the section below and attach additional pages if necessary.

State	License Number	Type of License	Date Issued	Status (Active, Inactive, or other, conditioned, restricted, limited)
NH 2008	14395	Medicine	4/1/2009	Active

If necessary, please use an additional sheet and check this box: .....□

11. Medical Professional Schools [26 VSA § 1368(a)(7)]

Please provide the names of medical professional schools you attended and the dates of graduation if not listed below.

UNIVERSITY OF VERMONT, Burlington, VT
1988

12. Graduate Medical Education/Residency [26 VSA § 1368(a)(8)]

Please provide information about any graduate medical education/residency attended or completed that is not listed below.

Fletcher Allen Health Care ,VT
Family Practice
1991

If necessary, please use an additional sheet and check this box: .....□

13. Specialty Board Certification [26 VSA § 1368(a)(9)]

Please verify the following information regarding your specialty board certification and update as necessary using the attached Specialty Codes List.

Family Practice
American Board of Family Practice
1991, 1998

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
0601		☒ yes □ no	American Board of Family Practice	1991	1998
		□ yes □ no			

14. Years of Practice [26 VSA § 1368(a)(10)]

Month and year you started practicing as a physician? Jul-91

15. Hospital Privileges [26 VSA § 1368(a)(11)] ☒ Check here if none

List all information for all hospitals where you currently have hospital staff privileges if not listed below:

None reported

ANY "YES" RESPONSE TO THE QUESTIONS BELOW MUST BE FULLY EXPLAINED ON THE ENCLOSED FORM A.

16. Have you ever applied for and been denied a license to practice medicine or any other healing art?

□ yes ☒ no

17. Have you ever withdrawn an application for a license to practice medicine or any other healing art?

□ yes ☒ no

18. Have you ever voluntarily suspended, surrendered or resigned a license to practice medicine or any other healing art in lieu of disciplinary action or any other reason?

□ yes ☒ no

19. Are any formal disciplinary charges pending or has any disciplinary action ever 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

20. Have you ever been denied the privilege of taking an examination before any state medical examining board?

□ yes ☒ no

21. Have you ever discontinued your education, training, or clinical practice for a period of more than three months?

□ yes ☒ no

22. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?

□ yes ☒ no

23. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?

□ yes ☒ no

24. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?

□ yes ☒ no

25. Do you currently or have you ever prescribed any prescription medication over the internet? This does not include prescribing you would do using electronic medical records in your practice.

□ yes ☒ no

26. Are you presently or have you ever been a defendant in a criminal proceeding?

□ yes ☒ no

PART III

(Unless otherwise ordered by a court, your responses to the questions in Part III are considered exempt from public disclosure.)

Any "yes" response to the questions below must be fully explained on the enclosed Form A.

27. To your knowledge, are you the subject of an investigation by any other licensing board under which you have not been charged as of the date of this application?

[redacted]

28. To your knowledge, are you presently the subject of a criminal investigation under which you have not been charged?

[redacted]

The following definitions are provided to assist you in answering questions 29 through 31.

"Ability to practice medicine" - This term includes:

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, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as a licensee.

"Chemical substances" - This term 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.

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

29. Do you have a medical condition that potentially or in any way impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?

[redacted]

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

30. Are you currently engaged in the use of alcohol or other chemical substances that potentially or in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety?

[redacted]

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a

monitoring program.

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

CONFIDENTIAL ASSISTANCE IS AVAILABLE

Since 1999, part of each license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a service of the Vermont Medical Society. This is a **confidential** program for the identification, treatment and rehabilitation of physicians affected by the disease of substance abuse. For further information about this program, call 802-223-0400 (a confidential line).

The following questions are required by Vermont law, 26 VSA § 1368, to update and maintain a data repository within the Department of Health and to make individual profiles on all health care professionals licensed, certified, or registered by the Department available to the public. Your physician profile is located at the following website http://healthvermont.gov.

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 32 through 37 have changed since your last application. We cannot process your application without them.

32. **Criminal Convictions** [26 VSA § 1368(a)(1)] ☒ Check here if none

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past ten years not listed below. **Please provide complete copies of documentation for each matter.**

None reported

33. **Nolo Contendere/Matters Continued** [26 VSA § 1368(a)(2)] ☒ Check here if none

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction not listed below. **Please provide complete copies of documentation for each matter.**

None reported

34. **Vermont Board of Medical Practice Matters** [26 VSA § 1368(a)(3)] ☒ Check here if none

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed.

None reported

35. **Licensing or Certification Authority Matters in Other States** [26 VSA § 1368(a)(4)]
☒ Check here if none

Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states, if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

36. **Restriction of Hospital Privileges** [26 VSA § 1368(a)(5)]

A. **Revocation/Involuntary Restrictions** ☒ Check here if none

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

B. **Other Restrictions** ☒ Check here if none AS 11/18/2010

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

37. **Medical Malpractice Court Judgments/Settlements** [26 VSA § 1368(a)(6A)]

A. **Judgments** ☒ Check here if none AS 11/18/2010

Please complete the attached Form A and provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you within the past 10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. **Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.**

None reported

B. **Settlements** ☒ Check here if none AS 11/18/2010

Please provide a description of all settlements of medical malpractice claims against you within the past 10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. **Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.**

None reported

38. **Appointments/Teaching** [26 VSA § 1368(a)(12)]

Note: Answering #38 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

A. Appointments ☐ Check here if none

Please provide information about your appointments to medical school or professional school faculties if not listed.

None reported

B. Teaching ☐ Check here if none

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years if not listed.

Allegra Shumway, MD

None reported

39. **Publications:** [26 VSA § 1368(a)(13)] ☒ Check here if none

Note: Answering #39 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years if not listed.

40. **Activities** [26 VSA § 1368(a)(14)] ☐ Check here if none

Note: Answering #40 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your professional or community service activities and awards if not listed.

None reported

41. **Practice Setting** [26 VSA § 1368(a)(15)] ☐ Check here if none

What is the location of your primary practice setting?

~~St Johnsbury, VT~~ Planned Parenthood of Northern New England

42. **Translating Services** [26 VSA § 1368(a)(16)] ☐ Check here if none

Please identify any translating services available at your primary practice location.
Are any translating services available at your primary practice location?

If yes, please describe here the translating services available:

None

43. **Medicaid/New Patients** [26 VSA § 1368(a)(17)]

A. **Medicaid participation**

Do you participate in the Medicaid program? ☒ yes ☐ no

B. **New Medicaid Patients**

Are you currently accepting new Medicaid patients? ☒ yes ☐ no

Part V

Reminder - You must also complete the enclosed Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions regardless of whether or not you have children

I hereby affirm that the information provided above is true and accurate, and that I have answered the questions to the best of my knowledge and ability.

Date: Nov 7, 2010 _____ Applicant's Signature

Physician Profile Update

26 VSA § 1368 requires the Department to provide you with a copy of your profile prior to the initial release to the public and each time your profile is modified or amended. We intend to use the information in your renewal application for your physician profile.

Please let us know whether you wish to have your profile omit the following information by checking the "OMIT" box below. If the box is not checked, we will include the information in your profile:

OMIT FROM PROFILE

- ☒ Appointments to medical school or professional school faculties, and an indication as to whether you have had a responsibility for teaching graduate medical education within the last 10 years.
- ☒ Information regarding publications in peer-reviewed medical literature within the last 10 years.
- ☒ Information regarding professional or community service activities and awards.

Again, thank you for your cooperation.

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

(Questions 16 and 17) Withdrawal or denial of License - Attach documents

State_____ Year_____
Circumstances under which license was withdrawn, denied, revoked, not renewed, or otherwise terminated_____

_____

(Question 18) Voluntarily surrendered or resigned a license to practice medicine or any healing art - Attach documents

State_____ Year_____

Circumstances_____

_____

(Question 19) Disciplinary charges or action - 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 of rights 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_____

_____

_____

(Question 20) Denial of examination privileges - Attach documents

State_____ Year_____

Circumstances under which examination privileges denied _____

_____

_____

(Questions 21 and 22) Residency Training Program(s) not completed - discontinued education, training, practice - Attach documents

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances _____

_____

(Question 23) Affecting Health Care Institution Staff Privileges, Employment or Appointment - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances _____

_____

(Question 24) Privilege to prescribe controlled substances - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

_____

_____

_____

(Question 25) Internet prescribing

Please provide a general description of your practice of internet prescribing

_____

_____

(Questions 26 and 28) Criminal Investigation - Proceeding - Attach documents

Court _____

City and State _____

Charge _____

Description _____

_____

_____

Status _____

_____

Conviction? _____ Yes _____ No Date _____

Plea? _____ Yes _____ No Date _____

(Question 27) Investigation by any other licensing board - Attach documents

Name of Licensing Board _____ Date _____

Location of Licensing Board _____

Circumstances _____

(Questions 29-30) Medical condition, treatment, use of chemical or illegal substances

Treating organization _____

Address _____ Telephone _____

Type of diagnosis, condition or treatment - field of practice - use of chemical substances

_____

_____

Dates of illness or dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance,or Monitoring Program _____

Address _____ Telephone _____

Contact person at Program _____

(Question 37) Medical Malpractice Claim

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):

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

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 or 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 appeal filed (month, day, year)
_____/_____/_____
Date appeal 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 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:

_____

_____

_____

VERMONT'S PRESCRIPTION CONFIDENTIALITY LAW
Prescriber Data-Sharing Program

CONSENT FORM

Under Vermont's Act 80, a law passed in 2007, pharmaceutical companies may not use information that identifies prescribers in prescription drug records for marketing or promoting prescription drugs unless the prescriber consents. The text of the law, which took effect July 1, 2009, is found at 18 V.S.A. § 4631. The Vermont Attorney General has links to the statute and further information about the implementation of this law on the website. Go to http://www.atg.state.vt.us/ and follow the link for Prescribed Products and then look for information on Prescription Confidentiality.

If you wish, you may permit your identifying information in drug prescription records to be used for marketing and promoting of prescription drugs. The only way to grant permission is by giving your consent in the manner described below. If you do not consent, your identifying information from prescription drug records cannot be used for marketing or promoting prescription drugs.

The list of everyone who has a current consent on file with their licensing board, as well as consent and revocation forms are available online at: http://healthvermont.gov/hc/med_board/bmp.aspx. You may check this site at any time to confirm your status. If you consent, your consent is effective until you revoke your consent. **If you wish to make a change, you may download consent and revocation forms at the web address above. If you do not have web access, you may contact your licensing board for assistance.**

How to consent: If you want to consent to the use of your information for marketing and promoting prescription drugs, sign your name, complete the form, and return it as part of your license application or license renewal. If you consent, your name will be included on the list of Vermont prescribers who have consented, and your information may be used for marketing and promoting prescription drugs. You may also complete this form at any time and mail it to your licensing board.

If you do not consent: If you do not wish your identifying information in prescription drug records to be used for marketing or promoting prescription drugs, you need do nothing.

If you choose not to consent, please leave this form blank.

* *

To consent, sign, date, and fill out the form below. Return the completed form with your license application or license renewal or mail the form to **Board of Medical Practice, PO Box 70, Burlington, VT 045470-0070.**

I consent:

_____ _____
Signature Date

_____
Name (printed or typed)

_____ _____
License type (profession) Vermont License Number

_____
Mailing Address

_____
City, State, Zip

VERMONT'S PRESCRIPTION CONFIDENTIALITY LAW
Prescriber Data-Sharing Program

REVOCATION OF CONSENT FORM

If at any time a prescriber wishes to revoke his or her consent to use of prescriber identifiable drug information, the revocation must occur using this form.

I _____ **(print name)** hereby **revoke** my consent to the use of regulated records which include prescription information containing my prescriber-identifiable data for the purpose of marketing or promoting a prescription drug.

_____ _____
Signature Date

_____
Name (printed or typed)

_____ _____
License type (profession) Vermont License Number

_____
Mailing Address

_____
City, State, Zip

Please mail your completed form to:

Board of Medical Practice
Vermont Department of Health
PO Box 70
Burlington, VT 05402-0070

State of Vermont

Department of Health

Board of Medical Practice

Statement of Good Standing

Regarding Any Unpaid Judgment Issued by the Judicial Bureau or District Court for Fines or Penalties for a Violation or Criminal Offense

I hereby state that I am in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense.

I understand that a license may not be issued or renewed without such a statement.

I further understand that, for the purposes of this section, a person is in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense if:

(1) 60 days or fewer have elapsed since the date a judgment was issued; or

(2) the person is in compliance with a repayment plan approved by the judiciary.

Signature: _____ Date: Nov 7, 2010

PLEASE NOTE:

In accordance with 4 V.S.A. §1110 (b), you must sign, date, and return this **Statement of Good Standing** in order for us to renew your license. Thank you.

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

You must answer questions 1, 2, and 3.

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 dues 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 shall 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 and payable and all returns have been filed, 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 regarding taxes:

☒ I hereby certify, under the pains and penalties or 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".

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 three 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 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.

or

☒ I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #* [redacted] Date of Birth [redacted]

* The disclosure of your social security number is mandatory, it 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 Vermont 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 and that I understand providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant _____ Date Nov 7, 2010

VERMONT

[redacted]

Department of Health
Board of Medical Practice
108 Cherry Street - PO Box 70
Burlington, VT 05402-0070
healthvermont.gov

[phone] 802-657-4220
[toll free] 802-745-7371
[fax] 802-657-4227

NOV 22 2010

Date: November 16, 2010

Dear Physician:

Your 2010 Physician's License Renewal application has been received by this office and cannot be processed until the following information is received.

- ☐ $500 renewal fee
- ☐ $25 late fee

Application

Part I

- ☐ Item 1
- ☐ Item 2
- ☐ Item 3
- ☐ Item 4
- ☐ Item 5
- ☐ Item 6
- ☐ Item 7
- ☐ Item 8

Part II

- ☐ Item 9
- ☐ Item 10
- ☐ Item 11
- ☐ Item 12
- ☐ Item 13
- ☐ Item 14
- ☐ Item 15
- ☐ Item 16
- ☐ Item 17

Part III

- ☐ Item 18
- ☐ Item 19
- ☐ Item 20
- ☐ Item 21
- ☐ Item 22
- ☐ Item 23
- ☐ Item 24
- ☐ Item 25
- ☐ Item 26
- ☐ Item 27
- ☐ Item 28
- ☐ Item 29
- ☐ Item 30
- ☐ Item 31

Part IV

- ☐ Item 32
- ☐ Item 33
- ☐ Item 34
- ☐ Item 35
- ☐ Item 36A
- ☑ Item 36B
- ☑ Item 37A
- ☐ Item 37B
- ☐ Item 38A
- ☐ Item 38B
- ☐ Item 39
- ☐ Item 40
- ☐ Item 41
- ☐ Item 42
- ☐ Item 43A
- ☐ Item 43B

Part V

- ☐ Date
- ☐ Signature

Child Support, Taxes, Unemployment Compensation Statement

- ☐ Number 1 – check one of the two statements
- ☐ Number 2 – check one of the two statements
- ☐ Number 3 – check one of the three statements
- ☐ Sign, Date, SSN, DOB

Additional Forms

- ☐ Completed form A
- ☐ Statement of Good Standing

The page(s) that need(s) completion (if applicable) is/are attached. Please complete the necessary item(s), initial, date and return as soon as possible so that processing may be finalized. **The information cannot be faxed.**

Thank you.

Sincerely,
Medical Practice Board

Enclosures